PRINTED: 02/13/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HLTH & RETILINGOLNTON    CALL   DESCRIPTION   STATE APPROVED   COMPANIANT   PREFIX   PRECIDED BY TULL   PREFIX   PRECIDENCE   PREFIX   PRECIDENCE   PRECIDED BY TULL   PREFIX   PRECIDENCE   PREFIX   PRECIDENCE   PRECIDENCE   PREFIX   PREFIX   PREFIX   PREFIX   PREFIX   PRECIDENCE   PREFIX   PREFI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			RVEY ED	
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HLTH & RETLINCOLNTON  SUMMANY ENTERIEST OF PERCENCESS PREETY TAGS  PREETY TAGS  FOOD  INITIAL COMMENTS  FOOD  INITIAL COMMENTS  No deficiencies were cited as a result of CINV investigation. Event ID #ROX511. F 157  483.10(b)(11) NOTIFY OF CHANGES (Another couling physician intervention; a significant change in the resident which results in linjury and has the potential for requiring physician intervention; a significant change in the resident's physician; is in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment; or a decision to transfer or discharge the resident from the facility as specified in §483.15(a).  The facility must also promptly notify the resident and, if known, the resident to require prosentative or interested family member where is a change in room or roommate assignment as specified in §483.15(a).  The facility must also promptly notify the resident and, if known, the resident segal representative or interested family member where is a change in trom or roommate assignment as specified in §483.15(a).  The facility must also promptly notify the resident and, if known, the resident segal representative or interested family member when there is a change in trom or roommate assignment as specified in §483.15(a).  The facility must also promptly notify the resident and, if known, the resident segal representative or interested family member when there is a change in trom or roommate assignment as specified in §483.15(a)(2); or a change in resident ingits under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's place.  Measures put in place to ensure that the alleged deficient practice does not recur include: The DON will conduct inservices		Steam Heather		A. BUII	DING			c l	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE (IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAGE CROSS-REFERENCED TO THE APPROPRIATE			345250	B. WN	G		2		
FOOD INITIAL COMMENTS  No deficiencies were cited as a result of CINV investigation. Event ID #ROX511.  F 157  A53.10(b)(11) NOTIFY OF CHANGES (INJURY/DECINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an existing form of treatment), or a decision to transfer or discharge the resident's englar epresentative or interested family member when there is a change in room or roommate assignment as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident or change in resident from the facility as specified in specified in §483.16(a)(2); or a change in resident family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident fights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's family member.			NTON	·	51	15 S GENERALS BLVD			
No deficiencies were cited as a result of CINV investigation. Event ID #ROX511.  F 157  K93-D  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident reports had documentation of responsible party notification. All incident reports had documentation of responsible party notification. Face sheets were audited for all residents and were current and in place.  • Measures put in place to ensure that the alleged deficient practice does not recur include: The DON will conduct inservices	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION	
investigation. Event ID #ROX511. F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatmently; or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.16(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  F 157  F 157  • The family member (son) for Resident #209 was notified 1/13/2013 of the fall on 1/11/13, was notified on 1/13/2013 of the fall on 1/12/2013, and was notified on 1/13/2013 of the fall on	F 000	INITIAL COMMENTS		F	000				
for Licensed staff to ensure that per the facility policy for Incident		investigation. Event I 483.10(b)(11) NOTIF' (INJURY/DECLINE/R)  A facility must immed consult with the reside known, notify the resion an interested family accident involving the injury and has the polintervention; a signific physical, mental, or p deterioration in health status in either life threlinical complications significantly (i.e., a nexisting form of treatm consequences, or to treatment); or a decise the resident from the §483.12(a).  The facility must also and, if known, the resor interested family mechange in room or rospecified in §483.15(resident rights under regulations as specifications.  The facility must record the address and phores.	D #ROX511. Y OF CHANGES GOOM, ETC)  iately inform the resident; ent's physician; and if dent's legal representative y member when there is an e resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a n, mental, or psychosocial reatening conditions or ); a need to alter treatment red to discontinue an ment due to adverse commence a new form of ion to transfer or discharge facility as specified in  promptly notify the resident ident's legal representative member when there is a mmate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of  rd and periodically update me number of the resident's	F	157	<ul> <li>The family member for Resident #209 was notified on 1/13/2013 fall on 1/12/2013, and was notified on 1/13/2013 of the on 1/13/201. The resident discharged home with fam 1-2013.</li> <li>The facility identified by the alleged definition practice by completing an all incident reports for the days to ensure there was documentation of responsing party notification. All incident reports had documentation responsible party notifications where audited for all residents and were current place.</li> <li>Measures put in place ensure that the alleged definition processor in the days to ensure the the the alleged definition.</li> </ul>	ified /11/13, 3 of the she fall illy on 2- led other al to be ficient audit for last 90 ible ent n of on. Face and in ace to ficient lude: vices e that	2:28-61	

Wymuc)

Event ID: ROX511

Preparation and/or execution of this plan 35 pa

Any deficiency statement ending with an asterisk (\*) denotes a descency which the institution may be excused from correcting providing it is determined that the other safeguards provide sufficient protection to the patients. (See instructions) Except or nursing nones, little fill dings stated above are disclosable and days following the date of survey whether or not a plan of corrections provided. For nursing names, the papping findings and as the constitution of the facility. If deficiences are cited, an approved plan of correction is requisited to positive and constitutions.

The plan of correction of this plan.

The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statically provided the prov

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			RVEY ED	
2.53#.30#.32.45#.			A. BUII	JILDING		C		
		345250	B. WN	G		01/31/2013		
	ROVIDER OR SUPPLIER	ITON		51	EET ADDRESS, CITY, STATE, ZIP CODE 15 S GENERALS BLVD INCOLNTON, NC 28093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 157	by: Based on observation interviews with staff, in facility failed to notify three falls for 1 of 4 staff or notification of chart.  The findings are: Resident #209 was addiagnosis including hydiabetes mellitus. An Set (MDS) dated 12/2 #209 was moderately.  Observation of Reside front of her chart revewas a family member.  Review of Resident #Fall reviews for falls of 01/12/13 at 8:45PM, arevealed Resident #2 not notified after the fall threview with Reside on 01/28/13 at 2:45 Pheen called after the fall threview with Reside on 01/13/13. Resident #stated she had been the staff had been unable face sheet and had not Resident #209's response.	ris not met as evidenced  ns, record reviews, and residents, and families, the the family of a resident with ampled residents reviewed nge (Resident #209).  dmitted on 12/18/12 with repertension, dementia, and admission Minimum Data 45/12 indicated Resident cognitively impaired.  ent #209's face sheet on the aled her responsible party  209's Interdisciplinary Post on 01/11/13 at 8:40PM, and 01/13/13 at 7:00PM 09's responsible party was alls.  nt #209's responsible party M revealed she had not 3 falls that had occurred f 01/11/13 through 209's responsible party old by a nurse that weekend to locate Resident #209's ot known how to contact	F	157	/Accident Reporting for Rethe responsible party is not all incidents as soon as postand that nurse documents responsible party notificat nurse will document family notification on the incident The DON/ADON or SDC with all incident reports Mondathrough Friday to ensure the documentation of notificatincidents and chart review/findings on an Administrative Nurse World The DON/ADON/SDC will padditional 1:1 education for observed occurrence of fair document notification. Medical records will conduct an autensure that a face sheet is medical record.  The Administrator DON review the findings of Administrative Nurse Work will monitor the effectiventhe above action plan for notification of change in the monthly QAPI meeting begored 2-14-2013 for 3 months an adjust the plan as indicated QAPI meeting monthly.	otified for ssible sthe sion. The yout report. Ill check by he tion of sksheet. Or ovide or any illure to edical adit to in each and ssheet, ess of the ginning d will		

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Event ID: ROX511

Facility ID: 922998

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Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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	ENT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
	·•	345250	B. WNG				C
NAME OF PRO	OVIDER OR SUPPLIER	040200	D. WINO	070	FET LEBELS OF LETTE TO COPE	01/	31/2013
	R HLTH & RET/LINCOLN	ITON		51	EET ADDRESS, CITY, STATE, ZIP CODE 16 S GENERALS BLVD INCOLNTON, NC 28093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	90000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 170 SS=C	had not been able to a sheet and therefore do information for Reside The interview further a responsible party was the 3 falls that had occurrence with the Direct at 1:27 PM revealed in nurses would notify the responsible person of 24 hours of each fall. 483.10(i)(1) RIGHT TO SEND/RECEIVE UNCURS The resident has the recommunications, inclusively receive mail.  This REQUIREMENT by:  Based on resident and facility failed to deliver residents in the facility. The findings are:  Resident #84 was addrog/13/2006. The lates 01/02/2013 assessed or long-term memory in the side of the	uring the weekend of 13/13. Nurse #1 stated they ocate Resident #209's face id not have contact ent #209's responsible party. revealed Resident #209's revealed Resident #209's revealed Resident #209's responsible party. The revealed Resident #209's revealed Resident weekend.  Pettor of Nursing on 01/31/13 revere expectation was that rephysician and the resident who falls within a resident who falls within regist to privacy in written regist to privacy in written regist to send and that is unopened.  It is not met as evidenced red staff interviews, the remail on Saturday for remail on Saturday for resident with no short problems.  AM during an interview the		157	The US Post Office of Lincolnto has reported to the Administrathat mail has not ever been delivered to the facility and the mail delivery to the facility will start Monday through Saturda beginning Tuesday 2-20-13. The Post Master also stated that effective August 5th, 2013, mawill only be delivered to the famonday through Friday as the Postal Service is canceling all Saturday mail delivery on said date. It should be noted that newspapers are delivered to the facility seven days a week and delivered every day to the residents with newspaper subscriptions.  The facility met with the Resident Council on 1/29/2013 their regular monthly meeting. Activity Director reviewed of Resident Rights, including mail delivery, with the residents in	ator at I I I I I I I I I I I I I I I I I I	2-29·13

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Event ID: ROX511

Facility ID: 922998

If continuation sheet Page 3 of 9

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required in the provisions of federal and class law

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OLIVILIN	OT ON WEDIONINE &	VILDICAID SERVICES				OMB NO. 0938-	0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345250	B. WNG			C 01/31/2013	
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HLTH & RET/LINCOLNTON		•	5	EET ADDRESS, CITY, STATE, ZIP CODE 15 S GENERALS BLVD INCOLNTON, NC 28093	0.1101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	Saturdays as that dep Saturdays. Resident be nice to get mail on around the holidays with mail.  On 01/29/2013 at 3:33 revealed one of her remail to the residents. department carried our residents Monday through one from the facility with the main post office of the residents on Sawas a mailbox present post office box with out the facility mailbox. The facility on Saturda 483.20(b)(1) COMPRIASSESSMENTS  The facility must conduct a comprehensive, according to the residents on Sawas and from the Facility on Saturda 483.20(b)(1) COMPRIASSESSMENTS  The facility must conduct a comprehensive, according to the facility must conduct a comprehensive, according to the facility must make a comprehensive assessment of a resident assessment in the facility must make a sassessment of a resident assessment in the facility must make a constructional capacity.	delivered at the facility on partment didn't work on #84 further stated it would Saturdays especially when she gets cards in the DPM the Activity Manager esponsibilities was to deliver She confirmed her at mail delivery to the bugh Friday. She stated no rent to collect the mail from an Saturdays.  DO AM in an interview the did there was no mail delivery sturdays. She noted there that the facility however the edithe mail to the facility coasional items coming to the Administrator confirmed the staff member in place to Post Office and bring it to ys.  EHENSIVE  uct initially and periodically urate, standardized ent of each resident's		272	attendance. There were no identified concerns of resident not receiving mail on Saturday.  Measures put in place ensure that the alleged deficied practice does not recur include Activity Director will work even Saturday to ensure that mail is delivered. The Administrator with the continued satisfaction with mail delivery. The Activity Director document residents' satisfaction with mail delivery. The Activity Director document residents' satisfaction will mail delivery in the Resident Council minutes.  The Administrator and Activity Director will review the findings of the monthly Reside Council meeting minutes, monthe effectiveness of the above action plan for the right to recemble mail in the monthly QAPI meeting and adjust the plan as indicated the QAPI meeting monthly for months.  F 272  Corrective action was accomplifor the alleged deficient practic regards to cognitive assessment completing modification of the assessments for Residents #31,	to ent e: ry si vill meir mil will on t eive ing d in 3 ished re in ts by MDS	43

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Facility ID: 922998

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 12		CONSTRUCTION	(X3) DATE	
		a enterior				(	С
		345250	B. WNG			01/	31/2013
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HLTH & RET/LINCOLNTON				51	EET ADDRESS, CITY, STATE, ZIP CODE 16 S GENERALS BLVD INCOLNTON, NC 28093		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	30030	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be Physical functioning a Continence; Disease diagnosis an Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments an Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and Documentation of pa	nographic information; atterns; ing; and structural problems; d health conditions; status;	F	272	and # 218 for the identified M Corrective action was also accomplished for the alleged of practice in regards CAAs by co a significant change in status assessment MDS for Residents # 141.  The facility identified of residents with the potential to affected by the alleged deficie practice for Comprehensive Assessments by completing th following: The Resident Care Management Director (RCMD) conducted an audit of all assessments including admissi comprehensive MDSs for activ resident. MDSs identified with incomplete cognitive assessme will have a modification of the completed based on the CMS Correction guidelines and reco worksheet all modifications completed. The Resident Care Management Director will also	deficien mpletin s other be nt e on and e ents MDS rd on	
	by: Based on record review and staff interviews, the facility failed to complete cognitive assessments included in admission comprehensive Minimum Data Sets (MDS) for 3 of 24 sampled residents. (Residents #31, #85, and #218) The facility also failed to complete Care Area Assessments included in an annual comprehensive MDS for 1 of 24 sampled residents. (Resident #141)				conduct an audit of the CAAs of admission and comprehensive completed in the past 12 mont all active resident. Resident Ca Management Director or MDS Coordinator will correct identified adding a late entry to the CAAs provide the omitted assessment	MDS hs on re ied by	

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and/or execution of this plan a does not constitute admission of the ment by the provider of the ment by the provider of the data as the second of conclusions and definition of the ment of the ment

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CENTER	S FOR WEDICARE &	VIEDICAID SERVICES		-		OMB NO	<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3 3		CONSTRUCTION		SURVEY
		345250	B. WNG				C /31/2013
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	0112013
DDIANCT	D UI TU O DET/I INCOLA	ITON			15 S GENERALS BLVD		
BRIAN CI	R HLTH & RET/LINCOLN			L	INCOLNTON, NC 28093		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	12/18/12 with diagnost dementia and depress admission MDS dated C0100 indicated a Bri Status (BIMS) should MDS review revealed C0200 thru C0400 we score was documented Section C0600 that as assessment for mental not coded. Sections Coalso left blank. Continuation Condition Coordinator verifying were complete.  An interview with the conducted on 01/31/1 confirmed the cognitive #31 was not completed score could not be desthrough C0500, a staff status should have be C0600 through C1000 stated her signature in the MDS was complete computer system used assessments indicated section was complete on the computer to reland did not realize this	admitted to the facility ses including Alzheimer's sion. A review of the id 12/25/12 revealed section ef Interview for Mental be conducted. Further no rating in BIMS sections are coded and no summary and in section C0500. Sked should a staff all status be conducted was c0700 through C1000 were mused MDS review revealed gened by the MDS all sections in this MDS  MDS Coordinator was 3 at 11:10 AM. She are assessment for Resident be she stated if a BIMS termined in sections C0200 assessment for mental and completed in sections be the MDS Coordinator and section Z0500 designated are She explained the detection document MDS detection was incomplete.	F	272	and will record on worksheet CAAs that had a late entry completed.  • Measures put in place ensure that the alleged defici practice does not recur included The Resident Care Managemed Director (RCMD) will provide education to the nurses that completed the cognitive assessments and CAAs that widentified in the audit. This education will be based on the CMS criteria, for the accurate completion of cognitive assessments and CAAs. The Resident Care Management Director (RCMD) will spot-chem MDSs weekly for the complet of cognitive assessments and and record the findings on the calendar.  • The Administrator and Resident Care Management Director (RCMD) will monitor effectiveness of the above act plan for Comprehensive Assessments in the monthly Omeeting and will adjust the plaindicated in the QAPI meeting monthly for 3 months.	e to ent de: ent ere e ck eness CAAs e the ion	
	An interview with the I 01/31/13 at 1:59 PM r	Director of Nursing on evealed her expectation					

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Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts allowed or conclusions set forth in the second of teticiencies. The provider of sides because a constant sides because and accounted to the provisions or federal and state level.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7/11/03/07/08/07/19/0		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345250	B. WNG		_		C
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HLTH & RET/LINCOLNTON		NTON		STF	REET ADDRESS, CITY, STATE, ZIP CODE 515 S GENERALS BLVD LINCOLNTON, NC 28093	01/	/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	the state of the s	e 6 ssments to be complete and	F	272			
	12/15/12 with diagnost review of the admission review of the admission revealed section CO10 Interview for Mental Strong to the section of the section of the section of the section CO500. See should a staff assessing conducted was not continued the section of t	Status (BIMS) should be MDS review revealed no as C0200 thru C0400 were any score was documented ction C0600 that asked ment for mental status be aded. Sections C0700 also left blank. Continued section Z0500 was signed tor on 12/27/12 verifying all were complete.					
	status should have be C0600 through C1000 stated her signature in the MDS was complet computer system used assessments indicate section was complete on the computer to reland did not realize this.	een completed in sections  D. The MDS Coordinator In section Z0500 designated Ite. She explained the Ite to document MDS Ite the entire cognitive Ite stated she depended Ite the correct information Ite section was not complete.					

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						CIVID IN	7. 0336-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY
		345250	B. WNG				С
		343230	B. WING			01/	31/2013
BRIAN CTR HLTH & RET/LINCOLNTON			5	EET ADDRESS, CITY, STATE, ZIP CODE 16 S GENERALS BLVD INCOLNTON, NC 28093			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	3. Resident #218 wa 12/18/12 with diagnos stroke. A review of a 12/25/12 revealed sea	ssments to be complete and s admitted to the facility ses including history of a n admission MDS dated ction C0100 indicated a	F	272			
	be conducted. Further rating in BIMS section coded and no summarin section C0500. See should a staff assessing conducted was not continued through C1000 were a MDS review revealed.	ntal Status (BIMS) should be MDS review revealed no as C0200 thru C0400 were any score was documented ction C0600 that asked ment for mental status be oded. Sections C0700 also left blank. Continued section Z0500 was signed attor on 12/31/12 verifying all MDS were complete.			à		
	conducted on 01/31/1 confirmed the cognitive #218 was not comple score could not be dethrough C0500, a status should have be C0600 through C1000 stated her signature in the MDS was comple computer system use assessments indicate section was complete on the computer to reand did not realize this.	ve assessment for Resident te. She stated if a BIMS termined in sections C0200 if assessment for mental een completed in sections in the MDS Coordinator in section Z0500 designated te. She explained the d to document MDS					

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						CIVID IN	J. 0330-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 100		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345250	B. WNG				С
		345250	B. WING			01	/31/2013
BRIAN CTR HLTH & RET/LINCOLNTON				5	EET ADDRESS, CITY, STATE, ZIP CODE 15 S GENERALS BLVD INCOLNTON, NC 28093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	correct.	ssments to be complete and	F	272			
	09/05/10 with diagnost psychosis, and depresannual MDS dated 07 care areas triggered a resident. A review of Assessments (CAA) in documentation to expregarding the resident these care areas were care plan. Two of the carried to care plan.	as problematic for the the 9 triggered Care Area evealed insufficient lain the basis for decisions as care plan. Seven of the designated as carried to m were designated as not A review of the Care Area evealed no documentation			r.		
	conducted on 01/31/1 confirmed the CAAs with the CAAs should contitue resident's condition Resident #141's CAAs required information. Stated a nurse assisted during the summer methics nurse's lack of eff CAAs.  An interview with the 101/31/13 at 1:59 PM recommendation of the conductive with the 101/31/13 at 1:59 PM recommendation.	vere incomplete. She stated ain information related to n and needs. She added is did not contain the The MDS Coordinator and with the MDS process onths. She was unaware of iciency with completion of					