### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

| <u> OLIVILI</u>          | OTOR WEDICARE &   | WEDICAID SERVICES   |                    |                   |   | <u>OMB N</u> | <u>0. 0938-0391</u>        |
|--------------------------|---|---|--------------------|-------------------|---|--------------|----------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                    |                   | CONSTRUCTION  | * · · ·      | E SURVEY<br>PLETED         |
|                          |   | 345362  | B. WNG             |                   |   | 06           | 5/27/2013                  |
|                          | ROVIDER OR SUPPLIER   | EMENT/CABARRUS  |                    | 25                | EET ADDRESS, CITY, STATE, ZIP CODE<br>0 BISHOP LANE<br>DNCORD, NC 28025   |              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | BE           | (X5)<br>COMPLETION<br>DATE |
| F 156<br>SS≃B            | 1   | 33.10(b)(1) NOTICE OF<br>RVICES, CHARGES  | F                  | 156               |   |              | 7/25/13                    |
|                          | and in writing in a langunderstands of his or regulations governing responsibilities during facility must also provunotice (if any) of the Signification of the Actimade prior to or upon resident's stay. Receany amendments to it writing.  The facility must informentiated to Medicaid be of admission to the nuresident becomes eligitems and services under which the resident matcher items and services under which the resident with the items and services inform each resident with items and services (i)(A) and (B) of this services (i)(A) and (B) of this service including any charges under Medicare or by  The facility must furnis legal rights which including any charges under Medicare or by | m each resident before, or on, and periodically during services available in the for those services, for services not covered the facility's per diem rate. |                    | R the record of F | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.  156 Notice of Rights, Rules, ervices and Charges  Criterial esident #44 was educated on the State Agency contact information regarding complaint exporting on 7/19/13. The Administrator verified the acility's posting of State agency contact information egarding complaint reporting on 7/19/13. |              | (X6) DATE                  |

Any deficiency statement enting with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards prowide soficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(X5) COMPLETION DATE

| DEDART!                  | AENT OF HEALTH AN   | ID HUMAN SERVICES  |                           |  | FORM APPR<br>OMB NO. 0938    | २०\<br>8-0 |
|--------------------------|---|--|---------------------------|--|------------------------------|------------|
| CENTERS                  | FOR MEDICARE &  | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE A. BUILDING | CONSTRUCTION   | (X3) DATE SURVE<br>COMPLETED |            |
| AND PLAN OF              | CORRECTION  | 345362   | B. WNG                    |  | 06/27/20                     | 13         |
| NAME OF PR               | OVIDER OR SUPPLIER  | 343362   | STR                       | EET ADDRESS, CITY, STATE, ZIP CODE<br>50 BISHOP LANE   |                              |            |
| BRIAN CE                 | NTER HEALTH & RETIF   | REMENT/CABARRUS  | C                         | ONCORD, NC 28025   |                              | (X5)       |
| (X4) ID<br>PREFIX<br>TAG | A ALL DEFICIENT   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  | 3E                           |            |
| F 156                    | A description of the funds, under paragram A description of the for establishing elig the right to request 1924(c) which dete non-exempt resour institutionalization a spouse an equitable cannot be consider toward the cost of medical care in his down to Medicaid A posting of name numbers of all per groups such as the agency, the State ombudsman progradvocacy network unit; and a statem complaint with the agency concerning misappropriation facility, and non-directives required.  The facility must name, specialty, physician responses | manner of protecting personal aph (c) of this section;  requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community the share of resources which red available for payment the institutionalized spouse's or her process of spending eligibility levels.  s, addresses, and telephone tinent State client advocacy e State survey and certification licensure office, the State ram, the protection and and the Medicaid fraud control tent that the resident may file a e State survey and certification of resident property in the compliance with the advance | •                         | Criteria 2 All residents have the potential to be affected by this alleged deficient practice. Notification of the State Agency contact information will be provided to current residents and families via mail enclosed with the July financial statement.  Criteria 3 The Activities Director will update the Resident Council Meeting Agenda by 7/25/13 to include the review of State Agency contact information regarding complaint reporting. Resident Council Meeting will be held by 7/25/13 to update current attendees on State Agency contact information regarding complaint reporting. The Administrator, Director of Nursing or Activities Director will randomly audit 5 residents per week for 12 weeks to verify understanding of availability of State Agency contact information formation. | A<br>be<br>nt                |            |

applicants for admission oral and written

information about how to apply for and use Medicare and Medicaid benefits, and how to

receive refunds for previous payments covered by

State Agency contact information

and document these audits on the

Opportunities will be corrected

by the Administrator or Activities Director daily as identified during these random

regarding complaint reporting,

monitoring tool.

audits.

| ENTERS                   | FOR MEDICARE DEFICIENCIES   | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE CON                      |  | (X3) DATE<br>COMP | LETED              |
|--------------------------|---|--|--|--|-------------------|--------------------|
| D PLAN OF                | CORRECTION  | IDENTIFICATION NUMBER:   |  |  | 06/               | 27/2013            |
|                          |   | 345362   | B. WNG                                 | THE CODE   |                   |                    |
|                          | OVIDER OR SUPPLIER  | TO A DADDIIS   | 250 B                                  | ADDRESS, CITY, STATE, ZIP CODE<br>SISHOP LANE<br>ICORD, NC 28025   |                   |                    |
| BRIAN CE                 | NTER HEALTH & RE  | TIREMENT/CABARRUS  | CON                                    | TROUBLE BLANCE CORRE   | CTION             | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX<br>TAG |   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | ひひじひ ぬこ           | DATE               |
| F 156                    | Continued From p  | page 2   | F 156                                  |  |                   |                    |
|                          | such benefits.  |  |  | <u>Criteria 4</u>  |                   |                    |
|                          | by: Based on reside failed to inform a state contact info 3 residents intervi PM., Resident # Resident Counc to contact the st complaint. She know where the facility.  | ew conducted on 6/26/13 at 3:45 44 stated she went to all of the il meetings and did not know how ate agency if she had a further indicated she did not information was posted in the  | rep<br>As<br>Im<br>Ac<br>Th<br>m<br>as | e results of the audits will borted in the monthly Qual surance Performance approvement meeting by the dministrator for 3 months. The committee will evaluate ake further recommendation indicated.  Pate of Compliance: Pate of Compliance: Pate of Compliance: | e<br>and          |                    |
| F 1!                     | stated she attermeetings. She complaint intak during the admover that inform 483.10(b)(11) I (INJURY/DEC)  A facility must consult with the known, notify or an interested accident involvingury and has intervention; a physical, mendatorication. | inded all the Resident Council indicated the number for the e unit is given to the residents ission process and she did not go nation during the meetings.  NOTIFY OF CHANGES LINE/ROOM, ETC)  immediately inform the resident; e resident's physician; and if the resident's legal representative ad family member when there is an wing the resident which results in the potential for requiring physician a significant change in the resident's tal, or psychosocial status (i.e., a in health, mental, or psychosocial er life threatening conditions or | F 157                                  | Criteria I The Director of Nursin informed the Physician Resident #54 of the midoses of IVIG on 6/28   | n for<br>issed    | 7/25               |

| NTERS                    | FOR MEDICARE &  | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA   |                   | IPLE CONSTRUC  |   | COM   | E SURVEY<br>IPLETED |
|--------------------------|---|--|-------------------|--|---|---|---------------------|
| MENT OF                  | DEFICIENCIES<br>CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDI         | NG   |   |   | 6/27/2013           |
|                          |   | ]<br>345362  | B. WNG            |  |   |   | 012112010           |
| ME OF PRO                | OVIDER OR SUPPLIER  | 04000  |                   | 250 BISHOP   | ESS, CITY, STATE, ZIP CODE<br>LANE  |   |                     |
| SIAN CEI                 | NTER HEALTH & RETIF   | REMENT/CABARRUS  |                   | CONCORD  | ), NC 28025   | SCHON   | (X6)                |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREI<br>TAI | :iX \  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)  |   | COMPLÉTION<br>DATE  |
| F 157                    | Continued From parclinical complication significantly (i.e., a existing form of treatment); or a detthe resident from the \$483.12(a).  The facility must all and, if known, the or interested familic change in room or specified in \$483. resident rights undergulations as specified in \$483. resident rights undergulation rights undergulation rights undergulation rights undergu | ge 3 as); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge ne facility as specified in a specified in paragraph as a specified in paragraph as a specified in paragraph (b)(1) of a specified in paragraph and the resident's a specified in paragraph and the resident's are or interested family member.  The specified in paragraph are specified in paragraph and the resident's are or interested family member.  The specified in paragraph are specified in paragraph and the resident's are a specified in paragraph and the resident's are and physician, resident and the specified in specified in form the attravenous immunoglobulin (IV and a replacement therapy for a deficiency, was not a ordered for 1 (Resident #54) of 1 and int with an order for IV IG and ings included: |                   | Res<br>Order<br>me<br>have<br>aff<br>def<br>Th<br>No<br>Co<br>win<br>re<br>O<br>m<br>do<br>vo<br>co<br>o | sidents with Physician ders to receive outpated ication administration the potential to be feeted by this alleged ficient practice. The Director of arsing, Staff Develop cordinator or Unit Mail complete an audit sidents with Physician redication administraturing the last 30 days erify scheduling and completion of these putpatient treatments of Nursing, Staff Develop audits the Director of Nursing, Staff Develop Coordinator or Unit Navill notify the Physical Responsible Party will of delays or lack of administration by 7/2 | ment anager of an's tion s to by of these opment Manager cian and ll be |                     |
|                          | 12/8/12 and wa  | vas admitted to the facility on<br>as re-admitted on 5/13/13 with<br>oses including immunoglobulin G<br>cy, a condition when the body  |                   |  |   |   | nuation sheet Pag   |

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 06/27/2013 345362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 250 BISHOP LANE CONCORD, NC 28025 BRIAN CENTER HEALTH & RETIREMENT/CABARRUS (X5) PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES 1D DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG Criteria 3 F 157 The Director of Nursing, Continued From page 4 doesn't produce enough immunoglobulin Staff Development Coordinator or Unit Manger (antibodies). The quarterly MDS assessment dated 6/20/13 will re-educate indicated that Resident #54 was cognitively intact. all Licensed Nurses, including those working On 6/25/13 at 7:50 AM, Resident #54 was PRN and weekends, on interviewed. She stated that she had Ig G the policy and procedure deficiency and she was supposed to receive IV related to Notification of IG treatment every month. She added that since Change including the she was admitted to this facility she had not notification of Physician and received the IV IG and that she was worried. Responsible Party regarding Review of the admission orders dated 12/8/12, Scheduling outpatient there was no order for IV IG to be given monthly. treatments by 7/25/13. On 4/25/13, there was a progress notes from the The Director of neurology clinic. Resident #54 was seen by the Nursing, Staff Development neurologist that day and the orders included " Coordinator or Unit Manager Gamunex-C (a replacement therapy for lg G will review the 24 hour report deficiency) 10 gram/100 ml (milliliter) - infuse 35 and carbon copies of grams by intravenous route at a rate of 1 Physician's Orders 4 times mg/kg/min (milligram/kilogram/minute) for 30 minutes, then may increase to 8 mgs/kg/min per week for 12 weeks to every 4 weeks with solumedrol (corticosteroid verify Physician notification used to reduce allergic reaction) 40 mgs and with a change of condition Benadryl (antihistamine used to treat allergic and document these audits on reactions) 50 mgs pre infusion. The notes indicated that the treatment would start at (name the monitoring tool. Opportunities will be of hospital) on 4/27/13. corrected by the Director of The MARs (Medication Administration Records)

the MAR.

for April, May and June, 2013 were reviewed.

Gamunex - C treatment was not transcribed to

On 4/29/13, there was a physician's order which included "Gamunex C 10% 35 gm (gram) IV

these audits

Nursing, Staff Development

daily as identified during

Coordinator or Unit Manager

| )FPARTM           | ENT OF HEALTH A  | ND HUMAN SERVICES   |             |                      |  | OMB NO. 0938-0                | 0391     |
|-------------------|--|---|-------------|----------------------|--|-------------------------------|----------|
| CENTERS           | FOR MEDICARE &   | MEDICAID SERVICES   | 0.00 341117 | PLE CONSTRUCTION     |  | (X3) DATE SURVEY<br>COMPLETED | }        |
| CATEMENT OF       | DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        |             | IG                   |  | John Street                   | }        |
| ND PLAN OF C      | ORRECTION  | IDENTIFICATION NOMBERS                                    | A. BUILDII  |                      |  |                               |          |
|                   |  |   | B. WNG      |                      |  | 06/27/2013                    | <u>-</u> |
|                   |  | 345362  | 1 21 1      | STREET ADDRESS, CITY | STATE ZIP CODE                           |                               |          |
| WALE OF DEC       | VIDER OR SUPPLIER  |   |             | 250 BISHOP LANE      | 1,000.00                                 |                               | }        |
|                   |  | WENT (CARAPRIS  |             | CONCORD, NC 2        | 8025                                     |                               |          |
| BRIAN CEN         | ITER HEALTH & RET  | REMENT/CABARRUS   |             |                      | "DED'S DI AN OF CORRECTION               | (X                            |          |
|                   | CLUMARY  | STATEMENT OF DEFICIENCIES                                 | ID          |                      | SODDECTIVE ACTION SHOULD I               | DE 1 04                       |          |
| (X4) ID<br>PREFIX |  | INVINIET DE PRECEDEU DE 1955                              | PREF        | ^ CPOSS-R            | EFERENCED TO THE APPROPRI<br>DEFICIENCY) | in i                          |          |
| TAG               | REGULATORY O   | R LSC IDENTIFYING INFORMATION)                            | 1           | <u> </u>             |  |                               |          |
| <u> </u>          |  |   |             |                      |  |                               |          |
|                   |  | _   | F           | 157                  |  |                               |          |
| F 157             | Continued From pa  | age 5   |             | ł                    |  | Ì                             |          |
|                   | every 4 week via p   | ort a cath ( a small device                               | ļ           |                      |  |                               |          |
|                   | installed under the  | skin to give easy access to the                           |             | <u>Criteria</u>      | 14                                       |                               |          |
|                   | vein); ig G and sui  | oclasses every 3 months;<br>s IV and Benadryl 50 mgs IV   |             |                      |  |                               |          |
|                   | solumedroi 40 mg   | 5 IV dilu Dollawiji                                       | 1           |                      |  | _                             |          |
|                   | pre infusion. "  |   |             | The res              | ults of the audits wil                   | 1                             |          |
|                   | There was no doc   | umentation in the records that                            | :           | he repo              | rted in the monthly                      |                               |          |
|                   | Resident #54 had   | received the IV IG  |             | Quality              | Assurance                                |                               |          |
|                   | (Gamunex-C) from   | n 4/27/13 to 6/26/13.                                     |             | Darforr              | nance Improvement                        |                               |          |
|                   | 1  |   |             |                      |  |                               |          |
|                   | On 6/26/13 at 10:  | 45 AM, administrative staff #1                            |             | meeting              | g by the Director of                     |                               |          |
|                   | was interviewed.   | She stated that the facility did                          |             | Nursing              | g for 3 months. The                      | •                             |          |
|                   | not receive the or   | der for IV IG treatment until esident was scheduled to    |             | commi                | ttee will evaluate and                   | 1                             |          |
|                   | 4/29/13 and the f  | ospital on 5/7/13. On 5/7/13,                             |             | make f               |  |                               |          |
|                   | 1 D Want #5/ WO  | nt to the nospilar ior iv io                              |             | recomr               | nendations as                            |                               |          |
|                   | treatment but he   | r porta cath was not working                              |             | indicat              | ed.                                      |                               |          |
|                   | I considered flush)  | en the IV IG Was not                                      |             | •••                  |  |                               |          |
|                   | A bozotolete   | Aministrative Stall # Liuturo                             |             | Date of C            | ompliance:                               |                               |          |
|                   | 1 dahat an 5/  | 0/12 Resident #34 was autiliaco                           |             | July 25, 2           |  |                               |          |
|                   | lia sha bacnital fo  | r natisea and vollithing and was                          |             | July 20, 2           | V 10 .                                   |                               |          |
|                   | re-admitted back   | to the facility on 5/13/13.                               |             |                      |  |                               |          |
|                   | Administrative s   | taff #1 further stated that the administer blood products |             |                      |  | 1                             |          |
|                   | Literation IV/ICES   | use not ntovided at the recircly.                         | ļ           |                      |  |                               |          |
| İ                 | Sho added that   | she had intofflied the physician.                         |             | ļ                    |  | ļ                             |          |
| į                 | 11 11 11 11 11 11 11 11 11 11 11 11 11   | forgot to document.                                       |             |                      |  | ļ                             |          |
| İ                 | The state of the s | tott tra did tidi expialli will color                     |             |                      |  |                               |          |
| l                 | - Lorrangements V  | vere not made to resident no                              |             |                      |  |                               |          |
| [                 | receive the IV I   | G treatment after 5/15/15                                 |             | ļ                    |  |                               |          |
|                   | (re-admission).  |   |             |                      |  | ł                             |          |
| Ì                 |  |   |             |                      |  |                               |          |
| [                 | 0" 002140 ct   | 1:39 PM, the physician was                                |             |                      |  |                               |          |
| }                 | 1 T  | ha abueician stated tildt tie troe to                     | ot          |                      |  |                               |          |
| 1                 | ە مائىرى   | SHANT THE WAS NOT LECEIMING WILL IN                       | /           | ,                    |  |                               |          |
| İ                 | I o manifely oc  | Ardered. He indicated that the in                         |             |                      |  |                               |          |
| 1                 | IG was ordere  | d by the infectious disease doctor                        |             |                      |  |                               |          |
| 1                 | 1.5  | ·   |             | Facility ID: 9529    | Ω1                                       | If continuation shee          | (Page f  |

| DEPARTM           | ENT OF HEALTH AN      | CEDVICES   |             |        |   | UNID 140.   |                    |
|-------------------|-----------------------|--|-------------|--------|---|-------------|--------------------|
| CENTERS           | FOR MEDICARE &        | MEDICAID SERVICES  | (X2) MULTI  | PLE CO | STRUCTION                                       | (X3) DATE S | ETED               |
| FATEMENT OF       | DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |             |        |   | }           |                    |
| ND PLAN OF (      | CORRECTION            | (DEM IDATION   | A. Boiles   |        |   | Ì           |                    |
|                   |                       | 0.45050  | B. WNG_     |        |   | 06/2        | 7/2013             |
|                   |                       | 345362   | _           |        | ADDRESS, CITY, STATE, ZIP CODE                  |             |                    |
| JAME OF PRO       | VIDER OR SUPPLIER     |  | ł           | STREET | BISHOP LANE                                     |             |                    |
|                   |                       | PENENTICABARRIIS   |             | 200 E  | CORD, NC 28025                                  |             |                    |
| BRIAN CE          | NTER HEALTH & RETIF   | SEIMEIA IVONDALITION   |             |        | PROVIDED'S PLAN OF CORRECTION                   |             | (X5)               |
|                   | SHMMARY S             | TATEMENT OF DEFICIENCIES   | ID<br>PREFI |        | - LOUGODECTIVE ACTION SHOULD B                  | <b>7</b> □  | COMPLETION<br>DATE |
| (X4) ID<br>PREFIX |                       | AV MILIET RE PRECEDED DI FULL  | TAG         |        | CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | MIC         | i                  |
| TAG               | REGULATORY OR         | LSC IDENTIFYING INFORMATION)   |             |        | DEFFORM   |             |                    |
|                   |                       |  |             |        |   | •           | ļ                  |
| ļ                 |                       |  | F           | 157    |   |             |                    |
| F 157             | Continued From pag    | ge 6   |             |        |   |             |                    |
|                   | and he expected the   | e facility to administer it. If  |             | 1      |   |             | 1.1.1.             |
|                   | not, he should have   | been informed so he could  |             | Ì      |   |             | 17/25/1            |
|                   | make other plans/ar   | rrangements.   | F           | 253    |   |             | 1.1                |
| F 253             | 483.15(h)(2) HOUS     | EKEEPING &   | ì           | ţ      |   |             |                    |
| SS=B              | MAINTENANCE SE        | EKNICES  |             |        | Criteria <u>I</u>                               |             |                    |
|                   |                       | avida housekeening and   |             |        | The Lint screens for each                       |             |                    |
|                   | The facility must pre | ovide housekeeping and<br>ces necessary to maintain a  |             |        | dryer were cleaned                              |             |                    |
|                   | maintenance service   | nd comfortable interior.   |             |        | immediately following                           |             |                    |
|                   | sanitary, orderly, at | The Commonweal Commonw |             |        | identification on 6/27/13.                      |             |                    |
|                   |                       |  |             |        | identification on orzer is:                     |             |                    |
|                   | This REQUIREME        | NT is not met as evidenced   |             |        | Criteria 2                                      |             |                    |
| 1                 | bur                   |  |             |        | All residents have the                          |             |                    |
| :                 | Desert on obcense     | ation, record review and staff   |             |        | All residents have and                          |             |                    |
| į                 | intentions the fac    | ility failed to ensure that a lint   |             |        | potential to be affected by                     | ۵           |                    |
| ]                 | screen in 1 of 3 clo  | othes dryers was cleaned   |             |        | this alleged deficient practic                  | ·           |                    |
| ]                 | regularly to prever   | nt a tire nazaro.  |             |        |   |             |                    |
| ]                 |                       | ما م   |             |        | Criteria 3                                      |             |                    |
|                   | The findings include  | gea.   |             |        | The Environmental Services                      | 5           |                    |
|                   | O= 6/07/13 at 6:3'    | 3 am, a tour of the laundry room   |             |        | Director will                                   |             |                    |
|                   | Luna conducted A      | housekeeper was present,   |             |        | re-educate all                                  |             |                    |
|                   | folding laundry an    | ad all three of the divers had   |             |        | Laundry staff on the                            |             |                    |
| 1                 | alothoe in them S     | the shared that they have a  |             |        | procedures, frequency and                       |             |                    |
|                   | achodule to clean     | the clothes dryers every two   |             |        | documentation of cleaning                       |             |                    |
|                   | hours and record      | the activity on a dryer log.   |             |        | the lint screens by 7/25/13.                    |             |                    |
| }                 | 1                     |  |             |        | The Environmental Service                       | 25          |                    |
|                   | When asked to in      | nspect the lint screens, she   |             |        | The Environmental Service                       | - P         |                    |
| 1                 | I am amount cook doc  | or to display them. The machine  |             |        | Director or the Maintenanc                      | ,0          |                    |
|                   | lint screens were     | clean with minimum lint on the   |             |        | Director will                                   |             |                    |
|                   | floor. However,       | the third dryer had heavy white<br>a and white lint on the floor of the  |             |        | randomly review the                             |             |                    |
|                   | James The house       | skeener stated that her  |             |        | documentaion log and                            |             |                    |
| 1                 | auponisor monit       | fored the dryer logs to ensure that  |             |        | validate accuracy 3 times p                     | per         |                    |
|                   | the screens were      | e cleaned throughout the day.  |             |        | week for 12 weeks and                           |             |                    |
| }                 | i                     |  |             |        | document these audits on                        | the         |                    |
| ļ                 | On 6/27/13 at 7:      | 44 am, the administrative staff #3   |             |        | document mese adams on                          | =-          |                    |
| -                 | was interviewed       | . He brought in the completed  |             |        | 1   |             |                    |

PRINTED: 07/10/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING \_\_\_ IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 06/27/2013 B. WNG 345362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 250 BISHOP LANE BRIAN CENTER HEALTH & RETIREMENT/CABARRUS CONCORD, NC 28025 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) 1D REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) **PREFIX** TAG monitoring tool Opportunities will be F 253 Continued From page 7 F 253 corrected by the dryer log that he kept in his office and it revealed Environmental Services that the activity for 6/27/13 had already been filled Director or the Maintenance out for the entire day. He stated that his expectation was for his staff to clean the lint Director daily as screens every two hours and if the screen was identified during these last cleaned at 8:00 pm yesterday, it should have random audits. still been clean this morning at 6:00 am. Criteria 4 The administrative staff returned at 7:55 am, stating that he had in-serviced his staff not to "pre-chart the dryer logs and to clean the screens The results of the audits will either after every 2 loads or 2 hours, whichever was lesser. His written guidelines, dated 6/27/13, be reported in the monthly emphasized that a clogged screen, preventing air Quality Assurance from circulating, could create a fire hazard. Performance Improvement meeting by the Environmental A follow up interview was conducted with the Services Director for 3 housekeeper at 6/27/13 at 11:22 am. She shared months. The committee will that she always filled out the log in advance. Yesterday she stated that she cleaned the lint evaluate and make further screens and planned to clean them again when recommendations as she arrived at 6:00 am, but didn't get the chance to complete the task, before they were inspected. indicated. F 278 483.20(g) - (j) ASSESSMENT F 278 ACCURACY/COORDINATION/CERTIFIED Date of Compliance: SS=B July 25, 2013. The assessment must accurately reflect the

resident's status.

assessment is completed.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the

Each individual who completes a portion of the assessment must sign and certify the accuracy of

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

|                         | CNT OF UEALTH AN   | ID HUMAN SERVICES   |              |       |  | OMB NO     | <u>0. 0938-0391</u> |
|-------------------------|--|---|--------------|-------|--|------------|---------------------|
| DEPARTM                 | FOR MEDICARE &   | MEDICAID SERVICES   |              |       | NETRICTION   | (X3) DATI  | E SURVEY            |
| CENTERS<br>CTATEMENT OF | DEFICIENCIES   |   |              |       | NSTRUCTION   | COM        | PLETED              |
| AND PLAN OF             | ORRECTION  | IDENTIFICATION NUMBER:  | A. BUILD     |       |  |            |                     |
|                         |  | 345362  | B. WNG       |       |  | 06         | 5/27/2013           |
|                         |  | 04000   | <u> </u>     | STREE | T ADDRESS, CITY, STATE, ZIP CODE   |            |                     |
|                         | VIDER OR SUPPLIER  |   |              | 250   | BISHOP LANE  |            |                     |
| BRIAN CEI               | NTER HEALTH & RETIF  | REMENT/CABARRUS   |              | CO    | NCORD, NC 28025  | N          | (X5)                |
| <b>D</b> 10101          |  | TATEMENT OF DEFICIENCIES  | 1D           |       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD FOR THE APPROPRIES OF T | ,          | COMPLETION          |
| (X4) ID<br>PREFIX       |  | CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | PRE<br>TA    |       | CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  |            | <u> </u>            |
| TAG                     |  |   | <del> </del> |       |  |            | 7/25/               |
|                         |  |   |              | 7278  | <u>Criteria</u>  | ıd         | '4 F                |
| F 278                   | Continued From page  | ge 8  |              | 2.0   | Late entry documentation ar  | .G         |                     |
| <u> </u>                | that portion of the a  | ssessment.  |              |       | signatures for staff members   | and        |                     |
| 1                       |  |   |              |       | completing sections C, D, E  | d for      |                     |
|                         | Under Medicare an  | d Medicaid, an individual who<br>gly certifies a material and   |              |       | K on the MDS were obtaine  | u 101<br>7 |                     |
|                         | in a continuament in a   | Program Assessing to  | Ì            |       | residents #54, #123, and #6  | /.         |                     |
| 1                       | the state of the s | andy hongity til flot more men.                                 |              |       |  |            |                     |
|                         | 1 + 4 000 fee agob 00  | esement: Of all thornors in the                                 |              |       | Criteria 2   |            |                     |
|                         | I will and knowle  | MIN CAUSES andured marriage                                     |              |       | All residents have the   |            |                     |
|                         | l ite a majaria  | i and taise statement in ~                                      |              |       | potential to be affected by  | 60         |                     |
|                         | resident assessme  | e than \$5,000 for each   |              |       | this alleged deficient practi  | ce         |                     |
|                         | assessment.  | e man coloco  |              |       |  |            |                     |
| 1                       | 1  |   |              |       | Criteria 3   |            |                     |
| ļ                       | Clinical disagreem   | nent does not constitute a                                      |              |       | The Regional Care  |            |                     |
| 1                       | material and false   | statement.  |              |       | Management Coordinator   |            |                     |
|                         |  |   |              |       | will re-educate all  |            |                     |
|                         | TIL DECLIBEME  | ENT is not met as evidenced                                     |              |       | MDS staff on the   |            |                     |
|                         | 1  |   |              |       | accurate completion of   | 41         |                     |
| 1                       | no and an record   | review and staff interview, the                                 |              |       | sections C, D, E and K of  | me         |                     |
|                         | 1 a 1114 8-25-al-fa 61   | acura that each section of the                                  |              |       | MDS to include signature   | 2S         |                     |
|                         | LIDO accomen   | te were signed by the market                                    |              |       | by the Interdisciplinary te  | am         |                     |
|                         | who completed it   | prior to completion date on 3<br># 123, and #67) of 17 sampled  |              |       | member completing each   |            |                     |
|                         | (Residents #54, I  | ngs included:   |              |       | section prior to signature   | of         |                     |
| }                       | residents. That  | igo monutos   |              |       | the MDS Coordinator  |            |                     |
| ĺ                       |  |   |              |       | completing the assessmen   | t          |                     |
|                         | 1. Resident # 54   | was admitted to the facility on                                 |              |       | and subsequent transmitta  | ii OI      |                     |
| ł                       | 12/8/12. The qu  | parterly Minimum Data Set (MDS) is signed as compete by the MDS |              |       | the MDS assessment, by   |            |                     |
| }                       | an audinotor on 6  | 3/20/13. Section 4 or the                                       |              |       | 7/25/13.   |            |                     |
|                         | accessment cor   | tained only one signature from                                  |              |       | • • •  |            |                     |
|                         | 1  | notor The secuulo out   |              |       |  |            | •                   |
|                         |  |   |              |       |  |            |                     |
|                         | lossiano C D I   | E and K Wele Collibied and man                                  |              |       |  |            |                     |
| ŧ                       | were no signatu  | ures from the staff that completed                              |              |       |  |            |                     |

them.

| DEPARTM           | ENT OF HEALTH AN             | ID HUMAN SERVICES   |                |          |  |                      | 0938-0391          |
|-------------------|------------------------------|---|----------------|----------|--|----------------------|--------------------|
| CENTERS           | FOR MEDICARE &               | MEDICAID SERVICES   | (VO) MINT      | IDLE CO  | ONSTRUCTION  | (X3) DATE S<br>COMPL | URVEY<br>ETED      |
| CTATEMENT OF      | DEFICIENCIES                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                |          | , and the second | 00,311, 2            |                    |
| AND PLAN OF       | CORRECTION                   | IDENTIFICATION NOMBER   | M. DOILO       |          |  |                      | m:0043             |
|                   |                              | 345362  | B. WING        |          |  | 06/2                 | 7/2013             |
|                   |                              | 340302  |                | STREE    | T ADDRESS, CITY, STATE, ZIP CODE   |                      |                    |
| NAME OF PRO       | OVIDER OR SUPPLIER           |   |                | 250      | BISHOP LANE  |                      |                    |
|                   | NTER HEALTH & RETII          | REMENT/CABARRUS   |                |          | NCORD, NC 28025  |                      |                    |
| BRIANCE           |                              |   | ID             | <u> </u> | PROVIDER'S PLAN OF CORRECTION  | 3E                   | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX |                              | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | PREF           |          | (EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | IATE                 | DATE               |
| TAG               |                              |   | <del> </del> - |          |  |                      |                    |
|                   |                              |   |                | 278      |  |                      |                    |
| F 278             | Continued From pa            | ge 9  | '              | -,0      | m D 11 of Cono   |                      |                    |
|                   | On 6/26/13 at 12:30          | PM, MDS coordinator #1  |                |          | The Resident Care  |                      |                    |
| 1                 | Large intensioned S          | the stated that she was not   |                |          | Management Director will   |                      |                    |
|                   | aware that the staff         | had to sign their sections  |                |          | randomly review 10   |                      |                    |
| 1                 | before she could si          | gn the assessment as  |                |          | completed MDS assessments  | •                    |                    |
|                   | complete.                    |   |                |          | weekly for 12 weeks to verify  | y                    |                    |
| Ĭ.                | o Donidoni #123 M            | vas admitted to the facility on   |                |          | accurate completion with   |                      |                    |
|                   | The admi                     | ission Minimum Data Oct   |                |          | signatures prior to  |                      |                    |
|                   | A IDOL TATOOMON              | turas signed as compete by  |                |          | transmission and   |                      |                    |
|                   | THE MIDE coordinat           | int on 6/5/13. Section 4 or the   |                |          | document these audits on the   |                      |                    |
| }                 | I accessment conta           | ined only one signature from  |                |          | monitoring tool  |                      |                    |
|                   | the MDS coordina             | tor. The sections she   |                |          | Opportunities will be  |                      |                    |
|                   | completed were A             | , B, G, H, I, J, L, M, N, O and P.<br>F, and K were completed but                         |                |          |  |                      |                    |
|                   | Sections C, D, E,            | natures from the staff that   |                |          | corrected by the   |                      |                    |
|                   | completed them.              |   |                |          | Resident Care Management   | _                    |                    |
| ļ                 |                              |   |                |          | Director or MDS Coordinator  | Γ                    |                    |
|                   | On 6/26/13 at 12:            | 30 PM, MDS coordinator #1   |                |          | daily as identified during   |                      |                    |
|                   | hower interviewed            | She stated that she was not   |                |          | these audits.  |                      |                    |
|                   | owere that the sta           | aff had to sign their sections  |                |          | ••••   |                      |                    |
| Į.                |                              | sign the assessment as  |                |          |  |                      |                    |
| <u> </u>          | complete.                    |   |                |          |  |                      |                    |
|                   |                              |   |                |          | Crite <u>ria 4</u>   |                      |                    |
|                   | 3 Resident # 67              | was admitted to the facility on   |                |          |  |                      |                    |
| j                 | LAMOND Thoms                 | adativ Minimuiii Dala Ger (MDG)   |                |          |  |                      |                    |
|                   | accoment Was                 | signed as complete by the made  |                |          | The results of the audits wi   | ll be                |                    |
|                   | anadinator on 6              | 125/13. Section 4 of the  |                |          | reported in the monthly Quali  |                      |                    |
|                   | assessment con               | tained only one signature from  |                |          | reported in the monthly cause  | -,                   |                    |
| ļ                 | the MDS coordin              | nator. The sections she<br>A, B, G, H, I, J, L, M, N, O, and                              |                |          | Assurance Performance  |                      |                    |
|                   | n Continue C                 | U E K SUG O Meta combiosog sax  |                |          | Improvement meeting by the   | i<br>Caranteria      |                    |
|                   | there were no s              | ignatures from the staff that   |                |          | Resident Care Management D   | urector              |                    |
| }                 | completed them               | ì.  |                |          | for 3 months. The committee  | e will               |                    |
| 1                 | 1                            |   |                |          | evaluate and make further  |                      |                    |
|                   | On 6/26/13 at 1              | 2:30 PM, MDS coordinator #1   |                |          | recommendations as indicate  | d,                   |                    |
|                   | intoniouio                   | A She stated that she was not   |                |          | (Commondation  |                      |                    |
|                   | aware that the               | staff had to sign their sections  |                |          | Date of Compliance:  |                      |                    |
| <u> </u>          |                              | Event ID:   | LUY            |          | July 25, 2013.   |                      |                    |
| FORM CN           | 1S-2567(02-99) Previous Vers | Siotis Onsolete   |                |          | July 25, 2015.   |                      |                    |

|                          | OF LICALTU  | AND HUMAN SERVICES   |                 |                |   |                    | O. 0938-039          |
|--------------------------|---|--|-----------------|----------------|---|--------------------|----------------------|
| EPARTME                  | EOR MEDICARE  | & WEDICAID SCHAIGES  |                 | */D! F ^^      | DNSTRUCTION   | (X3) DAT           | TE SURVEY<br>MPLETED |
| TEMENT OF                | DEFICIENCIES<br>ORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                 |                | JNG TNO OTTO  | [<br>]             |                      |
|                          |   | 345362   | B. WING         |                |   | 0                  | 6/27/2013            |
| ur of ppo                | VIDER OR SUPPLIER                                     |  |                 | STREE          | ET ADDRESS, CITY, STATE, ZIP CODE   |                    |                      |
|                          |   | ETIREMENT/CABARRUS   |                 |                | NCORD, NC 28025   |                    | (X5)                 |
| (X4) ID<br>PREFIX<br>TAG | SUMMAF  | RY STATEMENT OF DEFICIENCIES<br>SIENCY MUST BE PRECEDED BY FULL<br>Y OR LSC IDENTIFYING INFORMATION)   | ID<br>PRE<br>TA | FIX            | PROVIDER'S PLAN OF CORRECTIVE<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)              | <i>U U L</i>       | COMPLETIO            |
| F 278                    | mploto  | I sign the assessment as   |                 | = 278<br>F 309 |   |                    |                      |
| F 309<br>SS=D            | 483.25 PROVID<br>HIGHEST WEL                          |  |                 | F 309          | <u>Criteria l</u>   | d                  | 7/25                 |
|                          | provide the nec                                       | nust receive and the facility must essary care and services to attain highest practicable physical, ychosocial well-being, in  |                 |                | Resident #54 was discha from the facility on 7/5/1  | rgea<br>3.         |                      |
|                          | accordance with and plan of car                       | h the complehensive dessession.<br>e.  |                 |                | Criteria 2 Residents with Physiciar Orders to receive outpati medication administration have the potential to be              | ent                |                      |
|                          | 1   | EMENT is not met as evidenced  |                 |                | affected by this alleged deficient practice.  |                    |                      |
|                          | resident and s  | ord review, physician, family, staff interview, the facility failed to a intravenous immunoglobulin (IV  |                 |                | The Director of   | ment               |                      |
|                          | #54) of 1 sam<br>medication. I                        | c-C, as ordered for riccoldonic<br>pled resident with an order of IV IG<br>Findings included:  |                 |                | Coordinator or Unit Ma Will complete an audit residents with Physicia Orders for outpatient                                   | inger<br>of<br>n's |                      |
|                          | 12/8/12 and multiple diag (ig G) deficie doesn't prod | was admitted to the facility on<br>was re-admitted on 5/13/13 with<br>noses including immunoglobulin G<br>ency, a condition when the body<br>uce enough immunoglobulin |                 |                | medication administrat<br>during the last 30 days<br>verify scheduling and<br>completion of these<br>outpatient treatments be | to                 |                      |
|                          | (antibodies). The quarter                             | y MDS assessment dated 6/20/13   | ct.             |                | 7/25/13.  | •                  | 1                    |

indicated that Resident #54 was cognitively intact.

On 6/25/13 at 7:50 AM, Resident #54 was interviewed. She stated that she had Ig G deficiency and she was supposed to receive IV IG treatment every month. She added that since PRINTED: 07/10/2013 FORM APPROVED

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

(X5) COMPLETION DATE

| DEPARTM       | ENT OF HEALTH AN         | D HUMAN SERVICES   |          |       |  | (X3) DATE     |                |
|---------------|--------------------------|--|----------|-------|--|---------------|----------------|
| CENTERS       | FOR MEDICARE &           | MEDICAID SERVICES  | (X2) MUL | TIPLE | CONSTRUCTION   | COMP          | LETED          |
| STATEMENT OF  | DEFICIENCIES             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |          |       |  |               |                |
| AND PLAN OF   | CORRECTION               | IDEATH TO THE  | }        | •     |  | 061           | 27/2013        |
|               |                          | 345362   | B. WNG   | _     |  | 1 00/         | 2112010        |
|               |                          | 04000  |          | STR   | EET ADDRESS, CITY, STATE, ZIP CODE   |               |                |
| l             | VIDER OR SUPPLIER        |  |          |       | 50 BISHOP LANE   |               |                |
| RRIAN CEI     | NTER HEALTH & RETIF      | REMENT/CABARRUS  |          | C     | ONCORD, NC 28025   |               | (X5)<br>COMPLE |
|               |                          | TATEMENT OF DEFICIENCIES   | ID       |       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF T | ,,,,,,        | COMPLE         |
| (X4) ID       |                          |  | PRE      |       | CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | RIAIC         |                |
| PREFIX<br>TAG | REGULATORY OR            | LSC IDENTIFYING INFORMATION)   |          |       | OLI (G.E.)   |               | 1              |
|               |                          |  |          | _     |  |               | :              |
|               | 15                       | 20 11  | F        | 308   |  |               |                |
| F 309         | Continued From page      | this facility she had not  |          |       | Outtorio 3   |               |                |
|               | she was admitted it      | reatment and that she was  |          |       | <u>Criteria 3</u> The Director of Nursing,   |               |                |
|               | worried.                 | Tourist Transfer of the Control of t |          |       | Staff Development  |               |                |
| }             |                          |  | 1        |       | Coordinator or Unit Mana   | ger           |                |
|               | Review of the admi       | ssion orders dated 12/8/12,  |          |       | will re-educate  |               |                |
|               | there was no order       | for IV IG to be given monthly.   |          |       | all Licensed Nurses,   |               |                |
|               | On 4/25/13 there y       | was a progress notes from the  |          |       | including those working F  | PRN           |                |
|               | i t                      | Acinani #34 was soon of me   |          |       | and weekends, on   |               |                |
|               | in a sumple giet that da | v and the orders included  |          |       | the process for scheduling   | χ             |                |
|               | 1 a C /a ron             | Jacament Ittelapy ior is 9   |          |       | and verifying completion   | of            |                |
|               | deficiency) 10 grat      | m/100 ml (milliliter) - infuse 35<br>ous route at a rate of 1  |          |       | Physician ordered outpati  | ent           |                |
|               | I                        | aw/kilograffi/ffillings for ac   |          |       | medication administration  | n by          |                |
| 1             | I was shop mak           | mcrease to o myanymi   |          |       | 7/25/13.   | •             |                |
|               | I A wooke wit            | h sollimedial (controparation  |          |       | The Director of  |               |                |
|               | le coulor of teal        | ernic reactions 4 mgs and  |          |       | Nursing, Staff Developm  | ent           |                |
| 1             | 1 0 CD made              | amine used to treat allergic<br>s pre infusion. The notes  |          |       | Coordinator or Unit Mar  | ager          |                |
|               | reactions) 50 mgs        | treatment would start at (name   |          |       | will review the 24 hour i  | eport         |                |
|               | of hospital) on 4/2      | 27/13.   |          |       | and carbon copies of   | T             |                |
|               | i                        |  | Ì        |       | Physician's Orders 4 tin   | nes           |                |
| ]             | On 4/29/13, there        | was a physician's order which  |          |       | per week for 12 weeks t  | 0             |                |
| }             | ماند عام مند ا           | nex C 10% 35 gm (gram) IV<br>porta cath (a small device  |          |       | verify scheduling and  | -             |                |
|               | I be a line of unchar fr | se skin to give easy access to ""  | i<br>*   |       | completion of physician  | ì             |                |
|               | Later And Connot e       | THUSSES EVERY O BROTHING   |          |       | ordered outpatient medi  | cation        |                |
|               | solumedrol 40 m          | igs IV and Benadryl 50 mgs IV  |          |       | administration, audits v   | vill be       |                |
|               | pre infusion."           |  | 1        |       | documented on the  |               |                |
|               | There was no de          | ocumentation in the records that   | :        |       |  |               |                |
|               | Resident #54 ha          | ad received the IV IG treatment  | 1        |       | monitoring tool.<br>Opportunities will be  |               |                |
|               | from 4/27/13 to          | 6/26/13.   | 1        |       | corrected by the Direct  | or of         |                |
|               | i                        |  | i        |       | Nursing, Staff Develor   | ment          |                |
|               | The MARs (Med            | dication Administration Records)   | 1        |       | Coordinator or Unit M  | anager        |                |
| }             | for April, May at        | nd June, 2013 were reviewed.<br>reatment was not transcribed to  | į.       |       | daily as identified duri   | ng            |                |
| 1             | the MAR.                 | outinoin res-  | 1        |       | daily as identified duff   | ** <b></b> ** |                |
| ļ             | HIS MAN                  |  |          |       | these audits   |               |                |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO, 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING \_\_\_ 06/27/2013 B. WING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345362

STREET ADDRESS, CITY, STATE, ZIP CODE

250 BISHOP LANE CONCORD, NC 28025

NAME OF PROVIDER OR SUPPLIER

### BRIAN CENTER HEALTH & RETIREMENT/CABARRUS

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG

PREFIX TAG

F 309

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

PRINTED: 07/10/2013

F 309

Continued From page 12

The doctor's progress notes were reviewed. On 5/1/13, the notes revealed that Resident #54 had expressed concern that she had not received the IV IG since admission to the facility. The notes revealed that Resident #54 had missed 4 dosages of IV IG. The notes indicated that the resident was scheduled to receive it on 5/7/13. There were no other notes in the chart after 5/1/13.

On 6/26/13 at 10:45 AM, administrative staff #1 was interviewed. She stated that the facility did not receive the order for IV IG treatment until 4/29/13 and the resident was scheduled to receive it at the hospital on 5/7/13. On 5/7/13, Resident #54 went to the hospital and her porta cath was not working (would not flush) so the IV IG was not administered. Administrative staff #1 further stated that on 5/9/13, Resident #54 was admitted to the hospital for nausea and vomiting and was re-admitted on 5/13/13. Administrative staff #1 further stated that the facility does not administer blood products therefore IV IG was not provided at the facility. Administrative staff #1 did not explain why other arrangements were not made for Resident #54 to receive the IV IG treatment after 5/13/13 (re-admission).

On 6/26/13 at 11:30 AM, interview with Nurse #1 was conducted. After reviewing their appointment book, she stated that there was no scheduled date set up for Resident #54 to have her IV IG treatment at the hospital.

On 6/26/13 at 4:10 PM, a family member was interviewed. She stated that the orders from the neurology clinic, including the order for IV IG, was

#### Criteria 4

The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months. The committee will evaluate and make further recommendations as indicated.

Date of Compliance: July 25, 2013.

PRINTED: 07/10/2013 FORM APPROVED

| DEDADIM                  | ENT OF HEALTH AN   | D HUMAN SERVICES  |                   |           |  | OMB NO. 0938-0391             |
|--------------------------|--|---|-------------------|-----------|--|-------------------------------|
| DEPARTM                  | FOR MEDICARE &   | MEDICAID SERVICES   |                   | r:01 5 00 | DNSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
| STATEMENT OF             | DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   |           | JNSTROOTION  | COMILECTED                    |
| AND PLAN OF C            | ORRECTION  | IDEM III IOMIONI  | }                 |           |  | 06/27/2013                    |
|                          |  | 345362  | B. WNG            |           |  | 1 00/2/12010                  |
|                          |  |   |                   | STREE     | ET ADDRESS, CITY, STATE, ZIP CODE  |                               |
|                          | VIDER OR SUPPLIER  |   |                   | 250       | BISHOP LANE  |                               |
| BRIAN CEN                | ITER HEALTH & RETIF  | REMENT/CABARRUS   |                   | CO        | PROVIDER'S PLAN OF CORRECTION  | N (X5)                        |
| (X4) ID<br>PREFIX<br>TAG |  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | ix        | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP  | ) Uh                          |
| F 309                    | (4/25/13) and the trascheduled for 4/27/member did not und staff missed the ord for the IV IG. The concern that Resid IV IG since she was December, 2012. telling the staff about on it.  On 6/27/13 at 1:38 interviewed. The aware that Reside IG monthly as ord IG was ordered by and he expected the should have be | ne day of the appointment eatment (IV IG) was 13 at the hospital. The family derstand how and why the der from the neurology clinic family member voiced her ent #54 had not received her s admitted to the facility in She stated that she had been but it but nobody had followed on PM, the physician was physician stated that he was not ent #54 was not receiving the IV or the infectious disease doctor the facility to administer it, if not een informed so he could make | T.                | 309       |  | 7/25                          |
| F 32                     | other plans/arrange  | gements.<br>AIN NUTRITION STATUS  | Ì                 | F 32      | Criteria I   | May                           |
|                          | assessment, the resident - (1) Maintains acc status, such as tunless the residu  | ent's comprehensive facility must ensure that a ceptable parameters of nutritional body weight and protein levels, ent's clinical condition at this is not possible; and herapeutic diet when there is a  |                   |           | A Medication Variance Report was completed on 6/28/13 by the Director of Nursing, including notification of the Physician for the transcription error regard |                               |

FORM CMS-2587(02-99) Previous Versions Obsolete

by:

nutritional problem.

This REQUIREMENT is not met as evidenced

Event ID: LUY

transcription error regarding physician's orders for nutritional supplements for resident #53. The supplement order was transcribed to the Medication Administration Record for resident #53 on 6/28/13.

| EPARTM            | ENT OF HEALTH A        | ND HUMAN SERVICES   |            |          |   |             | CUBVEY           |
|-------------------|------------------------|---|------------|----------|---|-------------|------------------|
| ENTERS            | FOR MEDICARE &         | MEDICAID SERVICES   | (V2) MILIT | ripi e C | ONSTRUCTION   | (X3) DATE   | PLETED           |
| TELIERE OF        | DEFICIENCIES           |   | (XZ) MULI  | NG       |   | 1           |                  |
| PLAN OF (         | CORRECTION             | IDENTIFICATION NUMBER:  | A. BUILUII | NG       |   |             |                  |
|                   |                        |   |            |          |   | 06          | /27/2013         |
|                   |                        | 345362  | B, WING    |          | TIP CODE  |             |                  |
|                   |                        |   | :          | STRE     | ET ADDRESS, CITY, STATE, ZIP CODE                             |             |                  |
|                   | OVIDER OR SUPPLIER     | ·   |            |          | BISHOP LANE   |             |                  |
|                   | USED UEALTH & RET      | IREMENT/CABARRUS  |            | CC       | NCORD, NC 28025   |             | (X5)             |
| 3RIAN CEI         |                        |   | ID.        | ┺        | PROVIDER'S PLAN OF CORRECTION                                 | ON<br>O BE  | COMPLETION       |
| 10015             | SUMMARY                | STATEMENT OF DEFICIENCIES   | PREF       |          | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | RIATE       | DATE             |
| (X4) ID<br>PREFIX |                        | STATEMENT OF DET<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | TAC        |          | DEFICIENCY)   |             |                  |
| TAG               | REGULATORY             | JR 230 (DE77711 1000)   |            |          |   |             |                  |
|                   |                        |   |            |          |   |             |                  |
|                   |                        | * 4   | F          | 325      |   |             | Ţ                |
| F 325             | Continued From p       | age 14  | 1          |          | a to sta 0  |             |                  |
|                   | Based on record        | review and staff interview, the   |            |          | <u>Criteria 2</u>   |             |                  |
|                   | c - www. foiled to pro | wide the house supplement as  |            |          | مائستانا ومواورو  |             |                  |
|                   | 1 1 1                  | i tombar wellili logo iyi   |            |          | Residents with Physician's                                    | 1           |                  |
|                   | 1 /Posident #53) Of    | 3 sampled residence and accept  |            |          | Orders to receive nutritiona                                  | i           |                  |
|                   | for weight loss. F     | inding includes:  |            |          | supplements   |             |                  |
|                   | }                      |   |            |          | have the potential to be                                      |             |                  |
|                   | Resident #53 was       | admitted to the facility on   |            |          | nave the potential to   |             |                  |
|                   | 5/1/13 with multip     | le diagnoses including Diabetes   |            |          | affected by this alleged                                      |             |                  |
|                   | √ Mellitus, Hyperte    | islon, Depression, Another  |            |          | deficient practice.   |             |                  |
|                   | Vitamin D deficie      | ncy.  |            |          | The Director of   |             |                  |
|                   |                        | dated 5/28/13   |            |          | Nursing, Staff Developmen                                     | nt          |                  |
|                   | The admission M        | IDS assessment dated 5/28/13  |            |          | Coordinator or Unit Manag                                     | ger         |                  |
|                   | indicated that Re      | esident #53 was cognitively intact  |            |          | Coordinator of One Manage                                     | 5**         |                  |
|                   | and needed limit       | ed assistance with eating. The  |            |          | will complete an audit of                                     |             |                  |
|                   | assessment also        | o indicated that the resident's   |            |          | residents with Physician's                                    |             |                  |
| Į                 | weight was 131         | ibs (pourids).  |            |          | Orders for nutritional  |             |                  |
|                   |                        | and the dated 6/6/13 was  |            |          | supplements during the  |             |                  |
|                   | The care plan to       | or nutrition dated 6/6/13 was<br>problem was potential for weight                   |            |          | Supplements to  |             |                  |
| ł                 | reviewed. The          | oor food/fluid intake. The goal   |            |          | last 30 days to   | on          |                  |
|                   | loss related to p      | ght to be stabilized with no  |            |          | verify accurate transcripti                                   | OII         |                  |
| 1                 |                        | Li abando IN 90 0000. 109   |            |          | to the Medication   |             |                  |
| 1                 | significant weig       | luded to provide diet as ordered,   |            |          | Administration  |             |                  |
| Į.                | approaches inc         | supplements as ordered.   |            |          | Record by 7/25/13.  |             |                  |
| }                 |                        |   |            |          | The Director of Nursing,                                      |             |                  |
| Ì                 | met                    | cumented for Resident #53 were:   |            |          | THE Director of Franchis                                      |             |                  |
| ]                 | I ne weights do        | s   |            |          | Staff Development   | a ner       |                  |
|                   | 5/1/13 - 132 lbs       | he  |            |          | Coordinator or Unit Man                                       | ager        |                  |
| 1                 | 6/14/13 - 121          | hs  |            |          | will correct discrepancie                                     | s as        |                  |
| 1                 | 6/14/13 - 1211         | hs  |            |          | identified and Medicatio                                      | n           |                  |
| 1                 | <b>\</b>               |   |            |          | Variance Reports  |             |                  |
| 1                 | Davious of the         | doctor orders revealed that on  |            |          | variance reports  |             |                  |
| 1                 | rionida there          | was an order for nouse  |            |          | will be completed for   | hv          |                  |
| 1                 | cumlement 4            | oz (ounces) twice a day with  |            |          | opportunities identified                                      | υy          |                  |
| 1                 | medication pa          | iss.  |            |          | 7/25/13.  |             | 3                |
|                   | 1                      |   |            |          | 1   |             | 1                |
| Ì                 | The dietary n          | ogress notes dated 5/31/13 was  | .          |          |   |             |                  |
| -                 | reviewed The           | notes indicated that Resident #53   | 3's        |          |   |             |                  |
| Į.                | IGAICAACO' ELIC        | <del>-</del>  |            |          | Facility ID: 952981   | If continue | ation sheet Page |

| ENTERS                   | FOR MEDICARE &  | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  |                   |       | NSTRUCTION   | co  | TE SURVEY<br>MPLETED |
|--------------------------|---|--|-------------------|-------|--|---|----------------------|
| EMENT OF C               | DEFICIENCIES<br>CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDI         | NG    |  |   |                      |
|                          |   | 245262   | B. WING           |       |  |   | 06/27/2013           |
|                          |   | 345362   |                   | STREE | T ADDRESS, CITY, STATE, ZIP CODE   |   |                      |
|                          | VIDER OR SUPPLIER   |  |                   | 250   | BISHOP LANE  |   |                      |
| RIAN CEN                 | ITER HEALTH & RET   | TREMENT/CABARRUS   |                   | COI   | PROVIDER'S PLAN OF CORRECT   | TION  | (X5)                 |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREI<br>TAG | =IX   | PROVIDER'S PLAN OF CONTROL OF CON |   | COMPLETION<br>DATE   |
|                          | Continued From p weight was 121.6 lbs/7.7 % since ac resident had cons notes further indic supplement 4 oz medication pass promote weight s  Review of the Ju Administration R house suppleme twice a day but t AM (once a day)  On 6/27/13 at 10 interviewed. Sh administer the n She stated that supplement to f written on the N order was twice  On 6/27/13 at 10 was interviewe signed off the f not available fo that the house incorrectly.  483.25(I) DRU UNNECESSA  Each resident unnecessary drug when us | age 15 lbs, a weight loss of 10.2 dmission/within 30 days. The sumed 50-75% of her meal. The cated that an order for house (ounces) twice a day with was ordered on 5/23/13 to tability.  ne, 2013 Medication ecord (MAR) revealed that the nt was transcribed to be given he timing was written at 10:00 nolly.  0:30 AM, CMA #3 was he stated that she was assigned to nedications for Resident #53. she had administered the house Resident #53 once a day as it was MAR. She was not aware that the he a day.  10:35 AM, administrative staff #1 d. She stated that the nurse who MAR at the end of the month was or interview. She acknowledged supplement was transcribed  13 G REGIMEN IS FREE FROM RY DRUGS  15 drug regimen must be free from drugs. An unnecessary drug is any ed in excessive dose (including |                   | 325   | Criteria 3 The Director of Nursing, Staff Development Coordinator or Unit Mana will re-educate all Licensed Nurses, including those working F and weekends, on accurate transcription of physician's orders includinate transcription of physician's orders includinate transcription of Nursing, Staff Developments by Coordinator or Unit Mana will audit the carbon cop of Physician's Orders and Medication Administration Records 4 times per week for 12 weeks to verify accurate transcription of Physician's orders, the audits will be document the monitoring tool. Opportunities will be corrected by the Direct Nursing, Staff Develop Coordinator or unit Mana daily as identified during these audits  | PRN  ing by  nent hager hies hid horotion hese ted on  or of homent hager | 7/2                  |
|                          | without adequ   | apy), or for exceeding apply, or lor exceeding all adequate rits use; or in the presence of sequences which indicate the dose  |                   |       |  | 16 11-  | nuation sheet Page   |

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

COMPLETED

06/27/2013

(X5) COMPLETION DATE

| DEPARTM                  | IENT OF HEALTH AN  | MEDICAID SERVICES  |                   |  |
|--------------------------|--|--|-------------------|--|
| STATEMENT OF AND PLAN OF | F DEFICIENCIES   | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   | IPLE CONSTRUCTION  |
|                          |  | 345362   | B. WNG            |  |
|                          | OVIDER OR SUPPLIER   | REMENT/CABARRUS  |                   | STREET ADDRESS, C<br>250 BISHOP LAN<br>CONCORD, NO   |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | 1 00004  |
|                          |  | (2)  |                   | Crite  |
| F 329                    | Based on a compreresident, the facility who have not used given these drugs therapy is necessarias diagnosed and record; and reside drugs receive grading the street interest.   | or discontinued; or any  |                   | The report of the performance of |
|                          | by: Based on record the facility failed (thyroid-stimulating (Resident #233) unnecessary me Resident #233 w 4/24/13. Cumulating Cumu | of ten residents reviewed for dications. The findings included:  vas admitted to the facility ative diagnoses included  inimum Data Set (MDS) dated Resident #233 had short and bry impairment and was aired in decision-making. |                   | E 3 me Cr. A TSF Reside was w Cr  Reside replace potent allege Direct Devel Unit l   |
| Ì                        | order for Levoth   | hyroxine 112 mcg. (micrograms)   |                   | audit  |

#### Criteria 4

STREET ADDRESS, CITY, STATE, ZIP CODE

250 BISHOP LANE CONCORD, NC 28025

> The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months. The committee will evaluate and make further recommendations as indicated.

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

Date of Compliance: July 25, 2013.

#### F 329 Unnecessary medications

#### Criteria I

A TSH was collected for Resident #233 by 6/28/13 and was within normal limits.

#### Criteria 2

Residents receiving a thyroid replacement hormone have the potential to be affected by this alleged deficient practice. The Director of Nursing, Staff Development Coordinator or Unit Manager will complete an audit of all residents receiving a thyroid replacement hormone by 7/25/13 to verify a physician's order is in place for TSH monitoring.

| ATEMENT OF        | DEFICIENCIES   | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   | IPLE CONSTR                               |   | (X3) DATE S<br>COMPL  | ETED .             |
|-------------------|--|---|-------------------|---|---|---|--------------------|
| D PLAN OF C       | ORRECTION  | IDENTIFICATION NOWBER   |                   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |   | 06/2  | 27/2013            |
|                   |  | 345362  | B. WNG            |   | PRESS, CITY, STATE, ZIP CODE  |   | ,                  |
|                   | VIDER OR SUPPLIER  |   | İ                 | 250 BISH                                  | OP LANE   |   | Ì                  |
| RIAN CE           | TER HEALTH & RETI  | REMENT/CABARRUS   |                   | CONCO                                     | RD, NC 28025  PROVIDER'S PLAN OF CORRECT  | ION   | (X5)               |
| (X4) ID<br>PREFIX | SUMMARY S  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |   | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LUGE  | COMPLÉTION<br>DATE |
| F 329             | Continued From par po (by mouth) daily A review of the phy through 6/276/13 ir written for Residen drawn.  A review of the host level.  Medication Regimpharmacist dated no recommendation physician stated hand June 2013 ar medical record ar TSH level had be he usually receive recommendation resident. He was level had not been 483.25(m)(1) FR RATES OF 5% Control This REQUIRES by:  Based on reconsiderated by:  Based on re | ge 17 for hypothyroidism. sician orders from 4/24/13 adicated there were no orders t #233 to have a TSH level spital records revealed no TSH e Reviews by the consultant 5/21/13 and 6/17/ 13 indicated ons for a TSH level. w on 6/27/13 at 2:30 PM, the he saw Resident #233 in May and would have looked in the he had hospital records to see if a hen completed. He also stated hed a pharmacy consultant if tab work is needed for a s not aware that a base TSH en completed for Resident #233. EE OF MEDICATION ERROR |                   | The Der Un Lic wo req mo res rep 20 N ( ) | criteria 3  Director of Nursing, State velopment Coordinator or it Manager will re-educate ensed Nurses, including the rking PRN and weekends uirements for laboratory onitoring via TSH for those idents receiving a thyroid placement hormone by Jul 13. The Director of fursing, Staff Development Coordinator or Unit Managerill audit the carbon copie Physician's Orders 4 time week for 12 weeks to veriff TSH) monitoring is in places idents receiving thyroid replacement hormones, the audits will be documented monitoring tool.  Opportunities will be corrected by the Director Nursing, Staff Development Coordinator or Unit Managerill audits. | e all hose , on  e  y 25,  nt ger s of s per fy lab ace for l ese l on the  of ent ager | 7/25/              |

| PLAN OF (                | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BUILDIN        | IG  |  |   | 6/27/2013          |
|--------------------------|--|---|-------------------|---|--|---|--------------------|
|                          |  | 345362  | B. WNG            |   |  | <u> </u>                                | 014114013          |
|                          | OVIDER OR SUPPLIER   | 10000   |                   | 250 BISHOP  |  |   |                    |
| RIAN CE                  | NTER HEALTH & RETIF  | REMENT/CABARRUS   |                   |   | , NC 28025<br>PROVIDER'S PLAN OF COR   | RECTION                                 | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX<br>TAG |  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | " i ~   | (EACH CORRECTIVE ACTION S<br>ROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SMOOLU DE                               | DATE               |
| F 332                    | Continued From pag   | ge 18   | F                 | 332   |  |   |                    |
|                          | 4 Decident #258 Wi   | as admitted to the facility on  |                   |   | riteria 4  |   |                    |
|                          | 6/13/13 with multiple deficiency anemia. orders indicated that for Ferrous Sulfate by mouth three time deficiency anemia.  On 6/25/13 at 5:46 (CMA) #1 was obs pass. CMA #1 was administer the medincluding the Ferrous had not been delived on 6/25/13 at 6:00 She stated that the delivered on the had not been  | e diagnoses including from The June, 2013 physician's at Resident #258 had an order 325 mgs (milligrams) 1 tablet es a day with meals for iron  |                   | repor<br>Assu<br>Impr<br>Dire<br>then<br>will<br>reco | results of the audits reted monthly in the Grance Performance rovement meeting by ctor of Nursing for quarterly. The comevaluate and make sommendations as income of Compliance: 25, 2013. | y the<br>3 months<br>nmittee<br>further |                    |
|                          | 6/14/13. The Jurindicated that Repotassium chloring one tablet three milkshake.  On 6/25/13 at 5: during the medicate to prepare and the properties of the p | 1 was admitted to the facility ne 2013 physician's orders isident # 251 had an order for de 20 meq. (milliequivallents) times daily. Take with food or 23PM., CMA #3 was observed to administer the medications for nocluding the potassium chloride. |                   |   |  |   |                    |

| TEMENT OF                | DEFICIENCIES   | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   | IPLE CONS    | TRUCTION  | COV       | E SURVEY<br>IPLETED |
|--------------------------|--|---|-------------------|--------------|---|-----------|---------------------|
| ID PLAN OF C             | CORRECTION   | IDENTIFICATION NOMBER.  |                   |              |   | 0         | 6/27/2013           |
|                          | DVIDER OR SUPPLIER   | 345362  | B. WNG            | 250 BI       | DDRESS, CITY, STATE, ZIP CODE<br>SHOP LANE                            |           |                     |
| BRIAN CEI                | NTER HEALTH & RETIF  | REMENT/CABARRUS   |                   | <del>└</del> | PROVIDER'S PLAN OF COR  | RECTION   | (X5)<br>COMPLETION  |
| (X4) ID<br>PREFIX<br>TAG |  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | ΊX           | (EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHUDLU DE | DATE                |
| F 332                    | Continued From page  | ge 19   | F                 | 332          |   |           |                     |
|                          | evening meal would   | edication.  PM., CMA #3 stated the darrive at 6:00PM. She e potassium chloride should or a milkshake and she just   |                   |              |   |           |                     |
| ı                        | stated she expecte   | O AM., Administrative staff #1 ed all medications to be physician's order and the eshould have been given with tie.   |                   |              |   |           |                     |
|                          | 2/8/13. Cumulativ  | vas admitted to the facility on<br>ve diagnoses included a<br>accident (CVA). Resident #21<br>y feeding tube and received all<br>ne gastrostomy tube.                               |                   |              |   |           |                     |
|                          | during medication<br>medications and<br>via the feeding to | in pass. Nurse #2 was observed in pass. Nurse #2 prepared the administered the medications libe. She gave the medications 90 ml. (milliliters) of water and liter flush between the |                   |              |   |           |                     |
|                          | - Barriago to flui   | 59 PM., Nurse #2 stated the sh the gastrostomy tube before ations had been administered.  |                   |              |   |           |                     |
|                          | stated she expe<br>administer the r<br>gastrostomy tub     | 0:10 AM., Administrative staff #1 acted the nursing staff to medications per the facility be policy which stated to flush with ter between medications.  TED NURSE STAFFING         | 3                 | F 35         | 6   |           | 7/2                 |

| + - D : AT : 4 | TAIT OF HEALTH AN    | ID HUMAN SERVICES   |           |       | <u> </u>   |                 | 0938-0391      |
|----------------|----------------------|---|-----------|-------|--|-----------------|----------------|
| DEPARTM        | ENLA MEDICADE O      | MEDICAID SERVICES   |           |       | TON.   | (X3) DATE       | SURVEY         |
| CENTERS        | FOR MEDICARE &       | (X1) PROVIDER/SUPPLIER/CLIA   |           |       | NSTRUCTION   | COMPL           | .етео          |
| CTATEMENT OF   | DEFICIENCIES         | IDENTIFICATION NUMBER:  | A. BUILDI | NG    |  |                 | }              |
| AND PLAN OF C  | ORRECTION            |   |           |       |  | 061             | 27/2013        |
| •              |                      | 0.5000  | B. WNG    |       |  | 1 001.          | 2112010        |
|                |                      | 345362  |           |       | TADDRESS, CITY, STATE, ZIP CODE                              |                 |                |
|                | VIDER OR SUPPLIER    |   | ;         | STREE | BISHOP LANE  |                 | !              |
|                |                      |   |           | 250   | BISHOF LANG  |                 |                |
| BRIAN CEN      | ITER HEALTH & RETIF  | REMENT/CABARRUS   |           | COL   | NCORD, NC 28025  | <u> </u>        | (X5)           |
| DINAN          |                      |   | ID.       |       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | U               | COMPLETION     |
| (X4) ID        |                      | TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  OF INENTIFYING INFORMATION)  | PREF      |       | CROSS-REFERENCED TO THE AFFINOR                              | RIATE           | DATE           |
| PREFIX         | (EACH DEFICIENT      | CY MOST BETTIED INFORMATION)  | TAC       | }     | DEFICIENCY)  |                 | <u> </u>       |
| TAG            | REGODATORY           |   |           |       |  |                 | 2/25/12        |
| L              |                      |   |           |       |  |                 | 1/23/13        |
|                |                      |   | F         | 356   |  |                 | 1 .            |
| F 356          | Continued From page  | ge 20   | 1         | 1     |  |                 |                |
| ss=C           | INFORMATION          |   |           |       | Criteria I   |                 |                |
| 30-0           |                      |   |           |       | The Director of Nursing                                      |                 |                |
| Ì              | The facility must po | est the following information on  |           |       | The Director of Parisity                                     |                 |                |
| Ţ              | a daily basis:       |   |           |       | updated the Daily Facility                                   |                 |                |
|                | o Facility name.     |   |           |       | Staffing Posting by  |                 |                |
|                |                      |   |           |       | documenting the RN and                                       |                 |                |
| <b>\</b>       | The setal number     | and the actual nouls worked   |           |       | LPN hours separately by                                      |                 |                |
| 1              | in a collection of   | tegories of ICCEISEU and  |           |       |  |                 |                |
| 1              | by the following on  | staff directly responsible for  |           |       | 6/28/13.   |                 |                |
| 1              | resident care per s  | shift:  |           |       | •  |                 |                |
| }              | Dogistered N         | urses.  |           |       | Criteria 2   |                 |                |
|                | l lineand pro        | ofical nurses of licensed   |           |       | All residents have potential                                 | to              |                |
| 1              | - Licenson pie       | (as defined under State law).   |           |       | be affected by this practice.                                |                 |                |
| ļ              | - Certified nurs     | se aides.   |           |       | be affected by this provide                                  |                 |                |
| }              | o Resident census    |   |           |       |  |                 |                |
| 1              | l                    |   |           |       | <u>Criteria 3</u>  |                 |                |
| Ì              | The facility must r  | post the nurse staffing data  |           |       | <del></del>  |                 |                |
| - 1            | - : : : : : : : :    | in a dally pasis at the beginning   |           |       | The Administrator and  |                 |                |
| }              | specified above of   | ta must be posted as follows:   |           |       | Director of Nursing were r                                   | e-              |                |
| Ţ              | o Clear and read     | able format.  |           |       | Director of National the dai                                 | lv              |                |
| }              | o Clear and read     | place readily accessible to   |           |       | educated regarding the dai                                   | nta             |                |
| Ì              | o in a prominent     | place roughly and the state of |           |       | staffing posting requireme                                   | ints            |                |
| }              | residents and vis    | illors.   |           |       | by the Division Director of                                  | I               |                |
| }              | - to the mount       | , upon oral or written request,   |           |       | Education on 6/27/13. The                                    | e               |                |
| 1              | The facility must    | fing data available to the public   |           |       | Administrator or Director                                    | of              |                |
| Ì              | make nurse stall     | ost not to exceed the community   |           |       | Administrator of Director                                    | l <sub>xr</sub> |                |
| 1              | for review at a co   | OST HOT TO CAGGGG THE   |           |       | Nursing will audit the dai                                   | 1 y             |                |
| }              | standard.            |   |           |       | staffing posting daily for                                   | ł               |                |
| Ì              |                      | intain the posted daily nurse   |           |       | week, then weekly for 11                                     |                 |                |
|                | The facility must    | t maintain the posted daily nurse<br>a minimum of 18 months, or as  |           |       | weeks to ensure posting i                                    | S               |                |
| l              | staffing data for    | a minimum of to market  |           |       | weeks to ensure positing i                                   |                 |                |
| 1              | required by Stat     | te law, whichever is greater.   |           |       | timely and accurate.   |                 |                |
| }              |                      |   |           |       | Opportunities will be  |                 |                |
| ł              |                      | NEXIT is not met as evidenced   |           |       | corrected by the   |                 |                |
| ĺ              | This REQUIRE         | MENT is not met as evidenced  |           |       | Oliovio oy Dimorto   | r of            |                |
| ļ              | by:                  | tions, record review and staff  |           |       | Administrator or Directo                                     | . A             |                |
| 1              | Based on obse        | ervations, record review and staff  |           |       | Nursing daily as identific                                   | ea              |                |
| }              | to tame love the fe  | acility talled to post daily staining   |           |       |  |                 | ì              |
| Ì              | with accurate in     | nformation for 4 out of 4 days.   |           |       |  |                 | ion sheet Page |

| ENTERS                   | DEFICIENCIES  | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA   |             | PLE CONS |  | COM                       | E SURVEY<br>PLETED |
|--------------------------|---|--|-------------|----------|--|---------------------------|--------------------|
| PLAN OF C                | CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDIN  | IG       |  |                           | 20710043           |
|                          |   | 345362   | B. WNG_     |          |  | 1 00                      | 3/27/2013          |
|                          | OR OURD IEO   |  |             | STREET A | DDRESS, CITY, STATE, ZIP CODE  |                           |                    |
|                          | VIDER OR SUPPLIER   | OFFICARARRUS   |             |          | HOP LANE<br>ORD, NC 28025  |                           |                    |
| RIAN CEN                 |   | REMENT/CABARRUS  | <u> </u>    | 1        | THE PROPERTY OF CORRECT  | ION                       | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX<br>TAG |   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | PREF<br>TAG | T T      | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   |                           | DATE               |
| F 356                    | Continued From pa   | ge 21  | F           | 356      | Criteria 4   |                           |                    |
|                          | The findings includ   | ed:  |             | •        |  |                           |                    |
|                          | daily staffing was registered nurses.  On 6/25/13 at 9:05 noted to list all lice  | 0 am, during the initial tour, the noted to list all licensed nurses whift and did not recognize the ed for the licensed practical and am, the daily staffing was bensed nurses together, at each ecognize the actual hours ensed practical and registered |             |          | The results of these audits very be reported to the monthly QAPI meeting by the Administrator and the committee will make recommendations for furth action as needed.  |                           |                    |
|                          | nurses.   |  |             | Da       | ate of Compliance:   |                           |                    |
|                          | On 6/25/13 at 3:1   | 1 pm, the daily staffing was   |             | Ju       | ly 25, 2013.   |                           |                    |
|                          | noted to list all lic<br>shift and did not r<br>worked for the lic<br>nurses.   | ensed nurses together, at each recognize the actual hours ensed practical and registered   |             |          |  |                           |                    |
| F 3                      | #5 was approach He stated that he on to fill out the that it was done would make sur- 10:38 am, the re observed on the separate the ac licensed practic 71 483.35(i) FOOE STORE/PREPA | ARE/SERVE - SANHART  |             | F 371    | Criteria I The Fryer and the Meal T Carts were cleaned by the Dietary Manager on 6/28  Criteria 2 All residents have the potential to be affected I this alleged deficient pra related to the Fryer and Meal Tray Carts. | e<br>/13.<br>by<br>actice | 7/25               |

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| DEPARTM<br>CENTERS | FOR MEDICARE &   | MEDICAID SERVICES   | (X2) MULT   | IPLE CON | STRUCTION  | (X3) DATE S | SURVEY                     |
|--------------------|--|---|-------------|----------|--|-------------|----------------------------|
| STATEMENT OF       | DELIGITION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                   | A. BUILDI   |          |  | 06/:        | 27/2013                    |
|                    |  | 345362  | B. WNG      |          | TATE ZIP CODE  |             |                            |
|                    | OVIDER OR SUPPLIER   | 1   |             | 250 B    | ADDRESS, CITY, STATE, ZIP CODE ISHOP LANE  | ٠           |                            |
| BRIAN CEI          | NTER HEALTH & RETIF  |   | OI          | CON      | PROVIDER'S PLAN OF CORRECTION SHOULD GEACH CORRECTIVE ACTION SHOULD GO THE APPROVI | 0 0⊏        | (X5)<br>COMPLETION<br>DATE |
| (X4) ID<br>PREFIX  |  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREF<br>TAC |          | CROSS-REFERENCED TO THE APPROX<br>DEFICIENCY)                                      | RIATE       | JAN 2                      |
| TAG                | REGOLATORY   |   |             |          |  |             |                            |
| - 07/              | o was and Erom nad   | ne 22   | F           | 371      |  |             |                            |
| F 371              | Continued From page (2) Store, prepare, of under sanitary conditions | listribute and serve food   |             |          | <u>Criteria 3</u><br>The Dietary Manager will                                      |             |                            |

This REQUIREMENT is not met as evidenced

Based on observation, staff interview and record review the facility failed to maintain a deep fryer free from greasy buildup and to maintain 1 of 2 open rack meal carts free from debris between scheduled cleanings. The findings included:

1. Review of the Daily Cleaning Schedule revealed that the Fryer/Floor/Wall was to be cleaned once a week by #4 Cook. The description stated "drain grease from fryer, use cleaner to thoroughly clean inside and outside of fryer, clean wall and floor around fryer." The schedule indicated this was to be done on Tuesdays. The column for the initials of the person who completed the task was left blank.

On 6/24/13 at 11 AM the deep fryer was observed to have dark brown liquid (oil) in it with a build up of dark brown debris (approximately 1 - 2 inches in height) around all 4 sides of the interior of the deep fryer (1 - 2 inches above the level of the liquid). The outside of the deep fryer was observed to have greasy brown buildup on areas of the front and the one visible side panel.

On 6/26/13 at 12:20 PM the deep fryer was observed to have dark brown liquid (oil) in it with a build up of dark brown debris (approximately 1 -2 inches in height) around all 4 sides of the

re-educate all Dietary staff on the procedures, frequency and documentation of cleaning the Fryer and the Meal tray carts by 7/25/13. The education regarding the procedure for cleaning the Fryer includes the following details. The Fryer will be drained, deep cleaned using oven cleaner and rinsed once per week. After drying, fresh oil will be added to the Fryer. The Fryer baskets will be cleaned daily following use. The education regarding procedures for cleaning the Meal Tray Carts includes the following details. The Meal Tray Carts will be cleaned with Sanitizer and Stainless Steel Cleaner to removes spills and debris daily following use. The Meal Tray Carts will be deep cleaned 3 times per week using hot, soapy water and a scrub brush followed by Sanitizer and Stainless Steel Cleaner The Dietary Manager will

randomly review the documentation log and visually validate cleaning of the fryer and the meal tray carts 3 times per week for 12 weeks and document these audits on the monitoring tool

PRINTED: 07/10/2013

| ENTERS                     | FOR MEDICARE &   | ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIP         |         |   | (X3) DATE<br>COM  | SURVEY<br>PLETED   |
|----------------------------|--|--|---------------------|---------|---|-------------------|--------------------|
| ATEMENT OF<br>ID PLAN OF C | DEFICIENCIES<br>CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING         | 3       |   | 06                | 6/27/2013          |
|                            |  | 345362   | B. WNG              |         | OTATE ZIR CODE  |                   |                    |
|                            | an augustu   |  | \$                  | STREETA | DDRESS, CITY, STATE, ZIP CODE   |                   |                    |
|                            | OVIDER OR SUPPLIER   |  | 1                   | 250 BIS | SHOP LANE<br>ORD, NC 28025  |                   |                    |
| BRIAN CEN                  | NTER HEALTH & RET!   | REMENT/CABARRUS  |                     | CONC    | THE PLAN OF CORRECT   | ION               | (X5)<br>COMPLETION |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY S  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (       | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD 0-             | DATE               |
|                            | Erom na  | ge 23  | F                   | 371     |   |                   |                    |
| F 371                      | Continued From pa  | forer /1 - 2 inches above the  | ١                   |         | - with as will be   |                   |                    |
|                            | 1  | The children of the door "7"   |                     |         | Opportunities will be   |                   |                    |
|                            |  |  |                     |         | corrected by the  |                   |                    |
|                            | 1 611 6  | AN IND OUR VISIDIC SIGO POITE.   |                     |         | Dietary Manager   |                   |                    |
|                            | lar than of the  | a traville at this time to the   |                     |         | daily as identified during  |                   |                    |
|                            | that fried chicken h   | nad been prepared for lunch.   |                     |         | these audits.   |                   |                    |
|                            | observed to have a build up of dark 2 inches in height, interior of the dee level of the liquid) was observed to areas of the front  On 6/27/13 at 11: Dietary Manager cleaned weekly at the task they we She added that a review that clear but that she had  On 6/27/12 at 1: Administrative Staff were adher just failed to do. | dark brown liquid (oil) in it with brown debris (approximately 1 - 1) around all 4 sides of the p fryer (1 - 2 inches above the . The outside of the deep fryer have greasy brown buildup on and the one visible side panel.  20 AM., interview with the revealed that the fryer was to be and that when staff completed re to initial it off as completed at the end of the day she was to ning tasks had been completed not done it this week.  1:25 AM., interview with staff #7 revealed that she believed ring to the cleaning schedule and cument that the fryer had been ndicated that she was not aware on the fryer continued to look as it |                     |         | Criteria 4  The results of the audits of the reported in the month Quality Assurance Performance Improvement meeting by the Dietary Manager for 3 months. committee will evaluate make further recommendations as indicated.  Date of Compliance:  July 25, 2013. | ily<br>int<br>The |                    |
|                            | revealed the fo<br>Monday by Aid<br>description sta  | ne daily cleaning schedule od carts were to be cleaned on le #3 and Friday by Aide #6. The ted "spray carts with cleaner, wn thoroughly, wipe spills or olumn for the initials of the person   |                     |         |   |                   | ation sheet Page   |

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| DEPARTM       | ENT OF HEALTH AN                | ID HUMAN SERVICES  |           |             |   | (X3) DATE S | SURVEY             |
|---------------|---------------------------------|--|-----------|-------------|---|-------------|--------------------|
| CENTERS       | FOR MEDICARE &                  | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  |           |             | NSTRUCTION  | COMPL       | ETED               |
| STATEMENT OF  | DEFICIENCIES                    | IDENTIFICATION NUMBER:   | A, BUILDI | NG          |   |             | }                  |
| AND PLAN OF   | 00////2071                      |  |           |             |   | 06/2        | 27/2013            |
|               |                                 | 345362   | B. WNG    |             | T ADDRESS, CITY, STATE, ZIP CODE                            |             | 1                  |
|               | OVIDER OR SUPPLIER              |  |           | STREE       | BISHOP LANE   |             | į                  |
|               |                                 | DEMENT/CARARRUS  |           | CO          | NCORD, NC 28025   |             | ,                  |
| BRIAN CE      | NTER HEALTH & RETII             |  | ID        | <del></del> | - THE TOLO DI AN OF CORREC                                  | TION        | (X5)<br>COMPLETION |
| (X4) ID       | SUMMARY S                       | TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  ALCO (DENTIFYING INFORMATION) | PREI      | FIX         | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPL | ROPRIATE    | DATE               |
| PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OF | R LSC IDENTIFYING INFORMATION)   | TA        | 3           | DEFICIENCY)   |             |                    |
|               |                                 |  |           | 371         |   |             |                    |
| F 371         | Continued From pa               | ge 24  |           | 371         |   |             | 1                  |
|               | مملك است د                      | took was filled in With Initials   |           |             |   |             | }                  |
|               | for Monday. The F               | riday cleaning was not yet due.  |           |             |   |             | 1                  |
|               | 0.00 at 10:15 P                 | M 1 of 2 open rack meal carts  | Ì         | ļ           |   |             | 1                  |
| 1             | 1                               | rave to the unfilling toom.  | {         | Ì           |   |             |                    |
| }             |                                 |  | Ì         |             |   |             |                    |
| ļ             |                                 |  |           |             |   |             |                    |
| 1             | i onto when pushing             | I the toda carr bilor to arra arra-  |           |             |   |             |                    |
|               | delivering meal tra             |  |           |             | ·   |             |                    |
| 1             | On 6/27/13 at 11:1              | 3 AM 1 of 2 open rack meal   |           |             |   |             |                    |
| }             |                                 | magi fravs to the uniting  |           |             |   |             |                    |
|               |                                 | have a build-up of yellowish<br>iris on the vertical bars that staff                 |           |             |   |             |                    |
| Į.            | beige colored den               | pushing the food cart prior to   |           |             |   |             |                    |
|               | and after deliverir             | ng meal trays to residents.  |           |             |   |             |                    |
|               | 1                               |  |           |             |   |             |                    |
|               | On 6/27/13 at 11:               | 27 PM interview with   |           |             |   |             |                    |
| }             | Administrative St               | aff #7 revealed that she ere was debris on the open rack                             |           |             |   |             |                    |
| 1             | acknowledged th                 | ndicated that this had been a  | \         |             |   |             |                    |
|               | tillians also supp              | aware of and that  |           |             |   |             |                    |
| ł             | improvements ha                 | ad been made in keeping are  |           |             |   |             | ļ                  |
|               | mod carts clean                 |  | ļ         | F 42        | 25  |             | 712-10             |
|               |                                 | HARMACEUTICAL SVC -<br>OCEDURES, RPH   |           |             | Criteria I  |             | ાવિગા              |
| SS            | 1                               |  |           |             | The Director of Nur   | sing        |                    |
| }             | The facility must               | t provide routine and emergency  |           |             | completed Medicat   | ion         |                    |
|               | developed highly                | dicals to its residents, or obtain   |           |             | Variance Forms and  | i notified  |                    |
|               | مضعمات بأ                       | SAFAAMENI NESUNUUV III   |           |             | the Physician of mi   | ssed doses  |                    |
| <u> </u>      | §483.75(h) of th                | is part. The facility may permit connel to administer drugs if State                 | ,         |             | of Amhien ER on 5   | /20/13,     |                    |
|               | uniicensea pers                 | t only under the general   |           |             | 5/21/13 and 5/23/13   | 3 and for   |                    |
|               | supervision of a                | a licensed nurse.  |           |             | missed doses of VI  | mpat on     |                    |
|               | <b>,</b>                        | provide pharmaceutical services  |           |             | 5/29/13, 5/30/13 ar   | nd 5/31/13  |                    |
| Į.            | A facility must b               | provide pharmaceutical set vices   | ļ         |             | ر جد ترسوران  | . 6/20/13   |                    |

A facility must provide pharmaceutical services

(including procedures that assure the accurate

acquiring, receiving, dispensing, and

for Resident #54 on 6/28/13.

The Charge Nurse obtained

Ambien ER on 5/24/13 and Vimpat on 6/1/13 for resident

#54.

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 06/27/2013 R. WNG 345362 STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE NAME OF PROVIDER OR SUPPLIER CONCORD, NC 28025 BRIAN CENTER HEALTH & RETIREMENT/CABARRUS (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG F 425 Continued From page 25 administering of all drugs and biologicals) to meet Criteria 2 the needs of each resident.

All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing, Staff Developmernt Coordinator or Unit Manager will conduct an audit of all medications storage rooms, refrigerators and medications carts to verify medications currently ordered are available for administration. The audit will be completed by 7/25/13.

#### Criteria 3

The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on the policy and procedure for ordering and receiving medications by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will audit all medication rooms and medication carts weekly for 12 weeks to verify medication currently ordered are available for administration, these audits will be documented on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager daily as identified during these audits.

This REQUIREMENT is not met as evidenced Based on record review and staff, family and

The facility must employ or obtain the services of

a licensed pharmacist who provides consultation

on all aspects of the provision of pharmacy

services in the facility.

resident interview, the facility failed to ensure that medications were requested, received and administered as ordered as evidenced by missed dosages of medications due to unavailability for 1 (Resident # 54) of 10 sampled residents. Findings include:

Resident #54 was admitted to the facility on 12/8/12 and was re-admitted on 5/13/13 with multiple diagnoses including seizure disorder and insomnia.

The quarterly MDS assessment dated 6/20/13 indicated that Resident #54 was cognitively intact.

Review of the physician's orders on admission (5/13/13) revealed that Resident #54 was on Ambien ER (a sedative/helps with sleep) 12.5 mgs (milligrams) 1 tablet by mouth at bedtime for insomnia and Vimpat (anti seizure drug) 50 mgs -4 tablets by mouth twice a day for seizures.

The MARs (Medication Administration Records) for May, 2013 were reviewed. The MAR revealed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LUYY11

|                   | THE OF HEATTH AND  | ID HUMAN SERVICES   |        |  |                | ), 0930-0001        |
|-------------------|--|---|--------|--|----------------|---------------------|
| EPARTM            | ENT OF HEALTH AN   | ID HUMAN SERVICES   |        |  | (X3) DATE      | SURVEY              |
| <b>ENTERS</b>     | FOR MEDICARE &   | MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  |        | LE CONSTRUCTION                          | COW            | PLETED              |
| TEMENT OF         | DEFICIENCIES   | (X1) PROVIDENSOPPCIENTOEIN IDENTIFICATION NUMBER:   |        | ·  | }              | ł                   |
| PLAN OF C         | ORRECTION  | No.   | 1      |  | ne             | 3/27/2013           |
|                   |  |   | B. WNG |  |                | 3,2,1,2\(\sqrt{1}\) |
|                   |  | 345362  | 1      | STREET ADDRESS, CITY, STATE, ZIP CO      | DE             |                     |
|                   | TO OD CLUDDI ICO   |   | 15     | 250 BISHOP LANE                          |                | ļ                   |
| AME OF PRO        | VIDER OR SUPPLIER  |   | 1      | 200 BIOTOF LATE                          |                |                     |
| SOLANI CEN        | ITER HEALTH & RETI   | REMENT/CABARRUS   | 1      | CONCORD, NC 28025                        | CORRECTION     | (X5)                |
| SKIAN OLI         |  |   | ID.    | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC |                | COMPLETION<br>DATE  |
| 040.10            | SUMMARY S  | STATEMENT OF DEFICIENCIES   | PREFIX | \ \ADAGG.DEFFRENUEU IV                   | A LUC YOU LINE |                     |
| (X4) ID<br>PREFIX | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | TAG    | DEFICIEN                                 | (CY)           |                     |
| TAG               | REGULATORY   |   |        |  | <u></u> -      |                     |
|                   |  |   |        |  |                |                     |
|                   |  |   | F      | 425                                      |                | 1                   |
| F 425             | Continued From pa  | ge 26   |        | ļ  |                |                     |
|                   |  | Administered to Resident  |        |  |                |                     |
|                   |  |   |        | <u>Criteria 4</u>                        |                |                     |
|                   |  |   |        |  | 41             |                     |
|                   | l desiminatored d  | THE TO DELLIG OUT OF SUPPLY STATE   |        | The results of the au                    | dits will be   |                     |
|                   | was waiting for the  | pharmacy to deliver.  |        | reported monthly in                      | the Quality    |                     |
|                   |  |   |        | Assurance Performa                       | ince           |                     |
|                   | The MARe for May   | y, 2013 revealed that vimpat  |        | Assurance refronti                       | ng by the      |                     |
|                   |  |   |        | Improvement meeti                        | ing by the     |                     |
|                   |  |   |        | Director of Nursing                      | TOL 2 Inomine  |                     |
|                   |  |   |        | than quarterly. The                      | COMBINITE      |                     |
|                   | and 9:00 FW dose   | at vimpat was not administered  |        | will evaluate and m                      | ake further    |                     |
|                   | MAK indicated the  | of euroly.  | 1      | Will evaluate and in                     | a indicated.   |                     |
|                   | due to being out of  | or support  |        | recommendations a                        | is maioaroa.   |                     |
|                   | - CAle o musi  | rse's notes revealed that   |        |  |                |                     |
|                   | Review of the flui   | d seizure activity on 6/4/13 at   |        |  |                |                     |
|                   | Resident #54 had   | nessed) and on 6/6/13 at 5:00   |        | Date of Compliance                       | e:             |                     |
|                   | 12:45 AM (UNWIT  | nessed) and on order  |        | July 25, 2013.                           |                |                     |
| 1                 | PM (witnessed).  |   |        | July 25, 2015.                           |                |                     |
| }                 |  | 40 DM a family member was   |        |  |                |                     |
| }                 | On 6/26/13 at 4:   | 10 PM, a family member was  | 1      |  |                |                     |
| 1                 | interviewed. The   | e family member indicated that  | }      |  |                |                     |
| }                 |  |   |        |  |                |                     |
| 1                 |  |   |        |  |                |                     |
| ļ                 | 1  | A NOT RECEIVE LIGHT TO AND A  |        |  |                |                     |
| }                 | ويحسمان برا  | was mornen naving to com-   |        |  |                |                     |
|                   |  |   |        |  |                |                     |
| 1                 |  | il the solizare activity  | 1      |  |                |                     |
|                   | several doses of   | of the seizure medication might<br>e resident to have seizure activity.   |        |  |                |                     |
|                   | several doses of have caused the   | e resident to have solver also stated that Resident #54   |        |  |                |                     |
|                   | several doses of have caused the   | e resident to have solver also stated that Resident #54   |        |  |                |                     |
|                   | have caused th<br>The family men<br>had missed sev   | e resident to have selected that Resident #54 veral doses of her sleeping pill.   |        |  |                |                     |
|                   | have caused the The family mental had missed set   | e resident to have selected that Resident #54 veral doses of her sleeping pill.   |        |  |                |                     |
|                   | several doses of have caused the The family men had missed set On 6/27/13 at 8   | e resident to have selection to have selection to have selected that Resident #54 yeral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed to have a resident was out of  | •      |  |                |                     |
|                   | have caused the The family men had missed set On 6/27/13 at 8 She stated that  | e resident to have solven to have also stated that Resident #54 veral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed twhen a resident was out of the nurse, and the nurse.  | e      |  |                |                     |
|                   | have caused the The family men had missed set on 6/27/13 at 8 She stated that medication she                             | e resident to have selection to have selection to have selected that Resident #54 veral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed to when a resident was out of the informed the nurse, and the nurse that shock the pyxis, if not available   | e      |  |                |                     |
|                   | have caused the The family ment had missed set on 6/27/13 at 8. She stated that medication she was supposed              | e resident to have seizent #54 wher also stated that Resident #54 weral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed t when a resident was out of informed the nurse, and the nurse to check the pyxis, if not available  | e ,    |  |                | Į                   |
|                   | have caused the The family ment had missed set on 6/27/13 at 8 She stated that medication she was supposed the nurse wou | e resident to have selection to have selection to have selected that Resident #54 yeral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed the when a resident was out of the informed the nurse, and the nurse to check the pyxis, if not available lid call the pharmacy. She added   | e ,    |  |                | \                   |
|                   | have caused the The family ment had missed set on 6/27/13 at 8 She stated that medication she was supposed the nurse wou | e resident to have selection to have selection to have selected that Resident #54 yeral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed the when a resident was out of the informed the nurse, and the nurse to check the pyxis, if not available lid call the pharmacy. She added   | e ,    |  |                |                     |
|                   | have caused the The family ment had missed set on 6/27/13 at 8 She stated that medication she was supposed the nurse wou | e resident to have seizure e resident to have seizure her also stated that Resident #54 veral doses of her sleeping pill.  3:05 AM, CMA #2 was interviewed to when a resident was out of a informed the nurse, and the nurse to check the pyxis, if not available ld call the pharmacy. She added ally faxed the sticker for refill to the en 8 tablets/capsules were left on | e ,    |  |                |                     |

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 06/27/2013 B. WNG 345362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 250 BISHOP LANE CONCORD, NC 28025 BRIAN CENTER HEALTH & RETIREMENT/CABARRUS (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 425 F 425 | Continued From page 27 On 6/27/13 at 8:15 AM, Nurse #1 was interviewed. She could not remember if she was informed by the CMA when the ambien and vimpat ran out. She stated that when a resident ran out of medication, she checked the pyxis, and if not available she had to call the pharmacy. She further stated that after hours, the pharmacy had an emergency number that she could call. After hours, the pharmacy could call the back up pharmacy to deliver the medication. On 6/27/13 at 9:15 AM, Resident #54 was interviewed. She stated that she had not received some of her medications (ambient and vimpat) because the facility had ran out of supply. She indicated that she needed the ambien because she could not sleep at night and the vimpat for the seizures. She stated that she had 2 episodes of seizure activity this month of June. On 6/27/13 at 2:20 PM, administrative staff #1 was interviewed. She stated that she believed that the staff had faxed or scanned the sticker for refill to the pharmacy timely. She stated that the pharmacy did not send the medications because they (ambien and vimpat) were controlled medications and they needed a script. There was a delay in the delivery of the medications because the pharmacy had to wait for the script from the doctor. She indicated that from now on she would make sure that she had emergency supply of medications in the pyxis at all times. F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT Criteria I A TSH was collected for F 428 IRREGULAR, ACT ON Resident #233-by 6/28/13 and SS=D

The drug regimen of each resident must be

reviewed at least once a month by a licensed

was within normal limits.

PRINTED: 07/10/2013

| FNTERS                   | ENT OF HEALTH AN<br>FOR MEDICARE & I   | VIEDIONID OFFICE  | (X2) MULT | IPLE CO   | ONSTRUCTION  | (X3) DATE :          | LETED                      |
|--------------------------|--|---|-----------|---|--|----------------------|----------------------------|
| TEMENT OF                | DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BUILDI | NG  |  | nei                  | 27/2013                    |
| •                        |  | 345362  | B. WNG    |   |  | 1 06                 | 2112010                    |
|                          |  | 0.000   |           | STREE   | ET ADDRESS, CITY, STATE, ZIP CODE<br>BISHOP LANE   |                      |                            |
| AME OF PRO               | OVIDER OR SUPPLIER   |   |           | 250   | NCORD, NC 28025  |                      |                            |
| BRIAN CE                 | NTER HEALTH & RETIF  |   | ID        | ┸┈┯   | PROVIDER'S PLAN OF CORRECT   |                      | (X5)<br>COMPLETION<br>DATE |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S<br>(EACH DEFICIEN<br>REGULATORY OF   | TATEMENT OF DEFICIENCIES  OY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)   | PREF      | ix  | (EACH CORRECTIVE ACTION OF THE APPRICACE | PRIATE               | DATE                       |
| F 428                    | Continued From pa  | ge 28   | F         | 428   | Criteria 2  Residents receiving a thyroireplacement hormone have   | 1110                 |                            |
|                          | The pharmacist mu  | st report any irregularities to cian, and the director of reports must be acted upon.   |           |   | potential to be affected by alleged deficient practice.  Director of Nursing, Staff Development Coordinator Unit Manager will comple   | The or ted an ving a |                            |
|                          | This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and consultant pharmacist interview, the consultant pharmacist failed to report the missing laboratory monitoring of TSH (thyroid stimulating hormone) blood level for one (Resident # 233) of ten residents reviewed for unnecessary medications. The findings included:  Resident #233 was admitted to the facility 4/24/13. Cumulative diagnoses included hypothyroidism.  An Admission Minimum Data Set (MDS) dated 5/1/13 indicated Resident #233 had short and long term memory impairment and was moderately impaired in decision-making.  A review of physician orders dated 4/24/13 revealed an order for Levothyroxine 112 mcg. (micrograms) po (by mouth) daily for |   |           | thyroid replacement hormore 7/25/13 to verify a physicity order is in place for TSH monitoring.  Criteria 3  The Director of Pharmac Services, the Director of or Staff Development Coordinator will educate Consultant Pharmacist to baseline labs for monito residents on thyroid replacements on thyroid replacements of the following admission to facility by 7/25/13. The | y Nursing the prequest ring lacement st review the   |                      |                            |
|                          | physician orde   | e medical record revealed no<br>ers to obtain a TSH level; hospital<br>ords did not indicate a TSH level;<br>t results were reviewed with no TS |           |   |  |                      | ation sheet Pag            |

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING \_ IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 06/27/2013 B. WING 345362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 250 BISHOP LANE CONCORD, NC 28025 BRIAN CENTER HEALTH & RETIREMENT/CABARRUS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DATE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX of Pharmacy services will review TAG the pharmacy consultant report F 428 monthly for 3 months to verify Continued From page 29 F 428 level noted; Medication Regime Reviews by the residents receiving thyroid consultant pharmacist dated 5/21/13 and 6/17/ 13 replacement hormones have been indicated no recommendations. Hypothyroidism reviewed and verify a request for was noted as a diagnosis on the medication baseline lab monitoring has been regime review. completed. This review will be On 6/27/13 at 11:30 AM, the pharmacy consultant documented and provided to the stated if a resident received levothyroxine and facility via monthly report. had a TSH level noted in the medical record, he This report will be reviewed by would recommend the level be checked annually the Director of Nursing monthly or more often if problems were noted. When informed that there was not a base TSH level on and opportunities will be Resident #233's medical record since the corrected by the Director of admission date of 6/24/13 and that the Nursing, Staff Development Medication Regime Reviews dated 5/21/13 and Coordinator or Unit Manager as 6/17/13 had not indicated that a TSH level be obtained, he stated he waited three months from identified during these reviews. admission to see if the physician ordered a TSH level, then would make a recommendation in July for a TSH level. F 431 Criteria 4 483.60(b), (d), (e) DRUG RECORDS, F 431 LABEL/STORE DRUGS & BIOLOGICALS The results of the audits will be ss=D reported monthly in the Quality The facility must employ or obtain the services of a licensed pharmacist who establishes a system Assurance Performance of records of receipt and disposition of all Improvement meeting by the controlled drugs in sufficient detail to enable an Director of Nursing for 3 months accurate reconciliation; and determines that drug then quarterly. The committee records are in order and that an account of all will evaluate and make further controlled drugs is maintained and periodically recommendations as indicated. reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted Date of Compliance: professional principles, and include the appropriate accessory and cautionary July 25, 2013. instructions, and the expiration date when applicable.

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER:

OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING \_

PRINTED: 07/10/2013 FORM APPROVED

|                    | 06/27/2013 |
|--------------------|------------|
| 8. WNG             | <b></b>    |
| <br>STATE ZIP CODE |            |

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE CONCORD, NC 28025

| BRIAN CENTER REALTH & INC. |   |               | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE           | (X5)<br>COMPLETION<br>DATE |
|----------------------------|---|---------------|--|----------------------------|
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | DATE                       |
| IAG                        |   |               | Criterial  |                            |

#### Continued From page 30 F 431

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

345362

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on record review, observation and staff interview, the facility failed to discard expired medications in 2 (lower 300 hall and upper 200 hall medication carts) of 6 medications carts and 1 of 2 medication room refrigerators (100/300 hall). The findings included:

The facility's policy on "Insulin Storage Recommendations " dated 4/10/13 was reviewed.

The policy indicated that opened vial of Humalog was good for 28 days at room temperature.

1. On 6/27/13 at 10:55 AM, the medication carts were observed. On the lower 300 hall medication cart, there were 2 opened vials of Humalog that

F 431

The expired medications were discarded and replaced immediately following identification.

#### Criteria 2

All residents have the potential to be affected by this alleged deficient practice. An audit of all medications storage rooms, refrigerators and medications carts and all expired or opened and unlabeled items identified were discarded immediately. The audit will be completed by 7/25/13.

#### Criteria 3

The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on the policy and procedure for labeling and storing medications by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will audit all medication rooms and medication carts weekly for

| CENTERS                  | FOR MEDICARE &   | MEDICAID SERVICES   |                   |            | INSTRUCTION  | (X3) DAT<br>CON                 | E SURVEY<br>IPLETED |
|--------------------------|--|---|-------------------|------------|--|---------------------------------|---------------------|
| AND PLAN OF              | CORRECTION   | IDENTIFICATION NUMBER:  | A, BUILDI         | NG         |  |                                 | 6/27/2013           |
|                          | OVIDER OR SUPPLIER   |   |                   | 250<br>COI | T ADDRESS, CITY, STATE, ZIP CODE BISHOP LANE NCORD, NC 28025 PROVIDER'S PLAN OF CORRECT  | TION                            | (X5)<br>COMPLETION  |
| (X4) ID<br>PREFIX<br>TAG |  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | FIX        | (EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY)   | OPRIATE                         | DATE                |
| F 431                    | were expired. The of were 5/17/13 and 5/ (certified medication She stated that nurse checking the expiral medications in the PM, Nurse #1 was nurses were supposite expiration dates of insulin daily but the have been missed.  2. On 6/27/13 at 11 the upper 200 hall bottle of acid reduced date of 5/13. At 11 interviewed. She supposed to be chinsulin and the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications in bottle of acid reduced in the medications and compositories have been medications and compositories have been medications and compositories have been medications and compositories have been missed. | open dates written on the vials 19/13. At 11: 20 AM, CMA aide) #2 was interviewed. Sees were supposed to be tion dates of insulin and the medication carts daily. At 4:40 interviewed. She stated that sed to be checking the the medications including use 2 vials of Humalog might.  1:15 AM, the medication cart on was observed. There was a cer tablets with an expiration at 1:20 AM, CMA #2 was stated that nurses were recking the expiration dates of adications in the medication. PM, Nurse #1 was stated that nurses were recking the expiration dates of acididing insulin daily but this incer might have been missed.  4:30 PM., an observation of the gerator revealed seven(7) ositories (a medication used for expiration date of 4/13.  35 PM., Administrative staff #1 hecked the medication room ry morning for expired did not know how the | F                 | F 431      | 12 weeks to verify medication storage per policy, these auditivities will be documented on the monitoring tool.  Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Managed aily as identified during the audits.  Criteria 4  The results of the audits we reported monthly in the Quantity Assurance Performance Improvement meeting by Director of Nursing for 3 then quarterly. The commodile evaluate and make fur recommendations as indicated to the provide | ill be uality the months nittee | 7/25                |
|                          | 456   483.70(c)(2) ES<br>S=E   OPERATING C(  | ONDITION  |                   |            |  |                                 |                     |

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING \_ IDENTIFICATION NUMBER AND PLAN OF CORRECTION B. WING 345362 NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & RETIREMENT/CABARRUS SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 456 Continued From page 32 F 456 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced Based on observation, resident, family and staff by: interviews, the facility failed to make repairs, over an extended period of time, on a non-working whirlpool tub, post a sign on a non-working appliance (clothes dryer), in order to prevent a fire hazard and to use a toaster in a safe manner. The findings included: 1.] On 6/27/13 at 9:25 am, Administrative Staff #2 was interviewed about any equipment needing repairs in the facility. He mentioned that the facility had one whiripool tub that needed repairs. He shared that he had requested new parts to repair the seal on the door but encountered problems since the tub was old and the parts had been discontinued. He stated that the tub has needed this repair since prior to his employment, which began in 2009. For now, he explained that the residents do not use the tub; they only have access to the shower in the bathroom. A.] On 6/26/13 at 4:10 pm, the Responsible Party for Resident 54 stated that she was concerned that the tub on the 300 hall has not been working for a long time. She stated that Resident #54 preffered to have a tub bath and was not comfortable taking a shower.

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

06/27/2013

(X5) COMPLETION

STREET ADDRESS, CITY, STATE, ZIP CODE

250 BISHOP LANE

CONCORD, NC 28025 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

#### Criteria I

.The toaster and clothes dryer were repaired by 6/28/13. The facility has obtained approval for replacement of the whirlpool tub and the order has been placed.

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

#### Criteria 2

All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director or Administrator will complete an audit of essential equipment currently housed in the facility to verify the equipment is in working order, if not it is posted as "Out of Service", and verify repairs are in process, by 7/25/13.

PRINTED: 07/10/2013 FORM APPROVED

| DEPARTM                  | ENT OF HEALTH AN   | D HUMAN SERVICES  |                     |  |   |                   | <u>0938-0391                                    </u> |
|--------------------------|--|---|---------------------|--|---|-------------------|--|
| CENTERS                  | FOR MEDICARE &   | MEDICAID SERVICES   | 2/03 11111 715      | 3) E COI   | NSTRUCTION  | (X3) DATE SI      |  |
|                          | DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  |   | COMPLE            |  |
|                          |  | 345362  | B. WNG              |  |   | 06/27/2013        |  |
|                          |  | 340002  | 1 8                 | STREET   | ADDRESS, CITY, STATE, ZIP CODE  |                   |  |
|                          | OVIDER OR SUPPLIER   |   |                     | 250 E  | BISHOP LANE   |                   |  |
| BRIAN CEI                | NTER HEALTH & RETIF  | EMENT/CABARRUS  |                     | CON  | ICORD, NC 28025   |                   | (X5)   |
| (X4) ID<br>PREFIX<br>TAG | CA OU DESIGNA  | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ,  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | 86 (              | COMPLETION<br>DATE                                   |
| F 456                    | Continued From pag   | 55 am. Resident #38 stated  | F 4                 | 156  |   |                   |  |
|                          | that she would prefe<br>week, but the option   | r to take two tub paths a   |                     |  |   |                   |  |
|                          | that due to her joint take a tub bath, but D.] On 6/27/13 at 10 that she always too she was always afr shower.  Administrative Staf 6/27/13 at 10:45 ar whirlpool tub hasn' and that the reside 2. On 6/27/13 at 6 of the laundry roor present and was for three dryers was in examination it was clothes in them. To f their equipment no signs observed malfunctions.  On 6/27/13 at 9:2 was interviewed a repairs in the facility of the fa | :30 am, a tour was conducted in. The housekeeper was olding towels while one of the in operation. Upon closer is noted that all three dryers had the housekeeper stated that all was working and there were it on the dryers to indicate, any in our any equipment needing ity. He stated that the middle |                     | ecconomic of the conomic riteria 3  the Dietary Manager will reducate all Cooks on the safe us fithe toaster by 7/25/13. The administrator, Maintenance Director or Staff Development Coordinator will re-educate all staff on the process for reporting abeling of inoperable equipment in need of repair and abeling of inoperable equipment in Sequipment by 7/25/13. The Maintenance Director or Administrator will ensure installation of whirlpool tub following delivery.  The Maintenance Director or Administrator will randomly monitor essential equipment weekly for 12 weeks to verify equipment is in working order posted as "out of Service" if | g<br>I<br>nt<br>e |  |
|                          | a couple of days. technician came  | t of order and it had been out for<br>At 10:35 am, he indicated that a<br>to fix the dryer, which had a<br>or, which affected the drum<br>and that could create a fire  | I                   |  | awaiting repair and repairs in progress, these audits will be documented on the monitorin tool  | g                 | İ  |

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_\_ AND PLAN OF CORRECTION 06/27/2013 B. WNG 345362

NAME OF PROVIDER OR SUPPLIER

(X4) ID

PREFIX TAG

### BRIAN CENTER HEALTH & RETIREMENT/CABARRUS

STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE CONCORD, NC 28025

(X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

F 456

Continued From page 34

He shared that he had disabled the dryer from the electrical panel, to "lock it out" but did not hang a sign to say that it was out of order. The Administrative Staff #2 stated that he told Administrative Staff # 3 of his actions and expected him to inform his housekeeping staff.

The housekeeper was re-interviewed on 6/27/13 at 11:25 am. She stated that the dryer #2 had been working last Friday, (June 21), then it went down, but the staff was able to use it yesterday. She indicated that she did not know that it was out of order. Their protocol was if equipment malfunctioned, the staff reported this to their supervisor or Administrative Staff #2. A sign would be hung saying "Out of Commission" on the equipment. She wasn't sure who placed clothes in dryer #2, since the laundry room stayed unlocked during the night, so that third shift staff could access the equipment to launder clothes.

On 6/27/13 at 12:00 pm, Administrative Staff #3 provided documentation to demonstrate that he in-serviced his housekeeping staff about their policies and procedures.

3. On 6/27/13 at 3:00 PM during observation of the kitchen the conveyor toaster was observed. The toaster had a rack attached that was used to feed the bread into the conveyor of the toaster. This conveyor then passed the bread through the heating elements to toast the bread. The heating elements were in close proximity to the junction between the rack and conveyor. On the left side of the rack there was a wadded up napkin placed under the rack near the junction of the rack and conveyor belt. The napkin had brown markings on it that appeared to be singe or burn marks.

#### Criteria 4

The results of the audits will be reported monthly in the Quality Assurance Performance Improvement meeting by the Maintenance Director for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.

Date of Compliance: July 25, 2013.

PRINTED: 07/10/2013

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--|-----|--|-------------------------------|----------------------------|
|   |  | 345362  | B. WNG                                 |     |  | 06/;                          | 27/2013                    |
|   | OVIDER OR SUPPLIER   | EMENT/CABARRUS  |  | 28  | EET ADDRESS, CITY, STATE, ZIP CODE<br>50 BISHOP LANE<br>ONCORD, NC 28025   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD &<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | 3E                            | (X5)<br>COMPLETION<br>DATE |
| F 456   | On 6/27/13 at 3:10 in Administrative Staff # previously been unaw napkin on the toaster should not have been a hazard. The napkin.  On 6/27/13 at 3:15 Pl Administrative Staff # previously been awar napkin on the toaster Dietary Manager (DM had been placed und rack purposely in orderack so the bread wor properly. The DM ad removed and replace morning.  On 6/27/13 at 3:17 Pl and #7 acknowledged have been placed on hazard. They also stake been reported to maintenance would not start the start of t | terview with the 5 revealed he had not vare of the placement of the but he indicated that it placed there and could be n was then removed | F                                      | 456 |  |                               |                            |

|                          |  |   |                        | PRINTED: 07/26/2013  |
|--------------------------|--|---|------------------------|--|
|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                        | D 国区国IV 国和RM APPROVED NO. 0938-0391  |
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CUA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A BUILDII | TIPLE CONSTRUCTION AUG 1 2 2013 X3 DATE SURVEY COMPLETED   |
|                          |  | 345362  | B. WING                | CONSTRUCTION SECTION 07/24/2013  |
| NAME OF P                | PROVIDER OR SUPPLIER   |   | :                      | STREET ADDRESS; GHY; STATE: ZIL GODE:  |
| BRIAN C                  | ENTER HEALTH & RI  | ETIREMENT/CABARRUS  |                        | 250 BISHOP LANE<br>CONCORD, NC 28025   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  OATE  |
| K 000                    | INITIAL COMMENT  | S   | K 00                   | ) <sup>00</sup> k 045  |
| K 045<br>SS=D            | conducted as per Tat 42 CFR 483.70(a Health Care section publications. This be construction, one stautomatic sprinkler. The deficiencies deare as follows:  NFPA 101 LIFE SAI Illumination of mear discharge, is arrang lighting fixture (bulb) darkness. (This documents)   | de (LSC) survey was he Code of Federal Register); using the 2000 Existing of the LSC and its referenced uliding is Type III (211) ory, with a complete system.  termined during the survey  FETY CODE STANDARD  as of egress, including exit ed so that failure of any single will not leave the area in es not refer to emergency ce with section 7.8.) 19.2.8 | K 04                   | Correction for the alleged deficient practice noted as "egress illumination, exit discharge from day room would leave area in darkness," was to connect one of the toom's two light fixtures unswitched to emergency power to provide uninterrupted lighting in the room. The Maintenance Director will survey the remainder of the building to determine proper emergency lighting in all like areas and if need, correct upon discovery. All findings and corrections will be reported to and discussed during the next three monthly Safety Committee meetings with continued review quarterly thereafter until next annual survey.  Correction date 8/6/2013 |
| K 067<br>SS=E            | Surveyor: 27871 Based on observation approximately 8:30 a litems were noncomplicated: egress illuminated by the surveyor of th | 5.2.1, 9.2, NFPA 90A,   |                        | Correction for the alleged deficient practice noted as "all dampers in return vents throughout facility have excess lint build up on dampers," was to check and clean all return vent dampers in facility. The Maintenance Director will continue monitoring dampers with spot checks during monthly air conditioner p.m. and filter changes and check and clean all as needed quarterly. All findings will be eported to an discussed during monthly  |
| ABORATOR                 | DIRECTO'S OR PRODU   | RISUPPLIER REPRESENTATIVES SIGN   | ATURE                  | Almones tow for 8/8/2012   |

Any deherency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 952981

CW

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMEN                                | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | i .               |     | LE CONSTRUCTION<br>01 - MAIN BUILDING 01  |  | E SURVEY<br>PLETED         |
|---|--|--|-------------------|-----|---|--|----------------------------|
|   |  | 345362   | B. WING           |     |   | 07/  | 24/2013                    |
|   | PROVIDER OR SUPPLIER<br>CENTER HEALTH & R  | ETIREMENT/CABARRUS   |                   | 2   | REET ADDRESS, CITY, STATE ZIP CODE<br>250 BISHOP LANE<br>CONCORD, NC 28025  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE   | (X5)<br>COMPLETION<br>DATE |
| K 067                                   | Continued From pa<br>19.5.2.2  | ge 1   | K                 | 167 | K067 (cont) Safety committee meetings for the three months and continue quarter thereafter until next annual survey. Completion date 8/30/2013  | 'iy  |                            |
| SS=E                                    | Surveyor: 27871 Based on observati approximately 8:30 items were noncom include: all damper facility have excess 42 CFR 483.70(a) NFPA 101 LIFE SA Medical gas storage protected in accorda Standards for Healt (a) Oxygen storage   | ons and staff interview at am onward, the following pliance, specific findings in return vents through out lent build up on dampers.  FETY CODE STANDARD e and administration areas are ence with NFPA 99, in Care Facilities.  locations of greater than osed by a one-hour | Ko                | 76  | CO76 Correction for the alleged deficient noted as "oxygen cylinders were noted as "oxygen cylinders were noted as "oxygen cylinders were noted as "oxygen cylinders and properties of oxygen cylinders in secur the Maintenance Director will do specks during daily rounds to insure compliance and report all findings a nonthly Safety Committee meeting next three months and continue with the completion date of 8/30/2013 | ot in a ty and de er er racks bot the the the the  |                            |
|   | (b) Locations for sur<br>3,000 cu.ft. are vent<br>4.3.1.1.2, 19.3.2.4  | pply systems of greater than<br>ed to the outside. NFPA 99   |                   | *   |   | distributed oppin warpenmands) - Personagements  |                            |
| *************************************** | Surveyor: 27871 Based on observation approximately 8:30 sitems were noncompared to the surveyor of the surveyo | not met as evidenced by: ons and staff interview at am onward, the following oliance, specific findings iders were not in a secure   |                   |     |   | THE PROPERTY AND ADMINISTRATION OF THE PROPERTY ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADMINISTRATION OF THE PROPERTY AND ADM | ,                          |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER;                           |  |  | (X3) DATE SURVEY<br>COMPLETED                 |                            |  |
|--------------------------|---|---|--|--|---|----------------------------|--|
|                          |   | 345362  | B. WING  |  | 07/   | 24/2013                    |  |
|                          | PROVIDER OR SUPPLIER<br>CENTER HEALTH & F   | RETIREMENT/CABARRUS   | 1  | REET ADDRESS, CITY, STATE, ZIP CODE<br>250 BISHOP LANE<br>CONCORD, NC 28025  |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE |  |
|                          | 42 CFR 483.70(a)  | ea for emply and full cylinders.  | :<br>:   | Correction for the alleged deficient poted as "overhead lights in rooms is   | 206,  |                            |  |
| K 147<br>SS=E            | Electrical wiring an  | AFETY CODE STANDARD d equipment is in accordance tional Electrical Code. 9.1.2  | K 147211, and 314 had objects stored on top of light fixture," was immediate removal of the objects in those specified rooms. The Maintenance Director will survey the remainder of the building to locate any other like instances and correct upon   |  |   |                            |  |
|                          | This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff Interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: overhead bed lights in rooms 206, 211 and 314 had objects stored on top of light fixture.  42 CFR 483.70(a) |   |  | discovery. An inservice will be offer taff regarding storage and decoration bjects located on top of light fixture in explanation of hazards associated ame. All results and findings will be eported to and discussed during mosafety Committee meetings for the inhree months and continue with qualities until next annual survey. Completion date of 8/30/2012 | ed to alve ! es with ! d with ! enthly next . |                            |  |
|                          | :   |   | To the second se |  |   |                            |  |