		& MEDICAID SERVICES	1		OMB NO	APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	CON	E SURVEY IPLETED C
		345362	B. WING _			11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
BRIAN CI	ENTER HEALTH & R	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 00	о		
	complaint investiga ID# KS3S11.	ere cited as a result of the tion survey of 9/11/14. Event				
F 242 SS=D	483.15(b) SELF-DE MAKE CHOICES	ETERMINATION - RIGHT TO	F 24	2		10/21/14
	schedules, and hea her interests, asses interact with memb inside and outside	he right to choose activities, alth care consistent with his or assments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that e resident.				
	by: Based on observation interview the facility their own personal residents (Residentive were able to state to own, clean, night at residents (Residentive impaired but had cl available, provided included: 1. Resident # 38 w had cumulative diated disorder and depretion The Annual Minimu			F242 - 1 .Corrective Action was accorr the alleged deficient practice I Director Of Nursing conducting on 10-6-14 with resident #38, a #122 regarding their preference time attire. Each resident expr preference to wear their own n attire. These preferences rega time attire were communicated staff via the Nursing Communi 2. All residents have the poten affected by this alleged deficie The Social Services Director a Activity Director conducted inte alert and oriented residents an with family members for cognit impaired residents to determin	by the g interviews #57 and es for night ressed ight time arding night t to nursing cation Tool. tial to be nt practice. nd the erviews of d interviews tively	
		MDS also indicated that she assistance with dressing and		preference related to night time These interviews were comple		

Electronically Signed

(X6) DATE 10/03/2014

PRINTED: 10/20/2014

Any deficiency 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.

DEDADTMENT OF LIEALTH AND LUMANN CEDVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		345362	B. WING		– C – 09/11/201	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 242	choose what to we Review of the Care she had a Plan of O identified as sad af depression. One o Plan of Care was ' individual's decision Resident # 38 was AM. She was in be gown. Resident # 38 was 11:00 AM. She was in her own daytime wheelchair. When that she had worn a previous night and hospital gown at be would prefer to we she has told staff th permission to look nightgowns were lo resident said she o On 9/11/14 at 3:00 was interviewed. S staff to dress reside their choice. For re- their own preference Administrative Staff	portant to her to be able to	F 242	10-15-14 and preferences reg time attire were communicate nursing staff via the Nursing Communication Tool. 3. The Facility encourages res dress daily in their own clothir night time attire. All Nursing s including those working on the and as needed will be re-educ Director of Nursing, Staff Dev Coordinator or Unit Manager t the residentMs preferences at residents to dress in their owr include the residentMs choice their night time attire. The re- will be completed by 10-15-14 Director of Nursing or Unit Ma randomly observe and intervie residents during 3rd shift, wee weeks to verify night time attir are being honored, the result monitoring will be documenter facility monitoring tool. Oppo be corrected daily as identified Director of Nursing or Unit Ma 4. The results of these obser interviews will be submitted to Committee by the DON or Un for review by IDT members ea for 3 months. The QAPI Com evaluate the effectiveness and needed.	ad to the sidents to ng, including staff e weekends cated by the elopment to adhere to nd assist n clothing to regarding reducation k. The anager will ew 10 ekly for 12 re choices s of this d on the ortunities will d by the anager. vations and o the QAPI it Manager ach month mittee will	

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDII	NG.			C
		345362	B. WING _	_			_ 11/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS			50 BISHOP LANE		
Brazer				С	CONCORD, NC 28025		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
		,			DEFICIENCY)		
			1				
F 242	Continued From pa	ge 2	F 24	42			
		NA # 3) was interviewed on					
		She stated that she was					
		nt # 38 the previous evening					
	as well as the even	she dressed Resident # 38 in					
		bedtime and indicated that she					
		e resident 's preference.					
		-					
		as admitted 8/10/14 with					
	5	es including: dementia, numerus fracture and anxiety.					
		iumerus naciure and anxiety.					
	Review of the Admi	ssion Minimum Data Set					
		4 revealed Resident # 57 was					
		but could state her own					
		MDS also indicated that she					
		assistance with dressing and ortant to her to be able to					
	choose what to wea						
		Plan dated 8/23/14 revealed					
		a Plan of Care for "requires					
		e and intervention for (Activities of Daily Living). "					
		thes listed in this Plan of Care					
		ctive participation in tasks. "					
	5						
		observed on 9/9/14 at 8:00					
	AM in bed and wea	ring a hospital gown.					
	Resident # 57 was	observed on 9/11/14 at 9:25					
		ring a hospital gown. The					
		e and interviewed at this time.					
		not know why the staff put her					
		at night " they just put me in					
		Resident # 57 gave permission					
		t. A clean, light flannel, short was located in her closet. The					
		ps all the way up the front of					

Facility ID: 952981

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	-	AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUII -	TIPI		1	0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(С
		345362	B. WING			09/1	11/2014
NAME OF F	PROVIDER OR SUPPLIER						
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS					
(X4) ID		TEMENT OF DEFICIENCIES	ID				(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
			Image: Street address, city, state, zip code B. WING B. WING B. WING Dependence ID PREFIX CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 242		2	 				
F 242		-	F 24	42			
	the gown (from the	hemline to the neckline).					
		PM Administrative Staff # 1					
		She stated that she expected					
		ents in the night time attire of esidents who could not state					
		ces, she indicated that the					
	family 's preference	e should be followed.					
		f # 1 also indicated that if the					
		sonal night attire, like a gested the family ' s					
		the resident dressed in their					
	own night time attire						
		was admitted on 7/19/14 with					
		ses including Alzheimer 's					
	Depression.	Disorder, Anxiety and					
	Depression						
		ission Minimum Data Set					
		14 revealed Resident # 122 paired and unable to state her					
		The MDS also indicated that					
		sive assistance with dressing.					
		Plan dated 7/28/14 revealed a Plan of Care for " requires					
		ce and intervention for					
	completion of ADL	(Activities of Daily Living). "					
		ches listed in this Plan of Care					
		ictive participation in tasks. " Plan of Care for verbal and					
		symptoms with a target					
	behavior listed as '	" yells out " . One of the					
		n this Plan of Care was " allow					
	choices within indiv capabilities. "	vidual 's decision making					
	capabilities.						
	On 9/9/14 at 9:27 A	AM resident # 122 was					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		345362	B. WING				C 11/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			50 BISHOP LANE CONCORD, NC 28025		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 242	Continued From pa	ige 4	F 2	242			
		earing a hospital gown.					
		AM Resident # 122 was earing a hospital gown.					
	interviewed. She st why the resident wa at night time becaus She also said that t hospital gown on in other residents. Sh closet at this time a nightgown. On 9/11/14 at 3 PM interviewed. She st	AM Nursing Assistant # 4 was tated that she did not know as dressed in a hospital gown se she only worked day shift. this resident often had a the morning as did many he looked in the resident ' s and was able to locate a clean I Administrative Staff # 1 was tated that she expected staff					
	to dress residents in choice. For resider own preferences, si preference should b Staff # 1 also indica personal night attire suggested the fami	n the night time attire of their hts who could not state their he indicated that the family 's be followed. Administrative ated that if the family provided e, like a nightgown, this ly 's preference to have the their own night time attire for					
	9/11/14 at 4:00 PM. assigned to Reside as well as the even acknowledged that in a hospital gown a	NA # 3) was interviewed on . She stated that she was int # 122 the previous evening ing of 9/11/14. She she dressed Resident # 122 at bedtime and indicated that resident was often combative en.					
	Administration Reco	ing Notes, Medication ord, Treatment Administration or sheet revealed no					

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		AND HUMAN SERVICES				FORM	10/20/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	COM	E SURVEY PLETED C
		345362	B. WING				_ 11/2014
NAME OF F	PROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS			0 BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242		-	F 2	.42			
F 278 SS=D	483.20(g) - (j) ASSI	iors on 9/9/14 through 9/11/14. ESSMENT RDINATION/CERTIFIED	F 2	278			10/21/14
	The assessment m resident's status.	ust accurately reflect the					
	A registered nurse each assessment v participation of hea						
	A registered nurse assessment is com	must sign and certify that the pleted.					
		o completes a portion of the sign and certify the accuracy of assessment.					
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessment	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each					
	Clinical disagreeme material and false s	ent does not constitute a statement.					
	by: Based on record re facility failed to acc	NT is not met as evidenced eview and staff interview, the urately code the Minimum sessment for significant weight			F278 1. The Quarterly MDS for Resident with ARD 8-22-14 was corrected on		

Facility ID: 952981

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	-	AND HUMAN SERVICES			FORM. OMB NO.	APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345362	B. WING _			C 11/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 278	and failed to accura pressure ulcer for 1 residents. The find 1. Resident #80 wa 7/1/2011. A Quarte dated 8/22/14 spec 105 pounds with no gain. Review of Resident revealed the followi 2/23/14 124.2 poun 3/31/14 122.1 poun 4/27/14 110.6 poun 5/19/14 115.6 poun 6/24/14 106.4 poun 7/21/14 107.2 poun 8/4/14 105 pounds 8/12/14 104.2 poun 8/18/14 104.2 poun A Dietary progress Resident #80's curr pounds which was 180 days. On 9/10/14 at 4:28 stated she should h 8/22/14 with a signi resident experience percent during the p She said it was an o 2. Resident # 163 w	t #80) of 3 sampled residents ately code the MDS for (Resident #163) of 4 sampled ings included: as admitted to the facility erly Minimum Data Set (MDS) ified Resident #80 weighed o significant weight loss or t #80 ' s medical record ing documented weights: ids ids ids ids ids ids ids ids ids ids	F 2	 10-1-14 by the Resident Cat Management Director to acc the significant weight loss. Significant Change MDS for #163 with ARD 9-7-14 was c 10-1-14 by the Resident Cat Management Director to acc the status of pressure ulcers admission. 2. The coding of the MDS of with significant weight loss a pressure ulcers have the pot being affected by this alleged practice. The Director of Nu Manager and Resident Care Director will complete an aud Residents with significant we and/or pressure ulcers by ref weekly and monthly Weight weekly Pressure Ulcer Logs the Admission MDS assessme coded accurately to reflect th the resident. This audit will the by 10-15-14. Opportunities i be corrected by submitting a MDS by 10-15-14. 3. The Regional Care Mana Director will re-educate all M including those working as n 10-15-14 on the accurate co sections K and M on the MD Resident Care Management the MDS Coordinator will rar 10 completed MDS assessme for 12 weeks to verify accurated accurated to the sections 	aurately reflect The Resident orrected on re aurately reflect present upon f Residents nd/or cential of d deficient rsing, Unit Management dit of all eight loss viewing the Logs and the to validate ment and the nt have been to validate ment and the net and the net status of be completed dentified will corrected gement DS staff eeded by mpletion of S. The Director or ndomly review nents weekly	

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		AND HUMAN SERVICES			F	ORM	10/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	COM	E SURVEY PLETED
		345362	B. WING				C 11/2014
	PROVIDER OR SUPPLIER	ETIREMENT/CABARRUS		25	REET ADDRESS, CITY, STATE, ZIP CODE IO BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 278 F 279 SS=D	The nursing admiss indicated that Resid no pressure ulcer. The admission Min assessment dated Resident #163 had quarterly MDS asse indicated that Resid III pressure ulcers a present on admissi The physician's ord reviewed. There w pressure ulcers unt The weekly pressur #163 were reviewed indicated that Resid on the coccyx and of On 9/11/14 at 11:40 interviewed. She c documentation that ulcers or was treate admission. She furt ulcer should not ha admission on the q 8/5/14. 483.20(d), 483.20(H COMPREHENSIVE A facility must use t to develop, review a comprehensive pla The facility must de	sion intake form dated 5/2/14 dent #163 was admitted with imum Data Set (MDS) 5/18/14 indicated that no pressure ulcer. The essment dated 8/5/14 dent #163 had 2 areas of stage and the pressure ulcers were on. lers for Resident #163 were ere no treatment orders for il 5/27/14. re ulcer records for Resident d. The records dated 6/1/14 dent #163 had a pressure ulcer on the right ankle. 0 AM, MDS Nurse #1 was ould not find any Resident #163 had pressure ed for pressure ulcers on ther stated that the pressure ve been coded as present on uarterly assessment dated k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 2		will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Resident Care Management Director or MDS Coordinator as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Resident Care Management Director review by IDT members each month f months. The QAPI Committee will evaluate the effectiveness and amend needed.	e the for for 3	10/21/14

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	-	AND HUMAN SERVICES			FORM	10/20/2014 APPROVEE 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		345362	B. WING			C 11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including f under §483.10(b)(4 This REQUIREMEN by: Based on observat and staff interview, care plan for two of contractures (Resid findings included: 1. Resident #80 wa 7/1/2011. Cumulati Alzheimer's disease Minimum Data Set there was no function motion for the upper Medical record revion order dated 7/7/14 protector applied to contracture. A physician's histor	tables to meet a resident's nd mental and psychosocial tified in the comprehensive t describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment	F 2'	 F279 A Contracture Care F current interventions was Resident #80 and Resident Care Manager 10-6-14. Resident Care Manager 10-6-14. Residents with contrapotential to be affected to deficient practice. The F and Resident Care Man will complete an audit of Contracture, by reviewin currently coding for decr motion on the most rece subsequent therapy screer equired. The Resident validate a Care Plan is in reflects current intervent Contracture Management be completed by 10-15- 	s initiated for ent #103 by the nent Director on actures have the by this alleged Rehab Director agement Director all Residents with g residents eased range of ent MDS with eening as Care Manager will n place that tions for nt. This audit will	

Facility ID: 952981

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C
		345362	B. WING				_ 11/2014
	PROVIDER OR SUPPLIER	ETIREMENT/CABARRUS		25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 BISHOP LANE ONCORD, NC 28025	00	11/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	observed lying in be right foot and her le Contractures were Nurse #3 stated Re of her arms, legs an wedge was used be when she was up in foot brace was use prevention/ contract said Resident #80 h reduce pressure re She stated she did had been used for the A review of the care revealed there was contracture manage On 9/11/14 at 8:23 stated she saw Res 7/18/14 for a palm/ hand. She stated the fingers from digging further flexion contr hand of Resident # On 9/11/14 at 11:12 stated she would ex Resident #80 to inc contracture manage assistive devices. 2. Resident # 103 v	0AM, Resident #80 was ed. She had a brace on her ft hand was bandaged. noted of both legs and arms. sident #80 had contractures nd left hand. She stated a etween Resident #80's legs in the wheelchair and a right d for pressure ulcer ture management. Nurse #3 nad her left hand bandaged to duction between the fingers. not recall that a hand splint the left hand contracture. e plan for Resident #80 not a care plan in place for ement. AM, the occupational therapist sident #80 from 7/4/14 through protector splint for the left he splint was recommended rapy for prevention of the g into the palm and prevented acture of the fingers and left 80. AM, Administrative staff #1 kpect the care plan for lude a care plan for ement and use of any was admitted to the facility on e diagnoses including	F 2	79	includes the Resident Care Manag Director, MDS Coordinators, and R Program Manager will be re-educa the Regional Care Management Di by 10-15-14 related to the develop Comprehensive Care Plans, includ requirement for Care Planning rela Contractures. The Resident Care Management Director or the MDS Coordinator will randomly observe residents to validate care planned interventions for Contracture management are in place and revie Resident Care Plans for accuracy of for 12 weeks. The results of this monitoring will be documented on the facility monitoring tool. Opportunities be corrected daily by the Regional Management Director or MDS Coordinator as identified during the audits. 4. The results of these reviews will submitted to the QAPI Committee I Resident Care Management Director review by IDT members each montor months. The QAPI Committee will evaluate the effectiveness and amon needed.	ted by rector ment of ing the ted to 10 w the weekly he es will Care ese I be or for th for 3	

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		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		345362	B. WING				C 11/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279 F 282 SS=D	Resident # 103 was no limitation in rang extremities. The medical record reviewed. The corr 8/18/14 from nursin Resident #103 had had discomfort whe straighten out her h indicated that Resid when her left hand On 9/10/14 at 4:20 Resident #103 was in a fist position with prevent further decl Review of the care #103 had no care p contracture. On 9/11/14 at 11:40 interviewed. She st that Resident #103 She added that if st would have develop contracture. 483.20(k)(3)(ii) SEF PERSONS/PER CA	 m Data Set (MDS) 7/21/14 indicated that s cognitively impaired and had ge of motion of the upper ds for Resident # 103 were nmunication form dated ng to therapy indicated that a left hand contracture. She en the staff attempted to nand. The form further dent #103 yelled out in pain was straightened out. PM and 9/11/14 at 8:50 AM, observed. Her left hand was h no device observed to line in contracture. plan revealed that Resident olan to address the left hand O AM, MDS Nurse #1 was tated that she was not aware had a left hand contracture. he would have known she ped a care plan to address the RVICES BY QUALIFIED 	F 2				10/21/14
	accordance with ea						

Facility ID: 952981

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()	COMF	SURVEY
		345362	B. WING _			C 09/1	; 1/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•••	
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			50 BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 282	Continued From pa	age 11	F 28	82			
	This REQUIREME	NT is not met as evidenced					
	Based on record re interview, the facili plan on pressure ul and # 80) of 4 sam ulcers and failed to dialysis for 1 (Resid on dialysis. The fir 1. Resident #163 w facility on 5/2/14 wi Peripheral Vascula quarterly MDS asse indicated that Resid III pressure ulcers. The care plan for p date) was reviewed pressure ulcers on One of the approad	vas originally admitted to the th multiple diagnoses including r Disease (PVD). The essment dated 8/5/14 dent #163 had 2 areas of stage ressure ulcer (no revision d. The care plan problem was the right ankle and coccyx. ches was " measure and stage g the pressure ulcer healing			F282 1. Resident #112 and Resident #9 n longer reside at the facility. The Dire of Nursing reviewed the Care Plans f Resident #80 and Resident #163 on 10-4-14, the Interdisciplinary Team reviewed and updated the intervention reflect current resident needs and validated the interventions are in place outlined in the Care Plan. 2. Residents with Pressure Ulcers a Residents receiving Dialysis services have the potential to be affected by the alleged deficient practice. The Director Nursing and the Resident Care Management Director will complete a audit of all Residents with Pressure U and/ or receiving Dialysis to validate Care Plan is in place that reflects cur- interventions for Pressure Ulcers and Dialysis is in place. The Director of Nursing and the Resident Care	ector for ons to ce as ind s this ctor of an Ulcers a rrent d/or	
	reviewed. The reco that Resident #163 right ankle measuri (cm), and the wour The stage of the pr onset were blank. weekly measureme ulcer completed on 8/5/14, 8/12/14 and	re ulcer records were ords dated $6/1/14$ indicated had a pressure ulcer on the ing 1.5 x (by) 1.3 centimeter ad bed was yellow in color. ressure ulcer and the date of There were no records of ent and staging of the pressure 7/1/14, 7/8/14, 7/29/14, 18/19/14. re ulcer records dated 6/1/14			Management Director will observe al Residents with Pressure Ulcers and/ Dialysis to validate the facility staff ar aware of Care Planned interventions observe these interventions are in pla This audit will be completed by 10-15 3. The DON, Staff Development Coordinator or Unit Manager will re-educate all Nursing Staff including those working on the weekends and needed by 10-15-14 related to follow the Resident Care Plans for Pressure	f or re and ace. 5-14. g as <i>i</i> ng	

Facility ID: 952981

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		345362	B. WING _			C 11/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 282	and the wound bed record did not indic ulcer or the date of measured on 6/10, but the stage was b of weekly pressure on 7/1, 7/8, 7/29 an resident was sent to not related to the pur readmitted on 8/31/ On 9/10/14 at 9:00 observed during dru ulcer on the coccyx amount of slough of wound bed on the r slough. On 9/11/14 at 1:30 interviewed. She s had left a month or assigned to complet the pressure ulcer. had completed som weekly basis. On 9/11/14 at 2:25 was interviewed. St that the facility had pressure ulcer on a that the facility had month ago and the administrative staff nursing staff to ass weekly using the fa	a measuring 1.1 x 0.5 x 0.3 cm was yellow in color. The ate the stage of the pressure onset. The ulcer was 6/17, 6/24, 7/15, and 7/22/14 blank. There were no records ulcer assessment completed at 8/21/14. On 8/22/14, the o the hospital for other reason ressure ulcer and was (14. AM, Resident #163 was essing change. The pressure twas noted to have a small on the wound bed and the right ankle was covered with PM, Nurse #2 was tated that the treatment nurse so ago and recently she was ete the weekly assessment of She acknowledged that she he assessments but not on a PM, administrative staff #1 she stated that she was aware issues for not assessing the n weekly basis. She indicated lost the treatment nurse a y had a lot of changes on their . Her expectation was for the ess the pressure ulcers cility form which include the nt (width, length, depth) and	F 28	 completion and implementation planned interventions. The DON Manager will randomly observe Residents with Pressure Ulcers receiving Dialysis to review their Plans for required interventions at 12 weeks and to validate staff at of care planned interventions and interventions are in place. The this monitoring will be document facility monitoring tool. Opportube corrected daily by the Directo Nursing or Unit Manager as ider during these audits The results of these reviews submitted to the QAPI Committee Director of Nursing for review by members each month for 3 mon QAPI Committee will evaluate the effectiveness and amend as need. 	I or Unit 10 and/or Care weekly for e aware d these results of ed on the nities will r of tified will be e by the IDT ths. The e	

If continuation sheet Page 13 of 46

		AND HUMAN SERVICES				FORM	10/20/2014 APPROVED
		& MEDICAID SERVICES	(X2) MULT	FIPLE	E CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		345362	B. WING				C 11/2014
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	11/2014
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS					
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		ONCORD, NC 28025 PROVIDER'S PLAN OF CORRECTION	N	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
			p				
F 282	Continued From pa	ge 13	F 28	82			
	2. Resident #112 w	as admitted to the facility on					
		diagnoses including Diabetes post left humeral fracture. He					
	was discharged to a	an assisted living facility on					
		ssion Minimum Data Set dated 5/19/14 indicated that					
	Resident #112 had						
	The nursing admiss	sion intake form dated 5/5/14					
	indicated that Resident no pressure ulcer.	dent #112 was admitted with					
		ressure ulcer (no revision					
		I. The problem was pressure right and left heels. One of					
	the approaches was	s ["] measure and stage wound					
	weekly using the prassessment form. "	essure ulcer healing					
	The physician's ord	lers were reviewed. On 5/7/14,					
		to apply skin prep to bilateral On 6/3/14, there was an order					
		d to right heel and santyl					
		r which removes dead tissues) 6/17/14, there was an order to					
	apply santyl to both						
		ent's medical records revealed					
	no weekly assessm since admission to	nents of the pressure ulcers the discharge date.					
	On 9/11/14 at 1:30	PM, Nurse #2 was					
		tated that the treatment nurse					
		so ago and recently she was the the weekly assessment of					
	the pressure ulcer.	She indicated that in May,					
		d a treatment nurse but she weekly pressure ulcer					

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
						(С
		345362	B. WING			09/	11/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS			250 BISHOP LANE CONCORD, NC 28025		
	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
			<u> </u>				
F 282	Continued From pa	ige 14	F 2	82			
	assessments were completed or not.						
	0.044444						
		PM, administrative staff #1 She stated that she was aware					
	that the facility had	issues for not assessing the					
		weekly basis. She indicated					
		lost the treatment nurse a y had a lot of changes on their					
	administrative staff.	. Her expectation was for the					
		ess the pressure ulcers cility form which include the					
		nt (width, length and depth)					
	and description of the	he wound.					
		as admitted to the facility diagnoses included:					
	Alzheimer's disease						
	A Quarterly Minimum	m Data Set (MDS) 8/22/14 indicated Resident					
		o (2) pressure ulcer with the					
	oldest stage date of	f 8/3/14.					
	A care plan dated 6	6/4/14 and last reviewed					
	8/22/14 stated Resi	ident #80 had a stage 2					
	•	e coccyx/ sacral area. On					
		In noted the stage 2 pressure sacral area was now a stage					
	three (3). Approach	hes included, in part, measure					
		eekly using the pressure ulcer					
	healing assessmen						
		cer records documented by					
		viewed and revealed the					
	following: 8/7/14 stage 2 pres	sure ulcer to the left coccyx;					
	date on onset 8/3/1	4. Measurements: 1 ¼ cm.					
	(centimeters) x 2 cr						
	8/14/14 stage 2 to t Measurements: 1.0	ne left coccyx. 0 cm. x 1.8 cm. 8/21/14 stage					

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		AND HUMAN SERVICES				FORM): 10/20/2014 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DA	TE SURVEY MPLETED C
		345362	B. WING			09	/11/2014
	PROVIDER OR SUPPLIER	ETIREMENT/CABARRUS		250 BIS	TADDRESS, CITY, STATE, ZIP CO SHOP LANE ORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	2 to the left coccyx cm. 8/27/14 stage 2 to 5 Measurements: 2.8 9/9/14 stage 2 to th Measurements: 3.0 No pressure ulcer of between 8/27/14 at Hospice notes were following: 7/31/14 Redness n cream (skin protect 8/7/14 pressure ulce 2 cm. stage 2. 8/14/14 wounds: ct 8/21/14 Sacral wou cm. x 3 cm. 8/27/14 FS (facility dressed and appeal last week. No mea 9/8/14 1st wound la amt. (amount) of sl New wound 1 cm. 0n 9/10/14 at 11:50 stated the hospice ulcer and wound do hospice nursing no nursing notes and s were documented 1 On 9/10/14 at 3:30 she measured the Resident #80's coo She stated she usu afternoon and Resi her bed for wound	. Measurements: 3 cm. x 3 the left coccyx. 3 cm. x 2.5 cm. he left coccyx. cm. x 2.0 cm. measurements were recorded hd 9/8/14. e reviewed and revealed the oted to coccyx and barrier tant cream) applied. cer on right buttock 1 1/4 cm. x boccyx (no measurements) and is worsening bright red 3 staff) stated that wound was ared to have no change from asurements were noted. arger 3 cm. x 2 cm. with small ough (yellow/ green tissue).		82			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345362	B. WING _			C 11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	 8/27/14 with multipl Stage Renal Diseas Congestive Heart F Vascular Accident, Gastrointestinal Ble A review of the Poli Hemodialysis revise The review reveale check vital signs (V post-dialysis or in a s orders. A review of the Car resident #9 was con indicated the reside three times per wee and Friday. The inte the resident ' s VS of post-dialysis or acc orders. A review of the Phy from 8/27/14 to 9/10 physician ' s order the A review of the facil revealed resident # clinic and received 9/1/14, 9/3/14, and A review of the Nur and the VS and We to 9/11/14 was conto one time during the after receiving dialy not obtained during period after receiving 	le diagnoses including End se, Diabetes Mellitus, Failure, history of Cerebral Atrial Fibrillation, history of eed and Hypertension. Atrial Fibrillation, hi	F 28	82		

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		AND HUMAN SERVICES			FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		345362	B. WING			C 11/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	-	F 282			
	9/3/14. The VS wer	after receiving dialysis on e not obtained during the 24 eriod after receiving dialysis				
	11:40 AM on 9/10/1 residents receiving once a day. Nurse # the nursing staff wa residents receiving	onducted with Nurse #1 at 4. She stated the VS for hemodialysis were obtained #1 stated she was not aware as expected to obtain VS on hemodialysis every shift post-dialysis period.				
	AM 9/10/14. She sta expected to obtain V hemodialysis once a was not aware the r obtain VS on reside	onducted with Nurse #2 at 3:29 ated the nursing staff was VS on residents receiving a day. Nurse #2 stated she nursing staff was expected to ents receiving hemodialysis he 24 hour post-dialysis period.				
F 314 SS=D	Staff #1 on 9/10/14 expected the nursin for a 24 hour period hemodialysis. 483.25(c) TREATM		F 314			10/21/14
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece	prehensive assessment of a r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and from developing.				

Facility ID: 952981

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP			0938-039 SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					PLETED
						C)
		345362	B. WING			09/1	1/2014
IAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS			250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 314	Continued From pa	ge 18	F 3	314			
	by: Based on observat and staff interview, recommended setti promote wound hea stage the pressure basis for one of fou #163) reviewed for included: 1a. Resident #163 y facility on 5/2/14 wit Peripheral Vascular admission Minimun dated 5/18/14 indic no pressure ulcer. assessment dated a #163 had 2 areas of The care plan for pr date) was reviewed pressure ulcers on The approaches ind wound weekly using assessment form a mattress to bed. " The weekly pressur reviewed. The reco that Resident #163 right ankle measuri (cm), and the woun The stage of the pro onset were blank. weekly measureme	8/5/14 indicated that Resident f stage III pressure ulcers. ressure ulcer (no revision . The care plan problem was the right ankle and coccyx. cluded " measure and stage g the pressure ulcer healing nd pressure reduction re ulcer records were ords dated 6/1/14 indicated had a pressure ulcer on the ng 1.5 x (by) 1.3 centimeter d bed was yellow in color. essure ulcer and the date of There were no records of ent and staging of the pressure 7/1/14, 7/8/14, 7/29/14,			 F314 1. The Director of Nursing validated tair mattress settings for Resident #16 were correct settings to promote wou healing on 10-4-14. The Director of Nursing/Unit Manager completed a Nursing Assessment of the Pressure Ulcers present for resident #163 inclumeasuring and documentation of stage on the Weekly Pressure Ulcer Log or 9-19-14. 2. Residents with Pressure Ulcers has the potential to be affected by this alled deficient practice. The Director of Nuraind Unit Manager completed an observation and assessment of all residents with Pressure Ulcers and validated the current measurements a wound staging to be accurate on 10-4. The Director of Nursing and Unit Manager completed an audit of all residentMs of an air mattress to validate accurate settings according to the manufacture recommendations on 10-4-14. 3. The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate the Licensed Nursing Staff including those working weekends and as needed, regarding assessment of pressure ulcers including staging, measuring and documentation observations of the pressure ulcer. The Director of Nursing, Staff Development Coordinator or Unit Manager will be completed by 10-15. The Director of Nursing, Staff Development Coordinator or Unit 	63 ind uding ging n ave eged ursing and 4-14. hager with erMs d g on the ding on of This	

Facility ID: 952981

		AND HUMAN SERVICES				FORM	10/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (COM	E SURVEY PLETED
		345362	B. WING				C 11/2014
	PROVIDER OR SUPPLIER	ETIREMENT/CABARRUS		25	REET ADDRESS, CITY, STATE, ZIP CODE BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 314	also revealed that F ulcer on the coccyx and the wound bed record did not indic ulcer or the date of measured on 6/10, but the stage was b weekly pressure ulk 7/1, 7/8, 7/29 and 8 resident was sent to not related to the pr readmitted on 8/31/ On 9/10/14, there w area to coccyx with solution (1/2 streng spectrum antimicro debrider which rem with wet to dry with cleanse right ankle solution and cover y Dakins daily and as On 9/10/14 at 9:00 observed during dra ulcer on the coccyx amount of slough o wound bed on the r slough. The presso cleaned with ½ stre santyl ointment was on the right ankle w	re ulcer records dated 6/1/14 Resident #163 had a pressure measuring 1.1 x 0.5 x 0.3 cm was yellow in color. The ate the stage of the pressure onset. The ulcer was 6/17, 6/24, 7/15, and 7/22/14 blank. There was no record of cer assessment completed on 6/21/14. On 8/22/14, the o the hospital for other reason ressure ulcer and was /14. vas doctor's order to cleanse NA (sodium) hypochloride th Dakins solution, a broad bial), apply santyl (enzymatic oves dead tissues) and cover ½ strength Dakins daily and to with ½ strength Dakins with wet to dry with ½ strength	F 3	14	Manager will re-educate all Nursing including those working on weekend as needed regarding the proper sett for resident air mattresses according the manufacturerMs recommendation The DON or Unit Manager will review current Residents with Pressure Ulcer measurements and staging are completed. The DON or Unit Manage will randomly observe 10 residents requiring air mattresses weekly for 1 weeks to ensure accurate settings a maintained according to the manufacturerMs recommendation. results of this monitoring will be documented on the facility monitorin Opportunities will be corrected daily Director of Nursing or Unit Manager identified during these audits. 4. The results of these reviews will a submitted to the QAPI Committee by Director of Nursing for review by IDT members each month for 3 months. QAPI Committee will evaluate the effectiveness and amend as needed Direct Plan of correction regarding F was submitted to CMS regarding on sustainability of correction for F314.	Is and ings g to on. we rers ger 12 ire The ag tool. by the as be y the T The as be y the T The as	
	Dakins solution was On 9/11/14 at 1:30 interviewed. She s						

If continuation sheet Page 20 of 46

		AND HUMAN SERVICES				FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED C
		345362	B. WING				C 11/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS			50 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 20	F 3	314			
	had left a month or assigned to comple the pressure ulcer.	so ago and recently she was the the weekly assessment of She acknowledged that she he assessments but not on a					
	was interviewed. S that the facility had pressure ulcer on a that the facility had month ago and they administrative staff. nursing staff to ass weekly using the fa stage, measurement description of the w should have been of	PM, administrative staff #1 the stated that she was aware issues for not assessing the weekly basis. She indicated lost the treatment nurse a y had a lot of changes on their . Her expectation was for the ess the pressure ulcers cility form which include the nt (width, length, depth) and yound. She added that nurses checking the air mattress per setting and functioning.					
	facility on 5/2/14 wir Peripheral Vascular admission Minimun dated 5/23/14 indic no pressure ulcer. assessment dated	was originally admitted to the th multiple diagnoses including r Disease (PVD). The n Data Set (MDS) assessment ated that Resident #163 had The quarterly MDS 8/19/14 indicated that 2 areas of stage III pressure					
	date) was reviewed pressure ulcers on One of the approac mattress to bed. "	ressure ulcer (no revision I. The care plan problem was the right ankle and coccyx. thes was " pressure reduction					
	On 9/10/14 at 9:10	AM and on 9/11/14 at 9:45					

Facility ID: 952981

If continuation sheet Page 21 of 46

		AND HUMAN SERVICES		FOF	D: 10/20/2014 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) D	ATE SURVEY OMPLETED
		345362	B. WING		C 9/11/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 F 318 SS=D	air mattress. The a led lights The reside (4th led light from the recommended settil " 1-2 led lights from On 9/11/14 at 9:50 interviewed. She sin was responsible for the air mattress degree weight and the nurse setting daily but obvide been checked. Nurse setting was not correct the setting the setting was not correct the setting the setting was not correct the setting the setting written on the On 9/11/14 at 2:25 was interviewed. Shave been checking for proper setting a 483.25(e)(2) INCRE IN RANGE OF MO Based on the composition and decrease in range of This REQUIREMEN by: Based on record response	was observed in bed with an air mattress had a setting of 8 ent's air mattress was set on 4 he bottom). The ing written on the machine was a the bottom. " AM, Nurse #3 was tated that the nurse supervisor recommending the setting of pending on the resident's ses should be checking the viously the setting had not rse #3 acknowledged that the rect and stated that she would by following the recommended he machine. PM, administrative staff #1 she stated that nurses should g the air mattress setting daily nd functioning. EASE/PREVENT DECREASE TION prehensive assessment of a r must ensure that a resident e of motion receives ent and services to increase d/or to prevent further	F 314	1	of

Facility ID: 952981

If continuation sheet Page 22 of 46

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	FORM / MB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	SURVEY PLETED
		245202				(
		345362	B. WING _			09/1	1/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			50 BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 318	Continued From pa	age 22	F 3 ⁻	18			
F 310	management to pre (Resident #103) of contracture. The fi Resident # 103 was 7/31/13 with multip Dementia and Oste The annual Minimu assessment dated Resident # 103 was no limitation in rang extremities. The medical record reviewed. The record reviewed. The record Resident #103 was contracture. The contracture. The contracture indicated that the left hand. She attempted to straig further indicated the pain when her left h The therapy notes dated 8/19/14 indic house communicat Resident #103's left contracted. Reside so the hospice nurs	event further decline to 1 2 sampled residents with ndings included: s admitted to the facility on le diagnoses including	F 3		Nursing validated Resident #103 has current contracture management pl place on 10-4-14. 2. Resident's with contractures hav potential to be affected by this alleg deficient practice. The Rehab Direct the Director of Nursing and the Res Care Management Director will con- an audit of all Residents with Contra- to validate required Contracture Management is in place by reviewir residents currently coded for decrea- range of motion on the most recent with subsequent therapy screening required. The Rehab Director and Director of Nursing will complete an of all Residents with Contractures to validate required interventions are in place, the Care Plan is in place, and reflects current interventions. This will be completed by 10-15-14. The Administrator and Director of Nursing with Hospice providers on 9/15/14 to explain the requirement of an entra and exit conference with the Director Nursing or Unit Manager to discuss current residents needs and to revie care plan. 3. The Director of Rehab will educa- Licensed Nursing Staff including the working weekends and as needed a	lan in ve the led ctor, sident nplete actures ng ased MDS as the n audit o n d audit e nce or of s ew the ate the ose	
	with a wash cloth. The hospice notes indicated that on 8/ came to see Resid left hand was contr	were reviewed. The notes 27/14, the hospice nurse ent #103 and noted that her acted and was edematous. b passive range of motion to			Therapy Staff by 10-15-14 related to Contracture Management, including application and removal. The Reha Director or Occupational Therapist randomly observe 10 residents with contracture management plans were 12 weeks to validate interventions f contracture management are	g splint b will i ekly to	

Facility ID: 952981

If continuation sheet Page 23 of 46

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		IPLETED
		345362	B WING			C
	PROVIDER OR SUPPLIER	545362	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD		11/2014
		ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 318	indicated that the re rolled cloth in her h The notes further in visited the resident 9/8/14 and the note range of motion ex- to prevent further d resident's left hand On 9/10/14 at 4:20 Resident #103 was on a fist position wi prevent further dec On 9/11/14 at 9:30 interviewed. He sta department had rea from the nursing st left hand contractur resident was on ho called and indicated the facility's nursing to the resident's lef On 9/11/14 at 10:04 interviewed. She st Resident #103's lef indicated that the re and therapy had ca had seen the hospi but she did not kno provided for the left	and/fingers. She also esident was unable to keep a and to reduce contracture. Indicated that the hospice staff on 8/28/14, 9/3/14, 9/4/14 and es did not indicate whether ercises or any device was tried lecline in contracture to the PM and 9/11/14 at 8:50 AM, observed. Her left hand was ith no device observed to line in contracture. AM, the therapy staff #1 was ated that the therapy ceived a communication form aff regarding Resident #103's re. He added because the spice, the hospice nurse was d to defer the therapy and for g staff to apply rolled washcloth t hand. 4 AM, Nurse #2 was rated that she was aware of the ft hand contracture. She esident was referred to therapy alled the hospice nurse. She ice nurse visiting the resident w what care/treatment was t hand contracture.	F 31	8 implemented. The results of t monitoring will be documented facility monitoring tool. Oppor be corrected daily by the Direc Rehab as identified during the 4. The results of these review submitted to the QAPI Commi Director of Rehab for review b members each month for 3 m QAPI Committee will evaluate effectiveness and amend as n	d on the tunities will ctor of se audits. vs will be ttee by the y IDT onths. The the	
	but she did not kno provided for the left On 9/11/14 at 1:08 interviewed via tele hospice nurse who was not available.	w what care/treatment was				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 09								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED		
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	0	C		
		345362	B. WING		09	09/11/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE				
BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS		CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE		
F 318 F 322 SS=D	to keep her fingers She added that the communication bet the facility nursing s management to pro On 9/11/14 at 2:25 was interviewed. S was for the hospice nursing staff to com contracture manage resident. She also ensure that Resider to prevent her left h contracture. 483.25(g)(2) NG TF RESTORE EATING Based on the comp resident, the facility (1) A resident who h alone or with assist tube unless the resident demonstrates that u unavoidable; and (2) A resident who i gastrostomy tube re treatment and servi pneumonia, diarrhe metabolic abnorma	oblaced on the contracted hand from digging into her palm. re should have a ween the hospice nurse and staff as to what contracture ovide for the resident. PM, administrative staff #1 she stated that her expectation a nurse and the facility's nunicate as to what ement can be done for the indicated that she would nt #103 will be provided care hand to have further decline in REATMENT/SERVICES -	F 3	318		10/21/14		

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AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA					0938-0391	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED C		
		345362	B. WING	;			<i>,</i> 11/2014	
BRIAN C	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS					50 BISHOP LANE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 322	Continued From pa	ige 25	F:	322				
	by: Based on record re interview, the facilit gastrostomy (G) tul administering the m 143)of 1 sampled re tube feeding. The f 1. Resident #143 w 5/8/14 with multiple vascular accident (f The admission Min assessment dated Resident #143 had on tube feeding. The physician's ord #143 had an order (calorie) per G tube for 20 hours (4:00 F On 9/10/14 at 4:30 during the medicati observed to flush th followed with crush	NT is not met as evidenced eview, observation and staff y failed to check the be placement prior to nedications to 1(Resident # esident observed receiving finding included: ras admitted to the facility on diagnoses including cerebro CVA) and dysphagia. imum Data Set (MDS) 5/15/14 indicated that impaired cognition and was lers were reviewed. Resident dated 6/13/14 for Jevity 1.5 cal e at 70 milliliter (ml) per hour PM to 12 noon) via pump. PM, Nurse #4 was observed on pass. Nurse #1 was ne G tube with water and ed medication dissolved in as not observed to check the			 F322 The Physician was notified of the of Gastrostomy Tube placement verification prior to medication administration for Resident #143 the Director of Nursing on 9-11-14. The were no new orders as a result of notification. One to one re-educate completed by the Director of Nurse 9-11-14 with Nurse #1 related to verification administration with related to verification administration with related to verification. Residents with Gastronomy tube the potential of being affected by the Director of Nursing and Unit Manager conduct audit of all residents with Gastrost Tubes to validate a PhysicianMs Chas been obtained to verify placer prior to medication administration 15-14. The DON, Staff Development Coordinator or Unit Manager will 	by the nere this ion was ing on erifying r to urn es have his rector of cted an omy Order nent		
	administering the m On 9/10/11 at 5:05 interviewed. She s the placement for m				re-educate Licensed Nursing Staff including those working weekends needed, by 10-15-14 related to the a Gastrostomy Tube including ver of placement prior to medication administration with a return demon to validate understanding. The Di	and as care of fication		

Facility ID: 952981

		AND HUMAN SERVICES			FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		345362	B. WING			C 11/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		11/2014
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 322 F 334 SS=D	vomiting. On 9/11/14 at 2:15 was interviewed. S supposed to check to administering me resident on tube fee 483.25(n) INFLUEN IMMUNIZATIONS The facility must de that ensure that (i) Before offering th each resident, or th	ent had problems like PM, administrative staff #1 she stated that nurses were the placement/residual prior edications or water flush to a eding. NZA AND PNEUMOCOCCAL evelop policies and procedures the influenza immunization, the resident's legal	F 32	 Nursing or Unit Manager v random observations of L to include those working of and weekends, weekly for validate the verification of the Gastrostomy Tube pri- administration. The resu monitoring will be docume facility monitoring tool. Op be corrected daily by the I Nursing or Unit Manager a during these audits. The results of these re submitted to the QAPI Co Director of Rehab for revie members each month for QAPI Committee will eval effectiveness and amend 	icensed Nurses during all shifts r 12 weeks to placement of or to medication lts of this ented on the oportunities will Director of as identified eviews will be ommittee by the ew by IDT 3 months. The uate the	10/21/14
	benefits and potent immunization; (ii) Each resident is immunization Octol annually, unless the contraindicated or t immunized during t (iii) The resident or representative has immunization; and (iv) The resident's r	eives education regarding the cial side effects of the offered an influenza ber 1 through March 31 e immunization is medically the resident has already been his time period; the resident's legal the opportunity to refuse medical record includes cindicates, at a minimum, the				

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		AND HUMAN SERVICES				FORM	: 10/20/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	`´CO№	E SURVEY IPLETED C
		345362	B. WING				0 11/2014
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS			250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334	representative was the benefits and po immunization; and (B) That the reside influenza immuniza contraindications of The facility must de that ensure that (i) Before offering th immunization, each legal representative the benefits and po immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm	ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical r refusal. evelop policies and procedures he pneumococcal resident, or the resident's e receives education regarding tential side effects of the offered a pneumococcal ss the immunization is licated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical	F	334	4		

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		AND HUMAN SERVICES			FORM A	10/20/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345362	B. WING		C 09/1	, 1/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/1	1/2014	
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 334	immunization, unle	first pneumococcal ss medically contraindicated or resident's legal representative	F 33	4			
	by: Based on record re facility failed to offe to 2 of 5 (Resident residents. The findings includ 1. Resident #7 was 8/12/04 with multipl diabetes mellitus, a history of a cerebra hemiparesis. A review of the med #7 was not offered 2013-2014 influenz An interview was co Staff #1 on 9/11/14 nursing staff was e vaccine and to exp residents residing i was expected to ob influenza vaccine fr responsible party. to administer the in and to record the a Administration Rec also stated she exp	admitted to the facility on le diagnoses including history of pneumonia and a l vascular accident with dical record revealed resident an influenza vaccine for the		F334 1. The Unit Manager offered Reside and Resident #80 the Influenza Valon 10-3-14 and signed consent ob and administered. 2. Current residents have the poter be affected by this alleged deficient practice. The Unit Manager or Chan Nurse will offer all residents the 2014-2015 Influenza Vaccine. The Manager or Charge will provide documentation of consent obtained 10-31-14. Administration of the Int Vaccine will occur upon delivery of previously ordered vaccine. New admissions into the facility will also offered the Influenza vaccine by th Manager of the Charge Nurse upo admission through March 31, 2015 3. The DON, Staff Development Coordinator or Unit Manager will re-educate Licensed Nursing Staff including those working on weeker as needed by 10-15-14 related to the requirement of obtaining consent at offering the Influenza Vaccine and current residents and new admissi The DON or Unit Manager will random review the Influenza Consent Form	ccine tained ntial to it arge e Unit d by fluenza b be e Unit n 5. bbs e Unit n 5. bbs and ually to ons. domly		

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			PLETED
		345362	B. WING _			C 09/11/2014	
NAME OF I	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			50 BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 334	Continued From pa	age 29	F 33	34			
	facility staff to revie	ew.			the Medication Administration Rec		
	Staff #3 on 9/11/14 was unable to loca				10 residents weekly for 12 weeks validate the Influenza Vaccine is b offered, consent is obtained prior t administration of the Influenza Vac	eing o the cine,	
		ord of the influenza vaccine for 2013-2014 influenza season.			and the Influenza Vaccine is admir The results of this monitoring will be documented on the facility monitor Opportunities will be corrected dai	be ing tool.	
	7/1/2011 with multi	as admitted to the facility on ple diagnoses including a nia, hypertension, depression, egular heart beat.			Director of Nursing or Unit Manage identified during these audits. 4. The results of these reviews wi submitted to the QAPI Committee	er as Il be by the	
		dical record revealed resident d an influenza vaccine for the za season.			Director of Nursing for review by II members each month for 3 month QAPI Committee will evaluate the effectiveness and amend as need	s. The	
	Staff #1 on 9/11/14 nursing staff was e vaccine and to exp residents residing i was expected to ol	onducted with Administrative at 10:44 AM. She stated the expected to offer the influenza plain the risk factors to all of the in the facility. The nursing staff btain consent or refusal of the rom every resident or					
	responsible party. to administer the ir and to record the a Administration Rec also stated she exp	The nursing staff was expected offluenza vaccine if requested administration on the Medical cord. Administrative Staff #1 pected the resident's mation to be accessible for the					
	An interview was conducted with Administrative Staff #3 on 9/11/14 at 12:30 PM. She stated she was unable to locate the consent and administration record of the influenza vaccine for resident #80 for the 2013-2014 influenza season.						

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		AND HUMAN SERVICES & MEDICAID SERVICES	1		FORM	: 10/20/2014 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	E SURVEY IPLETED C
		345362	B. WING			0 11/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 364	Continued From pa	ge 30	F 36	64		
F 364 SS=D		JTRITIVE VALUE/APPEAR,	F 36	64		10/21/14
	food prepared by m	ves and the facility provides lethods that conserve nutritive ppearance; and food that is e, and at the proper				
	by: Based on meal obs resident interviews, palliative food for the residents (Resident The findings include An interview with R pm was conducted his meals in the mat the hot foods serve An interview with R pm was conducted food did not taste g An interview on 9/8 #7 was conducted. did not taste good fi not identify any part	NT is not met as evidenced servation, staff interviews and the facility failed to provide the sampled the facility failed to provide the facility failed to provide the facility		 F364 1. The Dietary Manager conduction interviews with Residents #7, # #128 by 10-4-14 to identify spector concerns related to meals. The concerns will be documented of Facility Concern Form, investig completed by the Dietary Manafollow up completed as require 10-6-14. 2. Current residents have the pbeing affected by this alleged of practice. The Dietary Manager during the next scheduled Residentified b group, Concerns will be documented by the Facility Concern Form, investig completed by the Dietary Manager during the next scheduled Residentified by group, Concerns will be documented to meals as identified by the Facility Concern Form, investor completed by the Dietary Manager Will interview a oriented residents to discuss and follow up completed as require the Facility Manager will interview a oriented residents to discuss and follow up completed as require the facility Manager will interview a oriented residents to discuss and follow up completed as require the facility Manager will interview and follow up completed as require the facility Manager will interview a oriented residents to discuss and follow up completed as require the facility Manager will interview and follow up completed as require the facility manager will interview and follow up completed as require the facility manager will interview and follow up completed as require the facility manager will interview and follow up completed as require the facility manager will interview and follow up completed as require the facility manager will interview and follow up completed as require the facility concern form, invest the facility manager will interview and follow up completed as require the facility concern form form form form form form form form	79 and cific se an the ation ger, and d by otential of leficient will meet dent concerns y the ented on estigation ger and d. The alert and	
	from the server on a was placed on an o main dining room w kitchen. The tray co	the steam table. A regular tray pen cart to be taken to the which was located outside the ontained grilled chicken, french per container, a plastic		concerns related to meals as id the group. Concerns will be do on the Facility Concern Form, investigation completed by the Manager, and follow up completed	lentified by cumented Dietary	

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		AND HUMAN SERVICES			FOF	ED: 10/20/201 RM APPROVE O. 0938-039	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) [(X3) DATE SURVEY COMPLETED	
		345362	B. WING			C 9/11/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			50 BISHOP LANE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 364	container of tropica plastic bowl contain The tray arrived in t pm and remained of resident ' s tray was 1:30 pm. The dietary manage cart and placed it of was removed from and grilled chicken	 c bowl containing lettuce and tomatoes. ray arrived in the main dining room at 1:06 nd remained on the cart until the last ent 's tray was served in the dining room at pm. dietary manager removed the tray from the and placed it on an empty table. The cover removed from the plate with the french fries yrilled chicken on it. The dietary manager completed by 10-15-14. 3. The Dietary Manager with the french fries yrilled chicken on it. The dietary manager completed by 10-15-14. 3. The Dietary Manager with the french fries yrilled chicken on it. The dietary manager 		required. These interviews will be completed by 10-15-14. 3. The Dietary Manager will re-educate the Dietary Staff including those working on weekends and as needed by 10-15-1 related to enhancing taste of foods serv and maintaining correct temperatures of foods served. The Administrator will sample a test tray served form the last meal cart leaving the kitchen 3 times pe week for 12 weeks to ensure quality tas of foods served. The Dietary Manager week make random observations daily on tray	4 ed r te vill		
	use some salt and tasted the grilled ch dry in texture and la tasted the french fri not seasoned. The french fries and sta flavorless. The diet	it was bland. The surveyor nicken which was luke warm, acked flavor. The surveyor ies which were cold and were dietary manager tasted the ted they were cold and were ary manager indicated the ved hot and it should have			line ensuring proper temps are maintained. The Dietary Manager, Soci Services Director and Activities Director will randomly interview 10 residents weekly for 12 weeks related to specific concerns related to meals. The results this monitoring will be documented on th facility monitoring tool. Concerns will be addressed daily by the Dietary Manage as they are identified during these audits 4. The results of these reviews will be submitted to the QAPI Committee by the Dietary Manager for review by IDT members each month for 3 months. Th QAPI Committee will evaluate the effectiveness and amend as needed.	of ee s.	
F 371 SS=E	483.35(i) FOOD PF STORE/PREPARE	ROCURE, /SERVE - SANITARY	F 3	71	enectiveness and amend as needed.	10/21/14	
	considered satisfact authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food ditions					

Facility ID: 952981

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938								
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	E CONSTRUCTION		SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			(· · /	PLETED	
						C	2	
		345362	B. WING			09 /1	1/2014	
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
		ETIREMENT/CABARRUS		2	50 BISHOP LANE			
DIVIANO				С	CONCORD, NC 28025			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		170		DEFICIENCY)			
F 371	Continued From pa	ae 32	F 3	71				
	oonandou i ioni pu	90 02	10					
		NT is not met as evidenced						
	by:							
		tions, record reviews, and staff			F371			
		ity failed to keep cole slaw			1. The deep fryer was drained and	av the		
		aise/dressing, and milk 41 degrees during operation			cleaned according to facility policy to Dietary Manager on 9-10-14. Oper			
		ed to air dry kitchenware			unlabeled or undated Food items w			
		storage, failed to clean deep			immediately discarded by the Dieta			
		failed to label and date			Manager 9-10-14. Dishes are now a			
		stored in refrigerators.			dried prior to stacking. Cole slaw w			
					discarded following unacceptable			
	Findings included:				temperature measurement.			
					2. All residents have the potential o			
		:05 pm a digital thermometer			affected by this alleged deficient pra			
		the temperature of cole slaw tover ice in a 4 inch deep tray			related to the cleaning of the deep f labeling dating and storing food iten			
		the steam table. The			proper food storage temperatures,			
		ered 55 degrees Fahrenheit.			proper dish drying procedures.	and		
		etary Manager (DM) reported			3. The Dietary Manager will re-educ	cate		
		prepared in the facility. The DM			the Dietary Staff including those wo			
		ture should be 45 degrees			weekends and as needed by 10-15			
		A also indicated the cole slaw			related to proper cleaning procedur			
		the refrigerator and was			according to the facility policy, frequ			
		er the tray line had been set			and documentation of the cleaning			
		the temperature of the cole es Fahrenheit at 11:30 am			deep fryer, preparing and serving m and the appropriate methods for sto			
		t out of the refrigerator.			and serving food at acceptable	Jing		
	when it was brough				temperatures and acceptable meth	ods for		
	2. On 9/10/14 at 12	:06 pm a digital thermometer			monitoring food temperatures include			
		the temperature of milk that			accurate documentation of food	5		
		6 inch deep tray pan with ice			temperature monitoring logs, prope	r		
	on the top of the mi	Ik containers and below the			drying of cleaned dishes and dating	and		
		e temperature of the milk was			labeling of stored foods items. The			
	43 degrees Fahren	heit. The DM indicated it was			Manager will observe the deep frye	r 3		

Facility ID: 952981

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		AND HUMAN SERVICES			F	FORM	10/20/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C	
		345362	B. WING				, 1/2014
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS			50 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	3. On 9/11/14 at 10 observed placing p washing machine of stored in a plate wa in. The DM was pre- removing plates fro- indicated the stack- used for service. The to have water on the warmer were 3 sma- stacked wet and 1 stated she usually b while before she stand Dietary aide #1 did was what she had of On 9/11/24 at 10:55 bowls and pie plate air dried prior to be 4. On 9/9/14 at 12:2 pm the deep fryer w of yellowish brown thick floating on bla front half of the deep	 t 45 degrees Fahrenheit. t:52 am dietary aide #1 was lates coming out of the dish onto a stack of plates being armer which was not plugged esent at the time and began om the plate warmer. The DM ed plates were ready to be here were 56 plates observed tem. On the edge of the plate all serving bowls that were wet pie plate. Dietary aide #1 left the dishes in the rack for a acked them in the warmer. not answer when asked if that done this time. a am the DM stated the plates, e should have been completely ing stacked. 45 pm and on 9/10/14 at 12:05 was observed to have a layer colored substance 1/4 inch ackish brown colored oil in the 	F 3	571	times per week for 12 weeks to ensur proper cleanliness is maintained and validate documentation of cleaning lo The Dietary Manager will randomly observe and validate the accuracy of temperatures obtained by the Dietary 3 times per week, to include all meals occurring both day and evening shifts 12 weeks and validate documentation temperature monitoring logs. The Die Manager will monitor foods being stor in the Kitchen as well as in the Nursin Unit Nourishment Rooms 3 times per week for 12 weeks to ensure labeling dating are completed. The Dietary Manager will make random observation of dishes to ensure dishes are being a dried prior to stacking. The Dietary Manager will observe 3 times per wee 12 weeks. Opportunities will be correct daily by the Dietary Manager or the C as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by Dietary manager for review by IDT members each month for 3 months. QAPI Committee will evaluate the effectiveness and amend as needed.	pgs. food staff s s, for n of tetary red ng r g and ions air ek for ected cook e the The	
	stated the deep fry weekly or as neede should have been of cooked to prevent a any resident who m 9/10/14 at 4:25 pm	er needed to be cleaned ed and that the deep fryer cleaned after the fish was any cross contamination for nay have an allergy to fish. the DM stated "the deep fryer					
	she could do her fro	use she did not have the oil so ench fries today (9/10/14). " Monday (9/8/14) fish was fried			vility ID: 052021		

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		AND HUMAN SERVICES				FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345362	B. WING				C 11/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS			50 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	e e i i i i i i i i i i i i i i i i i i	ige 34 id on Tuesday (9/9/14) crab	F 3	371			
	cakes where fried in	n the fryer. The DM further ries were fried today (9/10/14)					
	fryer is cleaned wee discussion revealed breaded during pre deep fryer on Mond was not cleaned aft	3 pm cook #1 stated the deep ekly on Saturdays. Further d fresh fish which she had paration had been fried in the lay (9/8/14) and the deep fryer ter frying the fish. The cook r as she knew, none of the rgic to shellfish.					
	located in the kitche crates containing 69 brown colored fluid identifying what and refrigerator. Cook #	am the walk in refrigerator en was observed to have 3 9 clear plastic containers with in them with no label or date d when it was placed in the 1 was present at the time and have been a label on the					
		am an interview with the DM cted the staff to date and label he refrigerator.					
	nourishment room I inspected. There we supplements broug specific residents o The containers wer resident ' s name. T bottles of a nutrition of a nutritional supp	I pm the refrigerator in the located on the 400 hall was ere containers of nutritional ht in by family members for bserved in the refrigerator. The not dated or labeled with the linere were four 8 ounces (oz) hal supplement and 2 cartons olement in the refrigerator d and not labeled with the					

Facility ID: 952981

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345362	B. WING			0 11/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER HEALTH & RI	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	items stored in the label and date on the supplements withou identified by the NA brought in for a resi On 9/11/14 an inter her staff was respo refrigerator in the n Also, the staff was re items stored in the labels. On 9/11/14 at 3:34 aide #2 revealed sh checking and stock hall. She indicated to items in the refriger that all the items we discussion revealed	 /11/14 at 3:15 pm stated all refrigerator were to have a nem. The nutritional ut a label or date on them were as items family members had ident. view with the DM revealed that insible for stocking the utritional room on the 400 hall. responsible for checking all refrigerator for dates and pm an interview with dietary he was responsible for ing the refrigerator on the 400 that she checked all of the rator for expirations dates, and ere labeled and dated. Further a that if she found items that 	F 37	1		
F 431 SS=D	items, she would the On 9/11/14 at 3:42 nutritional supplement have a label or the them. As she openent the sign on the outs that read: "everythin have a date and na nurse indicated that nutritional supplement stated the nutritional been labeled with the 483.60(b), (d), (e) E	pm Nurse #4 confirmed the ents in the refrigerator did not date they were brought in on ed the refrigerator she read side of the refrigerator door ng in the refrigerator needs to me of the resident on it. " The t she did not know who the ents belonged to. She also al supplements should have ne resident 's name and date.	F 43 [.]	1		10/21/14

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		AND HUMAN SERVICES				FORM	: 10/20/2014 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL		E CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				IPLETED
		345362	B. WING				C / 11/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		11/2014
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS		ETIREMENT/CABARRUS			50 BISHOP LANE		
	1			С	ONCORD, NC 28025		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI)		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
			<u> </u>				
F 431	Continued From pa	-	F 4	31			
		nploy or obtain the services of					
		cist who establishes a system of and disposition of all					
	controlled drugs in	sufficient detail to enable an					
		tion; and determines that drug rand that an account of all					
		maintained and periodically					
	reconciled.						
	Drugs and biologica	als used in the facility must be					
	labeled in accordan	nce with currently accepted					
		bles, and include the					
	appropriate access instructions, and the	e expiration date when					
	applicable.	F					
	In accordance with	State and Federal laws, the					
	facility must store a	Il drugs and biologicals in					
		nts under proper temperature it only authorized personnel to					
	have access to the	· ·					
		-					
		ovide separately locked, d compartments for storage of					
	controlled drugs list	ted in Schedule II of the					
		ug Abuse Prevention and and other drugs subject to					
		n the facility uses single unit					
	package drug distri	bution systems in which the					
	quantity stored is m be readily detected.	ninimal and a missing dose can					
	be readily detected.						
		NT is not met as evidenced					
	by:						
		tion, staff interview and					
		ne facility failed to have a nitor the temperature in 1 of 2			F431		

Facility ID: 952981

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		AND HUMAN SERVICES					10/20/201 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345362	B. WING	i			C 11/2014
NAME OF PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP	•	11/2014	
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS				250 BISHOP LANE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 431	Continued From pa	ge 37	F4	431			
	temperature range needing refrigeration Fahrenheit) for 1 of (100/300 hall refrigeration addication refrigeration 34 degrees Fahren medication refrigeration (PPD) within 30 day medication refrigeration (PPD) within 30 day medication refrigeration refrigerator). The fill Review of the facilitient Expiration of Medicion and Needles revised " Facility should en biologicals are stored temperatures accompliant Pharmacopeia guid Facility staff should vaccines twice a day (degrees Fahrenheet " Once any medication opened, Facility should expiration dates for staff should record	to store medications within the required for medications on (36 - 46 degrees 2 medication refrigerators erator), failed to identify logged ator temperature readings of heit as under the safe ator storage range, and failed in Purified Protein Derivative ys after opening in 1 of 2 ators (200/400 hall indings included: ty policy titled Storage and ation, Biologicals, Syringes d 1/1/13 revealed, in part: usure that medications and ed at their appropriate rding to the United States lelines for temperature ranges. monitor the temperature of ay. " "Refrigeration 36 it) - 46 (degrees Fahrenheit). "			 The Director of Nursing medications from the 100/3 Refrigerator on 9-11-14. T Nursing validated on 9-11-7 200/400 Hall medication ret thermometer in place and t are being recorded daily wit temperatures being maintain required range. The Director validated on 9-11-14 that the medication refrigerator has in place and temperatures recorded daily with temperatures recorded by the pire on 9-11-14. The DON, Staff Develop Coordinator or Unit Manager re-educate Licensed Nursin including those working we needed regarding storage a medications including acception and monitoring of refrigerator and monitoring of refrigerator 	300 Hall he Director of 14 that the frigerator has a temperatures ith ined in the ctor of Nursing he 100/300 Hall a thermometer are being atures being range. Expired d by the -14. hedications ge have the this alleged e medications refrigerator for of Nursing ment er will ng staff eekends and as and labeling of eptable temperatures tor	
	medication refrigera # 5. On observatio	:35 AM the 200/400 hall ator was observed with Nurse n this refrigerator did not have			Unit Manager will randomly refrigerators used for medi 2 times per week for 12 we the presence of a thermom temperatures, documentati	cation storage eeks to validate neter to monitor ion of daily	
		rrse # 5 was interviewed at this d that it was the night nurse			temperature monitoring, the of acceptable parameters of		

Facility ID: 952981

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TATEMEN	OF DEFICIENCIES OF CORRECTION	KIN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY PLETED
		345362	B. WING		C 09/11/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 431	refrigerator temper temperature log or refrigerator and ob 36 degrees F was shift, but confirmed be located inside th this time. During an interview on 9/11/14 at 12:30 not know what hap the 200/400 hall m there had been a p have reported it to that the medicatior refrigerator were b On 9/11/14 at 2:50 interviewed. She s previous night (9/1 responsibility for lo refrigerator temper when she went to g of the refrigerators and it was 36. She the other medication it was also 36. Nu not record these te she went to write th the other nurse wo done it. She furthe had a thermomete 2. On 9/11/14 at 1 medication refriger observation the the	 ble for logging the medication ratures. She reviewed the in the front of this medication iserved that a temperature of recorded for the previous night d that a thermometer could not he medication refrigerator at w with Administrative Staff # 3 D PM she indicated that she did opened to the thermometer in edication refrigerator but if problem with it staff should have it replaced. She added as that had been stored in that eing discarded. PM Nurse # 6 was stated that she had worked the 0/14) and had been assigned ogging the medication ratures. Nurse # 6 said that get some medication out of one she checked the temperature e added that she then checked on refrigerator temperature and rse # 6 revealed that she did emperatures herself as when hem on the log she saw that wrking with her had already r stated that both refrigerators 	F 43	 temperatures, and the accura and labeling of medications is these refrigerators. Opportun corrected daily by the Director or Unit Manager as identified audits. The results of these review submitted to the QAPI Comm Director of Nursing for review members each month for 3 in QAPI Committee will evaluate effectiveness and amend as 	tored in hities will be or of Nursing during these ws will be hittee by the v by IDT honths. The e the	

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		AND HUMAN SERVICES			PRINTED: 10/2 FORM APPF OMB NO. 0938	ROVED	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURV COMPLETE C	PLETED	
		345362	B. WING _		09/11/20	14	
	PROVIDER OR SUPPLIER	ETIREMENT/CABARRUS		STREET ADDRESS, CITY, STATE, ZI 250 BISHOP LANE CONCORD, NC 28025	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMP HE APPROPRIATE D	(X5) PLETION DATE	
F 431	Nurse # 5 was pres the reading on the the thermometer re- was interviewed at medications requiri stored under 32 de the exact temperatu- refrigerated medica degrees was to col- During an interview on 9/11/14 at 12:30 temperature readin cold for refrigerated the previous night. medications that has refrigerator were be 3. Review of the 20 refrigerator tempera- of the refrigerator re 2 and 3, 2014 the to 34 degrees (outside temperature range refrigeration). The action taken regard temperatures from 36 - 46 degrees F. Interview with Admi at 12:30 PM reveal forms that had bee and 100/300 hall m month of Septembe corporate or facility medication refrigera	sent and was asked to verify thermometer. She stated that ead 26 degrees F. Nurse # 5 this time and stated that ing refrigeration should not be grees F. She was uncertain of ure range appropriate for ations but indicated that 26 d. with Administrative Staff # 3 0 PM she indicated that a ing of 26 degrees F was too d medications but that the een recorded as 36 degrees F She added that the ad been stored in that	F 43				

Facility ID: 952981

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 431 Continued From page 40 it as a reminder of the out of range temperatures F 431			AND HUMAN SERVICES				FORM	APPROVED
A. BOILDING C 345362 B. WING 09/11/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH & RETIREMENT/CABARRUS STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX F 431 Continued From page 40 F 431 it as a reminder of the out of range temperatures F 431	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •		E CONSTRUCTION	(X3) DATE	E SURVEY
Image: Name of provider or supplier 345362 B. WING Og/11/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE 250 BISHOP LANE BRIAN CENTER HEALTH & RETIREMENT/CABARRUS CONCORD, NC 28025 28025 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE F 431 Continued From page 40 it as a reminder of the out of range temperatures F 431 F 431	AND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE F 431 Continued From page 40 it as a reminder of the out of range temperatures F 431				B. WING	B. WING			
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS CONCORD, NC 28025 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE F 431 Continued From page 40 it as a reminder of the out of range temperatures F 431	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE F 431 Continued From page 40 it as a reminder of the out of range temperatures F 431 F 431 F 431	BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS					
it as a reminder of the out of range temperatures	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
so they can then adjust the temperature or report the problem if it does not resolve. 4. Review of the Product Information Sheet for Tuberculin PPD (TUBERSOL) dated February 2013 revealed " A vial of TUBERSOL which has been entered and in use for 30 days should be discarded." On 9/11/14 at 11:37 AM the 200 and 400 hall medication refrigerator was observed to contain 3 vials of opened Tuberculin PPD. All 3 vials were opened and dated when opened. One of the 3 vials was dated as being opened on 8/1/14, the remaining two had been open less than 30 days. Nurse # 5 was present at this time and confirmed that the Tuberculin PPD vial had a hand written date of 8/1/14 indicating it was opened more than 30 days ago. Nurse # 5 stated she was aware the Tuberculin ppd needed to be discarded after opening within a particular time frame but she thought it was greater than 30 days. During interview with Administrative Staff # 3 on 9/11/14 at 12:30 PM she acknowledged that Tuberculin PD should be discarded 30 days after it is opened for use. F 520 SS=E COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; staff.	F 520	it as a reminder of t so they can then ad the problem if it doe 4. Review of the Pro Tuberculin PPD (TU 2013 revealed " A v been entered and in discarded. " On 9/11/14 at 11:37 medication refrigeration vials of opened Tub opened and dated w vials was dated as a remaining two had Nurse # 5 was press that the Tuberculin date of 8/1/14 indica 30 days ago. Nurse the Tuberculin ppd opening within a pa thought it was great During interview wit 9/11/14 at 12:30 PM Tuberculin PPD sho after it is opened fo 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAM A facility must main assurance committe nursing services; a facility; and at least	he out of range temperatures ljust the temperature or report es not resolve. oduct Information Sheet for JBERSOL) dated February vial of TUBERSOL which has in use for 30 days should be and the 200 and 400 hall ator was observed to contain 3 berculin PPD. All 3 vials were when opened. One of the 3 being opened on 8/1/14, the been open less than 30 days. tent at this time and confirmed PPD vial had a hand written ating it was opened more than e # 5 stated she was aware needed to be discarded after rticular time frame but she ter than 30 days. th Administrative Staff # 3 on A she acknowledged that build be discarded 30 days r use. IBERS/MEET NS tain a quality assessment and ee consisting of the director of physician designated by the					10/21/14

Facility ID: 952981

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION (X3) D			E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		345362	B. WING			(
NAME OF F	PROVIDER OR SUPPLIER	545502	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/1	11/2014
				50 BISHOP LANE			
BRIAN C	ENTER HEALTH & RE	ETIREMENT/CABARRUS		C	CONCORD, NC 28025		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
1/10		,			DEFICIENCY)		
			I				
F 520	Continued From pa	ge 41	F 5	20			
		ment and assurance t least quarterly to identify					
		to which quality assessment					
	and assurance activ	vities are necessary; and					
		ments appropriate plans of					
	action to correct ide	entified quality deficiencies.					
	A State or the Secr	retary may not require					
		cords of such committee					
		uch disclosure is related to the					
	requirements of this	committee with the					
		s section.					
	Good faith attempts	by the committee to identify					
		deficiencies will not be used as					
	a basis for sanction	IS.					
		NT is not met as evidenced					
	by:	record review and staff			5520		
		record review and staff y ' s quality assessment and			F520 1. The Administrator held a Quality		
		ee failed to maintain			Assurance Performance Improvem	ent	
	implemented proce	dures and monitor these			meeting with the Interdisciplinary Te		
		ne committee put in to place in			including the Medical Director, Dire	ctor of	
		ruary 2014. This was for five			Nursing, Director of Rehab, Social	r 02	
		hich were originally cited June trification survey and February			Services Assistant, Dietary Manage 9-25-14, focusing on the areas of M		
		plaint investigation. The			assessment, development of Care		
	deficiencies were in	the areas of assessment,			treatment and services to prevent/h	ieal	
		e plans, treatment and			pressure ulcers, Sanitation in the ki	tchen	
		/ heal pressure ulcers, chen and drug labeling/			and drug labeling and storage with implementation of a plan of correcti	on	
		nued failure of the facility			including on going monitoring to su		
		surveys and one complaint			improvement.		
	investigation of reco	ord show a pattern of the			2. All residents have the potential to		
		sustain an effective quality			affected by this alleged deficient pra	actice.	
	assurance program	 The findings included: 			The QAPI committee led by the		

Facility ID: 952981

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM OMB NO.	APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		345362	B. WING			C 11/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
BRIAN C	ENTER HEALTH & R	ETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETIC DATE
F 520	Continued From pa	age 42	F 52	0		
	1 a coccoment c	nontropy Cross refer E279		Administrator met on 9-25- reviewed the Survey citation		
		accuracy. Cross refer F278. record review and staff		corrections completed by t		
		ty failed to accurately code the		during the last 36 months i		
	Minimum Data Set	(MDS) for pressure ulcers for		Assessments, developmer	nt of Care Plans	
		f 4 sampled residents and for		and treatment and services		
	three sampled resi	oss for 1 (Resident #80) of		prevent/heal Pressure Ulce Sanitation and Drug labelir		
		dents.		A root cause analysis was		
	During a recertifica	tion survey conducted 6/27/13,		a plan for sustainability wa		
		d for F278 for failing to ensure		and submitted to CMS to in		
		MDS was signed by the		reporting by the Director of	f Nursing and	
		pleted it prior to the On the current follow up/		Administrator. 3. The Divisional Director of	of Clinical	
		ey/ complaint investigation, the		Services will re-educate th		
		ited for failing to accurately		Assurance Performance Ir		
		pressure ulcers and for		committee by 10-15-14 on		
	significant weight le	DSS.		requirements of the comm identification of areas of or		
	On 9/11/14 at 4:46	PM, Administrative staff #3		implementation of actions,		
		een many changes in staff in		correct opportunities, and		
		ent. She stated the two people		monitoring to maintain imp		
		n the MDS department had not MDS assessments that had		interventions. The Quality Performance Improvement		
		d. She stated there had been		continue to meet on at the		
		people that had cone in to do		monthly basis identifying n		
		v person had been hired and		well as reviewing past iden		
		oblem would be resolved with		with updated interventions		
	the addition of a ne	ew person.		The Divisional Director of Services will attend a QAP		
	1 b. development	of care plan. Cross refer F		monthly for 3 months for va	•	
		servation, medical record		opportunities will be correc		
	review and staff inf	erview, the facility failed to		identified by the Administra	ator and the	
		n for contracture management		Divisional Director of Clinic		
		nge of motion in the left hand		4. The results of these revi		
		pled residents reviewed for ement (Resident #80 and		submitted to the QAPI Cor Administrator for review by		
	#103).			each month for 3 months.		
			1	Committee will evaluate th		

			FORM	: 10/20/2014 APPROVED . 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CON	TE SURVEY MPLETED C	
345362	B. WING _			0 /11/2014	
ER		STREET ADDRESS, CITY, STATE, ZIP C			
RETIREMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025			
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE	
cation survey conducted 6/27/13, ited for F279 for failing to develop ne resident for appropriate use of a the current follow up/ rvey/complaint investigation, the a recited for failure to develop a tracture management and e of motion. services to prevent/ heal Cross refer F 314. Based on dical record review and staff cility failed to follow the etting for the air mattress to nealing and to measure and re ulcer consistently on a weekly four residents reviewed for (Resident #163). int investigation dated 2/20/14, ited at F 314 for failure to float a a sordered for treatment of On the current follow survey/complaint investigation, to follow the recommended mattress to promote wound g to measure and stage the onsistently. 46 PM, Administrative staff #3 's previous plans were to monitor he risk meeting and the problem he stated they continued to have until mid July when the meetings if the second week in August. aff #4 stated the problems in ulcers, development of the		20 and amend as needed.			
	A RETIREMENT/CABARRUS STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) page 43 ication survey conducted 6/27/13, ided for F279 for failing to develop one resident for appropriate use of in the current follow up/ invey/complaint investigation, the in recited for failure to develop a intracture management and the of motion. If services to prevent/ heal Cross refer F 314. Based on dical record review and staff cility failed to follow the etting for the air mattress to healing and to measure and ure ulcer consistently on a weekly four residents reviewed for (Resident #163). int investigation dated 2/20/14, ited at F 314 for failure to float a is as ordered for treatment of On the current follow in survey/complaint investigation, to follow the recommended mattress to promote wound ing to measure and stage the onsistently. 46 PM, Administrative staff #3 y's previous plans were to monitor the risk meeting and the problem he stated they continued to have until mid July when the meetings if the second week in August. taff #4 stated the problems ure ulcers, development of the	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDII 345362 B. WING ER RETIREMENT/CABARRUS STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) ID PREFIX TAG page 43 F 53 ication survey conducted 6/27/13, itted for F279 for failing to develop on the current follow up/ urvey/complaint investigation, the n recited for failure to develop a thracture management and te of motion. F 53 's services to prevent/ heal Cross refer F 314. Based on dical record review and staff cility failed to follow the etting for the air mattress to healing and to measure and ure ulcer consistently on a weekly four residents reviewed for (Resident #163). wint investigation dated 2/20/14, dited at F 314 for failure to float a s as ordered for treatment of On the current follow n survey/complaint investigation, to follow the recommended mattress to promote wound ng to measure and stage the onsistently. 46 PM, Administrative staff #3 /'s previous plans were to monitor the risk meeting and the problem he stated they continued to have until mid July when the meetings til the second week in August. taff #4 stated the problems	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345362 B. WING ER STREET ADDRESS, CITY, STATE, ZIP O 250 BISHOP LANE CONCORD, NC 28025 STATEMENT/CABARRUS STREET ADDRESS, CITY, STATE, ZIP O 250 BISHOP LANE CONCORD, NC 28025 STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) (EACH CORRECTIVE ACTION) page 43 ication survey conducted 6/27/13, ited for F279 for failing to develop ne resident for appropriate use of n the current follow up/ irvey/complaint investigation, the n recited for failure to develop a tracture management and te of motion. F 520 'services to prevent/ heal Cross refer F 314. Based on dical record review and staff Dilty failed to follow the etting for the air mattress to healing and to measure and tree ulcer consistently on a weekly four residents reviewed for (Resident #163). Int investigation dated 2/20/14, ited at F 314 for failure to float a s as ordered for treatment of On the current follow s survey/complaint investigation, to follow the recommended mattress to promote wound g to measure and stage the onsistently. A6 PM, Administrative staff #3 /s previous plans were to monitor the risk meeting and the problem he stated the problems is the second week in August. taff #4 stated the problems ju the second week in August.	TH AND HUMAN SERVICES FORM RE & MEDICAD SERVICES OMB NO (X1) PROVDERSUPPLERCLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION at5362 B. WING 09 ER STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE STATEMENT/CABARRUS STREET ADDRESS, CITY, STATE, ZIP CODE 250 BISHOP LANE STATEMENT OF DEFICIENCIES ID PROVDER'S PLAN OF CORRECTION NOY MUST BE PRECEDED BY FULL PREFIX PROVDER'S PLAN OF CORRECTION NOY MUST BE PRECEDED BY FULL PREFIX PROVDER'S PLAN OF CORRECTION NOY MUST BE PRECEDED BY FULL PREFIX PREFIX Ication survey conducted 6/27/13, ited for F279 for failing to develop a tracture management and te of motion. F 520 and amend as needed. 'services to prevent/ heal Cross refer F 314. Based on dical record review and staff Gial record review and staff cility failed to follow the etiling for the air mattress to healing and to measure and tre ucer consistently on a weekly four residents reviewed for (Resident #163). No the current follow up/ int investigation dated 2/20/14, ited at F 314 for failure to float a s as ordered for treatment of a so as ordered for treatment of a so aso readered for treatment of a so as	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345362 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CC 200 BY BRIAN CENTER HEALTH & RETIREMENT/CABARRUS STREET ADDRESS, CITY, STATE, ZIP CC 200 BY Image: Continued From page 44 Defence 500 BY Continued From page 44 F 520 Continued From page 44 F 520 Continued From page 44 F 520 do so many changes that the facility had experienced with interim Director of Nursing staff and, somewhere along the way, the ball was dropped. Administrative staff #4 stated the plan did not work because of the system changes within administration. 1 d. sanitary conditions. Cross refer F 371. Based on observation, record review, and staff interview the facility failed to keep slaw salad made with mayonnaise/dressing at or below 41 degrees during operation of the tray-line, failed to label and date opened food items stored in refrigerators. During the recertification survey conducted 6/27/13, the facility was cajain cited for failure to maintain a deep fryer after use, and failed to label and the mayon diver bray again cited for failure to clean the deep fryer after use. On 9/11/14 at 4:46 PM, Administrative staff #3 stated there would be new monitoring. 1 e. drug label/ storage. Cross refer F 431. Based on observation, staff there wad				(X2) MULT	TIPLE			NO. 0938-0391
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document review the facility failed to have a thermometer to monitor the temperature in 1 of 2		kitchen on a weekly concerns. Administ would be new moni 1 e. drug label/ st Based on observati document review th	y basis and there had been no trative staff #3 stated there itoring. corage. Cross refer F 431. ion, staff interview and he facility failed to have a					

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		AND HUMAN SERVICES				FORM	10/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345362	B. WING				C 11/2014
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F 520	temperature range needing refrigeration Fahrenheit) for 1 of (100/300 hall refriger Tuberculin Purified within 30 days after refrigerators (200/4 to identify logged m temperature readin as under the safe n During the recertified 6/27/13, the facility to discard expired n medication carts an refrigerators. On t recertification surver facility was again of expired medications On 9/11/14 at 4:46 stated the issue have a process in place of checked the medications	to store medications within the required for medications on (36 - 46 degrees 2 medication refrigerators erator),failed to discard Protein Derivative (PPD) opening in 1 of 2 medication 00 hall refrigerator), and failed nedication refrigerator gs of 34 degrees Fahrenheit nedication storage range.	F	520			

Facility ID: 952981

If continuation sheet Page 46 of 46