TAC         REGULATORY OR LSC IDENTIFYING INFORMATION         TAC         CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY           F 246         483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES         F 246         12/2/15           A resident has the right to reside and receive scruces in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.         F 246         1           This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to make a call bell accessible to 3 (Residents #85, #108, and #153) nd 35 residents.         F246         1         Residents #95, #108, and #153 had their call bell nove the capabilities to the resident at the time of notification.           10, Paesident #85 was admitted to the facility on by/29/15. A review of the 14 day assessment Minimum Data Stet (MDS) revealed Resident #85 was slightly cognitively impaired, required extensive assistance with 2 or more people for all activities of daily living (ADLs) including bed mobility and transfers, was always incontinent of bladder (urine) and stool (bowel), and had a functional limitation related to (IV) range of motion (ROM) which resulted from impairment of 1 upper and 1 lower extremily. Active diagnoses included aphasis (inability to speak), cerebrovascular accident (CVA), and hemiplegia/hemiparesis (paralysis).         3. Nursing staff was re-educated on facility policy regarding call bell placement and accessibility by the Director of Nursing and or Unit Managers will conduct call bell audits b limes a week x2 weeks, then 10		-	D HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER       A BUILDING       COMPLETED         144001       9 WN0       5 WN0       11/05/2015         STREET ADDRESS, CITY, STRE, JP CODE         BRIAN CENTER NURSING CARELEXI         (%1) 0       SUMMARY STATEMENT OF DEFICIENCIES       0       PROVIDERS PLAN OF CORRECTION       11/05/2015         (%1) 0       SUMMARY STATEMENT OF DEFICIENCIES       0       PREVIDENT OR NEL       27 BRIAN CENTER DRVE       12/2/15         (%1) 0       SUMMARY STATEMENT OF DEFICIENCIES       0       PREVIDENT OR NEL       12/2/15         (%1) 0       SUMMARY STATEMENT OF DEFICIENCIES       0       PREVIDENT OR NEL       12/2/15         (%21) 0       COMPLETED OR NELL       0       PREVIDENT OR NELL       0       0         (%24) 0       RESULTION OR LOCARECTIVATION OR LOCARE	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				DWB NC	<u>). 0938-0391</u>
INME OF PROVIDER OR SUPPLIER       Integration         BRIAN CENTER NURSING CARE/LEXI       STREET ADDRESS, CITV, STATE, ZIP CODE         Image: Center RUNSING CARE/LEXI       Image: Center RUNKE         Image: Center RUNSING CARE/LEXI       EXPROPTIONAL Control of Control of Center RUNKE         Image: Center RUNCE RUNCE RESCERD BY VILL RECOLLATORY OR LSC DENTIFYING INFORMATION       PROVIDER DIA NUC CORRECTION RECOLLATORY OR LSC DENTIFYING INFORMATION       Image: DENTIFYING INFORMATION       Ima			. ,					
BRIAN CENTER NURSING CARELEXI         279 BRIAN CENTER DRIVE LEXINGTON, NC 27292           PHETRX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED by FULL REGULATORY OR LSC DENTIFYING INFORMATION)         IP         PRECEX (EACH CORRECTIVE ACTION BHOLD BE (EACH CORRECTIVE ACTION HOULD BE (EACH CORRECTIVE ACTION BEEN (EACH CORRECTIVE ACTION HOULD BE (EACH CORRECTIVE ACTION HOULD BE (EACH CORRECTIVE ACTION HOULD BE (EACH CORRECTIVE ACTION BE (EACH CORRECTIVE ACTION HOULD BE (EACH CORRECTIVE ACTION HINTED ACTION HOULD BE (EACH CORRECTIVE ACTION HINTE ACTION BE ACTION (EACH OTHER EST ACTION HINTE ACTION HOULD ACTION (EACH OTHER EST ACTION HINTE ACTION (EACH OTHER EST ACTION HINTE ACTION HINTE ACTION (EACH OTHER EST ACTION HINTE ACTION H	345011		B. WING			11/05/2015		
BRANCENTER NURSING CARELEXi         LEXINGTON, NC 27292           (M) ID PHEFIX TAG         ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WATE TE PROCEEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PROCEENERS PLAY OF CORRECTIVE ATTERNATION DEFICIENCY         ID PROVIDENT PLAY OF CORRECTIVE ATTERNATION DEFICIENCY         ID PROVIDENT PLAY OF CORRECTIVE (EACH DEFICIENCIES)         ID PROVIDENT PLAY OF CORRECTIVE DEFICIENCY         CORRECTIVE PLAY OF CORRECTIVE DEFICIENCY         CORRECTIVE PLAY OF CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTIVE DEFICIENCY         CORRECTION DEFICIENCY	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHUCK DEPICENCY         DEPOTIDER FLAND CORRECTION (EACH DEPICENCY MUST & PROCEEDE by FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         DEPOTIDER FLAND CORRECTION (EACH OPRECIDE AND CORRECTION ADD DE CACH OPRECIDE ADD CORRECTION ADD DE CACH OPRECIDE ADD CORRECTION (EACH OPRECIDE ADD CORRECTION DEPICIENCY)         OPSIL (EACH OPRECIDE ADD CORRECTION (EACH OPRECIDE ADD CORRECTION (EACH OPRECIDE ADD CORRECTION DEPICIENCY)         OPSIL (EACH OPRECIDE ADD CORRECTION (EACH OPRECIDE ADD CORRECTOR (EACH OPRECIDE					2	79 BRIAN CENTER DRIVE		
Prefry TAG         IEACH DEFICIENCY MIG INFORMATION         PREFX TAG         IEACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCES         COMALTINE DEFICIENCY         COMALTINE DEFICIENCY           F 246         483.15(e)(1) REASONABLE ACCOMMODATION SSEE         F 246         12/2/15           A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.         F 246         1         Resident #85, #108, and #153 had their call bell accessible to 3 (Residents #85, #108, and # 153) or 35 residents.         F 246         1         Resident at the time of notification.           1.1. Resident #55 was slightly cognitively impaires (paralysis). A review of the care plans dated 10/8/15 revealed care plans for: "communication impairment (can say yes or no and mod head yes or no and gives a         2         All resident of Nursing and or Nursing and Unit Managers, completed 11/5/15. The Director of Nursing and or Unit Managers. (b) and will be and mode head yes or no and gives a	BRIAN CE	INTER NURSING CARE/L	EXI		L	EXINGTON, NC 27292		
SS=E       OF NEEDS/PREFERENCES         A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.         This REQUIREMENT is not met as evidenced by:         Based on observations, record review, and staff and resident interviews, the facility failed to make a call bell accessible to 3 (Residents #85, #108, and #153 had their call bell accessible to 3 (Residents #85, #108, and #153 had their call bell cords restored to a position accessible to the resident at the time of notification.         1A, Resident #85 was admitted to the facility on 9/28/15. A review of the 14 day assessment Minimum Data Set (MDS) revealed Resident#85 was slightly cognitively impaired, required extensive assistance with 2 or more people for all activities of daily living (ADLs) including bed mobility and transfers, was always incontinent of bladder (urine) and slool (bowel), and had a functional limitation related to ( <i>i</i> / <i>i</i> ) range of motion (ROM) which resulted from impairment of 1 upper and 1 lower extremity. Active diagnoses included aphasia (inability to speak), cerebrovascular accident (CVA), and hemiplegia/hemiparesis (paralysis).       3. Nursing staff was re-educated on facility policy regarding call bell placement and accessibility by the Director of Nursing and Unit Managers, completed 11/6/15. The Director of Nursing and or Unit Managers, completed 11/6/15. The Director of Nursing and or Unit Managers, completed 11/6/15. The Director of Nursing and or Unit Managers, completed 11/6/15. The Director of Nursing and or Unit Managers, completed 11/6/15. The Director of Nursing and or Unit Managers, completed 11/6/15. The Director of Nursing and or Unit Managers, completed 11/6/15. The Director of Nursing and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
by: Based on observations, record review, and staff and resident interviews, the facility failed to make a call bell accessible to 3 (Residents #85, # 108, and # 153)) of 35 residents.F2461-Residents #85, #108, and #153 had their call bell cords restored to a position accessible to the resident at the time of notification.1-1A.) Resident #85 was admitted to the facility on 9/29/15. A review of the 14 day assessment Minimum Data Set (MDS) revealed Resident #85 was slightly cognitively impaired, required extensive assistance with 2 or more people for all activities of daily living (ADLs) including bed mobility and transfers, was always incontinent of bladder (urine) and stool (bowel), and had a functional limitation related to (r/t) range of motion (ROM) which resulted from impairment of 1 upper and 1 lower extremity. Active diagnoses included aphasia (inability to speak), cerebrovascular accident (CVA), and hemiplegia/hemiparesis (paralysis).3-Nursing staff was re-educated on facility policy regarding call bell placement and accessibility by the Director of Nursing and Unit Managers, completed 11/5/15. The Director of Nursing and or Unit Managers will conduct call bell audits 5 times a week x2 weeks, then 10		OF NEEDS/PREFER A resident has the rig services in the facility accommodations of ir preferences, except w the individual or other	ENCES ht to reside and receive with reasonable ndividual needs and when the health or safety of	F	246			12/2/15
' thumbs up ' ), a potential for injury during transfers r/t weakness, gait (walk), balance, and right sided paralysis, ADLs, and falls. All care plans included measureable goals, andresidents randomly every week x 1 month, then randomly every month x2months to ensure ongoing compliance.		by: Based on observation and resident interview a call bell accessible and # 153)) of 35 resi Findings included: 1A.) Resident #85 wa 9/29/15. A review of th Minimum Data Set (M was slightly cognitivel extensive assistance activities of daily living mobility and transfers bladder (urine) and st functional limitation re (ROM) which resulted and 1 lower extremity aphasia (inability to sp accident (CVA), and h (paralysis). A review of the care p care plans for: " com say yes or no and nod ' thumbs up ' ), a pote transfers r/t weakness right sided paralysis, J	ns, record review, and staff /s, the facility failed to make to 3 (Residents #85, # 108, dents. s admitted to the facility on he 14 day assessment IDS) revealed Resident #85 y impaired, required with 2 or more people for all g (ADLs) including bed , was always incontinent of ool (bowel), and had a elated to (r/t) range of motion d from impairment of 1 upper . Active diagnoses included peak), cerebrovascular nemiplegia/hemiparesis elans dated 10/8/15 revealed munication impairment (can d head yes or no and gives a intial for injury during s, gait (walk), balance, and ADLs, and falls. All care			<ol> <li>Residents #85, #108, and #153 had their call bell cords restored to a position accessible to the resident at the time of notification.</li> <li>All residents who have the capabilities to utilize a call bell have the potential to be affected by the alleged deficient practice. A review of all residen with potential to be affected was conducted by the Director of Nursing an unit managers on 11/5/15 and appropria corrective actions were taken.</li> <li>Nursing staff was re-educated on facility policy regarding call bell placeme and accessibility by the Director of Nursing and Unit Managers, completed 11/5/15.The Director of Nursing and or Unit Managers will conduct call bell aud 5 times a week x2 weeks, then 10 residents randomly every week x 1 mon then randomly every month x2months to</li> </ol>	n hts id ate ent its th,	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		-	-					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/20/2015

PRINTED: 12/07/2015

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.

**Electronically Signed** 

			000 100		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345011		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING		11/05/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
BRIAN CENTER NURSING CARE/LEXI				279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 246	Continued From page	e 1	F 24	16	
	The resident (Reside to person and time. N hand/arm. Resident is and right lower extrem non-verbal-able to an	ng notes included an I 9/29/15 and read, in part,  " nt #85) is alert and oriented		corrections are achieved a The director of nursing will results of these audits and during the Quality Assess Process Improvement mee months then quarterly. The will evaluate and make furt recommendations as indica	report the observation nent and eting monthly x3 e QAPI team ther
	An observation on 11 #85 revealed the resi side rails raised. The beside the right side of An interview was con 11/4/15 at 9:51 AM. F shaking his head that	/4/15 at 9:50 AM of Resident dent in bed with both upper call bell was on the floor of the bed. ducted with Resident #85 on Resident #85 indicated by t he would be unable to			
	paralyzed and was un also stated the call be An interview on 11/4/ usually assigned to th #85 resided revealed	cause his right arm was nable to call out for help. He ell was usually on the floor. 15 at 10:10 AM with NA #1, ne same hall where Resident call bells were used by needed help. She also stated			
	reach them and staff call bell placement. S call bells where on th B.) On 11/4/15 at 2:00	where the residents could checked 'periodically' for the could not state why the e floor. 0 PM, the call bell was r under the left side of the			
	bed of Resident #108 bed with 2 quarter sid the quarterly MDS da resident had no cogn #108 had no impairm	B. The resident was lying in the rails raised. A review of the 7/20/15 revealed the itive impairment. Resident ent of any upper or lower			
	position.	eady without numan om a seated to a standing ducted with Resident #108			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/05/2015		
AND I LAN OF	CONTRECTION	IDENTIFICATION NOWBER.	A. BUILD	NG _				
		345011	B. WING					
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>		
BRIAN CE	INTER NURSING CARE/L	EXI			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD AG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 246	on 11/4/15 at 2:05 PM unable to reach his ca call for help if needed the call bell was usua An interview was com AM with NA #2, who view same hall where Resi residents used call be stated the facility used call bells from falling of responsibility of every the call bells were atta reach for the resident where missing the sta around the side rail at the call bells were on C.) On 11/5/15 at 10:0 made of Resident #18 in a wheelchair beside observed on the floor of the 14 day MDS as revealed the resident impairment, the resident steady for transfers of assistance. An interview was com on 11/5/15 at 10:10 A for help because she She further stated she where she could reac usually on the floor. An interview with Nur assigned to the unit w resided) on 11/4/15 at staff member was resident bell placement and en	A and revealed he was all bell and was not able to . Resident #108 also stated Ily on the floor. ducted on 11/4/15 at 11:10 was usually assigned to the ident #108 resided revealed ells to call for help. She also d clips or hooks to keep the on the floor and it was the r staff member to make sure ached to the bed and within s. She stated if the clips aff wrapped the call bell nd she could not state why the floor. D5 AM, an observation was 53. The resident was sitting e the bed. The call bell was beneath the bed. A review essessment dated 10/29/15 had no cognitive ent required extensive .s except eating, had no of any limb, and was not r walking without human ducted with Resident #153 M and she stated she called could not reach her call bell. e wanted her call bell placed h it if needed, but it was se #1 (the unit manager	F	246				

Facility ID: 923005

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PRINTED: 12/07/2015

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345011	B. WING		11/05/2015
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CO	DE
BRIAN CE	NTER NURSING CARE/	LEXI		BRIAN CENTER DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE
F 246		e 3 her right arm the call bell side, and never on the floor.	F 246		
F 278 SS=D	She could not say we floor. An interview was corn nursing (DON) on 11. DON stated, " If a re bell it should be within paralyzed on the right bell to be on the left sis be on the floor. My elemember to make sur- for all residents able An interview with Nur- AM revealed the facil secure the call bells of the clip or hook is mis- cord around the side be on the floor. " Nur- the call bells were on 483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus- resident's status. A registered nurse m each assessment wit participation of health A registered nurse m assessment is comple Each individual who of assessment must sig-	hy the call bells where on the inducted with the director of /4/15 at 10:30 AM., The sident is able to use a call in reach. If a resident is it side I would expect the call side. The call bell should not expectation is for every staff e the call bell is reachable to use them. " rse #2 on 11/5/15 at 10:10 lity used clips or hooks to to the bed. She stated, " If ssing we wrap the call bell rail. The call bells should not rse #2 was not to state why the floor. SSMENT DINATION/CERTIFIED st accurately reflect the ust conduct or coordinate th the appropriate in professionals. ust sign and certify that the leted.	F 278		12/2/15

Facility ID: 923005

If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345011		B. WING			11/05/2015		
NAME OF PROVID	DER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		11/00/2010	
				27	9 BRIAN CENTER DRIVE			
BRIAN CENTE	R NURSING CARE/I	LEXI			EXINGTON, NC 27292			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETIO		
will fals sub \$1, will to o res per ass Cliii ma Thi by: Ba fac Da Fre (PA rev Fin 1.) cur De dis Re forn to b exp wa Re Da rev rev Thi 1.) cur Thi Thi 1.) cur Thi thi thi thi cur Thi Thi Thi Thi Thi Thi Thi Thi Thi Thi	se statement in a n oject to a civil moni 000 for each asse fully and knowingly certify a material ai ident assessment halty of not more the sessment. hical disagreement terial and false stat s REQUIREMENT used on record revi lity failed to accura- ta Set (MDS) asse eadmission Screen ASRR) for 2 of 4 re iewed for PASRR dings included: Resident #5 was a nulative diagnoses pression, anxiety, ease. view of the PASRR m revealed that Re- be a PASRR level biration date of 6/8 s renewed on 4/2/ view of Resident # ta Set (MDS) asse ealed Section A of ect PASRR determ interview with the 5/15 at 10:16 AM i	y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each t does not constitute a tement. ' is not met as evidenced iew and staff interviews, the ately code on the Minimum ssments to reflect ling and Resident Review sident in the sample II. (Resident #5 and #23). admitted on 6/9/10 with s which included: dementia and bipolar R Determination notification esident #5 was determined II since 6/8/10 with an /11. Resident #5 ' s PASRR 13 with no expiration date. t5 ' s Admission Minimum ssment dated 1/9/15 the MDS was not coded to	F	278	<ul> <li>F278</li> <li>1- Residents #5 and #23 have harmost recent Comprehensive MDS modified to reflect the level II PASR the Resident Care Director on 11-5-</li> <li>2- All residents with level II PASR the potential to be affected by the a deficient practice. The resident Care Management Director will complete audit of all residents with level II PASR to validate the MDS assessment habeen coded accurately to reflect the resident status. The audit was compon 11-19-154</li> <li>3- The District Care Management Director re-educated all MDS staff caccurate completion of section A on 11/5/15. The Resident Care Manage Director will randomly review 5 com MDS weekly for 1 month then bi we</li> </ul>	R by 15. R have lleged an RSS as obleted		

Facility ID: 923005

If continuation sheet Page 5 of 7

PRINTED: 12/07/2015

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/07/2015 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345011		B. WING			11/	05/2015	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	NTER NURSING CARE/L	EXI		27	9 BRIAN CENTER DRIVE		
BRIANCE	INTER NORSING CARE/			LE	EXINGTON, NC 27292		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page there was no need for		F 2	278	for 2 months to verify accurate		
	An interview on 11/5/ MDS Coordinator reveloc because he was code Coordinator did not the She continued that he PASRR II. She indicat corrections and modif assessment. An interview on 11/5/ administrator revealed that the MDS coding was 2. Resident #23 was 2/4/15 with diagnoses depression and psych A record review of the Determination Notificat that the Nursing Facil appropriate. A review of the admiss revealed Section A of reflect PASRR II dete An interview on 11/05 facility 's social worked was continuous. Ther Resident #23 became the renewal. When R facility, the PASRR was 5/6/15. When renewad PASARR B which was	<ul> <li>15 at 11:30 AM with the ealed that she thought that ealed as a B, the MDS ink he was a PASRR II.</li> <li>a had never been coded as a provide the the ealed that never been coded as a ted she would make the ealed to the facility on the ealed that his expectation was would be correct.</li> <li>admitted to the facility on the facility on the ealed to the facility on the ealed that his expectation was would be correct.</li> <li>PASRR Level II attorn dated 5/6/15 revealed ity Placement was</li> <li>sion MDS dated 2/4/15 the MDS was not coded to rmination,</li> <li>/2015 at 10:16 AM with the er indicated that the Letter B e was no need for renewals.</li> <li>PASARR II on 5/6/15 with the evaluation the expired on al came in, it came back as a so continuous.</li> <li>15 at 11:30 AM with the</li> </ul>			for 2 months to verify accurate completion. The results of the monitori will be documented on the PASRR QA Audit Tool. Opportunities will be correc by the Resident Care Director or MDS coordinator as identified during audits. 4- The measures put in place are to ensure corrections are achieved and sustained: the Resident care Management Director will report the results of these audits to the QAPI meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.	ted	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM /	12/07/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345011		B. WING			11/05/2015		
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STA			
BRIAN CENTER NURSING CARE/LEXI				279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 278	coding. She was not level 2 when she carr corrections. An interview on 11/5/	aware Resident #23 was he in. She would send in 15 at 11:45 AM with the d that his expectation was	F 2	78			

Event ID: WDY511

Facility ID: 923005

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