DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	LE CONSTRUCTION		E SURVEY MPLETED
		345011	B. WING			2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	2/01/2017
				279 BRIAN CENTER DRIVE		
BRIAN CE	INTER NURSING CARE			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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIF (INJURY/DECLINE/F		F 15	.7		3/8/17
	(g)(14) Notification of	Changes.				
	consult with the resid	nediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				
		ving the resident which las the potential for requiring n;				
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or				
	a need to discontinue	erse consequences, or to				
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).					
	(14)(i) of this section, all pertinent informati	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the				
		also promptly notify the dent representative, if any,				
	(A) A change in room	or roommate assignment				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					02/24/2017

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345011	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRIAN CE	INTER NURSING CARE/	EXI			79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 157	State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the This REQUIREMENT by: Based on observatio and staff interviews, t Physician or the Nurs indwelling catheter was bladder of 1 of 3 sam indwelling catheter (R Findings included: Resident #3 was adm 2016 with diagnoses neuromuscular dysfun stage 4 pressure ulce Review of the clinical Physician's Order dat to receive an indwelling retention. The annual minimum 12/15/16 indicated Re intact; had an indwelling stage 4 pressure ulce Plan dated 1/4/17 rev receive catheter care	0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and resident representative(s). is not met as evidenced ns, record reviews, resident he facility failed to notify the e Practitioner when the as dislodged from the pled residents with an tesident #3). which included: nction of bladder, and a r of the sacrum. record revealed a ed 5/17/16 for Resident #3 ng catheter due to urinary data set (MDS) dated esident #3 was cognitively ing catheter; and had a r to her sacrum. The Care ealed the resident was to	F	157	F 157 Immediate Correction was achieved fo the alleged deficient practice on 2/1/17 when the Unit Manager notified the Nu Practitioner of the dislodged indwelling catheter for resident #3. An order was received at that time that the catheter v not to be re-inserted. The facility recognizes that all resident with indwelling catheters have the potential to be affected by the alleged deficient practice. Measures implemented to ensure that alleged deficient practice does not recu includes: On 2/23/17 the Director of Nursing provided education to nurse #1 regard the expectations for physician notificat related to the indwelling catheter being dislodged. Education for licensed staff regarding requirements/expectations for physicia notification was provide by the DON/ADON, This education was completed by 3/7/17.	, was s the ur ing ion	

Facility ID: 923005

If continuation sheet Page 2 of 17

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345011			02/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE	
BRIAN CE	ENTER NURSING CARE/	LEXI		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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 157	9:21am, Resident #3 finishing her breakfas resident's indwelling of place. The resident re- not replaced the indw became dislodged the During an interview of Treatment Nurse stat approximately 11:30a #3's pressure ulcer, s resident's indwelling of intact dislodged from during care and need revealed that when a dislodged, sometimes twenty-four hours bef due to trauma, but; the trauma to Resident # On 2/1/17 at 10:15am in her wheelchair in the there was not a cather resident's wheelchair During an interview of Unit Manager revealed	was sitting up in bed, st. It was observed that the catheter bag was not in evealed the facility staff had velling catheter after it e day before. n 2/1/17 at 9:31am, the ed that on 1/31/17 at um, after treating Resident the informed N#1 (nurse) the catheter with the bulb still the resident's bladder led to be replaced. She resident's catheter became is nurses would wait fore replacing the catheter lere was no evidence of 3. n, Resident #3 was observed the facility's beauty salon; eter bag attached to the	F 157	A review of residents with cathete ensure proper placement was co by the Unit Managers on 2/28/17 An audit of Nursing Notes for 2/1/17-3/2/17 was completed by to or designee on 3/3/17 to ensure p notification was completed as app Monitoring to ensure that the alle deficient practice does not recur in The DON or designee will review per week to ensure appropriate p notification. The DON will summares results of weekly reviews and pre- monthly to the QAPI committee for months or until substantial complia achieved.	mpleted the DON physician propriate. ged includes: 5 charts hysician arize the esent pr 3
	the day before and th had informed N#1 at During an interview o DON (Director of Nur resident's indwelling o was reported to N#1,	n 2/1/17 at 10:37am, the sing) indicated when the catheter dislodged and it her expectation was for N#1 to the Unit Manager and/or			

			A			<u>3-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	ſ
		345011	B. WING		C 02/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		-
BRIAN CE	NTER 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	LETIO
F 157	Continued From page	e 3	F 15	7		
	The DON revealed th					
	document the resider	•				
	dislodged, she failed anyone.	to document if she notified				
F 224	483.12(a)(1) PROHIE	ЗІТ	F 22	4	3/8/17	7
SS=G	MISTREATMENT/NE	GLECT/MISAPPROPRIATN				
	a) The facility must-					
		ental, sexual, or physical				
	abuse, corporal punis	shment, or involuntary				
	seclusion.					
	by:	is not met as evidenced				
		ns, staff, nurse practitioner		F224		
		ews and record reviews the				
	•	to with incontinence for two of		Immediate correction was achiev		
	-	ts with incontinence. The Resident #5 with worsened		the alleged deficient practice whe Resident #5 and Resident #3 we		
	-	tis for five hours and failed to		provided incontinence care by th		
		ith a leaking indwelling		On 2/21/17 C.N.A #1 performance		
	urinary catheter.			reviewed and action taken accord		
	The findings included	l:		the facility s progressive discipli	ne.	
				The facility acknowledges that al		
		admitted to the facility on		residents who are incontinent ha		
		s of pressure ulcer on the		potential to be affected by the all	eged	
	and diabetes.	istance with personal care,		deficient practice.		
				Measures implemented to ensure	e the	
	The Quarterly Minimu	um Data Set (MDS) dated		alleged deficient practice does no	ot recur	
	1/25/17 indicated Res			includes:		
	-	t term memory, required of two persons for bed		Education to include review of th Abuse/Neglect Policy definitions	-	
		id dressing, extensive		provided by the DON/ADON for (
	assistance of one per			This education completed on 3/7		
	personal hygiene, tot	al dependence of two staff		included expectations for deliver		
		ys incontinent of bowel and		incontinence care in a timely man	nner and	
	bladder and had a sta	age 4 pressure ulcer		prior to meals.		

Event ID: U7GV11

Facility ID: 923005

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STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL			
		345011	B. WING		C 02/0	1/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
			279 BRIAN CENTER DRIVE					
BRIAN CE	INTER NURSING CARE	LEXI		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 ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE		
F 224	Continued From page	e 4	F 22	4				
	The care plan dated 12/7/16 for a problem of requiring extensive assistance with activities of daily living. Approaches included the resident was to participate to her fullest extent as possible, observe for decline and therapy per physician order. The care plan had an update of 1/31/17 for a problem of incontinence of bowel and bladder which had no goal or approaches. Review of the wound physician progress note dated 1/30/17 indicated a diagnosis of "Incontinence Associated Dermatitis" with the progress as "Deteriorated. Entire buttocks and posterior thighs are inflamed."			Beginning 2/27/17 Unit M designee will monitor 5 ir residents per day for 2 w residents per week for 4 that incontinence care is a timely manner. Beginning 2/27/17 DON/ randomly monitor 3-5 res for 4 weeks to validate th care is provided as expe Beginning 2/27/17 all new will be provided educatio incontinence care expect their orientation period.	ncontinent reeks and then 5 weeks to ensure being provided in ADON will sidents per week nat incontinence cted. wly hired C.N.As on regarding tations during			
	Resident #5 was in b Nursing Assistant (N/ care for Resident #5 Observations of incor Nursing Assistant (N/ pads were positioned mid back to her uppe on top of the sheet ar back and partially und The cloth pads were to the bottom. A drie outer edges of pad #2 folded with the pad si between her legs. Th small ball. The reside perineal area, and bu "scalded" in appearant urine odor, and the re- the "gown tail" which	A) #2, revealed two cloth I under the resident from her r thighs. Cloth pad #2 was nd under the resident's mid der the top pad (pad #1). wet from the top of the pads d yellow ring was at the 2. A disposable brief was ide next to the resident ne brief was folded into a ent's skin on the inner thighs, ittocks was red and nce. There was a strong esident's gown was wet at was underneath the nd upper thighs. During	Monitoring implemented to ensualleged deficient practice does not include the DON summarizing of weekly monitoring of incontinuity will present a report to QAPI confor 3 months or until substantial compliance is achieved.		e does not recur arizing the results ncontinence and API committee			

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345011	B. WING				C 101/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER NURSING CARE/	EXI			279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	area was off and layir dressing looked like a that was brown in cold On 1/31/17 a 10:15 A incontinence care, Re had been in to check morning. She continu- clean person, did not the observation of inc- complained of discom Interview with Nursing 11:35 AM revealed sh between her legs. N/ changed her last did the she had not checked incontinence since co She further explained Resident #5 because residents up for break #1 explained she had breakfast. Interview with the Nur 4:25 PM revealed if R couple of hours, it cour worse. The resident to catheter, and the staff frequently for incontin- barrier. Interview with the wor 5:29 PM revealed he weekly basis for wour the resident to be well on her buttocks had v	ng under the buttocks. The a piece of wet rolled gauze or. M, during observations of esident #5 explained no one her, or clean her that ued with she was "always a like being dirty." During ontinence care Resident #5 ifort when cleaned. Q Aide (NA) #1 on 1/31/17 at he did not put the folded brief A#1 explained "Whoever that." The NA responded the resident for oming on duty at 6:20 AM. she had not checked she was getting other cfast in the dining room. NA five residents to get up for rese Practitioner on 2/1/17 at Resident #5 was left wet for a uld make the dermatitis did not want an indwelling f would need to check her tence and use a protective und physician on 2/1/17 at saw the resident on a nd care. Each visit he found a with urine. The dermatitis vorsened during the past should check her often and	F	224			

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345011	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2017
					279 BRIAN CENTER DRIVE		
BRIAN CE	INTER NURSING CARE/	_EXI			LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	9 6	F	224	4		
	5:50 PM revealed she	ector of Nursing on 2/1/17 at e would expect the aides to care at least every three					
	5/2/16 with diagnosis	admitted to the facility on of neuromuscular dder, bladder spasms and a					
	dated 12/15/16 indica or short term memory assistance of one sta occasionally incontine	ent of urine and always The MDS indicated an					
	indicated the presence and an indwelling cat assistance with activi impaired mobility. The care plan dated ² bowel incontinence a catheter included app ordered, check reside	rea Assessments (CAAs) the of urinary incontinence heter. The resident required ties of daily living due to 1/4/17 for a problem of nd an indwelling urinary broaches of catheter care as the every two hours and s needed, provide peri care t episode.					
	AM revealed the resid catheter in place. The right side by the Treat treatment. The dispo wearing was saturate by the padding in the	sable brief the resident was d with urine, as evidenced					

Facility ID: 923005

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/10/201 MAPPROVEI D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		PLETED
		345011	B. WING				C /01/2017
NAME OF PF	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE	LEXI			79 BRIAN CENTER DRIVE		
				L	EXINGTON, NC 27292		1
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 224	Continued From page	e 7	F2	224			
	wet extending up the resident's gown was	resident's back, and the wet. There was a strong					
	urine smell at the bec	ISIQE.					
		atment nurse on 1/31/17 at					
		e alternating air mattress the resident. The physician					
		er leaked and had tried					
	different sizes withou of urine.	t success to prevent leakage					
	Aide (NA) #1 reveale assistance with activi explained she would hour for this resident.	at 11:20 AM with Nursing d Resident #3 required total ties of daily living. NA #1 check for incontinence every Further interview revealed esident's room to pass the					
	incontinence care as interview NA#1 expla way down to Resider	d not provided a check for of this time. During the ined she had not made her it #3's room yet, due to nts for breakfast in the dining					
	revealed she had bee the catheter leaking.	ent #3 on 2/1/17 at 9:30 AM en left wet on 1/31/17 due to					
	5:50 PM revealed she for incontinence at lea	-					
F 241 SS=G	483.10(a)(1) DIGNIT INDIVIDUALITY	Y AND RESPECT OF	F 2	241			3/8/17
	resident in a manner promotes maintenand	reat and care for each and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and					
	-						

Facility ID: 923005

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<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345011	B. WING			C 02/01/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER NURSING CARE/	LEXI	279 BRIAN CENTER DRIVE				
				LE	EXINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 241	Continued From page	e 8	F 2	41			
	promote the rights of This REQUIREMEN						
		ons, resident and staff d reviews the facility failed to			F241		
	promote residents' di checks were not prov	gnity when incontinence vided and Residents #5 and			Immediate correction was achieved for the alleged deficient practice when	r	
		om excessive urine for two of its with incontinence. The			Resident #5 and Resident #3 were provided incontinence care by the C.N On 2/21/17 C.N.A #1 performance was reviewed and action taken according to	S	
		admitted to the facility on is of a pressure ulcer on the			the facility s progressive discipline.	-	
	sacrum, need for ass and diabetes.	istance with personal care,			The facility acknowledges that all residents who are incontinent have the potential to be affected by the alleged	9	
	1/25/17 indicated Re				deficient practice.		
	extensive assistance	t term memory, required of two persons for bed			Measures implemented to ensure the alleged deficient practice does not reco	ur	
	assistance of one pe	-			includes: Education regarding treatment of		
		tal dependence of two staff ays incontinent of bowel and age 4 pressure ulcer.			residents with dignity and respect was provided by the DON/ADON for C.N.A This education completed on 3/7/17 included expectations for delivery of		
		12/7/16 for a problem of sistance with activities of			incontinence care in a timely manner a prior to meals.	and	
	daily living. Approach to participate to her f	nes included the resident was ullest extent as possible,			Beginning 2/27/17 Unit Managers or designee will monitor 5 incontinent		
	order. The care plan	nd therapy per physician had an update of 1/31/17			residents per day for 2 weeks and ther residents per week for 4 weeks to ensu	ure	
		ntinence of bowel and o goal or approaches.			that incontinence care is being provide a timely manner. Beginning 2/27/17 DON/ADON will		
	Resident #5 was in b	1/17 at 10:11 AM revealed ed lying on her back. The			randomly monitor 3-5 residents per we for 4 weeks to validate that incontinent		
	Nursing Assistant (Na care for Resident #5	A) #1, who was assigned to was not available.			care is provided as expected. Beginning 2/27/17 Department Manag	ers	

Facility ID: 923005

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TATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-03 TE SURVEY	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	3	CON	MPLETED	
		245044	B. WING			С	
	ROVIDER OR SUPPLIER	345011	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE			
	ROVIDER OR SUPPLIER		279 BRIAN CENTER DRIVE		-		
BRIAN CE	NTER NURSING CARE/	LEXI		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 241	Continued From page	2 Q	F 24	1			
	Observations of incor	ntinence care, provided by	1 27	and Manager on Duty will com			
	·	A) #2, revealed two cloth I under the resident from her		Dignity Audits daily for 4 week Beginning 2/27/17 all newly hi			
		r thighs. Cloth pad #2 was		will be provided education reg			
	-	nd under the resident's mid		treating residents with dignity			
		der the top pad (pad #1).		during their orientation period.			
	-	wet from the top of the pads d yellow ring was at the		Monitoring implemented to en	sure that the		
		2. A disposable brief was		alleged deficient practice does			
	folded with the pad si	ide next to the resident		includes the DON summarizin	g the results		
		ne brief was folded into a		of weekly audits completed by			
	perineal area, and bu	ent's skin on the inner thighs,		Department Managers and pro	-		
		nce. There was a strong		until substantial compliance is			
		esident's gown was wet at					
	the "gown tail" which						
		nd upper thighs. During esident #5 was turned to					
		nat was on the sacral/coccyx					
		ng under the buttocks. The					
	dressing looked like a that was brown in col	a piece of wet rolled gauze or.					
	On 1/31/17 a 10:15 A	M, during observations of					
		esident #5 explained no one					
		her, or clean her that ued with she was "always a					
		like being dirty." During					
	· ·	continence care Resident #5					
	complained of discon	nfort when cleaned.					
		g Aide (NA) #1 on 1/31/17 at					
		he did not put the folded brief					
		A #1 explained "Whoever that." The NA responded					
	she had not checked	-					
	incontinence since co	oming on duty at 6:20 AM.					
	She further explained Resident #5 because	she had not checked					

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345011	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					279 BRIAN CENTER DRIVE		
BRIAN CE	INTER NURSING CARE/L	_EXI			LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	residents up for break #1 explained she had breakfast. Interview with the Dire 5:50 PM revealed she provide incontinence hours. 2. Resident # 3 was 5/2/16 with diagnosis dysfunction of the bla pressure ulcer. Review of the annual dated 12/15/16 indica or short term memory assistance of one sta occasionally incontine incontinent of bowel. indwelling urinary cat Review of the Care A indicated the presence and an indwelling cat assistance with activit impaired mobility. The care plan dated 2 bowel incontinence an catheter included app ordered, check reside assist with toileting as after each incontinent Observations of Resid AM revealed the reside catheter in place. The right side by the Treat treatment. The dispo wearing was saturate by the padding in the	Afast in the dining room. NA five residents to get up for ector of Nursing on 2/1/17 at e would expect the aides to care at least every three admitted to the facility on of neuromuscular dder, bladder spasms and a Minimum Data Set (MDS) ted Resident #3 had no long problems, required total ff for toileting, was ent of urine and always The MDS indicated an heter was in use. rea Assessments (CAAs) e of urinary incontinence heter. The resident required ties of daily living due to 1/4/17 for a problem of nd an indwelling urinary proaches of catheter care as ent every two hours and a needed, provide peri care t episode. dent #3 on 1/31/17 at 11:00 dent had an indwelling e resident was turned to her tment nurse to do the sable brief the resident was d with urine, as evidenced	F	241			

Facility ID: 923005

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/10/2 FORM APPRO\ OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345011	B. WING		02/01/2017
NAME OF PF	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CC	DDE
BRIAN CE	NTER NURSING CARE/I	EXI		BRIAN CENTER DRIVE XINGTON, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETI TE APPROPRIATE DATE
F 241 F 312 SS=G	resident's gown was y urine smell at the bed Interview with the tre 11:15 AM revealed th was wet underneath f was aware the cathet different sizes withour of urine. Interview on 1/31/17 a Aide (NA) #1 revealed assistance with activit explained she would hour for this resident. she had been in the r breakfast tray, but ha incontinence care as interview NA#1 expla way down to Residen getting up five residen room. Interview with Reside revealed she had beet the catheter leaking. this had occurred "oft Interview with the Dir 5:50 PM revealed she for incontinence at lea 483.24(a)(2) ADL CA DEPENDENT RESID (a)(2) A resident who activities of daily living services to maintain g personal and oral hyg	resident's back, and the wet. There was a strong lside. atment nurse on 1/31/17 at e alternating air mattress the resident. The physician er leaked and had tried t success to prevent leakage at 11:20 AM with Nursing d Resident #3 required total ties of daily living. NA #1 check for incontinence every Further interview revealed esident's room to pass the d not provided a check for of this time. During the ined she had not made her t #3's room yet, due to nts for breakfast in the dining mt #3 on 2/1/17 at 9:30 AM en left wet on 1/31/17 due to Further interview revealed en." ector of Nursing on 2/1/17 at e would expect staff to check ast every three hours. RE PROVIDED FOR ENTS is unable to carry out g receives the necessary good nutrition, grooming, and	F 241		3/8/17
	by: Based on observatio	ns, staff, nurse practitioner		F312	

Facility ID: 923005

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		MEDICAID SERVICES				OMB NO. 093		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
						с		
		345011	B. WING			02/01/20	17	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
BRIAN CENTER NURSING CARE/LEXI			279 BRIAN CENTER DRIVE					
				LEXINGTO	DN, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COME	(X5) PLETIC DATE	
F 312	Continued From page	≥ 12	F 31	2				
	-	ews and record reviews the		2				
	facility 1. Failed to ch		Immer	diate correction was achieved for				
	incontinence in five h		-	eged deficient practice when				
	worsening incontinen			ent #5 and Resident #3 were				
	physician.) 2. Failed		provid	ed incontinence care by the C.N.	A.			
	incontinence for two o			21/17 C.N.A #1 performance was				
	with incontinence. Th	ne findings included:			ed and action taken according to			
				the fac	cility⊡s progressive discipline.			
		admitted to the facility on		The fe	willing advacuated as that all			
	11/7/16 with diagnosis sacrum, need for assist			cility acknowledges that all nts who are incontinent have the				
	and diabetes.			ial to be affected by the alleged				
					ent practice.			
	The care plan dated ?	12/7/16 for a problem of						
		ssistance with activities of		Measu	ures implemented to ensure the			
	daily living. Approach	es included the resident was		allege	d deficient practice does not recu	ır		
		Illest extent as possible,		includ				
	observe for decline a			tion regarding ADL care standard	ds,			
	order.				ing providing incontinence care			
				-	2-3 hours, was provided by the			
		Im Data Set (MDS) dated			ADON for C.N.A s. This educati	ion		
	1/25/17 indicated Res				eted on 3/7/17 included tations for delivery of incontinenc			
	-	t term memory, required of two persons for bed		· ·	a timely manner and prior to	. с		
	mobility, transfers, an			meals				
	assistance of one per				ning 2/27/17 Unit Managers or			
		al dependence of two staff			nee will monitor 5 incontinent			
		ys incontinent of bowel and		reside	nts per day for 2 weeks and then			
	bladder and had a sta	age 4 pressure ulcer.			nts per week for 4 weeks to ensu			
					continence care is being provided	d in		
		update of 1/31/17 for a			ly manner.			
		ice of bowel and bladder			ning 2/27/17 DON/ADON will	-1/		
	which had no goal or				mly monitor 3-5 residents per we			
	dated 1/30/17 indicate	physician progress note		-	veeks to validate that incontinenc s provided as expected	e		
		ated Dermatitis" with the			ning 2/27/17 all newly hired C.N.A	As		
		ated. Entire buttocks and			provided education regarding AL			
	posterior thighs are in				tandards, including incontinence			
					uring their orientation period.			

Facility ID: 923005

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345011 NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER			· · ·	(X3) DATE SURVEY COMPLETED C 02/01/2017		
		B. WING		0				
			STREET ADDRESS, CITY, STATE, ZIP 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE # DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 312	Observations on 1/31 Resident #5 was in bo Nursing Assistant (NA care for Resident #5 w Observations of incor Nursing Assistant (NA pads were positioned mid back to her upper on top of the sheet ar back and partially und The cloth pads were w to the bottom. A drive outer edges of pad #2 folded with the pad si between her legs. Th small ball. The reside perineal area, and bu "scalded" in appearar urine odor, and the re- the "gown tail" which resident's buttocks ar incontinence care, Re- side. The dressing th area was off and layin dressing looked like at that was brown in col- On 1/31/17 a 10:15 A incontinence care, Re- had been in to check morning. She continu- clean person, did not the observation of inco- complained of discorr	 /17 at 10:11 AM revealed ed lying on her back. The A) #1, who was assigned to was not available. Intinence care, provided by A) #2, revealed two cloth a under the resident from her r thighs. Cloth pad #2 was not under the resident's mid der the top pad (pad #1). wet from the top of the pads d yellow ring was at the 2. A disposable brief was de next to the resident the brief was folded into a ant's skin on the inner thighs, ttocks was red and nce. There was a strong esident's gown was wet at was underneath the nd upper thighs. During esident #5 was turned to her nat was on the sacral/coccyx ng under the buttocks. The a piece of wet rolled gauze or. M, during observations of esident #5 explained no one her, or clean her that used with she was "always a like being dirty." During continence care Resident #5 mort when cleaned. g Aide (NA) #1 on 1/31/17 at ne did not put the folded brief 	F 31		not recur g the results esenting a s months or			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/10/2017 RM APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345011	B. WING			02	C 2/01/2017
NAME OF F	ROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CENTER NURSING CARE/LEXI					279 BRIAN CENTER DRIVE		
	I				LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 312	 she had not checked incontinence since co She further explained Resident #5 because residents up for breal #1 explained she had breakfast. Interview with the Nu 4:25 PM revealed if F couple of hours, it co worse. The resident catheter, and the staff frequently for incontine barrier. Interview with the wo 5:29 PM revealed he weekly basis for wout the resident to be we on her buttocks had weeks. The staff keep the skin free fro Interview with the Dir 5:50 PM revealed she provide incontinence hours. Resident # 3 was 5/2/16 with diagnosis dysfunction of the bla pressure ulcer. Review of the annual dated 12/15/16 indicator of one statoccasionally incontine 	the resident for oming on duty at 6:20 AM. I she had not checked she was getting other kfast in the dining room. NA I five residents to get up for rse Practitioner on 2/1/17 at Resident #5 was left wet for a uld make the dermatitis did not want an indwelling if would need to check her hence and use a protective und physician on 2/1/17 at saw the resident on a nd care. Each visit he found t with urine. The dermatitis worsened during the past is should check her often and m urine. ector of Nursing on 2/1/17 at e would expect the aides to care at least every three admitted to the facility on of neuromuscular idder, bladder spasms and a Minimum Data Set (MDS) ated Resident #3 had no long y problems, required total	F	312	2		

Facility ID: 923005

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	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMF	LETED	
		245044					C	
345011			B. WING			02/01/2017		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE			
BRIAN CE	NTER NURSING CARE/	_EXI		LEXINGTON, NC 27292				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	-	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 312	Continued From page	a 15	F	312	2			
	indwelling urinary cat			012				
		rea Assessments (CAAs)						
		e of urinary incontinence						
		heter. The resident required ties of daily living due to						
	impaired mobility.							
	The care plan dated ²	1/4/17 for a problem of						
		nd an indwelling urinary						
		proaches of catheter care as						
	ordered, check resident every two hours and assist with toileting as needed, provide peri care							
	after each incontinent	· · ·						
	Observations of Resi	dent #3 on 1/31/17 at 11:00						
		dent had an indwelling						
		e resident was turned to her						
	right side by the Treat	tment nurse to do the sable brief the resident was						
		d with urine, as evidenced						
	by the padding in the							
		ad under the resident was						
		resident's back, and the						
	urine smell at the bed	wet. There was a strong Iside.						
		atment nurse on 1/31/17 at						
		e alternating air mattress						
		he resident. The physician er leaked and had tried						
		t success to prevent leakage						
	of urine.							
		at 11:20 AM with Nursing						
		d Resident #3 required total						
		ties of daily living. NA #1 check for incontinence every						
		Further interview revealed						
		esident's room to pass the						

Facility ID: 923005

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 03/10/2017 FORM APPROVED OMB NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345011	B. WING		_	C 02/01/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/	_EXI		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 CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		
F 312	breakfast tray, but ha incontinence care as interview NA#1 expla way down to Residen getting up five resider room. Interview with Reside revealed she had bee the catheter leaking. Interview with the Dire	d not provided a check for of this time. During the ined she had not made her t #3's room yet, due to hts for breakfast in the dining ent #3 on 2/1/17 at 9:30 AM en left wet on 1/31/17 due to ector of Nursing on 2/1/17 at e would expect staff to check	F 31				

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