	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		345362	B. WING		08/23/2018
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER HEALTH & RETI	REMENT/CABARRUS		0 BISHOP LANE ONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 000	INITIAL COMMENT	S	F 000		
		was conducted from 3/23/20018. Immediate fied at:			
		684 at a scope and severity J 580 at a scope and severity J			
	The tags F684 cons Care.	tituted Substandard Quality of			
		y began on 8/14/2018 and 23/2018. An extended survey			
F 580 SS=J	Notify of Changes (I CFR(s): 483.10(g)(1	njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 580		10/2/18
	consult with the resi consistent with his or representative(s) wh (A) An accident invo results in injury and physician intervention	mediately inform the resident; dent's physician; and notify, or her authority, the resident nen there is- olving the resident which has the potential for requiring			
	mental, or psychoso deterioration in heal status in either life-tl clinical complication (C) A need to alter the	ocial status (that is, a th, mental, or psychosocial hreatening conditions or			
	treatment due to adv commence a new fo	verse consequences, or to orm of treatment); or nsfer or discharge the			

Electronically Signed

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.

09/05/2018

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/24/201 FORM APPROVEI OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/23/2018		
		345362	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CE	NTER HEALTH & RETIR	REMENT/CABARRUS		50 BISHOP LANE ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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)	SHOULD BE COMPL		
F 580	(14)(i) of this section, all pertinent informati is available and prov physician. (iii) The facility must resident and the resid when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite d §483.5) must disclos its physical configural locations that compri part, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record rev physician interviews, the facility failed to ne resident with a high to resident serviewed for (Resident #1). Resides sustained high blood resulted in a hospital	ification under paragraph (g) the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, n or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph n. record and periodically mailing and email) and resident posite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct fy the policies that apply to then its different locations T is not met as evidenced riew, staff, nurse practitioner, and dialysis staff interviews, otify a physician to report a plood glucose level for 1 of 7 or diabetic management dent #1 experienced glucose levels which	F 580	F580 1. The plan should address the p that lead to the deficiency cited: Resident #1 has had physician related to diabetic management a follows: On 8/3/18 reads as follows:	orders		

Facility ID: 952981

If continuation sheet Page 2 of 28

						0.0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	LETED		
			A. DOILDING			C		
		345362	B. WING			23/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010		
				250 BISHOP LANE				
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS		CONCORD, NC 28025				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)		
PREFIX TAG		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTI) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE DEF				COMPLETION DATE		
F 580	Continued From page	e 2	F 58	0				
	-	began on 8/14/2018 when						
		tify a physician of a blood		Check fasting blood sugar one-tir	ne a day			
	glucose level which	was elevated above 450		at 3 am.	-			
		er (mg/dl) and administered						
		sician order. The Immediate		Novolog 10 unit before meals, an				
		ed on 8/23/2018 when the mplemented an acceptable		sliding scale: if 0 - 200 = 0 units; = 6 units; 251 - 300 = 9 units; 30				
	credible allegation of			12 units; 351 - 400 = 15 units; 40				
		remains out of compliance at		18 units; 451+ = 20 units, after m				
a a f		everity of D (isolated with no		at bedtime.				
	-	ential for more than minimal						
		ediate jeopardy) to complete		A new order dated 8/9/18 read as	s follows:			
		e monitoring systems put into						
	-	lated to notifying physician of		Novolog 6 unit subcutaneously be				
	resident changes.			each meals AND Inject as per slid scale: if 0 - 60 Notify NP/MD; 61				
	Findings included:			units; $201 - 250 = 2$ units; $251 - 3$				
	i mango moladea.			units; 301 - 350 = 6 units; 351 - 4				
	A review of the facility	y policy titled "Physician		units; 401 - 450 = 10 units & rech				
	Services" with a revis	sion date of November 2017		FSBS in 2 hours; if FSBS still > 4	00, notify			
	revealed an on-call p			NP/MD; 451+ Notify NP/MD,				
		hen the attending physician		subcutaneously before meals and	d at			
		able", for example after 6:00		bedtime.				
	PM and on the week	ends before noon.		On August 18, 2018 at approxima	toly 2.12			
	Resident #1 was adm	nitted to the facility on		am Nurse #1 obtained FBS of 45	-			
		noses to include diabetes,		administered 20 units of Novolog				
		ase, high blood pressure and		based on previous instruction from				
	dementia. A review			physician, however she did not n	otify the			
		received dialysis treatment		physician of the results or receive	-			
	•	on Tuesday, Thursday and		new orders. Nurse # 1 rechecked				
	Saturday.			6:45 am of 531 and administered				
	A review of the care p	plans for Resident #1		of Novolog. Nurse # 4 obtained F 9:30 am of 450 and administered				
	-	in place dated 1/11/2018		of Novolog sliding scale and 6 un				
		2/28/2018 that addressed her		scheduled 70/30 per order (8-9-1				
		s and non-compliance with		Nurse #4 reported to Dialysis the				
		interventions to include		blood sugar of 450 at 9:30 are an	-			
	roport all aigns and a	ymptoms of hyperglycemia		coverage per dialysis communica	tion			

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If continuation sheet Page 3 of 28

		MEDICAID SERVICES				T T	O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	· · ·	E SURVEY
		345362	B. WING			0	C 3/23/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	REMENT/CABARRUS			50 BISHOP LANE ONCORD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 3	F 58	80			
	(high blood glucose)				form.		
		ns for diabetes as ordered					
	by the physician.				On August 18, 2018 approximately 10		
	A review of the trainir	ng attendance log dated			am resident transported to dialysis Ce by wheelchair. Nurse # 4 reports per	nter	
		service entitled "Changes in			progress note dated 8-18-18 resident		
		d as attended by Nurse #1			alert and oriented but complained of lo	wer	
	and Nurse #2.				back pain . Tylenol was administrated		
	- , , ,				resident request. Nurse # 4 received of	all	
	-	rterly Minimum Data Set			from resident #1 husband at	4 . /	
		18 assessed Resident #1 to without behaviors or rejection			approximately 2 pm to inform the facili that dialysis was transferring resident		
	of care.				the hospital. Nurse # 4 called Dialysis		
					determine if resident was transferred t		
		as reviewed, and physician			the hospital. The Dialysis center inform	ned	
		8 revealed an order to check			facility resident was transferred to the		
		glucose level before meals,			hospital due to pain on left side and	-	
	at bedtime and as ne	eded.			resident request to be transferred to th hospital.	e	
	A physician order dat	ed 8/9/2018 specified blood			Resident #1 was admitted to the hospi	tal	
		ed at 3:00 AM daily due to			with admitting diagnosis of Diabetic	tui i	
	-	se levels. There were no			Ketoacidosis.		
		insulin at that time. There					
	was no stop date on	the order.			Nurse #1 was suspended on 8/23/18.		
	A physician order dat	ed 8/9/2018 for Novolog			A Root Cause analysis was conducted	l by	
	insulin, inject subcuta	aneously before meals and at			the Interdisciplinary Team (IDT) which		
		cale: blood glucose results			included the Administrator (NHA), the		
		ctitioner (NP) or physician			Director of Nursing (DON), the Nurse		
	•	, inject 2 units of Novolog dl, inject 4 units of Novolog			Manager, and the District Director of Clinical Services on 8/23/18 and it was		
		dl, inject 6 units of Novolog			determined that Nurse #1 did not have		
	-	dl, inject 8 units of Novolog			physician orders for resident #1 to		
		ll; inject 10 units of Novolog			administer Novolog Insulin 20 units on		
		lood glucose, if remained			August 18 2018. Nurse #1 failed to no		
	÷	NP/MD, if greater than 451			the attending physician on August 18,		
	mg/dl, notify NP/MD.				2018 per the physician order. The roc		
	The purging potes	are reviewed, and a note			cause analysis identified that Nurse #		
	The nursing notes we	ere reviewed, and a note			failed to review Resident #1 physician	2	

Facility ID: 952981

						NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		. ,	ATE SURVEY OMPLETED
			A. BUILDING	G		С
		345362	B. WING			08/23/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		00/23/2010
				250 BISHOP LANE		
BRIAN CE	NTER HEALTH & RETIR	REMENT/CABARRUS		CONCORD, NC 28025		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PRÉFIX TAG	(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED		COMPLETION DATE
F 580	Continued From pag	e 4	F 58	80		
	dated 8/13/2018 writ	ten by Nurse #1 noted a		orders prior to administ	ration of Novolog	
	blood glucose result	of 533 mg/dl at 3:00 AM. The		insulin 20 units.	-	
		ntacting the on-call physician				
	· · ·	er of 20 units of Novolog		2. The procedure for im		
		tered and the blood glucose		acceptable plan of corre		
		ote written by MD #2 on / documented a one-time		specific deficiency cited	1.	
		n to administer 20 units of		All residents who have	physician orders to	
		to monitor the blood glucose		perform fasting blood s		
	-	e nurse documented at 6:07		administration have a p	-	
	AM the blood glucos	e had been rechecked at		affected by this alleged		
	6:00 AM with a "High	n" result. Nurse #1		On 8/23/18 the Director		
		ninistered 20 units of		Nurse Managers condu		
	-	se #1 documented "no		residents identified with		
		abetic distress observed."		and/or obtaining fasting	-	
		ian contact documented in or the documented blood		the last 30 days to valid		
		h" at 6:00 AM 8/13/2018.		insulin administration w according to the current		
		documentation by MD #2 in		orders. The twenty four		
		notes after 8/13/2018 to		physician orders were r		
		ervice had been notified of		Director of Nursing and	•	
	an elevated blood gli	ucose.		to ensure residents that	-	
				condition during the las	t 30 days had been	
		18 at 6:07 AM written by		identified and appropria		
		ed a blood glucose result of		taken. The resident's m		
	U	histration of 20 units of		were then reviewed by		
		iding scale at that time. ed "NAD" (no apparent		Nursing and Nurse Mar there is nursing docume	-	
	distress) in her note.			supporting the completi		
	-	ation that the physician was		assessment following o		
		≠1 ' s blood glucose of "High".		change in condition and	-	
		8/15/2018 at 3:19 AM		Physician following the		
	-	documented a blood glucose		The Nurse Managers co	•	
	reading of "High" at 3			notification to the Physi	-	
		ninistration of 20 units of		opportunities identified	a result of this	
		sliding scale" and that		review.		
		D noted. The medical record		On August 12, 2019 at	approvimately 2:00	
	containeu no iniorma	ation that the physician had		On August 13, 2018 at	approximately 3.00	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE		DNSTRUCTION	(X3) DATE	D. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	PLETED
			A. BOILDING				С
		345362	B. WING				23/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
				250	BISHOP LANE		
BRIAN CE	INTER HEALTH & RETIR	EMENT/CABARRUS		CON	NCORD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 580	Continued From page	a 5	F 58	20			
1 300	-		F DC		(EDC) reading of LIICLI for Desident #	1	
	blood glucose level o	п пуп.			(FBS) reading of HIGH for Resident # Nurse #1 contacted Tele Health physic		
	A nursing note dated	8/15/2018 at 6:36 AM			services and order was received to		
	-	locumented a blood glucose			administrated Novolog 20 units insulin		
		AM. The nurse administered			(subq). At approximately 6:00 am on		
		nsulin "per sliding scale" and			August 13, 2018 Nurse #1 rechecked	the	
	Resident #1 had "no	signs/symptoms of diabetic			resident fasting blood sugar (FBS) wit		
		al record contained no			reading of High. Nurse #1 administrat		
		hysician had been notified			20 units of Novolog insulin (subq). Or		
		dent #1 ' s blood glucose			August 15, 2018 at approximately 3:00		
	level of 508 mg/dl.				am Nurse #1 obtained fasting blood su		
		0/10/2010 at 0:20 AM			reading of HIGH on Resident #1. Augu		
		8/16/2018 at 6:36 AM locumented a blood sugar			15, 2018 at approximately 6:00 am Nu #1 obtained fasting blood sugar of 508		
		6:30 AM, the administration			Nurse #1 administrated 20 units of).	
	-	g insulin and Resident #1			Novolog (subq).		
		oms of diabetic distress".					
	• • •	ontained no information that					
		en notified on 8/16/2018 of		0	On 8/23/18 The Director of Nursing ar	nd	
	Resident #1 's blood	glucose level of 485 mg/dl.		1	Nurse Managers re-educated current		
	Nurse #1 wrote a not	e dated 8/18/2018 at 3:16			Licensed Nurses regarding the facility		
		a blood glucose result of			policy for Changes in Resident Condit	ion,	
		1, the administration of 20			with a focus on assessment following		
		lin and Resident #1 had "no			HIGH blood sugar or blood sugar that		
	signs/symptoms of di				outside physician order parameter. Th		
		ined no information that the notified on 8/18/2018 at 3:16			re- education of current Licensed Nurs also included the 5 steps regarding	ses	
		blood glucose level of 454			medication administration, to include		
	mg/dl.				validation of resident physician orders		
					prior to administration of insulin, or		
	A nursing note dated	8/18/2018 at 6:52 AM			performing of fasting blood sugars.		
	-	evealed a blood glucose			twenty-two of the facility's licensed nu	rses	
	result of 531 mg/dl at	6:30 AM. Nurse #1		r	received the in-service as of 8/23/18.		
		inistration of 20 units of					
	Novolog insulin and F				No staff shall work after 8/23/18 before		
	signs/symptoms of di				receiving this education. This educatio		
		ined no information that the			has been added to the Facility Orienta		
		notified on 8/18/2018 at 6:52			program for all new hires and agency		
	AIVI OF RESIDENT #1 'S	blood glucose level of 531		t	to be completed prior to beginning wo	ι κ	1

Facility ID: 952981

If continuation sheet Page 6 of 28

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		TE SURVEY MPLETED
		345362	B. WING			0	C 8/23/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0.20.2010
				2	50 BISHOP LANE		
BRIAN CE	NTER HEALTH & RETIR	EMENI/CABARRUS		с	ONCORD, NC 28025		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580	Continued From page	6		580			
1 000				000	after 8/23/18.		
	mg/dl.						
	A nursing note writter	h by Nurse #2 dated			3. The monitoring procedure to ensure	Э	
		1 documented the blood			that the plan of correction is effective a	and	
	•	mg/dl at 10:30 AM. Nurse			that specific deficiency cited remains		
		nistration of 20 units of			corrected and/or in compliance with th	e	
	•	iding scale orders dated			regulatory requirements:		
	8/9/2018 and commu	dialysis treatment center.			On 8/24/18 a new process will be initia	atod	
	•	ontained no information that			during the morning clinical meeting 5	aleu	
		en notified on 8/18/2018 by			times per week for 12 weeks. This wi	II	
		it #1 's blood glucose result			include a review, by the Director of		
	of 450 mg/dl.	5			Nursing and Nurse Managers, of		
	Ū				residents identified with physician orde	ers	
	A review of the hospit	tal records revealed			for fasting blood sugars and/or insulin	to	
		nitted to the hospital for			validate the following process was		
	recurrent diabetic ket				completed as implemented.		
		ed intravenous fluids and					
		reduce her blood glucose			-The attending physician was notified	of	
		note for the hospitalization aled the resident was			fasting blood sugar outside physician	ition	
		inal pain, chest discomfort			order parameters and/or change cond	luon	
		ath. Blood glucose level at			-The physician orders for fasting blood	4	
		d at 6:58 PM was 581 mg/dl.			sugars and/or insulin are being followe		
		the Intensive Care Unit for					
	continual monitoring	and treatment of DKA with			-Residents receiving insulin and/or fas	sting	
		Resident #1 was discharged			blood sugars had current physician	-	
	back to the facility on				orders.		
		ary physician (MD #1) was					
		2018 at 8:57 AM. MD #1			-The Director of Nursing will report the	9	
	· ·	was non-compliant and had			results of this monitoring during the	ittoo	
		se control. He was not aware ad not been notified of			monthly QAPI meeting and the comm will make recommendations as neede		
		se levels for Resident #1.				u.	
					4. Facility Administrator is responsible	for	
	An interview was con	ducted with NP #1 on			implementing this acceptable plan of	.01	
		1. She reviewed the order for			correction.		
		ated 8/9/2018 and stated					
	-	nurse practitioner should					

Facility ID: 952981

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	S FOR MEDICARE &					<u>IO. 0938-03</u>		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED		
			A. BUILDING	G				
		345362	B. WING			C		
		545562	B. WING			8/23/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	=			
BRIAN CE	NTER HEALTH & RETIR	REMENT/CABARRUS	250 BISHOP LANE					
				CONCORD, NC 28025				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETIO		
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE		
F 580	Continued From page	e 7	F 58	30				
		the blood glucose results						
		n 8/14/2018, 8/15/2018,						
		2018. She further reported it						
		that MD or NP were notified						
	of elevated blood glu	cose in a diabetic resident						
		or complications related to						
	elevated blood gluco							
		ewed on 8/22/2018 at 9:19						
		urse #1 reported she had						
	•	sident #1 on 8/13/2018,						
		3, 8/16/2018 and 8/18/2018 00 PM to 7:00 AM). Nurse #1						
		d Resident #1 ' s blood						
		every night she worked						
	-	1 's blood glucose was						
		nes she would have very low						
		or very high blood glucose						
	-	orted that a "High" reading						
	usually indicated a bl	ood glucose over 500 mg/dl.						
	Nurse #1 reported sh	e had called the on-call						
		8/13/2018 at 3:25 AM and						
		-call physician (MD #2) about						
		g scale. Nurse #1 reported						
	she conveyed the an							
		dent #1 for blood glucose						
		ID #2 instructed her to give						
		urse #1 went on to explain ause MD #2 had ordered						
		he sliding scale, she had not						
		rder. Nurse #2 reported that						
		old her to use the sliding						
		for blood glucose results in						
		concluded by reporting she						
		sician order to use the						
		protocol for the 3:00 AM						
		s and she had used the						
		nsulin protocol to administer						
	20 units of insulin wh	en Resident #1 ' s blood						
		50 mg/dl during her shift						

Facility ID: 952981

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(V2) DAT	E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	PLETED		
						С		
		345362	B. WING		08	/23/2018		
NAME OF PI	ROVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP COL	DE			
BRIAN CE	NTER HEALTH & RETIR	REMENT/CABARRUS		BISHOP LANE NCORD, NC 28025				
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From page	e 8	F 580					
		want to bother the on-call						
	An interview via phone call was conducted with MD #2 and MD #3 on 8/22/2018 at 11:28 AM. MD #2 reported she was the physician on-call the night of 8/13/2018 and she had given the order to cover the blood glucose result of 533 with 20 units of Novolog insulin. MD #2 went on to explain she had asked Nurse #1 to read the sliding scale to determine the amount of insulin to administer to Resident #1. MD #2 went on to explain she had not given an order to use the sliding scale insulin orders for future 3:00 AM blood glucose checks and her expectation was staff would call for orders for blood glucose results obtained at 3:00 AM. MD #3 added the on-call service was contracted by the facility was to be used for off-hour physician contact for any issues, and he reported it was his expectation that nursing staff would call the on-call agency to provide care for residents during physician off-hours.							
	PM. Nurse #2 reporte AM to 3:00 PM) on 8, report from Nurse #1 Nurse #2 reported sh glucose two hours aff glucose at 8:30 AM a administered insulin a scale orders dated 8/ explain the orders for 8/9/2018 ordered for	ewed on 8/22/2018 at 12:00 ed she worked day shift (7:00 /18/2018 and had received at the beginning of her shift. he had checked the blood ter the 6:30 AM blood and it was 450. Nurse #2 as ordered on the sliding /9/2018. Nurse #2 went on to r sliding scale insulin on a physician to be called if as more than 450, so she had hered insulin and had not						

Facility ID: 952981

If continuation sheet Page 9 of 28

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345362	B. WING				C /23/2018
NAME OF PI	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
BRIAN CE	NTER HEALTH & RETIR	EMENT/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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	interviewed via phone PM. She reported sh Resident #1 and had provide dialysis treatr Nurse #1 reported tha did not feel well and v upon her arrival at the 8/18/2018. The nurse (swelling) Resident # blood pressure, pain glucose of 464. Dialys dialysis center NP an symptoms. The dialys Dialysis Nurse #1 to a dialysis treatment to F the emergency room treatment. The Director of Nursir on 8/21/2018 at 3:39	or dialysis treatment. urse (Dialysis Nurse #1) was a call on 8/22/2018 at 12:54 e was very familiar with been assigned to her to ment on 8/18/2018. Dialysis at Resident #1 told her she vanted to go to the hospital e dialysis center on went to describe the edema 1 had in her face, her low in her abdomen and blood sis Nurse #1 contacted the d reported Resident #1 's sis center NP ordered for attempt to provide the Resident #1 and to send to for evaluation after mg (DON) was interviewed PM and she reported it was nursing would contact a	F	580			
	abnormal blood glucc The DON was intervie 12:15 PM and she fur why Nurse #1 had no physician service for	ewed again on 8/23/2018 at ther stated she did not know t contacted the on-call the elevated blood glucose The DON reported Nurse led until a medication					
	Staff Development Ma Immediate Jeopardy	rector of Nursing, and Area anager were notified of on 8/22/2018 at 3:10 PM e following credible allegation dy removal:					

Facility ID: 952981

If continuation sheet Page 10 of 28

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/24/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345362	B. WING		C 08/23/2018
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP C	
BRIAN CE	NTER HEALTH & RETIR	EMENT/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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 580	Continued From page	e 10	F 5	80	
	respectfully submits to to lift the allegation of identified on August of Resident #1 has had diabetic managemen On 8/3/18 reads as for Check fasting blood so am. Novolog 10 unit befor scale: if 0 - 200 = 0 251 - 300 = 9 units; 3 400 = 15 units; 401 - units, after meals and A new order dated 8/ Novolog 6 unit subcut meals AND Inject as Notify NP/MD; 61 - 20 units; 251 - 300 = 4 u - 400 = 8 units; 401 - FSBS in 2 hours; if F	14, 2018 for F580 physician orders related to t as follows: bllow: sugar one-time a day at 3 re meals, and per sliding 0 units; 201 - 250 = 6 units; 601 - 350 = 12 units; 351 - 450 = 18 units; 451+ = 20 d at bedtime 9/18 read as follows: taneously before each per sliding scale: if 0 - 60 00 = 0 units; 201 - 250 = 2 units; 301 - 350 = 6 units; 351 450 = 10 units & recheck SBS still > 400, notify NP/MD, subcutaneously			
	#1 obtained FBS of 4 units of Novolog insu instruction from phys notify the physician o new orders. Nurse # of 531 and administe Nurse #1 did not noti resident fasting blood On August 18, 2018 a resident transported	approximately 10:30 am			

Facility ID: 952981

If continuation sheet Page 11 of 28

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCT	ION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		CO	MPLETED
						С	
		345362	B. WING				8/23/2018
NAME OF PI	ROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS		250 BISHOP LA			
	l			CONCORD, N	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 COR ACH CORRECTIVE ACTION DSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 11	F 5	80			
		nt alert and oriented but					
		back pain. Tylenol was					
		ident request. Nurse # 4					
		sident #1 's husband at					
		o inform the facility that					
		ing resident to the hospital.					
	-	ysis to determine if resident e hospital. The Dialysis					
		ty resident was transferred					
1	to the hospital due to						
	-	e transferred to the hospital.					
	Resident #1 was adm	nitted to the hospital with					
		f Diabetic Ketoacidosis.					
	Nurse # 1 was suspe						
	-	is was conducted by the n (IDT) which included the					
		the Director of Nursing					
		inager, and the District					
		ervices on 8/23/18 and it was					
	determined that Nurs	e #1 failed to notify the					
		n of the high fasting blood					
		an order. The root cause					
	-	at Nurse #1 failed to review					
	Resident #1 physicial administration of Nov						
		plementing the acceptable					
		the specific deficiency cited;					
		have physician orders to					
	perform fasting blood	-					
		a potential to be affected by practice. On 8/23/18 the					
	Director of Nursing a	-					
	-	f residents identified with					
		/or obtaining fasting blood					
	sugars for the last 30	days to validate that					
		ied per orders regarding					
	abnormal fasting bloc	od sugars. The orts and medical records of					
	wenty-tour-hour repo	orts and medical records of	1	1			1

If continuation sheet Page 12 of 28

	OF DEFICIENCIES	MEDICAID SERVICES				O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDIN			С
		345362	B. WING		05	3/23/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		5/23/2010
				250 BISHOP LANE	52	
BRIAN CE	NTER HEALTH & RETIR	REMENT/CABARRUS		CONCORD, NC 28025		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE IE APPROPRIATE	COMPLETIO
F 580	Continued From page	e 12	F 5	80		
		and fasting blood sugar				
		d by the Director of Nursing				
	and Nurse Managers to ensure physicians were					
		fasting blood sugars per				
	physician orders. Th	-				
		n to the Physician for any				
		ed as a result of this review.				
		ctor of Nursing and Nurse				
		ed current Licensed Nurses				
		policy for "Changes in with a focus on physician				
		nal fasting blood sugars per				
		venty-two of the facility 's				
		eived the in-service as of				
	No staff shall work af	ter 8/23/18 before receiving				
		education has been added to				
	the Facility Orientation	on program for all new hires				
	and agency staff to b	e completed prior to				
	beginning work after					
	÷ .	edure to ensure that the plan				
	of correction is effect					
	-	ains corrected and/or in				
	compliance with the i	regulatory requirements;				
	2. On 8/24/18 a new	process will be initiated				
		linical meeting 5 times per				
		This will include a review, by				
		ng and Nurse Managers, of				
		ith physician orders for				
	•	to validate that physician				
		bnormal blood sugars.				
		cian was notified of fasting				
		physician order parameters				
	and/or change condit					
	and/or insulin are bei	for fasting blood sugars				
		nsulin and/or fasting blood				

If continuation sheet Page 13 of 28

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
						С
		345362	B. WING			8/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH & RETIR	REMENT/CABARRUS		250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pag	e 13	F 580			
		mittee will make				
		ninistrator is responsible for ceptable plan of correction.				
	8/23/2018 at 7:15 PM					
	diabetes were review current orders for ins	ents with the diagnosis of ved and found to have sulin, fingerstick blood and orders for notifying the				
	could state the 5 righ administration (right right route, right docu verbalize the steps to blood sugar out of pa status. All nurses con complete when notify elevated blood gluco	were interviewed, and all the of medication drug, right dose, right time, umentation) and all could o notifying a physician for a arameters or for a change of uld state the correct form to ying a physician of an se or change in status ad, Assessment Response -				
F 684	Quality of Care		F 684			10/2/18
SS=J	CFR(s): 483.25					
	§ 483.25 Quality of c Quality of care is a fu	are				

Facility ID: 952981

If continuation sheet Page 14 of 28

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
	CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDI	NG _		C	
		345362	B. WING			08	B/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	NTER HEALTH & RETIR			25	50 BISHOP LANE		
	ATER HEALTH & RETIN			С	ONCORD, NC 28025		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From page	e 14	F	684			
1 001		nt and care provided to		004			
;	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure						
		e treatment and care in					
	accordance with prof	essional standards of					
	practice, the compret	nensive person-centered					
	care plan, and the res	sidents' choices.					
		F is not met as evidenced					
	by:				500/		
		iew, staff, nurse practitioner,			F684		
		and dialysis staff interviews,					
	-	otain a physician ' s order to a high blood glucose level for			1. The plan should address the proc		
	1 of 7 residents revie				that lead to the deficiency cited:	69969	
	management (Reside				that lead to the denotency cited.		
	÷ .	ed high blood glucose levels			Resident #1 has had physician orde	ers	
		ospitalization for diabetic			related to diabetic management as		
		us complication of diabetes).			follows:		
		began on 8/14/2018 when tain a physician order to treat			On 8/3/18 reads as follows:		
		od glucose which was			Check fasting blood sugar one-time	a dav	
		milligrams per deciliter			at 3 am.	,	
	(mg/dl) and administer						
		Immediate Jeopardy was			Novolog 10 unit before meals, and p		
		8 when the facility provided			sliding scale: if 0 - 200 = 0 units; 201		
	and implemented an	•			= 6 units; 251 - 300 = 9 units; 301 - 3		
		ate jeopardy removal. The f compliance at a lower			12 units; 351 - 400 = 15 units; 401 - 18 units; 451+ = 20 units, after meal		
	•	f D (isolated with no actual			at bedtime.	s anu	
		or more than minimal harm					
		jeopardy) to complete			A new order dated 8/9/18 read as fo	lows:	
		e monitoring systems put into				-	
		lated to notifying physician of			Novolog 6 unit subcutaneously befor	е	
	resident changes.				each meals AND Inject as per sliding		
					scale: if 0 - 60 Notify NP/MD; 61 - 20	0 = 0	
	Findings included:				units; 201 - 250 = 2 units; 251 - 300		
					units; 301 - 350 = 6 units; 351 - 400		
		y policy titled "Physician	1		units; 401 - 450 = 10 units & recheck		1

Facility ID: 952981

		MEDICAID SERVICES				<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		345362	B. WING		0.0	C 3/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		123/2010
				250 BISHOP LANE		
BRIAN CE	INTER HEALTH & RETIR	REMENT/CABARRUS		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 15	F 684	4		
1 004		sion date of November 2017	F 004	FSBS in 2 hours; if FSB	Sotill > 400 potify	
	revealed an on-call p			NP/MD; 451+ Notify NP/	· ·	
	-	when the attending physician		subcutaneously before r		
	is not generally availa	able", for example after 6:00		bedtime.		
	PM and on the week	ends before noon.				
		····		On August 18, 2018 at a		
		nitted to the facility on		am Nurse #1 obtained F		
		noses to include diabetes, ase, high blood pressure and		administered 20 units of based on previous instru	•	
	•	of the medical record		physician, however she		
		1 received dialysis treatment		physician of the results of	-	
		on Tuesday, Thursday and		new orders. Nurse # 1 re	•	
	Saturday.	5× 5		6:45 am of 531 and adm	inistered 20 units	
				of Novolog. Nurse # 4 o		
	A review of the care			9:30 am of 450 and adm		
		in place dated 1/11/2018		of Novolog sliding scale		
		2/28/2018 that addressed her		scheduled 70/30 per ord		
		s and non-compliance with		Nurse #4 reported to Dia		
		interventions to include ymptoms of hyperglycemia		blood sugar of 450 at 9: coverage per dialysis co		
	(high blood glucose)			form.	mmunication	
		ns for diabetes as ordered				
	by the physician.			On August 18, 2018 app	roximately 10:30	
				am resident transported		
	The most recent qua	rterly Minimum Data Set		by wheelchair. Nurse #	4 reports per	
		18 assessed Resident #1 to		progress note dated 8-1		
		without behaviors or rejection		alert and oriented but co	•	
	of care.			back pain . Tylenol was	•	
				resident request. Nurse		
		as reviewed, and physician 8 revealed an order to check		from resident #1 husbar		
		l glucose level before meals,		approximately 2 pm to ir that dialysis was transfe		
	at bedtime and as ne	-		the hospital. Nurse # 4	-	
				determine if resident was	-	
	A physician order dat	ted 8/9/2018 for Novolog		the hospital. The Dialysi		
		aneously before meals and at		facility resident was tran		
		cale: blood glucose results		hospital due to pain on le		
		ctitioner (NP) or physician		resident request to be tra	ansferred to the	
	(MD): 201-250 mg/dl	, inject 2 units of Novolog		hospital.		

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		MEDICAID SERVICES				1	<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	G			
		345362	B. WING				С
		345362				0	8/23/2018
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS					
	1			CO	DNCORD, NC 28025		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETIC
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 684	Continued From page	e 16	F 68	34			
	insulin; 251-300 mg/d	ll, inject 4 units of Novolog			Resident #1 was admitted to the hosp	ital	
		II, inject 6 units of Novolog			with admitting diagnosis of Diabetic		
	insulin; 351-400 mg/c	II, inject 8 units of Novolog			Ketoacidosis.		
		II; inject 10 units of Novolog					
		lood glucose, if remained			Nurse #1 was suspended on 8/23/18.		
	•	NP/MD, if greater than 451					
	mg/dl, notify NP/MD.				A Root Cause analysis was conducted	-	
					the Interdisciplinary Team (IDT) which		
		ed 8/9/2018 specified blood			included the Administrator (NHA), the		
	-	d at 3:00 AM daily due to			Director of Nursing (DON), the Nurse		
	•	se levels. There were no			Manager, and the District Director of	_	
		nsulin at that time. There			Clinical Services on 8/23/18 and it was		
	was no stop date on t	ine order.			determined that Nurse #1 did not have physician orders for resident #1 to	•	
	The nursing notes we	ere reviewed, and a note			administer Novolog Insulin 20 units on		
	-	en by Nurse #1 noted a			August 18 2018. Nurse #1 failed to no		
		of 533 mg/dl at 3:00 AM. The			the attending physician on August 18,	-	
	-	ntacting the on-call physician			2018 per the physician order. The roc		
		er of 20 units of Novolog			cause analysis identified that Nurse #*		
		ered and the blood glucose			failed to review Resident #1 physician		
	to be monitored. The	nurse documented at 6:07			orders prior to administration of Novole		
	AM the blood glucose	e had been rechecked at			insulin 20 units.		
	6:00 AM with a "High	" result. Nurse #1					
	documented she adm				2. The procedure for implementing the	;	
	-	e #1 documented "no			acceptable plan of correction for the		
		betic distress observed."			specific deficiency cited:		
		an contact documented and					
		ocumented in the medical			All residents who have physician order		
		ented blood glucose level of			perform fasting blood sugar and /or ins	suin	
	"High" at 6:00 AM 8/1	3/2010.			administration have a potential to be	ico	
		#2 on 8/13/2018 at 3:50 AM			affected by this alleged deficient praction of 8/23/18 the Director of Nursing and		
		me order had been given to			Nurse Managers conducted an audit of		
		f Novolog insulin and to			residents identified with orders for insu		
		cose for Resident #1. There			and/or obtaining fasting blood sugars		
		nentation by MD #2 in the			the last 30 days to validate FBS and		
	patient progress note	-			insulin administration was completed		
					according to the current physicians		
	A note dated 8/14/20	18 at 6:07 AM written by			orders. The twenty-four hour reports a	and	

Facility ID: 952981

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		MEDICAID SERVICES				OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SU COMPLE	
			A. BOILDING			с	
		345362	B. WING				3/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE		
				250 BISHOP	LANE		
	INTER HEALTH & RETIF	KEMEN I/GADARRUS		CONCORD,	NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETIO DATE
F 684	Continued From pag	e 17	F 68	4			
		ed a blood glucose result of			an orders were reviewed by the		
		histration of 20 units of			r of Nursing and Nurse Manage	rs	
	-	liding scale at that time.			re residents that have a change		
	Nurse #1 documente	ed "NAD" (no apparent		conditio	on during the last 30 days had b	een	
	distress) in her note.				ed and appropriate action had be	een	
		ation that the physician was			The resident's medical records		
		#1 's blood glucose of "High"			en reviewed by the Director of		
	or a physician order	had been obtained.			and Nurse Managers to validat		
	A nursing note dated	I 8/15/2018 at 3:19 AM			nursing documentation present ting the completion of a nursing		
	-	documented a blood glucose			ment following of a significant		
	reading of "High" at 3				in condition and notification to t	he	
		ninistration of 20 units of		-	an following the significant chan		
		sliding scale" and that		-	rse Managers completed		
		D noted. The medical record			tion to the Physician for any		
	contained no informa	ation that the physician had		opportu	inities identified a result of this		
	been notified on 8/15	5/2018 of Resident #1 ' s		review.			
	blood glucose level o	of "High" or a physician order					
	had been obtained.				just 13, 2018 at approximately 3		
					se 1 obtained fasting blood sug		
	-	8/15/2018 at 6:36 AM			eading of HIGH for Resident #1		
		documented a blood glucose			#1 contacted Tele Health physici	an	
		AM. The nurse administered			s and order was received to		
		nsulin "per sliding scale" and signs/symptoms of diabetic			strated Novolog 20 units insulin At approximately 6:00 am on		
		al record contained no			13, 2018 Nurse #1 rechecked t	he	
		physician had been notified		-	t fasting blood sugar (FBS) with		
		ident #1 ' s blood glucose			of High. Nurse #1 administrate		
		a physician order had been			s of Novolog insulin (subq). On		
	obtained.			August	15, 2018 at approximately 3:00		
					se #1 obtained fasting blood su	-	
	-	8/16/2018 at 6:36 AM		-	of HIGH on Resident #1. Augu		
	-	documented a blood sugar			8 at approximately 6:00 am Nur		
		t 6:30 AM, the administration			ined fasting blood sugar of 508.		
		g insulin and Resident #1			#1 administrated 20 units of a (suba)		
		oms of diabetic distress". contained no information that			g (subq).		
		en notified on 8/16/2018 of					
		d glucose level of 485 mg/dl			3/18 The Director of Nursing and	.	

Facility ID: 952981

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		MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	. ,	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
		0.45000				С
		345362	B. WING			8/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
BRIAN CE	NTER HEALTH & RETIR	EMENT/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 (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE
IAG			IAG		IENCY)	
F 684	Continued From page	e 18	F 68	34		
	or a physician order l		1 00	Nurse Managers re-edu	icated current	
		lad been obtained.		Licensed Nurses regard		
	Nurse #1 wrote a not	e dated 8/18/2018 at 3:16		policy for Changes in R		
		a blood glucose result of		with a focus on assessr		
		1, the administration of 20		HIGH blood sugar or bl		
	-	lin and Resident #1 had "no		outside physician order	-	
	signs/symptoms of di			re- education of current		
		ined no information that the		also included the 5 step		
		notified on 8/18/2018 at 3:16		medication administration		
		s blood glucose level of 454		validation of resident ph		
		order had been obtained.		prior to administration o	-	
				performing of fasting blo		
	A nursing note dated	8/18/2018 at 6:52 AM		twenty-two of the facility	-	
		evealed a blood glucose		received the in-service		
	result of 531 mg/dl at					
		inistration of 20 units of		No staff shall work after	8/23/18 hefore	
	Novolog insulin and F			receiving this education		
	signs/symptoms of di			has been added to the		
		ined no information that the		program for all new hire		
		notified on 8/18/2018 at 6:52		to be completed prior to		
		s blood glucose level of 531		after 8/23/18.		
		order had been obtained.				
				3. The monitoring proce	edure to ensure	
	A nursing note writter	n by Nurse #2 dated		that the plan of correction		
		I documented the blood		that specific deficiency		
		mg/dl at 10:30 AM. Nurse		corrected and/or in com		
	•	inistration of 20 units of		regulatory requirements		
		liding scale orders dated				
	8/9/2018 and commu	-		On 8/24/18 a new proce	ess will be initiated	
		e dialysis treatment center.		during the morning clini		
	-	ontained no information that		times per week for 12 w	-	
	the physician had be	en notified on 8/18/2018 by		include a review, by the		
	-	nt #1 ' s blood glucose result		Nursing and Nurse Mar		
		D sliding scale for insulin		residents identified with		
	-	ne resident was to have 10		for fasting blood sugars		
	_	lin with a blood glucose level		validate the following pr		
	of 450 mg/dl.	-		completed as implement		
	A review of the hospi	tal records revealed		-The attending physicia	n was notified of	

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		MEDICAID SERVICES				8-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
		345362	B. WING		C 08/23/201	10
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		10
				250 BISHOP LANE	0002	
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS		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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMP D THE APPROPRIATE D/	X5) PLETIO ATE
F 684	Continued From page	a 10	F 684	4		
1 004	-	nitted to the hospital for	F 004	fasting blood sugar outsid	do physician	
	recurrent diabetic ket	•		order parameters and/or		
		ed intravenous fluids and				
	intravenous insulin to	reduce her blood glucose		-The physician orders for	fasting blood	
		note for the hospitalization		sugars and/or insulin are		
		aled the resident was				
		nal pain, chest discomfort		-Residents receiving insu	-	
		ath. Blood glucose level at		blood sugars had current	physician	
		d at 6:58 PM was 581 mg/dl. the Intensive Care Unit for		orders.		
		and treatment of DKA with		-The Director of Nursing	will report the	
	-	Resident #1 was discharged		results of this monitoring		
	back to the facility on	8/21/2018.		monthly QAPI meeting a	nd the committee	
		ary physician (MD #1) was 2018 at 8:57 AM. MD #1		will make recommendation	ons as needed.	
	reported Resident #1 unstable blood glucos	was non-compliant and had se control.		4. Facility Administrator is implementing this accept correction.		
		ducted with NP #1 on				
		I. She reviewed the order for				
	-	ated 8/9/2018 and stated				
		nurse practitioner should the blood glucose results				
		n 8/14/2018, 8/15/2018,				
	8/16/2018. She furthe					
	expectation that orde	rs were followed for				
		otential for complications				
	related to elevated bl	ood glucose levels.				
	Resident #1 was inter	rviewed on 8/22/2018 at				
		ed she was not certain why				
	she had a recent hos					
		ewed on 8/22/2018 at 9:19				
	-	urse #1 reported she had				
	-	sident #1 on 8/13/2018,				
		6, 8/16/2018 and 8/18/2018				
		00 PM to 7:00 AM). Nurse #1 I Resident #1 ' s blood				
	glucose at 3:00 AM e					

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		MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	IPLETED
						С
		345362	B. WING		08	3/23/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT/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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Continued From page 20		F 684	4		
	because Residents #	1 ' s blood glucose was				
		nes she would have very low				
	blood glucose levels or very high blood glucose levels. Nurse #1 reported that a "High" reading usually indicated a blood glucose over 500 mg/dl.					
	•	had called the on-call				
		8/13/2018 at 3:25 AM and				
		-call physician (MD #2) about				
		g scale. Nurse #1 reported				
	she conveyed the an	dent #1 for blood glucose				
		ID #2 instructed her to give				
	-	urse #1 went on to explain				
		ause MD #2 had ordered				
	-	ne sliding scale, she had not				
		der. Nurse #2 went on				
		ID #2 had told her to use the rotocol for blood glucose				
		Nurse #1 concluded by				
		t written a physician order to				
		insulin protocol for the 3:00				
		ecks and she had used the				
		nsulin protocol to administer				
		en Resident #1 ' s blood 50 mg/dl during her shift				
	•	want to bother the on-call				
	physician.					
		ne call was conducted with n 8/22/2018 at 11:28 AM, MD				
		the physician on-call the				
		id she had given the order to				
		ose result of 533 with 20				
	units of Novolog insu	lin. MD #2 went on to explain				
		#1 to read the sliding scale				
		ount of insulin to administer				
		2 went on to explain she had				
	not alven on order to	use the sliding scale insulin				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MLII TI	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /		· · · ·	IPLETED
						С
		345362	B. WING		0	8/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	NTER HEALTH & RETIR			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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 21	F 68	84		
		was staff would call for				
		ose results obtained at 3:00				
	AM. MD #3 added th	e on-call service was				
		ility was to be used for				
		ntact for any issues, and he				
		pectation that nursing staff				
	residents during phys	agency to provide care for				
	Nurse #2 was intervie	ewed on 8/22/2018 at 12:00				
	PM. Nurse #2 reporte	ed she worked day shift (7:00				
	AM to 3:00 PM) on 8/	18/2018 and had received				
		at the beginning of her shift.				
		e had checked the blood				
	glucose two hours af	nd it was 450. Nurse #2				
	•	as ordered on the sliding				
		9/2018. Nurse #2 went on to				
		for sliding scale insulin on				
		a physician to be called if				
	-	s more than 450, so she had				
		ered insulin and had not				
		lurse #2 concluded by				
		I had complained of back stered Tylenol prior to				
	Resident #1 leaving f					
	The dialysis center n	urse (Dialysis Nurse #1) was				
	interviewed via phone	e call on 8/22/2018 at 12:54				
		e was very familiar with				
		been assigned to her to				
		ment on 8/18/2018. Dialysis				
		at Resident #1 told her she wanted to go to the hospital				
	upon her arrival at the					
		e went to describe the edema				
		1 had in her face, her low				
		in her abdomen and blood				
	glucose of 464. Dialy		1	1		1

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 09/24/20 FORM APPROV MB NO. 0938-03
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		X3) DATE SURVEY COMPLETED
		345362	B. WING				C 08/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	l	I	STF	REET ADDRESS, CITY, STATE, ZIP COE)E	
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS		250	BISHOP LANE		
				co	NCORD, NC 28025		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIAT	E (X5) COMPLETIC DATE
F 684	symptoms. The dialys Dialysis Nurse #1 to a dialysis treatment to I the emergency room treatment. The Director of Nursin on 8/21/2018 at 3:39 her expectation that r physician for all patie abnormal blood gluco The DON was intervit 12:15 PM and she fun why Nurse #1 would without an order or w contacted the on-call elevated blood glucos DON reported Nurse until a medication retw with her. The Administrator, Di Staff Development M Immediate Jeopardy and they provided the of Immediate Jeopardy Brian Center Health a respectfully submits t	d reported Resident #1 ' s sis center NP ordered for attempt to provide the Resident #1 and to send to for evaluation after ng (DON) was interviewed PM and she reported it was nursing would contact a nt issues, including ose results. ewed again on 8/23/2018 at ther stated she did not know have administered insulin hy Nurse #1 had not physician service for the se levels of Resident #1. The #1 had been suspended raining could be completed rector of Nursing, and Area anager were notified of on 8/22/2018 at 3:10 PM e following credible allegation dy removal: and Retirement Cabarrus his allegation of compliance	F	684			
	diabetic management On 8/3/18 reads as for Check fasting blood s am.	14, 2018 for F684 physician orders related to t as follows:					

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 09/24/2018 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		ONSTRUCTION	(X3) [DATE SURVEY OMPLETED
		345362	B. WING				C 08/23/2018
	ROVIDER OR SUPPLIER	EMENT/CABARRUS		250	REET ADDRESS, CITY, STATE, ZIP COU BISHOP LANE NCORD, NC 28025	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	251 - 300 = 9 units; 3 400 = 15 units; 401 - units, after meals and A new order dated 8// Novolog 6 unit subcu meals AND Inject as Notify NP/MD; 61 - 20 units; 251 - 300 = 4 u - 400 = 8 units; 401 - FSBS in 2 hours; if F3 NP/MD; 451+ Notify I before meals and at b August 18, 2018 at a #1 obtained FBS of 4 units of Novolog insu instruction from physi notify the physician o new orders. Nurse # of 531 and administer Nurse # 4 obtained F administered 10 units and 6 units of schedu Nurse #4 reported to sugar of 450 at 9:30 a dialysis communication On August 18, 2018 a resident transported 1 wheelchair. Nurse # dated 8-18-18 resident complained of lower I administrated per res received call from res approximately 2 pm to dialysis was transferr	0 units; 201 - 250 = 6 units; 01 - 350 = 12 units; 351 - 450 = 18 units; 451+ = 20 4 at bedtime 9/18 read as follows: taneously before each per sliding scale: if 0 - 60 00 = 0 units; 201 - 250 = 2 nits; 301 - 350 = 6 units; 351 450 = 10 units & recheck SBS still > 400, notify NP/MD, subcutaneously bedtime. pproximately 3:13 am Nurse 54 and administered 20 lin based on previous ician, however she did not f the results or receive any 1 rechecked FBs at 6:45 am red 20 units of Novolog. BS at 9:30 am of 450 and a of Novolog sliding scale led 70/30 per order (8-9-18). Dialysis the fasting blood am and insulin coverage per on form. approximately 10:30 am to dialysis Center by 4 reports per progress note nt alert and oriented but back pain. Tylenol was ident request. Nurse # 4	F	684			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 09/24/2018 FORM APPROVED OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345362		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 08/23/2018			
		B. WING							
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS					0 BISHOP LANE DNCORD, NC 28025				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 684	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	684					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) [DATE SURVEY COMPLETED		
345362				C 08/23/2018			
l		STR	EET ADDRESS, CITY, STATE, ZIP COI	DE			
BRIAN CENTER HEALTH & RETIREMENT/CARARRUS			250 BISHOP LANE				
			NCORD, NC 28025				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
(EACH DEFICIENCY MUST BE PRECEDED BY FULL		684					
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345362 EMENT/CABARRUS ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) E 25 Insure residents that have a luring the last 30 days had ppropriate action had been s medical records were then ctor of Nursing and Nurse there is Nursing Int supporting the completion ent following of a significant ind notification to the the significant change. The in to the Physician for any id a result of this review. At approximately 3:00 am ting blood sugar (FBS) Resident #1. Nurse #1 sician services and order instrated Novolog 20 units sly). At approximately 6:00 18 Nurse #1 rechecked the I sugar (FBS)with reading of nistrated 20 units of Novolog sly). On August 15, 2018 at m Nurse #1 obtained fasting of HIGH on Resident #1. pproximately 6:00 am Nurse lood sugar of 508. Nurse #1 s of Novolog	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345362 B. WING CONSTRUCT SEARCH	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CC A. BUILDING 345362 B. WING EMENT/CABARRUS STR 250 COI ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ID PREFIX TAG ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ID PREFIX TAG a 255 F 684 nsure residents that have a luring the last 30 days had ppropriate action had been s medical records were then ctor of Nursing and Nurse there is Nursing nt supporting the completion ent following of a significant ind notification to the ne significant change. The n to the Physician for any d a result of this review. at approximately 3:00 am ting blood sugar (FBS) Resident #1. Nurse #1 sician services and order nistrated Novolog 20 units sly). At approximately 6:00 18 Nurse #1 rechecked the I sugar (FBS)with reading of nistrated 20 units of Novolog sly). On August 15, 2018 at m Nurse #1 obtained fasting of HIGH on Resident #1. pproximately 6:00 am Nurse lood sugar of 508. Nurse #1 s of Novolog ctor of Nursing and Nurse boolcy for "Changes in with a focus on assessment sugar or blood sugar that is er parameter. The re-	MEDICAID SERVICES (*1) PROVIDER:SUPPLEXICLA IDENTIFICATION NUMBER: (*2) MULTIPLE CONSTRUCTION A BUILDING 345362 B. WING STREET ADDRESS, CITY, STATE, ZIP COL 250 BISHOP LANE CONCORD, NC 28025 EMENT/CABARRUS STREET ADDRESS, CITY, STATE, ZIP COL 250 BISHOP LANE CONCORD, NC 28025 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) SC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO ACTION SC IDENTIFYING INFORMATION) EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) SC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ACTION CROSS-REFERENCED TO ACTION CROSS-REFERENCED TO TO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO ACTION TAG STREET ADDRESS, CITY, STATE, ZIP COL 250 BISHOP LANE (CONCORD, NC 28025 TO SOUTH SE ACTION TAG TO THE THE ACTION TO ACTION TAG TO THE THE ACTION TO CROSS-REFERENCED TO ACTION TAG TO THOTO TO ACTION TO ACT ON ACTION TO ACTION TO ACT ON ACTION TO ACTION TAG TO THOTO TO ACTION TO ACT ON ACT	MEDICAID SERVICES OVE (x1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) (x3) (x3) (x3) (x3) (x3) (x3) (x3)		

Facility ID: 952981

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345362	B. WING			C 08/23/2018	
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS			250 BISHOP LANE CONCORD, NC 28025		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR L	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	included the 5 steps r administration, to incl physician orders prior or performing of fastir of facilities licensed n in-service as of 8/23/ ⁷ No staff shall work aff this education. This e the Facility Orientatio and agency staff to be beginning work after a The monitoring proce of correction is effecti deficiency cited rema compliance with the r On 8/24/18 a new pro- the morning clinical m 12 weeks. This will ir Director of Nursing ar residents identified wi fasting blood sugars a following process was implemented. The attending physici blood sugar outside p and/or change condit The physician orders and/or insulin are bein Residents receiving in sugars had current ph The Director of Nursin	regarding medication ude validation of resident to administration of insulin ing blood sugars. Twenty-two urses received the 18. ter 8/23/18 before receiving ducation has been added to in program for all new hires e completed prior to 8/23/18. dure to ensure that the plan ve, and that specific ins corrected and/or in egulatory requirements; becess will be initiated during neeting 5 times per week for include a review, by the nd Nurse Managers, of ith physician orders for and/or insulin to validate the s completed as an was notified of fasting bysician order parameters ion. for fasting blood sugars ing followed.	F	684			

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2018 // APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345362		B. WING			_	C 08/23/2018		
NAME OF PF	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STA	TE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT/CABARRUS			50 BISHOP LANE ONCORD, NC 28025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	584				

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