CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0338-039 STATEMENT OF PERCENCES 029 MUTHE CONSTRUCTION 029 MUTHE CONSTRUCTION 020 MUTHE CONSTRUCTION	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			F	ORM APPROVED
AND PLAN OF CORRECTION IDENTFICATION NUMBER: A BUILDING COMPLETED 348317 NUME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 3P CODE C BRIAN CENTER HLTH & RETIREMENT STREET ADDRESS, CITY, STATE, 3P CODE COMPLETED CAN D PLAN OF ORGENEST IN NOT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 3P CODE COMPLETED PRETIX SUMMARY STATEMENT OF DEFICIENCIES If Complete Status of CORRECTION COMPLETED Yad SUMMARY STATEMENT OF DEFICIENCIES If Complete Status of CORRECTION COMPLETED Yad SUMMARY STATEMENT OF DEFICIENCIES If Complete Status of Correct Status of Correct Status of Correct Status of Correct Status Status Complete Status of Correct Status Complete Status Complete Status of Correct Status Complete Status of Correct Status Complete S	CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OME	3 NO. 0938-0391
345317 NMRE OF PROVIDER OR SUPPLIER STREET AUDRESS, CITY, STATE, 2P CODE BRAN CENTER HLTH & RETIREMENT SUBJARY TAGE SUBJARY PAGE SUBJARY PAGE SUBJARY PAGE SUBJARY STATEMENT OF DEPICENCIES SUBJARY PAGE The SUB				` '			COMPLETED
BRIAN CENTER HLTH & RETIREMENT 246 DARY ROAD CLATON, NC 27520 OMJID PHERK TAG SUMMARY STATEMENT OF DEPICIENCIES (EAULOSCIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG CANON INC 27520 F 000 INITIAL COMMENTS F 000 PREFIX TAG F 000 INITIAL COMMENTS F 000 The surveyor entered the facility on 10/30/18 to conduct a compliant investigation and exited on 10/37/18. Additional information was obtained on 11/5/18 and 11/9/18. Therefore, the exit date was changed to 11/9/18. F 000 F 580 SS=D CFR(s): 483.10(g)(14)(0)-(V)(15) F 580 F 580 11/21/18 GLAR DEVICES (A) A accident involving the resident representative(5) when there is- (A) A na accident involving the resident which results in injury and has the potential for requiring physician intervention: (B) A significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications): (C) A need to allow free treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in \$483.15(c)(10); (B) The facility must also promptly notify the resident from the facility as specified in \$483.45(c)(10); (B) The facility must also promptly notify the resident from the facility as specified in \$483.45(c)(10); (C) A head to also representative, if any, when there is- (A) A change in room or roommate assignment III A change in room or roommate assignment			345317	B. WING			-
BRANCENTER HLTH & RETIREMENT CLAYTON, NC 27520 (04)10 PREFIX TW Isoundary Statement of Deficiencies (EACH Deficiency Must Be Intelesce as YPUL) RECULATION: ON LSC DENTIFYING INFORMATION) ID PREFIX PREFIX PROVIDERS FUN OF CORRECTION (EACH DEFICIENCIES) 09. (00.00000000000000000000000000000000	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAYTOR, NC 27520 PRETRY TAG SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PRETRY TAG D PRET	BRIAN CE	NTER HI TH & RETIREM	IENT				
PREFX TAG (EACH DEFICIENCY MULT BE PRECIDED BY FULL REGULTORY OR LS: DEFINITIVING INFORMATION) PREFIX TAG (EACH OBFICIENC ACTION SHOLD DBE CROSS REFERENCED to THE APPROPRIATE COMPLETION DEFICIENCY F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 The surveyor entered the facility on 10/30/18 to conduct a complaint investigation and exited on 10/31/18. Additional information was obtained on 11/5/78 and 11/9/18. Therefore, the exit date was changed to 11/9/19. Therefore, the exit date was changed to 11/9/19. Therefore, the exit date was changed to 11/9/19. Therefore, the exit date was changed to the adverse consequences, or to commence a new form of treatment); or (10) A decision to tarafser or discharge the resident from the facility must also promptly notify the resident from the facility must also promptly notify the resident and the resident rep	BRIANCE				CLAYTON, NC 27520		
The surveyor entered the facility on 10/30/18 to conduct a complaint investigation and exited on 10/31/18. Additional information was obtained on 11/5/18 and 11/9/18. Therefore, the exit date was changed to 11/9/18. 11/21/18 F 580 Notify of Changes (Injury/Decline/Room, etc.) F 580 SS=0 CFR(s): 483.10(g)(14)(i)-(iv)(15) F 580 (i) A facility must immediately inform the resident; consult with the resident's physician, and notify, consistent with the or exident with changes. (i) A facility must immediately inform the resident representative(s) when there is- (A) An accident involving the resident vinch resident is in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a a deterioration in the ating room of treatment due to alter treatment significantly (that is, a a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(2) is available and provided upon request to the physician, metal al pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician, and provided upon request to the physician, and provided upon request to the physician, and provided upon request to the physician. (ii) The facility must also promptly notify the resident and here is more representative, if any, when there is.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
conduct a complaint investigation and exited on 10/31/18. Additional information was obtained on 11/5/18 and 11/9/18. Therefore, the exit date was changed to 11/9/18. 11/21/18 F 580 CFR(s): 483.10(g)(14)(i)-(iv)(15) F 580 SS=0 CFR(s): 483.10(g)(14)(i)-(iv)(15) \$483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident thick is, a deterioration in health, metal, or psychosocial status in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, metal, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in \$483.15(c)(1)(i). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in \$483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 000	INITIAL COMMENTS		F 0	00		
F 580 SS=D Notify of Changes (Injury/Decline/Room, etc.) F 580 11/21/18 SS=D CFR(s): 483.10(g)(14)(i)(i)(i)(15) F 580 11/21/18 \$483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is. (A) A change in room or roommate assignment Image: Complex c		conduct a complaint i 10/31/18. Additional 11/5/18 and 11/9/18.	nvestigation and exited on information was obtained on				
 (i) A facility must immediately inform the resident; consistent with the relation is physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (ii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment 		Notify of Changes (In		F 5	80		11/21/18
		 (i) A facility must imm consult with the residu consistent with his or representative(s) whee (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosocc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to advec commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and proving physician. (iii) The facility must a resident and the residow when there is- 	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in 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 lent representative, if any,				
			-		דודו ר		

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.

11/19/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/12/201 RM APPROVE <u>O. 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 11/09/2018	
		345317	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER HLTH & RETIREM	IENT			04 DAIRY ROAD CAYTON, NC 27520		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that compris part, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT	10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and	F	580			
	facility staff, radiology physician, the facility physician of the radio performed on 1 of 3 m #1). The findings included Resident #1 was adm Her cumulative diagn kidney disease requir diabetes, and corona recent history of coro (CABG) of two blood A review of Resident Data Set (MDS) asse	failed to promptly notify the logy results from an x-ray esidents reviewed (Resident : hitted to the facility on 9/5/18. oses included end-stage ing hemodialysis, Type 2 ry artery disease with a nary artery bypass grafting vessels. #1 's admission Minimum ssment dated 9/12/18			Resident #1 was discharged from the facility on October 22nd 2018. Current residents have the potential the affected by the same alleged deficien practice. Radiology reports from 10/14 thru 11/14/18 of current residents wer reviewed by the Director of Nursing of 11/19/18 to ensure there were no radiology reports the physician was n aware of or not notified timely. No negative findings were noted. Systemic measures implemented to ensure the same alleged deficient pra- does not recur include: November 1st 2018 the Assistant Direct	o be t 4/18 re n ot ot	
	revealed the resident	had intact cognitive skills for			of Nursing started educating the licen	sed	

Facility ID: 922982

If continuation sheet Page 2 of 11

(EACH DEFICIENC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317 ENT ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	A. BUILDING B. WING S 2	E CONSTRUCTION ESTREET ADDRESS, CITY, STATE, ZIP CODE ENDINE CODE ESTREET ADDRESS, CITY, STATE, ZIP CODE ESTREET ADDRESS,	(X3) DATE SURVEY COMPLETED C 11/09/2018
SUMMARY ST SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ENT ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	04 DAIRY ROAD CLAYTON, NC 27520	-
SUMMARY ST SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	04 DAIRY ROAD CLAYTON, NC 27520	
SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	CLAYTON, NC 27520	
(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT	
ontinued From page			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
Attensive assistance ressing, eating, and ssessed to be totally bileting and locomoti review of the reside accluded the following ag docusate (a stool ablet by mouth two ti banagement, hold fo (12/18). Review of a grievance uthored by the facilit DON) was conducted ehalf of Resident #1 f the resident ' s stor he was turned in bec uring early morning esident went to an ou in 10/19/18. After re esident #1 reported eport stated, "Nurse	 Resident #1 required with bed mobility, transfers, personal hygiene; she was a dependent on staff for on off the unit. ent 's physician orders medications, in part: 100 softener) to be given as one mes a day for bowel r diarrhea (initiated on e report (dated 10/19/18) ry 's Director of Nursing d. This report was filed on and indicated the left side mach hit the bed rail when d for patient care on 3rd shift hours of 10/19/18. The utside physician consultation turning to the facility, ly complained of pain. The notified MD (Medical 	F 580	nurses on timely notification of radio reports to the physicians. The educe was completed on November 15th 2 Newly hired licensed nurses will red this education by the Director of Nursing/designee during the orienta process. On November 1st 2018 the Director Nursing and the Assistant Director of Nursing implemented taking the rad reports to the clinical start up meetin The results will be reviewed to ensu- there is documentation by the license nurse that the physician was notified the results. The clinical start-up mee- occurs Monday thru Friday. The rev- radiology reports will be completed weekend by the Registered Nurse of This process will ensure daily monit This monitoring will be on-going. Ne- findings will be addressed when not	ation 2018. ceive ation r of of diology ng. ure sed d of eting view of on the on call. toring. egative ted. nd y
bdominal x-ray obtai esults were electroni adiologist on 10/19/1 ne-page written repor ritten in capital letter age. It read: Results: There is mil ponsistent with ileus (Report of a 1-view ined on 10/19/18. The cally signed by the 8 at 7:28 PM. The ort included the word "alert" rs diagonally across the d colonic dilatation a medical term for the lack		Interdisciplinary Team weekly times weeks, biweekly times 2 and month times 3. Additional interventions will implemented by the Interdisciplinary if deemed necessary. The results of the weekly, biweekly monthly audits will be reviewed by t Quality Assurance Performance Improvement committee monthly fo	nly I be y Team and the or 3
	sident went to an or 10/19/18. After re- sident #1 reported port stated, "Nurse octor) of pain and al d completed." review of Resident cluded a Radiology dominal x-ray obtai sults were electroni diologist on 10/19/1 e-page written repo- titten in capital letter ge. It read: esults: There is mil nsistent with ileus (movement somewi	eview of Resident #1 's medical record cluded a Radiology Report of a 1-view dominal x-ray obtained on 10/19/18. The sults were electronically signed by the diologist on 10/19/18 at 7:28 PM. The e-page written report included the word "alert" itten in capital letters diagonally across the	sident went to an outside physician consultation 10/19/18. After returning to the facility, soldent #1 reportedly complained of pain. The port stated, "Nurse notified MD (Medical octor) of pain and abdominal x-ray was ordered d completed." review of Resident #1 's medical record cluded a Radiology Report of a 1-view dominal x-ray obtained on 10/19/18. The sults were electronically signed by the diologist on 10/19/18 at 7:28 PM. The e-page written report included the word "alert" itten in capital letters diagonally across the ge. It read: esults: There is mild colonic dilatation nsistent with ileus (a medical term for the lack movement somewhere in the intestines that	sident went to an outside physician consultation 10/19/18. After returning to the facility, sident #1 reportedly complained of pain. The bort stated, "Nurse notified MD (Medical actor) of pain and abdominal x-ray was ordered d completed."This monitoring will be on-going. No findings will be addressed when no The results of the clinical start up a weekend monitoring of the radiolog reports and timely notification of the physician will be reviewed by the Interdisciplinary Team weekly times 2 and month times 3. Additional interventions will implemented by the Interdisciplinary if deemed necessary.weither in capital letters diagonally across the ge. It read: esults: There is mild colonic dilatation nsistent with ileus (a medical term for the lack movement somewhere in the intestines thatThis monitoring will be on-going. No findings will be addressed when no the findings will be addressed when no the addressed when no the results of the clinical start up a weekend monitoring of the radiolog reports and timely notification of the physician will be reviewed by the Interdisciplinary Team weekly times 2 and month times 3. Additional interventions will implemented by the Interdisciplinary if deemed necessary.The results of the weekly, biweekly monthly audits will be reviewed by the guality Assurance Performance Improvement committee monthly for months to determine the effectivend

Facility ID: 922982

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/12/20 FORM APPROVE MB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTR	RUCTION	(X3) DATE SURVEY COMPLETED
		345317	B. WING				C 11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET AL	DDRESS, CITY, STATE, ZIP COI	DE	
BRIAN CE	INTER HLTH & RETIREN	IENT		204 DAIRY CLAYTO	Y ROAD N, NC 27520		
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
F 580	significant pathologic moderate amount of Conclusion: Mild colo Moderate amount of An undated handwritt Report read, "Called (docusate); check for abbreviation for Clost that may cause diarrh serious intestinal con A review of Resident included a Nursing N PM. The note indicat member was called a transfer Resident #1 's physician was con transferred to the hos 10/21/18. An interview was con PM with a representative contracted radiology representative report capital letters diagonar report meant, "What y positive on the diagnar representative also st auto-faxed to the faci fax) on 10/19/18 at 7: representative provid was sent to. During an interview c	small bowel loops are e is no soft tissue mass or calcification. There is a colonic and rectal stool. onic ileus colonic and rectal stool." ten notation on the Radiology to MD; Hold Colace • C.diff." C. diff is an tridium difficile, a bacteria nea and potentially more ditions. #1 's medical record ote dated 10/21/18 at 10:18 ted the resident 's family and a request was made to to the hospital. The resident tacted and the resident was spital at 8:00 PM on ducted on 10/31/18 at 3:20 tive from the facility 's service. Upon inquiry, the ed the word "alert" written in ally across the radiology you are looking for is osis." The radiology	F 5	Perfo monit Addit and it subst	ormance Improvement c itor for any negative patt itional interventions will b implemented as needed stantial compliance. Administrator is respons ementation of this plan o	terns/trends be develope I to sustain sible for	d

Facility ID: 922982

If continuation sheet Page 4 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345317	B. WING				C 09/2018
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				:	204 DAIRY ROAD		
BRIAN CE	NTER HLTH & RETIREM	ENI			CLAYTON, NC 27520		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580	Resident #1 's Radio 10/19/18. An interview was com PM with Nurse #1. N nurse who was assign on 10/19/18, 10/20/18 was also the nurse wit the hospital on 10/21/ confirmed the handwin 10/19/18 Radiology R 10/21/18. During a fo on 10/31/18 at 4:00 P was unsure of the exa Report was received. was found on the faci on 10/21/18 during 2r PM). A telephone interview at 12:21 PM with the (and physician for Re interview, the physicia alert noted on the rad have been notified of x-ray, "sooner than 2 physician indicated he anything differently if radiology results soor 10/21/18). However, liked to have asked the assessment question became available. He a lot of things." The p based on his understa condition on 10/19/18 would have made the	adiology service to send logy Report to the facility on ducted on 10/30/18 at 4:09 urse #1 was the 2nd shift ned to care for Resident #1 3 and 10/21/18. Nurse #1 ho sent the resident out to (18. Upon inquiry, the nurse ritten notations on the Report were made by her on ollow-up interview conducted M, Nurse #1 reported she act time when the Radiology The nurse stated the report lity 's backup fax machine nd shift (3:00 PM - 11:00 was conducted on 10/31/18 facility 's Medical Director sident #1). During the an stated if there was an iology report, he should the results of the resident 's days." When asked, the e may not have done he had been notified of the ner than he was (on he stated he would have he nurse some patient s when the radiology report e reported, "Ileus can mean hysician indicated that anding of the resident 's a and 10/20/18, he likely s ame treatment decisions	F	580			
	condition on 10/19/18 would have made the	and 10/20/18, he likely					

Facility ID: 922982

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		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	D
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345317	B. WING		11/09/2018	
NAME OF PF	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HLTH & RETIREM	ENT		204 DAIRY ROAD CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		I
F 580	docusate and to test f An interview was con PM with the facility 's Director of Nursing (A interview, the Adminis asked what their expe- notifying the physician report. They reported did not call with a critic not yet have the radio expected for the nurs within 24 hours.	or C. diff.). ducted on 10/31/18 at 4:40 Administrator and Assistant	F 580		11/21/18	
SS=D	CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a residents that residents received accordance with profer practice, the compreh- care plan, and the residents This REQUIREMENT by: Based on staff and precord views from the 's office, the facility far new physician 's order recommendations may for the treatment of a to provide treatments accordance with the precord set of the treatments the precord of the treatment of the treatmen	ndamental principle that Int and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. T is not met as evidenced hysician interviews, and facility and cardiac surgeon ailed to accurately initiate		Resident #1 was discharged from the facility on October 22nd 2018. Current residents have the potential to affected by the same alleged deficient practice. Physician consults from 10/14/18 thru 11/14/18 of current residents were reviewed by the Director of Nursing on 11/19/18 to ensure new physician orde	be	

Facility ID: 922982

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/12/20 FORM APPROVE OMB NO. 0938-039	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345317	B. WING		C 11/09/2018	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	NTER HLTH & RETIREN			204 DAIRY ROAD		
			CLAYTON, NC 27520			
(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 COMPLETION	
F 684	Continued From page	- 6	F 684	4		
	The findings included		1 00-	were transcribed correctly. The		
	The infantys included			medication administration reco		
	Resident #1 was adm	nitted to the facility on 9/5/18.		treatment administration record		
	Her cumulative diagn	oses included end-stage		10/14/18 thru 11/14/18 were a	lso	
	-	ring hemodialysis, Type 2		reviewed by the Director of Nu	rsing at this	
		ry artery disease with a		time to identify any missing		
	-	nary artery bypass grafting		documentation. Negative findin	ngs were	
	(CABG) of two blood	vessels.		addressed when/if noted.		
	A review of Resident	#1 's admission Minimum				
		essment dated 9/12/18		Systemic measures implemen		
		had intact cognitive skills for		ensure the same alleged defic	ient practice	
		 Resident #1 required with bed mobility, transfers, 		does not recur include:		
		personal hygiene; she was		November 1st 2018 the Assist	ant Director	
		y dependent on staff for		of Nursing started educating th		
		ion off the unit. Section M of		nurses regarding physician co		
		t revealed Resident #1 was		accurate transcription of physi		
		I wounds and received		The Assistant Director of Nurs	-	
	surgical wound care	at the facility.		educated licensed nurses rega	-	
	A roviow of the reside	ent 's care plan included the		completion of documentation a The education was completed		
	following areas of foc	-		November 15th 2018. Newly h		
		: [Resident ' s name] has		licensed nurses will receive the		
		skin integrity of the left leg		by the Director of Nursing/des		
	and sternum related t	to being status post CABG.		the orientation process.		
	A review of Resident	#1 ' s medical record		On November 1st 2018 the Di	rector of	
		on-Pressure Condition		Nursing and the Assistant Dire		
		The resident was noted to		Nursing implemented taking th		
		with a surgical incision		consults to the clinical start up	u	
		red as 18.5 centimeters (cm)		review to ensure the consulting		
	• •	of the surgical incision were		orders are transcribed correct		
		approximated with 17 strips. No drainage noted,		the clinical meeting documenta medication/treatment records		
	slight redness around			reviewed for missed entries. T		
	engine roundoo aroune			start-up meeting occurs Monda		
	Further review of the	resident 's medical record		Friday. This review will be com	-	
	included a Progress I	Record dated 9/12/18 from		the weekend by the Registere	-	

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONTRACTION		A. BUILDING		C
		345317	B. WING		11/09/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER HLTH & RETIREM	IENT		204 DAIRY ROAD CLAYTON, NC 27520	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 684	Continued From page	e 7	F 684		
	an outside consultations in a outside consultation is office. This record in not progressing as de recommendations may office included applying times a day at the disincision. Notes indicates a seen for follow-up at the in one week. A review of the resider Treatment Administration from 9/12/18 (to 9/19), distal end of the surging wet to dry dressing where the dry dressing should be of needed every day shift review of the Septerm treatment was completed of the surging documented as comparesident) on 9/14/18, Resident #1 's medic Progress Record date consultation with her This record reported the sternal wound was not and appeared to have well as deeper. The slough as well as a semade from the surged applying and changing the sternal wound was mage applying and changing the sternal wound was maged to thave the sternal wound was maged to the sternal wound was m	on with her cardiac surgeon ' reported the resident was esired. Written ade from the surgeon 's ing wet to dry dressings three tal end of the sternal ted the resident was to be the cardiac surgeon 's office ent 's September 2018 tion Record (TAR) revealed (18) an order to cleanse the ical incision and pack with as only scheduled once daily The TAR indicated the hanged every day and "as ift for surgical care". Further ber 2018 TAR revealed the eted once daily on 9/13/18, 9/19/18. However, jical incision was not bleted (or refused by the 9/15/18, or 9/18/18. eal record included a ed 9/19/18 from another cardiac surgeon 's office. the resident was seen for a The record indicated her of progressing as desired e become bigger in size as wound was noted to have cab. Recommendations	F 084	 call. This process will ensure daily monitoring. This monitoring will be on-going. Negative findings will be addressed when/if noted. The results of the clinical start up m and weekend monitoring of consult physician orders and medication/treatment record complwill be reviewed by the Interdisciplin Team weekly times 4 weeks, biweet times 2 and monthly times 3. Additi interventions will be implemented be Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly biweekly biweekly monthly audits will be reviewed by the Interdisciplinary Team if deemed necessary. Monitoring: The Administrator is responsible for implementation of this plan of correlation implementation of this plan of correlation implementation of this plan of correlation intervention is plan of correlation of this plan o	r r r r r

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/12/2018 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	
		345317	B. WING			C 11/09/2018	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				:	204 DAIRY ROAD		
BRIAN CE	BRIAN CENTER HLTH & RETIREMENT				CLAYTON, NC 27520		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	revealed on 9/19/18 a end of the surgical ind dry dressing was sche at 7:00 AM and 3:00 F September 2018 TAR Resident #1 ' s surgic documented as comp resident) on 9/20/18 at 3:00 PM, 9/24/18 at 3 9/26/18 at 3:00 PM, 9 9/27/18 at 3:00 PM. A grievance report da behalf of Resident #1 indicated concern was member in regards to changes. The docum grievance/complaint a was authored by the f Director of Nursing (D treatments were ackn missed at that point in practice to place the 2 treatments on the ress Administration Record shift nurse would not was due. Further rev September 2018 TAR practice was initiated A telephone interview at 1:35 PM with the fa who also served as R When asked, the phys #1 ' s cardiac surgeor for her incision wound recommendations ma	ant 's September 2018 TAR an order to cleanse the distal cision and pack with wet to eduled twice daily each day PM. Further review of the a revealed the treatment for al incision was not leted (or refused by the at 3:00 PM, on 9/21/18 at :00 PM, 9/25/18 at 3:00 PM, /27/18 at 7:00 AM, or ted 9/24/18 and filed on was reviewed. The report is expressed by a family Resident #1 's dressing tentation of the and facility follow-up report facility 's Administrator and DON). Two missed owledged as having been in time. The facility initiated a 2nd shift wound care ident 's Medication d (MAR) to ensure the 2nd miss seeing that a treatment iew of Resident #1 's and MAR revealed this	F	684	4		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
	OURILETION	BENTH IOATION NOMBER.	A. BUILD	ING	<u> </u>		C
		345317	B. WING				09/2018
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HLTH & RETIREM	ENT			204 DAIRY ROAD		
	1				CLAYTON, NC 27520		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	9	F	684	34		
	to be initiated and foll	owed.					
	An interview was com PM with the facility 's Director of Nursing (A interview, the facility ' (Nurse #2) was identi who had transcribed I wound treatment order three times daily as re- surgeon 's office). Up her expectation 'woul recommendation) to b Doctor), verified, and During the interview of 4:40 PM, the Adminis the facility did identify treatments for Reside facility started includin needing to be done by resident 's MAR to al these. When asked, no plans were current treatments were comp physician 's orders of Assurance and Perfor (QAPI) committee. U Administrator stated s wound care treatment A telephone interview at 3:04 PM with the N saw Resident #1 while cardiac surgeon 's of inquiry, the NP review resident 's wound an recommendations/ord	ducted on 10/31/18 at 4:40 a Administrator and Assistant ADON). During the s former wound care nurse fied as the staff member Resident #1 ' s 9/12/18 ers as once daily (versus ecommended by the cardiac bon inquiry, the ADON stated ld be for it (the wound care be called to our MD (Medical transcribed as written." conducted on 10/31/18 at trator and ADON reported two missed wound care ent #1. They stated the ng wound care treatments y the 2nd shift nurse on the ert nurses to complete the Administrator reported tly in place to ensure wound pleted in accordance with r to involve the Quality rmance Improvement pon inquiry, the she would have expected ts, "To be done as ordered." was conducted on 11/5/18 lurse Practitioner (NP) who e she was followed at the fice for wound care. Upon wed the progression of the					

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	345317		B. WING		_	C 11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
BRIAN CE	ENTER HLTH & RETIREM	ENT		204 DAIRY ROAD CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	
F 684	the 9/12/18 office visi dry dressing needed daily. This recomment writing to the facility. she recalled having a from the facility with of possibly a change of the NP stated, "Absol A telephone interview at 3:30 PM with the fa nurse (Nurse #2). Du reported she did not se #1. Upon inquiry, the questions (in general recommendations/or office about the frequ When asked, the nurse continued to be follow surgical wound care, surgeon 's recommendations/or	tated it was determined at t that the resident 's wet to to be completed three times indation was relayed in When the NP was asked if ny calls or communication questions, concerns, or orders to the wound care, utely not." was conducted on 11/5/18 acility 's former wound care tring the interview, Nurse #2 specifically recall Resident in nurse did not recall any being raised in relation to ders from a surgeon 's ency of dressing changes. Se reported if a resident wed by the surgeon for the facility would follow the indations as orders because e considered the primary	F 68	4		

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