BRIAN CENTER(X4) ID PREFIX TAGInitialE 000InitialE 000InitialF 000An contraction facial requerts Prej INITF 000The contraction contraction Prej INITF 000The contraction contraction contraction Contraction Prej INITF 000The contraction <br< th=""><th>(EACH DEFICIENCY REGULATORY OR L tial Comments in unannounced reconducted on 7/11/21 cility was found in conducted on 7/11/21 cility was found in conducted on CFR 483 eparedness. Event ITIAL COMMENTS the survey team enter conduct a recert an ited on 7/15/21. Act tained on 7/21/21. E anged to 7/21/21. E</th><th>ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ertification survey was through 7/15/21. The ompliance with the .73, Emergency ID #T7WX11. ered the facility on 7/11/21 id complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR</th><th>B. WING ST 20</th><th>TREET ADDRESS, CITY, STATE, ZIP CODE 14 DAIRY ROAD LAYTON, NC 27520 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE API DEFICIENCY)</th><th>HOULD BE COMPLETION</th></br<>	(EACH DEFICIENCY REGULATORY OR L tial Comments in unannounced reconducted on 7/11/21 cility was found in conducted on 7/11/21 cility was found in conducted on CFR 483 eparedness. Event ITIAL COMMENTS the survey team enter conduct a recert an ited on 7/15/21. Act tained on 7/21/21. E anged to 7/21/21. E	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ertification survey was through 7/15/21. The ompliance with the .73, Emergency ID #T7WX11. ered the facility on 7/11/21 id complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR	B. WING ST 20	TREET ADDRESS, CITY, STATE, ZIP CODE 14 DAIRY ROAD LAYTON, NC 27520 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
BRIAN CENTER(X4) ID PREFIX TAGInitialE 000InitialE 000InitialF 000An contraction facial requerts Prej INITF 000The contraction contraction Prej INITF 000The contraction contraction contraction Contraction Prej INITF 000The contraction 	ER HEALTH & RETIRI 	EMENT CLAYTON 	E 000	A DAIRY ROAD LAYTON, NC 27520 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	ECTION (X5) HOULD BE COMPLETION
BRIAN CENTER(X4) ID PREFIX TAGInitialE 000InitialE 000InitialF 000An contraction facial requerts Prej INITF 000The contraction contraction Prej INITF 000The contraction contraction contraction Contraction Prej INITF 000The contraction 	ER HEALTH & RETIRI 	ATEMENT OF DEFICIENCIES 	E 000	A DAIRY ROAD LAYTON, NC 27520 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	HOULD BE COMPLETION
(X4) ID PREFIX TAGInitialE 0000InitialE 0000InitialF 0000InitialF 0000InitialThe to col exite obtain chailF 0000The to col exite obtain chailF 0000The to col exite obtain chailF 0000The to col exite obtain chailF 0000The to col exite obtain chailF 0000The to col exite obtain chailF 5500Res	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L tial Comments in unannounced reconducted on 7/11/21 cility was found in ca quirement CFR 483 eparedness. Event ITIAL COMMENTS in e survey team enter conduct a recert an ited on 7/15/21. Ac tained on 7/21/21. E anged to 7/21/21. E	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ertification survey was through 7/15/21. The ompliance with the .73, Emergency ID #T7WX11. ered the facility on 7/11/21 id complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR	E 000	LAYTON, NC 27520 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	HOULD BE COMPLETION
F 000 Initia F 000 Initia An cone facil requ Prej F 000 INIT The to co exite obta chai Pas 483 The Care 4 of sub: F 550 Res	(EACH DEFICIENCY REGULATORY OR L tial Comments in unannounced reconducted on 7/11/21 cility was found in conducted on 7/11/21 cility was found in conducted on CFR 483 eparedness. Event ITIAL COMMENTS the survey team enter conduct a recert an ited on 7/15/21. Act tained on 7/21/21. E anged to 7/21/21. E	ertification survey was through 7/15/21. The ompliance with the .73, Emergency ID #T7WX11. ered the facility on 7/11/21 id complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR	E 000	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	HOULD BE COMPLETION
An condition facili requ Prej F 000 INIT The to condition obtain chart Pas 483 The Cart 4 of subsise F 550 Res	n unannounced reconducted on 7/11/21 cility was found in conducted on 7/11/21 cility was found in conducted and the survey team enter conduct a recert and team enter conduct a recert and team on 7/15/21. Act tained on 7/21/21. Enter anged to 7/21/21. Enter the survey for the survey for the survey team enter conduct a recert and team enter conduct a	through 7/15/21. The ompliance with the .73, Emergency ID #T7WX11. ered the facility on 7/11/21 id complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR			
F 000 F 000 F 000 F 000 F 000 F 000 F 000 F 000 F 000 F 550 Res	nducted on 7/11/21 cility was found in co quirement CFR 483 eparedness. Event ITIAL COMMENTS ne survey team ente conduct a recert an ited on 7/15/21. Ac tained on 7/21/21. anged to 7/21/21. E	through 7/15/21. The ompliance with the .73, Emergency ID #T7WX11. ered the facility on 7/11/21 id complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR	F 000		
to cr exite obta char Pas 483 The Carr 4 of subs F 550 Res	conduct a recert an ited on 7/15/21. Ac tained on 7/21/21. anged to 7/21/21. E	d complaint survey and Iditional information was Therefore, the exit date was Event ID# T7WX11. was identified at: CFR			
483 The Card 4 of sub: F 550 Res	•				
sub F 550 Res	e tag F684 constitu	a scope and severity (J). ted Substandard Quality of rvey was conducted.			
33-0 011	of the 10 complaint bstantiated resulting esident Rights/Exerc FR(s): 483.10(a)(1)(	g in deficiencies. cise of Rights	F 550		8/2/21
The self- acce outs	lf-determination, an cess to persons and	Rights. ht to a dignified existence, d communication with and d services inside and cluding those specified in			
with resid pror her indiv	th respect and digni sident in a manner a pmotes maintenanc r quality of life, reco	y must treat each resident ity and care for each and in an environment that e or enhancement of his or ognizing each resident's ity must protect and the resident.			

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.

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROV MB NO. 0938-03	/ED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED	
		345317	B. WING			C 07/21/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	NTER HEALTH & RETIR			204 DAIRY ROAD			
DIVIANOL				CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	NC
F 550	Continued From page	1	F	550			
	§483.10(a)(2) The factor access to quality care severity of condition, or must establish and mapractices regarding tra- provision of services of residents regardless of §483.10(b) Exercise of The resident has the or rights as a resident of or resident of the Unit §483.10(b)(1) The factor resident can exercise interference, coercion from the facility. §483.10(b)(2) The resi- free of interference, co- reprisal from the facilit rights and to be suppor exercise of his or her subpart. This REQUIREMENT by: Based on observation interviews, the facility collection bag of an in- for 1 of 4 residents (R indwelling urinary cath The findings included Resident # 56 was add	sility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her the facility and as a citizen ed States. sility must ensure that the his or her rights without , discrimination, or reprisal dident has the right to be percion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced h, record review and staff failed to keep the urine dwelling catheter covered esident #56) reviewed for neter.		F550 Resident Rights/Exercise On 07/11/21, the Assistant Dire Nursing placed a privacy cover collection bag. On 07/11/21, a 100% audit of a with a urinary catheter was com the Assistant Director of Nursing audit was to ensure all urinary of bags were emptied and had a p cover on the collection bag. Th	ector of on the II residents npleted by g. The catheter privacy	5	

Event ID: T7WX11

Facility ID: 922982

If continuation sheet Page 2 of 25

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ATE SURVEY OMPLETED
		345317	B. WING			C
	ROVIDER OR SUPPLIER	040017		STREET ADDRESS, CITY, STATE,		07/21/2021
	ROVIDER OR SOFFLIER			204 DAIRY ROAD	ZIF CODE	
<b>3RIAN CE</b>	ENTER HEALTH & RETIF	REMENT CLAYTON		CLAYTON, NC 27520		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX		N OF CORRECTION E ACTION SHOULD BE	(X5) COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED	D TO THE APPROPRIATE CIENCY)	DATE
F 550	Continued From pag	e 2	F 55	50		
	The admission Minim	num Data Set dated 6/23/21		of Nursing corrected a	ll concerns	
	revealed she was se	verely cognitively impaired		identified during the au		
		g catheter. She required		ensuring all urinary cat	theter bags have a	
	extensive assistance	with activities of daily living.		privacy cover.		
		ed 7/9/21 revealed Resident		An in-service was initia		
		g catheter. The interventions		Development Coordina		
		heter bag and tubing below		with all staff in regardir		
		ler, check tubing for kinks		respect including resid		
	frequently each shift,			include ensuring a priv		
	pain/discomfort due	t to physician for signs or		urinary catheter collect hired staff and contract		
	symptoms of a urinal			in-serviced regarding of		
				including resident priva		
		n from the doorway of		ensuring a privacy cov		
		on 7/11/21 at 4:07 PM with		catheter collection bag	-	
		A) #1, the urinary catheter sible hanging from the side		Development Coordina	ator.	
		as no privacy bag to cover		100% of all residents v	vith a urinary	
		d urine was observed in the		catheter will be monito		
	-	ervation NA #1 stated the bag		Supervisors weekly x 4	•	
		d because she could see the		monthly x 1 month utili		
		e bag. She then stated the		Catheter Audit Tool. Th		
		ed with a privacy cover. She		ensure all urinary cath	-	
	-	hy the privacy cover was not		emptied and had a priv		
	on the collection bag			collection bag. The nu		
	On 7/11/04 -+ 4:40 D			immediately re-trained	-	
		M Nurse #4 stated she 56's catheter bag from the		Supervisor for any ider concern. The Director		
	doorway. She said th	-		review and initial the U		
	-	ed to be emptied. Nurse #4		Audit Tool weekly x 4 v	-	
		ne collection bag should		x 1 month to ensure al	-	
	have a privacy cover	e e e e e e e e e e e e e e e e e e e		were addressed.		
	On 7/11/21 at 4:20 P	M the Assistant Director of		The Director of Nursing	g will present the	
		d not noticed the uncovered		findings of the Urinary		
		his previous visit to Resident		to the Executive Qualit		
	#56's room. He repo	orted the urinary collection		committee monthly for	2 months. The	
	bag should have a p	rivacy cover. He stated the		Executive QA Committ	ee will meet	

Event ID: T7WX11

Facility ID: 922982

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		MEDICAID SERVICES	1			D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY PLETED
		345317	B. WING			C / <b>21/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07	/21/2021
BRIAN CE	NTER HEALTH & RETIR	REMENT CLAYTON		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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 550	privacy covers are pa collection bags, so he privacy cover was no of the nursing staff sh cover was in place.	e 3 ackaged with the urine e did not know why the t present. He indicated any nould ensure the privacy nfidentiality of Records	F 550	monthly for 2 months and review th Urinary Catheter Audit Tools to det trends and/or issues that may need further interventions put into place determine the need for further freq of monitoring.	ermine d and to	8/2/21
	CFR(s): 483.10(h)(1) §483.10(h) Privacy a The resident has a rig	-(3)(i)(ii)				
	telephone communic and meetings of fami	edical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a				
	residents right to pers right to privacy in his written, and electroni the right to send and mail and other letters materials delivered to	cility must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened a, packages and other o the facility for the resident, ered through a means other				
	and confidential pers (i) The resident has the of personal and medi provided at §483.70( federal or state laws.	sident has a right to secure onal and medical records. he right to refuse the release ical records except as i)(2) or other applicable				

Facility ID: 922982

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY IPLETED
		345317	B. WING			C 07/21/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	REMENT CLAYTON	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583	Continued From page	e 4	E E	583			
1 000		ong-Term Care Ombudsman		505			
		t's medical, social, and					
		s in accordance with State					
	law.						
		Γ is not met as evidenced					
	by:						
	Based on observatio	ons staff and resident			F583 Personal Privacy/Confidentiality	/ of	
		failed to lock the electronic			Records		
		n to provide privacy and					
	-	lical records for 1 of 1			On 07/13/21, Nurse #3 locked the 200		
	resident reviewed for	privacy (Resident #25).			medication cart⊡s computer screen. T		
	Einstein aus im also die de				Director of Nursing educated Nurse #3		
	Findings included:				ensuring the medication cart s composite screen remained locked with not in us		
	Resident #25 was ad	lmitted to the facility on			screen remained locked with hot in us	с.	
		25's active diagnoses			On 07/13/21, a 100% audit of all		
		tery disease, heart failure,			medication cart s and nurse stations	with	
		perlipidemia, and thyroid			computer screens was conducted by t	he	
	disorder.				Assistant Director of Nursing and Dire	ctor	
					of Nursing. The audit was to ensure a		
		num data set assessment			computer screens were locked and di	d	
		ed she was assessed as			not display resident information. The		
	cognitively intact.				Director of Nursing and Assistant Dire	ctor	
	During on choon/otio	n on 7/12/21 at 2:11 DM tha			of Nursing corrected all concerns		
	-	n on 7/13/21 at 2:11 PM the cart was observed against			identified during the audit to ensure al computer screens were locked and die		
		a computer mounted on the			not display resident information.	4	
		h was positioned to face the			not alopidy rookont information.		
		entrance. The medication			An in-service was initiated by the Staf	f	
		by staff and the screen was			Development Coordinator on 07/14/21		
	observed to have the	e photo, name, 4			with all staff related to ensuring all		
	-	s, room number, date of			computer screens were locked and die		
		physician, gender, most			not display resident information. All ne	ewly	
		pressure, respirations,			hired staff and contracted staff will be		
	temperature, blood s				in-serviced regarding ensuring all		
	-	nd code status of Resident			computer screens were locked and die		
		screen and was able to be			not display resident information by the	;	
		00 hall hallway and entrance.			Staff Development Coordinator.		

Facility ID: 922982

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 08/25/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X:	B) DATE SURVEY COMPLETED
		345317	B. WING			C 07/21/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON		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 CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 583	Continued From page	• 5	F 58	33		
	cart from a resident's During an interview o			100% of all medication stations with computer monitored by the Nurse weekly x 4 weeks then	screens will be e Supervisors	
	screen was supposed resident information v	l to be locked to not display vhen the nurse left the ended. This was to provide		utilizing the Privacy an Audit Tool. This audit is medication cartors and computer screens rem	d Confidentiality s to ensure all I nurse stations with	
	During an interview o Director of Nursing st	n 7/13/21 at 2:21 PM the ated the computer screens		not in use. The emplo immediately re-trained Supervisor for any ider	yee will be by the Nurse ntified areas of	
	ensure privacy and corresidents. She conclu	en unattended by staff to onfidentiality of records for ided Nurse #3 should have or to leaving the medication		concern. The Director review and initial the P Confidentiality Audit To weeks then monthly x all areas of concerns y	Privacy and bol weekly x 4 1 month to ensure	
	During an interview o Resident #25 stated s her medical information see it. She concluded medical history and s business but her own	she absolutely did not want on left where anyone could I this was because her tatus was not anyone's		The Director of Nursing findings of the Privacy Audit Tool to the Execu Assurance (QAPI) com 2 months. The Executi will meet monthly for 2 the Privacy and Confid to determine trends an may need further inter- place and to determine further frequency of mo	g will present the and Confidentiality utive Quality nmittee monthly for ive QA Committee months and review lentiality Audit Tools id/or issues that ventions put into e the need for	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)	-(3)	F 65	55		8/2/21
	Planning §483.21(a) Baseline §483.21(a)(1) The fac implement a baseline that includes the instr	sive Person-Centered Care Care Plans cility must develop and care plan for each resident uctions needed to provide centered care of the resident				

Facility ID: 922982

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345317	B. WING				_ 21/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	The baseline care pla (i) Be developed with admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac comprehensive care p care plan if the compr (i) Is developed withi admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fa resident and their rep of the baseline care p limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fa on behalf of the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on record revi	al standards of quality care. In must- in 48 hours of a resident's Ium healthcare information y care for a resident ted to- d on admission orders. Hendation, if applicable. cility may develop a plan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary plan that includes but is not f the resident. resident's medications and I treatments to be acility and personnel acting y. mation based on the details e care plan, as necessary. i is not met as evidenced iew and staff interviews the	F	655	F655 Baseline Care Plan		
		lete a baseline care plan					

Facility ID: 922982

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 08/25/202 RM APPROVEI NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		TE SURVEY MPLETED
		345317	B. WING				C 07/21/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				20	4 DAIRY ROAD		
BRIAN CE	NTER HEALTH & RETIR			CL	LAYTON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	Continued From page	~ 7					
F 000	Continued From page		F 6	55			
		mission for 3 of 5 residents			On 07/12/21, a baseline care plan wa		
		e care plans (Resident #166,			created and entered into the electron	IC	
	Resident #168, and F	Resident #316).			health record for Resident #166.		
	Findings included:				On 07/13/21, a baseline care plan wa	as	
	0				created and entered into the electron		
	1. Resident #166 was			health record for Resident #316.			
	7/9/21. Resident #16	6's active diagnoses					
	included transient cer	rebral ischemic attack,			On 07/13/21, a 100% audit of all resi	dent	
	nontoxic single thyroi	id nodule, gastro-esophageal			care plans was completed by the MD	S	
	reflux disease, hyper	tension, hyperlipidemia, and			Coordinator. This audit was to ensur	e	
	anemia.				that all residents have a baseline car	е	
					plan entered into the electronic healt		
		lent #166's chart on 7/12/21			record within 48 hours or admission.		
		dent's chart did not have a			MDS Coordinator corrected all conce	erns	
	care plan.				identified during the audit to include		
					ensuring that all residents have a bas	seline	
		on 7/12/21 at 11:37 AM the			care plan entered into the electronic		
		tated the unit manager or, if			health record within 48 hours or		
	the unit manager wor				admission.		
	-	complete baseline care plans			An in complete the initiated by the MC		
		mission. The Director of			An in-service was initiated by the MD		
		hit manager was working the			Nurse and Staff Development Coord on 07/13/21 with all licensed nurses		
	-	agement should have			regards to ensuring that all residents		
		ne care plan. Upon checking			a baseline care plan entered into the		
	-	she concluded a baseline			electronic health record within 48 hou		
		en completed within the 48			admission. This in-service emphasize		
	hours.				checking completing the initial baseli		
		s readmitted to the facility on			care plan in the electronic health reco		
		noses including failed			within 48 hours for all admissions. A		
	pancreas (a gland wh				newly hired nurses and contracted nu		
		ncontrolled type 1 diabetes			will be in-serviced regarding complet	ing	
		ndition where the pancreas			the initial baseline care plan in the		
	produces little or no i	nsulin).			electronic health record within 48 hou	urs	
					for all admissions by the Staff Facilitation	ator	
	The discharge minim	um data set (MDS)			or MDS Nurse.		
		dent #168 dated 07/06/2019					
	indicated he was mod	derately impaired for daily			100% of all residents will be monitore	ed by	

Facility ID: 922982

If continuation sheet Page 8 of 25

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SUR	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETI	
		345317	B. WING		С	
		545517	D. WING	STREET ADDRESS, CITY, STATE, ZI	07/21/2	2021
NAME OF P	ROVIDER OR SUPPLIER			204 DAIRY ROAD	PCODE	
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON		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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE CO O THE APPROPRIATE	(X5) DMPLETIO DATE
F 655	Continued From page	28	F 65	55		
1 000	10	rther indicated he received	FU	the Nurse Supervisors w	eekly x 1 weeks	
		it of 7 look back period days.		then monthly x 1 month		
				Baseline Care Plan Audi		
		#168's medical record		is to ensure that all resid		
		's order dated 07/02/2019 for		baseline care plan enter		
	insulin glargine (a lon	g acting injectable es) 12 units subcutaneously		electronic health record admission. The nurse wi		
	(under the skin) each	, .		re-trained by the Nurse S	-	
		e e e mig.		identified areas of conce		
	A review of Resident	#168's base line care plan		of Nursing will review an	d initial the	
		ndicated no focus area for		Baseline Care Plan Audi	2	
	diabetes mellitus or ir present.	nsulin administration was		weeks then monthly x 1 all areas of concerns we		
		1 PM an interview with		The Director of Nursing v	will procent the	
		ne completed the admission		findings of the Baseline (		
		ent #168 on 07/02/2019. She		Tools to the Executive Q		
		Resident #168's physical		(QAPI) committee month		
		r nursing assessments but		The Executive QA Comm		
		seline care plan. She stated		monthly for 2 months an Baseline Care Plan Audi		
	she thought the MDS	nurse did those.		determine trends and/or		
	On 07/13/2021 at 9:1	6 AM an interview with MDS		need further intervention	5	
	Nurse #1 indicated sh			and to determine the nee		
		are plans. She stated back in		frequency of monitoring.		
	-	ot sure who was doing them				
	unit manager comple	ity's process was that the ted them.				
	On 07/13/2021 at 8.1	7 AM an interview with the				
		DON) indicated she was not				
	aware of what the fac					
		care plans in July 2019. She				
		ility process was that the				
		ted the baseline care plan esident's admission to the				
		io say if the unit manager				
		n she did them. The DON				
	further indicated Resi					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345317	B. WING				C / <b>21/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	<ul> <li>plan should have incluadministration. She si triggered nursing staff and symptoms of high which would be importing the would be imported in the would be would be</li></ul>	uded diabetes and insulin tated this would have f to be monitoring for signs n and low glucose levels rtant for a resident with 20 AM an interview with the ed Resident #168 should care plan completed within resion to the facility which nagement and insulin as re-admitted to the facility iagnoses including diabetes oma (a brain cancer). um data set (MDS) dent #316 dated 06/28/2021 derately impaired for daily rther indicated he required assistance of staff for rgiene, toileting, and bathing. incontinent of bowel and cal record for Resident #316 s order dated 07/09/2021 for lrate diet (a therapeutic diet which limits the amount of med). ew of Resident #316's ted no baseline or	F	655	5		

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		ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMF	LETED
		345317	B. WING				C 21/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	011	21/2021
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON		:	204 DAIRY ROAD		
					CLAYTON, NC 27520		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
F 655	Continued From page		F	655	5		
the baseline care plan She stated Resident #		#316 should have had a					
	•	mpleted within 48 hours of					
		acility. She further indicated Ild be the one assigned to					
	complete the baseline	e care plan for Resident					
	#316.						
		31 PM an interview with					
		ne was the unit manager. responsibility to complete					
		or residents within 48 hours					
		he went on to say Resident					
		l to the facility on Friday aseline care plan would					
		/11/2021. Nurse #6 stated					
	worked that weekend	nday and she had not					
	On 07/12/2021 at 12:	05 DM on interview with the					
		05 PM an interview with the DON) indicated there was no					
	staff member present	in the facility on 07/11/2021					
		Resident #316's baseline his baseline care plan					
	should have been cor	mpleted within 48 hours of					
	Resident #316's adm had not been.	ission to the facility and it					
		20 AM an interview with the ed Resident #316's baseline					
		e been completed within 48					
	hours of his admissio	n to the facility and it had					
F 684	not been. Quality of Care		F	684	4		7/27/21
SS=J	CFR(s): 483.25						
	§ 483.25 Quality of ca	are					
		ndamental principle that					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/25/20 FORM APPROV OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345317	B. WING		C 07/21/2021
NAME OF P	ROVIDER OR SUPPLIER	L	S	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •
BRIAN CE	ENTER HEALTH & RETIR	EMENT CLAYTON		04 DAIRY ROAD SLAYTON, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 684	facility residents. Bas assessment of a resid that residents receive accordance with profi- practice, the compre- care plan, and the resident This REQUIREMENT by: Based on record rev- interviews the facility transcribe the hospita on readmission to the glucose monitoring al coverage as recomm discharging physiciar (Resident #168) revie management. This re- being admitted to the diabetic ketoacidosis administration of intra- formation of a toxic c by prolonged high blo threatening. Findings included: A review of the hospin Resident #168 dated discharge to outside included glucose mon and at bedtime (HS), insulin given per a sli subcutaneously (SQ) meals, insulin glargin SQ each evening, an immunosuppressant	nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices. T is not met as evidenced iew and staff and physician failed to reconcile and al physician discharge orders e facility and failed to provide ind sliding scale insulin ended by the hospital in for 1 of 3 resident ewed for diabetic esulted in Resident #168 hospital on 07/06/2019 for (DKA) which required the avenous insulin. DKA is the hemical in the blood caused bod glucose which can be life tal discharge summary for 07/02/2019 indicated facility physician orders intoring before meals (AC) insulin lispro (a fast acting ding scale ) 0-10 units (U) three times daily with e (a long acting insulin) 12 U d prednisone (an medication that can cause els) 5 milligrams (mg) by	F 684	Past noncompliance: no plan of correction required.	

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	-	ID HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		345317	B. WING				C 21/2021
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
BRIAN CE	ENTER HEALTH & RETIR	EMENT CLAYTON			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 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 12	F	684	4		
	Resident #168 was re 07/02/2019 with diagr pancreas (a gland wh transplantation, uncor mellitus (a chronic co produces little or no ir and long term use of medication. The facility physician dated 07/02/2019 ind SQ each evening and No facility physician of AC and HS or insulin method based on the No focus area for dial administration was pr plan initiated 07/02/20 On 07/13/2021 at 8:1 facility director of nurs was not in her current 2019. She stated she summary dated 07/02 physician admission of 07/02/2019. She state included glucose mor insulin lispro sliding s should have entered f must have missed the error. On 07/13/2021 interview with the DO remember if she calle 07/02/2019 to verify F admission orders whe	eadmitted to the facility on noses including failed nich secretes insulin) ntrolled type 1 diabetes ndition where the pancreas nsulin), kidney transplant immunosuppressant orders for Resident #168 icated insulin glargine 12 U d prednisone 5 mg po QD. orders for glucose monitoring lispro sliding scale (a dosing glucose result) were found. betes mellitus or insulin esent on the baseline care 019 for Resident #168. 7 AM an interview with the sing (DON) indicated she t position as the DON in July used the hospital discharge 2/2019 to enter the facility orders for Resident #168 on ed this discharge summary nitoring AC and HS and cale orders which she but had not. She stated she tose orders, and this was an at 12:12 PM a follow up N indicated she could not					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY PLETED
		345317	B. WING				C 21/2021
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON			04 DAIRY ROAD 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	07/02/2019. A review of the medic (MAR) for Resident # 07/01/2019-07/31/207 insulin glargine 12 U = from 07/03/2019 through prednisone 5 mg poor 07/03/2019 through 0 monitoring results or a administration was interview, Nurse #5 in insulin glargine 12 U = PM on 07/03/2019. S care to Resident #168 7AM-3PM. She stated #168's glucose or adr insulin because Resid physician's orders for observe anything unu her shift from 3PM-11 7AM-3PM on 07/06/2 no complaints. On 07/13/2021 at 10: Nurse #6 indicated sh glargine 12 U SQ to F 07/04/2019. She stated Resident #168's glucos scale insulin because physician's orders for observe anything unu her shift from 3PM-11 #168 had no complaint	hit manager for the facility on action administration record 168 dated 19 indicated he received SQ each evening at 9:00 PM ugh 07/05/2019 and Jaily at 9:00 AM from 7/06/2019. No glucose sliding scale insulin dicated on this MAR. 16 AM, during a telephone idicated she administered SQ to Resident #168 at 9:00 he stated she also provided 3 on 07/06/2019 from d she did not check Resident minister any sliding scale dent #168 did not have that. She stated she did not isual with Resident #168 on PM on 07/03/2019 or 019 and Resident #168 had 35 AM an interview with he administered insulin Resident #168 at 9:00 PM on ed she did not check ose or administer any sliding Resident #168 did not have that. She stated she did not isual with Resident #168 had	F	684			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	
		345317	B. WING				21/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH & RETIR	EMENT CLAYTON			04 DAIRY ROAD CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	with Nurse #7 indicate glargine 12 U SQ to F 07/05/2019. She state Resident #168's gluco scale insulin on 07/05 #168 did not have phy further indicated she unusual with Residen 3PM-11PM that day a complaints. Nurse #7 provided care to Resi on 07/06/2019. She i not complained of any not noticed anything u been reported to her She stated on 07/06/2 member asked her to because he wasn't fet to say she did this an reading of "HI". She s member requested her On 07/21/2021 at 11: with nursing assistant to Resident #168 on 0 3PM-11PM shift indic Resident #168. NA #2 anything unusual with had any complaints, s the nurse. On 07/13/2019 at 8:2 manufacturer's guidel glucose monitor provi a reading of "HI" mea greater than 600 mg	ed she administered insulin Resident #168 at 9:00 PM on ed she did not check ose or administer any sliding i/2019 because Resident ysician's orders for that. She did not observe anything t #168 on her shift from ind Resident #168 had no went on to say she also dent #168 from 3PM-11PM ndicated Resident #168 had y symptoms to her, she had unusual, and nothing had by the nursing assistant. 2019 Resident #168's family check his glucose level eling right. Nurse #7 went on d the result had been a tated Resident #168's family e be sent out to the hospital. 16 AM a telephone interview f (NA) #2 who provided care 07/06/2019 on the ated she did not recall 2 stated if she noticed a resident or if a resident she would immediately notify	F	684			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		345317	B. WING				0
NAME OF PI	ROVIDER OR SUPPLIER	010011			STREET ADDRESS, CITY, STATE, ZIP CODE	077	21/2021
				2	204 DAIRY ROAD		
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON			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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	PM written by Nurse a family member report feeling right. It further was assessed but did functional status, or re His glucose level was had been a reading o family member reque out to the hospital. Re at 5:20 PM. Multiple attempts to c family member were of A review of the discha assessment for Resid indicated he was mod decision making. It fur insulin injections 2 of days. A review of the hospit indicated Resident #1 07/06/2019 for DKA th lack of insulin therapy reported he had not b home with glucose mainsulin. He was comp weakness, shortness alert and interactive a record revealed Resident was 627 mg/dl on adr required treatment wir manage his glucose la	be dated 07/06/2019 at 6:07 #7 revealed Resident #168's ed Resident #168 was not revealed Resident #168 not have any mental status, espiratory status change. checked, and the result f "HI". Resident #168's sted Resident #168 be sent esident #168 left the facility ontact Resident #168's unsuccessful. arge minimum data set lent #168 dated 07/06/2019 lerately impaired for daily rther indicated he received ut of 7 look back period al record dated 07/10/2019 68 was admitted on nat was likely the result of a v. His family member een managed at the nursing onitoring and sliding scale laining of increased of breath and he was not as s his baseline. The hospital dent #168's glucose level mission to the hospital. He th insulin intravenously to evels until these were less occurrences. He could then insulin. He was transitioned	F	684			
	manage his glucose l than 250 mg/dl on 2 c be transitioned to SQ to SQ insulin on 07/0	evels until these were less occurrences. He could then insulin. He was transitioned					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/25/2021 MAPPROVED O. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345317	B. WING			07	C 7/21/2021	
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	04 DAIRY ROAD			
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON		С	LAYTON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	Continued From page	e 16	E F	684				
		Q and frequent glucose						
	Resident #168 was d	ischarged from the hospital d not return to the facility.						
	On 07/14/2021 at 9:09 AM a telephone interview with Physician #1 indicated he had been Resident #168's facility physician. He stated he expected the nurse to use the hospital discharge summary dated 07/02/2019 to determine Resident #168's facility admission orders and call him to verify these orders when they were entered and to get							
	could not recall if the Resident #168's order indicated if Resident orders included gluco	ed. Physician #1 stated he nurse called him to verify rs on 07/02/2019. He further #168's hospital discharge ose monitoring AC and HS le insulin these orders						
	should have been en 07/02/2019. He state facility admission ord would have been rec	tered by the nurse on d if Resident #168 had his ers entered correctly, he eiving glucose monitoring AC						
	on those results to tre stated this was the st	sliding scale insulin based eat any high readings. He andard of care for someone Resident #168, and insulin						
	resident for signs and complications without	on to say simply observing a I symptoms of diabetic t monitoring their glucose ne standard of care. He						
	insulin could have ve #168's hospitalization	oring and sliding scale ry likely prevented Resident n on 07/06/2019 for DKA with r 600 mg/dl. Physician #1						
	stated DKA was a se	rious complication of iabetes that put Resident						
	unconsciousness tha	t lasts for a prolonged or an damage, and death.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMF	E SURVEY PLETED
		345317	B. WING				C / <b>21/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH & RETIR	EMENT CLAYTON			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 17	F	684	L L		
		09 AM the facility provided taken by the facility for tag					
	All residents with a di risk.	agnosis of diabetes are at					
	diabetic was reviewed or Designee on 6/25/2 blood sugar monitorir orders were accurate used to audit the curr	lood sugar monitoring was					
	on the system for rev readmit orders, include summaries from the h are reconciled onto the included clarifying an with the physician and	nursing staff were educated iewing new admit and ding reviewing the discharge nospitals to ensure all orders ne resident MAR. Education d verifying physician orders d about monitoring residents dications that can negatively					
	Nursing or Designee licensed staff will wor facility will ensure all agency licensed staff for reviewing new adu including reviewing the from the hospitals to	esident MAR and will have larifying and verifying					

Facility ID: 922982

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345317	B. WING				C / <b>21/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page monitoring residents of medications that can The new admit /readr as the monitoring tool medication reconcilia comparing the physic orders to the electron entries. This checklist by the Director of Nur discussed with the int The facility conducted and reviewed the mon results. The results of reported by the Direct at the QAPI meeting of QAPI team will review months. Our date of compliant The plan of correction review of the in-service which covered glucos administration and the competency checklist 24 hour admission ch was initiated in April 2	e 18 with diabetes and negatively impact diabetes. nit checklist is being utilized effective 6/25/21 to ensure tion has been completed by ian discharge summary ic medical record order to continues to be completed sing or Designee and is erdisciplinary team. If a QAPI meeting on 6/25/21 hitoring tool and audit of these audits will be tor of Nursing or Designee monthly for 3 months. The y and approve all audits for 3 ce is 6/26/21. In was verified through the records dated 6/25/2021 the monitoring, medication to admission process, the is for all licensed staff, the ecklist auditing tool which		68			
	hospital orders accura The QAPI meeting mi reviewed. These inclu the 24 hour admission the reconciliation of th	inutes dated 6/25/2021 were ided an ongoing review of n checklist which includes ne physician's orders from d admission to the facility to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/25/202 <sup>2</sup> RM APPROVEE IO. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DAT	E SURVEY IPLETED	
		345317	B. WING		C 07/21/2021		
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO	•		
BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON		DAIRY ROAD NYTON, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page information.	e 19	F 684				
	The blood sugar cheo dated 6/25/21 was re	ck and parameters audit tool viewed.					
5 750	verified.	compliance of 6/26/2021 was	F 750			0/0/04	
F 758 SS=D	CFR(s): 483.45(c)(3)	vchotropic Meds/PRN Use (e)(1)-(5)	F 758			8/2/21	
	affects brain activities processes and behave	opic Drugs. hotropic drug is any drug that s associated with mental <i>r</i> ior. These drugs include, drugs in the following					
	categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic						
	Based on a comprehered resident, the facility n	ensive assessment of a nust ensure that					
	psychotropic drugs a unless the medication	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral interventio	ents who use psychotropic I dose reductions, and ons, unless clinically n effort to discontinue these					
	§483.45(e)(3) Reside psychotropic drugs p	ents do not receive ursuant to a PRN order					

Facility ID: 922982

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		ND HUMAN SERVICES			FO	ED: 08/25/202 RM APPROVE NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		345317	B. WING		o	7/21/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
BRIAN CE	NTER HEALTH & RETIR	REMENT CLAYTON		204 DAIRY ROAD		
510,01 02				CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 758	Continued From pag	e 20	F7	58		
		on is necessary to treat a				
		ondition that is documented				
	\$492 45(a)(4) DDN a	unde ver for a second status size day, as				
		orders for psychotropic drugs s. Except as provided in				
		attending physician or				
	prescribing practition	<b>•</b> • •				
		RN order to be extended				
		or she should document their				
	rationale in the reside indicate the duration	ent's medical record and for the PRN order.				
	\$483.45(e)(5) PRN c	orders for anti-psychotic				
		I4 days and cannot be				
	-	attending physician or				
	· • ·	er evaluates the resident for				
	the appropriateness					
		T is not met as evidenced				
	by:	view, and staff, pharmacist,		F758 Free from Unn	aa Davabatranhia	
		ews the facility failed to have		Meds/PRN Use	ec esycholiophic	
		needed antipsychotic				
		residents reviewed for		On 07/13/21, Nurse #	41 updated the order	
	unnecessary medica	tions (Resident #167).		for Zyprexa 5 milligra		
				Resident #167 to incl		
	Findings included:			date for 14 days post	admission.	
	Resident #167 was a	admitted to the facility on		On 07/13/21, a 100%	audit of all	
		agnoses included diabetes		psychotropic medicat		
	mellitus, hypertensio	n, and anemia.		by the Assistant Direc	•	
				audit was to ensure the		
		e plan dated 7/9/21 revealed		psychotropic medicat		
	-	d for behavior problems. The d to administer medications		discontinuation date.		
	as ordered.			Nursing corrected all	concerns identified	
				PRN psychotropic me		
	Resident #167's orde	er dated 7/9/21 revealed she		discontinuation date.		
		a tablet 5 milligrams give 1				

Facility ID: 922982

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/25/2021 MAPPROVED O. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345317	B. WING			C 07/21/2021	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				20	4 DAIRY ROAD		
BRIAN CE	NTER HEALTH & RETIR			CI	LAYTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From page	o 01					
1750			F 7	58		~	
		y 6 hours as needed for			An in-service was initiated by the Stat		
	÷	vior or hallucinations. The			Development Coordinator on 07/13/2	1	
	and was documented	e of 7/9/21 with no end date			with all licensed nurses in regards to ensuring that all PRN psychotropic		
		as muennite.			medications included a discontinuatio	n	
	Resident #167's med	lication administration record			date. This in-service emphasized		
		d she received Zyprexa 5			checking psychotropic medications fo	r	
	milligrams once on 7/				newly admitted residents to ensure th		
	g				PRN psychotropic medications includ		
	During an interview o	on 7/12/21 at 3:04 PM Nurse			discontinuation date. All newly hired		
	-	form the admission orders			nurses and contracted nurses will be		
	for Resident #167. SI	he stated the physician			in-serviced regarding checking		
	verified the orders ov	er the phone and were			psychotropic medications for newly		
	entered into the e-cha	art. She further stated this			admitted residents to ensure that all F	PRN	
	resident did come to	the facility from the hospital			psychotropic medications included a		
		Zyprexa 5 milligrams as			discontinuation date by the Staff		
	-	s and she read the orders to			Facilitator.		
		em in the system per the					
		immary and the facility			100% of all residents who receive		
		hem. She concluded she			psychotropic medications will be		
	was not aware as nee				monitored by the Nurse Supervisors		
	medications were rec	quired to have a stop date.			weekly x 4 weeks then monthly x 1 m		
	During on interview o	on 7/12/21 at 3:16 PM the			utilizing the Psychotropic PRN Medica Audit Tool. This audit is to ensure that		
	Director of Nursing st				PRN psychotropic medications includ		
	-	tions were required to have			discontinuation date. The nurse will b		
	a stop date of 14 day	•			immediately re-trained by the Nurse		
		er for as needed Zyprexa 5			Supervisor for any identified areas of		
		urs did not have an end date			concern. The Director of Nursing will		
	and it should have an				review and initial the Psychotropic PR	2N	
					Medication Tools weekly x 4 weeks th		
	During an interview o	on 7/12/21 at 3:32 PM			monthly x 1 month to ensure all areas		
		l at this time, as needed			concerns were addressed.		
		tions would need to be					
		der within 14 days of the			The Director of Nursing will present th	e	
	• •	not be ordered with no end			findings of the Psychotropic PRN		
	date or as indefinite p	per current regulations.			Medication Tools to the Executive Qu	ality	
					Assurance (QAPI) committee monthly		
	During an interview o	on 7/13/21 at 8:03 AM			2 months. The Executive QA Commit	tee	

Event ID: T7WX11

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
						с
		345317	B. WING		07	21/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH & RETIR	REMENT CLAYTON		04 DAIRY ROAD CLAYTON, NC 27520		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 758	Continued From pag	e 22	F 758			
	Physician #1 stated a	as needed antipsychotic		will meet monthly for 2 months and i	review	
		Zyprexa should have a 14		the Psychotropic PRN Medication To		
		ther stated Resident #167's		determine trends and/or issues that	•	
		Zyprexa 5 milligrams every 6 stop date and he was		need further interventions put into pl and to determine the need for furthe		
	unaware it did not ha	•		frequency of monitoring.	•	
F 761	Label/Store Drugs ar	nd Biologicals	F 761			8/2/21
SS=D	CFR(s): 483.45(g)(h)	(1)(2)				
	Drugs and biological	of Drugs and Biologicals s used in the facility must be e with currently accepted				
	professional principle					
	appropriate accesso	ry and cautionary				
	instructions, and the applicable.	expiration date when				
	§483.45(h) Storage o	of Drugs and Biologicals				
	§483.45(h)(1) In acc	ordance with State and				
	Federal laws, the fac	ility must store all drugs and				
	0	compartments under proper				
	personnel to have ac	, and permit only authorized ccess to the keys.				
		cility must provide separately affixed compartments for				
		drugs listed in Schedule II of				
	-	Drug Abuse Prevention and				
		and other drugs subject to				
		the facility uses single unit				
		ution systems in which the nimal and a missing dose can				
	be readily detected.	-				
		Γ is not met as evidenced				
	by:	and readered review and staff		E761 Lobal/Store Druge and Distant	icolo	
	interviews the facility	ons, record review, and staff		F761 Label/Store Drugs and Biolog	icais	

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/25/2021 M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345317	B. WING _			C 07/21/2021		
NAME OF P	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CE	NTER HEALTH & RETIR	REMENT CLAYTON			04 DAIRY ROAD			
				С	LAYTON, NC 27520		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	Continued From page	e 23	F 7	761				
		frops and failed to keep an		•	On 07/13/21, the Director of Nursing			
	unattended medicatio				removed the expired medications from	n the		
		ewed (400 Hall Medication			400 hall medication cart.			
	Findings included:				On 07/13/21, Nurse #3 locked the 20 medication cart.	) hall		
	1. Resident #45 was	admitted to the facility on			On 07/28/21, an audit of 100% of all			
		agnoses included anemia,			medication carts to include the medic	ation		
	hypertension, diabete	es mellitus, dementia, and			cart on the 400 hall was completed by	/ the		
	glaucoma.				Assistant Director of Nursing and Sta Development Coordinator. The audit	was		
		num data set assessment			to ensure no expired medications we			
		ed he was assessed as ly impaired. He required			stored in the medication carts and the medication carts were locked. The	it all		
		with bed mobility, transfers,			Director of Nursing corrected all conc	erns		
		et use, and personal hygiene.			identified during the audit to include			
		ate with corrective lenses.			removal of expired medications and ensuring all medication carts were loo	ked.		
		plan dated 3/15/21 revealed						
		for impaired visual function			An in-service was initiated by the Sta			
	•	e interventions included			Development Coordinator on 07/14/2	1		
		ctitioner consults as needed, I symptoms of acute eye			with all licensed nurses in regards to medication labeling and storage and			
		sident where items are			ensuring all medication carts are lock	ed at		
	placed and be consis				all times. This in-service emphasized			
					checking medications before			
		dated 3/15/21 revealed he			administration for expiration dates an	d		
		0.005% instill one drop in			ensuring that all medication carts are	-		
	both eyes at bedtime	ior glaucoma.			locked when not being used to delive medication. All newly hired nurses an			
	During observation o	n 7/13/21 at 1:35 PM			contracted nurses will be in-serviced	u		
		an 0.005% eye drops were			regarding medication labeling and sto	rage		
		Hall Medication Cart with no			and ensuring all medication carts are	J		
		ed on medication. The			locked at all times by the Staff Facilita	tor.		
		imented as dispensed to the						
		ne medication had a yellow			100% of all medication carts will be			
		the medication was to be			monitored by the Nurse Supervisors	onth		
	remgerated until oper	ned and discarded after 6			weekly x 4 weeks then monthly x 1 m	onui		

Facility ID: 922982

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVICE COMPLETED BUILDING         NAME OF PROVIDER OR SUPPLIER       345317       B. WING       07/21/20 07/21/20 07/21/20 DEVENDER OR SUPPLIER         BRIAN CENTER HEALTH & RETIREMENT CLAYTON       STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY ROAD CLAYTON, NC 27520       C         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION SHOULD BE       COMPLETER C			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/25/ FORM APPRC OMB NO. 0938-1	OVED
JA45317         B. WING         OT721/20           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 2/P CODE         STREETA DDRESS, 2/P CO	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS_CITY, STATE, ZIP CODE           BRAN CENTER HEALTH & RETIREMENT CLAYTON         Interview CLAYTON, NC 2750           (P410) PREDULTORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION)         Interview CLAYTON, NC 2750           (P410) PREDULATORY OR LSC IDENTIFYING INFORMATION         Interview CLAYTON, NC 2750           (P410) PREDULATON, NC 2750         Interview CLAYTON (P410)			345317	B. WING		07/21/2021	ł
BRIAN CENTER HEALTH & RETIREMENT CLAYTON         CLAYTON, NC 27820           (YA)ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BERECEDED BY FULL RECOLLATORY OR LSC DENTIFYING INFORMATION)         ID PREFIX TAG         PREVIX PREFIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX TAG         CONTINUED SPLAN OF CORRECTION PREVIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX PREVIX TAG         PREVIX PREVIX PREVIX PREVIX TAG         PREVIX P	NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
(M) ID PRETX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX           F 761         Continued From page 24 weeks of being open.         F 761         I utilizing the Medication Storage and Labeling Audit Tool. This audit is to ensure no expired medication when opened as it must be discarded after 6 weeks of being open. She further stated the medication needication was or was not passed the expiration date now due to not knowing when it was opened.         F 761           During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after ix weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.         F 100 interview on 7/13/21 at 2:11 PM the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.         F 761           During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart from a resident's room and she should not have left it unlocked.         F 761           During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.         The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tool so the Executive Quality Assurance (QAPI) committee mothy for 2 months. The Executive QA Committee will meedication Storage and Labeling Audit Tools to deter	BRIAN CE	NTER HEALTH & RETIR	EMENT CLAYTON				
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC.IDENTIFYING INFORMATION)         PREFX TAG         (EACH DERICITIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         COM CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY           F 761         Continued From page 24 weeks of being open.         F 761         utilizing the Medication Storage and Labeling Audit Tool. This audit is to ensure no expired medications were stored in the medication carts and that all medication carts are locked. The nurse will be immediately re-trained by the Nurse further stated the medication was dispensed on 5/177/21 which was eight weeks ago. She concluded she was unable to tell if the medication was or was not passed the expiration date now due to not knowing when it was opened.         F 761           During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.         The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tools to determine trends and unattended. Al:212 PM an urse aide was observed to walk by the unlocked medication cart. At 213 PM Nurse #3 returned to the unlocked medication cart from a resident's room and she should not have left unlocked.         The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.           During an interview on 7/13/21 at 2:11 PM the Director of Nursing stated the 200 Hall Medication cart should have been locked while she was in th							
<ul> <li>weeks of being open.</li> <li>Utilizing the Medication Storage and Labeling Audit Tool. This audit is to ensure no expired medications were stored in the medication carts and that all medication carts are locked. The nurse will be immediately re-trained by the Nurse further stated the medication date now due to not knowing when it was opened.</li> <li>During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.</li> <li>2. During observation on 7/13/21 at 2:11 PM the 200 Hall Medication cart was observed unlocked and unattended. At 2:12 PM a nurse aide was observed to walk by the unlocked medication cart. At 2:13 PM Nurse #f3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.</li> <li>During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication cart. At 2:13 PM Nurse #f3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.</li> <li>During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication carts</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLE	TION
<ul> <li>weeks of being open.</li> <li>Utilizing the Medication Storage and Labeling Audit Tool. This audit is to ensure no expired medications were stored in the medication carts and that all medication carts are locked. The nurse will be immediately re-trained by the Nurse further stated the medication was dispensed on 5/17/21 which was eight weeks ago. She concluded she was unable to tell if the medication was or was not passed the expiration date now due to not knowing when it was opened.</li> <li>During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.</li> <li>2. During observation on 7/13/21 at 2:11 PM the 200 Hall Medication cart was observed unlocked and unattended. At 2:12 PM a nurse aide was observed to walk by the unlocked medication cart. At 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.</li> <li>During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication cart. At 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.</li> <li>During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication carts</li> </ul>	F 761	Continued From page	e 24	E 76'	1		
#2 stated Xalatan should have an open date written on the medication when opened as it must be discarded after 6 weeks of being open. She further stated the medication was dispensed on 5/17/21 which was eight weeks ago. She concluded she was unable to tell if the medication was or was not passed the expiration date now due to not knowing when it was opened.medication carts and that all medication concern. The Director of Nursing will review and initial the Medication Storage and Labeling Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed.During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tools to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Medication Storage and Labeling Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.Hereina the need for further frequency of monitoring.During an interview on 7/13/21 at 2:21 PM the unlocked medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.Hereina the and the all medication cart. At 2:13 PM Nurse #3 stated the 200 Hall Medication		weeks of being open.		170	utilizing the Medication Storag Labeling Audit Tool. This audit	is to ensure	
further stated the medication was dispensed on 5/17/21 which was eight weeks ago. She concluded she was unable to tell if the medication was or was not passed the expiration date now due to not knowing when it was opened.Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Medication Storage and Labeling Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed.During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tools to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Medication Storage and Labeling Audit Tools to othe etermine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.The Director of Nursing stated medication cartsDuring an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication cartsDuring an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication carts		#2 stated Xalatan sho written on the medica	ould have an open date ation when opened as it must		medication carts and that all m carts are locked. The nurse w	nedication /ill be	
concluded she was unable to tell if the medication was or was not passed the expiration date now due to not knowing when it was opened.review and initial the Medication Storage and Labeling Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed.During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded.The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tools to the Executive Quality Assurance (QAPI) committee monthly for 2 months and review will meet monthly for 2 months and review will meet monthly for 2 months and review the Medication Storage and Labeling Audit Tools to determine trends and/ roisues that may need further interventions put into place and to determine the need for further frequency of monitoring.During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart from a resident's room.Puring an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked.Puring an interview on 7/13/21 at 2:12 PM the Director of Nursing stated medication carts		further stated the me	dication was dispensed on		Supervisor for any identified a	reas of	
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Facility ID: 922982

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