STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and physician interviews the facility failed to notify the physician of a residents eye enucleation	F 157	1.SBAR (Situation, Assessment, Recommendation) was completed for resident #25 on 11/3/16 by Licensed	12/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 157	Continued From page 1 (removal of the eye) that began draining purulent drainage for 1 of 2 sampled residents (Resident #25) and failed to notify the physician of a blood sugar that exceeded the ordered parameters for 1 of 2 sampled residents (Resident #38). The findings included: 1. Resident #25 was admitted to the facility on 09/30/16 with diagnoses that included chronic obstructive pulmonary disease (COPD), weakness, tracheostomy, dementia, seizures, and pneumonia. Review of the most recent comprehensive minimum data set (MDS) dated 10/12/16 revealed that Resident #25 was cognitively intact with unclear speech. No behaviors were identified. Resident #25 required extensive assistance of 2 person with bed mobility and transfers and required total assistance of one staff member for personal hygiene. Review of a wound consult from the hospital dated 09/05/16 read in part that there was not a right eye ball in place but the opening was draining some Serosanguineous drainage with a small amount of erythema noted. The recommendation was to cleanse it with normal saline and apply dry gauze daily. Review of initial admission assessment dated 09/30/16 revealed that Resident #25's eyes were abnormal and vision was impaired. Resident #25 was missing right eye due to an auto accident. The assessment was signed by Nurse #1. Observation on 10/31/16 at 5:09 PM of Resident #25 revealed he was in bed and non-verbal due	F 157	Nurse and NP notified. Nurse Practitioner assessed resident on 11/3/16. MD notified #38□s blood sugar with no new orders received. 2.Current residents with dressings have the potential to be affected by the alleged deficient practice. Nurse Manager completed an audit of residents with dressings on 11/3/16 to insure no abnormal drainage noted. Current residents with blood sugar monitoring parameters have the potential to be affected by the alleged deficient practice. ADON completed an audit of all residents with blood sugar parameters and notified MD if necessary on 11/3/16. 3.Licensed nursing staff will be re-educated by DON/ADON by 11/30/16 on SBAR and notification to MD/NP. Administrative RN will assess all residents with dressings 5 times weekly for 2 weeks for notification of changes in abnormal drainage. Nurse Manager will continue to assess all dressings for changes and notification weekly for 3 months. Nurse Manager will audit residents with blood sugar monitoring with parameters 5 times weekly for 2 weeks and then weekly for 3 months. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	

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F 157	Continued From page 2	F 157		

to tracheostomy. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing that was visible from around the sunglasses contained no date indicating when it had been applied. The dressing was clean and dry.

Observation on 11/01/16 at 9:58 AM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing that was visible from around the sunglasses contained no date indicating when it had been applied but the edges were frayed. The dressing had a 50 cent piece size area of purulent drainage noted to the dressing.

Observation on 11/02/16 at 9:25 AM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing that was visible from around the sunglasses contained no date indicating when it had been applied and the edges were frayed. The dressing had 2 50 cent piece size areas of purulent drainage noted on the dressing. The surrounding area around the dressing was crusty with dried hard substance.

Observation on 11/02/16 at 11:47 AM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing that was visible from around the sunglasses contained no date indicating when it had been applied with and had frayed edges. The dressing had 2 50 cent piece size areas of purulent drainage noted on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 157	Continued From page 3	F 157		

dressing. The surrounding area around the dressing was crusty with dried hard substance.

Observation on 11/02/16 at 3:41 PM of Resident #25 revealed he was up in his wheelchair at bedside and remained non-verbal. The dressing covering his right eye area had been changed and was clean and dry. There was no date indicating when the dressing had been applied. The crusty substance was no longer present.

Interview with Nurse #1 on 11/03/16 at 10:38 AM revealed that she routinely took care of Resident #25 and stated that Resident #25 was very demanding with staff and did become belligerent with staff at times. Nurse #1 confirmed that she had worked with Resident #25 on 11/01/16 and 11/02/16 and confirmed that she had changed the dressing to Resident #25's right eye area on 11/02/16 sometime after lunch. Nurse #1 stated she was not sure how often the dressing over his right eye area was scheduled to be changed. Nurse #1 stated she had noticed the green drainage on the dressing on 11/01/16 but "was going to wait and see" but stated she would go ahead and have the doctor look at it when she was in the facility.

Interview with the Assistant Director of Nursing (ADON) on 11/03/16 at 11:52 AM revealed that she was not aware of the wound consult dated 09/05/16 that came with Resident #25 from the hospital. The ADON stated that the wound consult recommendation for a dry dressing were not included in the discharge orders and due to the time frame from the consult and the actual discharge she would not include those as discharge instructions. The ADON stated that if the staff noted the green drainage on 11/01/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 4	F 157		

she would have expected them to immediately contact the physician and complete a report.

Interview with the Nurse Practitioner (NP) on 11/03/16 at 1:47 PM revealed that she had evaluated Resident #25 on 11/02/16 near the end of the business day. The NP stated this was a focused visit for Resident #25's complaints of insomnia, the NP stated she did not remove the dressing and did not evaluate the eye. The NP stated she was not aware of any purulent drainage that had come from the right eye area.

Interview with the physician on 11/03/16 at 2:59 PM revealed that she was new to the facility and had been there for approximately 3 to 4 weeks. The physician stated that she had evaluated Resident #25 previously for respiratory distress and he was place on antibiotic therapy at that time. The physician stated that each time she had evaluated Resident #25 he had a patch covering the right eye area. The physician also stated that if the right eye area started draining purulent drainage that was a new problem for him and she would be expected to be notified so that she could assess the issue. The physician stated that Resident #25 was currently on Levaquin (antibiotic) for his pulmonary issues but Levaquin was not good for anaerobic bacteria which is what we would be concerned with purulent drainage from the eye area so the Levaquin would not cover that bacteria. The physician stated she would not culture the area due to the risk of contamination but would use an empiric antibiotic that would cover the anaerobic bacteria. The physician again stated with the purulent drainage she would expect to be notified and put on the list to be seen.

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	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 157	Continued From page 5	F 157		

Interview with the Director of Nursing on 11/03/16 at 3:47 PM stated that she expected Nurse #1 to contact the physician the same day that she noticed the purulent drainage and document her findings in the medical record.

2. Resident #38 was admitted to the facility on 05/25/14 with diagnoses that included diabetes mellitus.

Review of the most recent quarterly minimum data set (MDS) dated 08/19/16 revealed that Resident #38 was cognitively intact. The MDS also revealed that Resident #38 required extensive assistance of one staff member with transfers, dressing, toileting, and personal hygiene. The MDS further indicated that Resident #38 received 7 days of insulin injections.

Review of physician order dated 09/29/16 read Finger Stick Blood sugar before meals and at bedtime. Notify physician if blood sugar is less than 70 or greater than 400. On 11/02/16 at 9:00 PM Resident #38's blood sugar was 528.

Review of an administration note dated 11/02/16 at 10:31 PM indicated that Nurse #2 had given 8 units of Humalog insulin.

Review of the medical record for Resident #38 revealed no notification to the physician as stated in the order.

Interview on 11/03/16 at 10:15 AM with Resident #38 stated that the staff checked her sugar 4 times a day and her sugars were not stable at all. Resident #38 stated that lately they have been very low, but also at times they run really high. Resident #38 stated she was unaware if the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 157	Continued From page 6	F 157		

notified the physician when her sugar was really low or really high. Resident #38 stated she often worried about taking large doses of insulin because then her sugar would drop very quickly so they had to pay close attention to it.

Interview with Nurse #2 on 11/03/16 at 3:39 PM revealed that she routinely took care of Resident #38. Nurse #2 confirmed that Resident #38's blood sugar last evening was 528 and she had taken the full 8 units of insulin as ordered. Nurse #2 stated she did not contact the physician last night when Resident #38's sugar was 528 because in the past when she would contact them they would instruct her to give the resident 8 units of regular insulin. Nurse #2 stated she was confident that 8 units would not bottom the resident's blood sugar out with it being so high so she did not contact the physician and the next time Resident #38's sugar was checked it was 160.

Interview with the physician on 11/03/16 at 2:59 PM revealed that she was new to the facility and had been there for approximately 3 to 4 weeks. The physician stated that if Resident #38's blood sugar had been 528 she would have expected to have been notified per the physician order. The physician did stated that after she was familiar with each diabetic resident she may alter their insulin orders and change the parameters but she was not there yet, so she would expect the staff to follow the physician order and notify her of a blood sugar less than 70 or above 400.

Interview with the Director of Nursing (DON) on 11/03/16 at 3:47 PM revealed that she expected the staff to notify the physician of a blood sugar of 528 per the physician order and document that in

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	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 157	Continued From page 7 the medical record.	F 157		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label a urinal and a fracture bed pan in 2 resident bathrooms (Room #106 and #310) on 2 of 7 resident hallways, failed to repair 13 resident doors (Resident Room #103, #201, #205, #207, #305, #310, #311, #401, #405, #512, #601, #700 and #706) with broken and splintered laminate and wood on the edges of the bottom half of the doors (100, 200, 300, 400, 500, 600 and 700 halls), failed to repair 1 of 2 doors to the recreation room with broken and splintered laminate on the lower edges of the door (100 hallway), failed to repair a set of smoke prevention doors (700 hall) with broken and splintered laminate on the lower edges of the doors on 1 of 7 hallways and failed to repair a wall behind a resident's bed with deep gouges into the sheetrock (Room #410-A) on 1 of 7 resident hallways. The findings included: 1. a. Observations on 10/31/16 at 5:06 PM in the bathroom of Room #106 revealed a urinal in a clear plastic bag hanging from a handrail in the	F 253	1.Door and wall repair completed on 11/21/16. Urinal and bedpan discarded 11/3/16. New urinal and bed pan labeled 11/3/16. 2.Current residents have the potential to be affected by the alleged deficient practice. Maintenance Director and Administrator completed an audit of all doors and walls on 11/7/16 to identify doors and walls in need of immediate repair. Current residents utilizing a urinal or bed pan have the potential to be affected by the alleged deficient practice. An audit of resident bathrooms for unlabeled urinals and bed pans completed on 11/4/16 with no other areas of concern noted. 3.Administrator/Maintenance Director to complete staff in-service regarding the identification of splintered doors and wall gouges and completing maintenance request forms for these identified areas by 11/30/16. DON/ADON will complete staff re-education regarding proper labeling of urinals and bedpans by 11/30/16. Resident Ambassadors (department heads) will complete weekly audits to	12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 253	Continued From page 8 bathroom with no resident name on it. Observations on 11/01/16 at 10:15 AM in the bathroom of Room #106 revealed a urinal in a clear plastic bag hanging from a handrail in the bathroom with no resident name on it. Observations on 11/02/16 at 2:45 PM in the bathroom of Room #106 revealed a urinal in a clear plastic bag hanging from a handrail in the bathroom with no resident name on it. Observations on 11/03/16 at 9:25 AM in the bathroom of Room #106 revealed a urinal in a clear plastic bag hanging from a handrail in the bathroom with no resident name on it. b. Observation on 10/31/16 at 5:10 PM in the bathroom of Room #310 revealed a fracture bed pan in a clear plastic bag inside a metal rack in the bathroom with no resident name on it. Observations on 11/01/16 at 10:18 AM in the bathroom of Room #310 revealed a fracture bed pan in a clear plastic bag inside a metal rack in the bathroom with no resident name on it. Observations on 11/02/16 at 2:50 PM in the bathroom of Room #310 revealed a fracture bed pan in a clear plastic bag inside a metal rack in the bathroom with no resident name on it. Observations on 11/03/16 at 9:30 AM in the bathroom of Room #310 revealed a fracture bed pan in a clear plastic bag inside a metal rack in the bathroom with no resident name on it. During an interview on 11/03/16 at 3:23 PM with Nurse Aide #2 she stated resident care items such as bed pans, bath basins and urinals were supposed to be stored in a plastic bag in the resident's bathroom and should be labeled with the resident's name with a black marker.	F 253	identify wall, door repair needs and unlabeled urinals and bedpans in bathrooms. Resident Ambassadors will audit these areas 5 times a week for 4 weeks and then weekly for 2 months. Areas of concern noted will be brought to morning meeting for review to ensure identified areas have been addressed. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	

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F 253	Continued From page 9	F 253		

During an interview on 11/03/16 at 3:25 PM with the Assistant Director of Nursing (ADON)she explained resident care items such as bed pans, bath basins and urinals were supposed to have the resident's name written on them and they should be stored in a plastic bag.

During a tour with the ADON on 11/03/16 at 3:27 PM she confirmed a urinal in the bathroom of Room #106 was in a clear plastic bag but there was no resident name on it. She also confirmed a fracture bed pan in the bathroom of Room #310 was in a clear plastic bag but had no resident name on it. She stated both the urinal and fracture bed pan should have had resident names clearly written on them.

During an interview on 11/03/16 at 4:27 PM with the Director of Nursing she stated it was her expectation for resident care equipment such as bed pans, bath basins and urinals to be labeled with the resident's name on them and they should be stored in a plastic bag. She stated she expected when staff noticed resident care equipment did not have a resident's name on it they should change it out and write the resident's name on it.

2. a. Observations of Room #103 on 11/01/16 at 4:39 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.

Observations on 11/02/16 at 3:56 PM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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F 253	Continued From page 10 the door of Resident Room #103 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:32 AM revealed the door of Resident Room #103 had broken and splintered laminate on the edges of the bottom half of the door. b. Observations of Room #201 on 11/01/16 at 4:41 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 3:58 PM revealed the door of Resident Room #201 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:34 AM revealed the door of Resident Room #201 had broken and splintered laminate on the edges of the bottom half of the door. c. Observations of Room #205 on 11/01/16 at 4:42 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 3:59 PM revealed the door of Resident Room #205 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:35 AM revealed the door of Resident Room #205 had broken and splintered laminate on the edges of the bottom half of the door. d. Observations of Room #207 on 11/01/16 at 4:43 PM revealed the door of the resident's room	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 11 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:00 PM revealed the door of Resident Room #207 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:36 AM revealed the door of Resident Room #207 had broken and splintered laminate on the edges of the bottom half of the door. e. Observations of Room #305 on 11/01/16 at 4:45 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:02 PM revealed the door of Resident Room #305 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:38 AM revealed the door of Resident Room #305 had broken and splintered laminate on the edges of the bottom half of the door. f. Observations of Room #310 on 11/01/16 at 4:46 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:04 PM revealed the door of Resident Room #310 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:39 AM revealed the door of Resident Room #310 had broken and splintered laminate on the edges of the bottom half of the door.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 12 g. Observations of Room #311 on 11/01/16 at 4:49 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:05 PM revealed the door of Resident Room #311 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:40 AM revealed the door of Resident Room #311 had broken and splintered laminate on the edges of the bottom half of the door. h. Observations of Room #401 on 11/01/16 at 4:51 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:08 PM revealed the door of Resident Room #401 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:43 AM revealed the door of Resident Room #401 had broken and splintered laminate on the edges of the bottom half of the door. i. Observations of Room #405 on 11/01/16 at 4:52 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:09 PM revealed the door of Resident Room #405 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:44 AM revealed the door of Resident Room #405 had broken and	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 13 splintered laminate on the edges of the bottom half of the door. j. Observations of Room #512 on 11/01/16 at 4:55 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:11 PM revealed the door of Resident Room #512 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:47 AM revealed the door of Resident Room #512 had broken and splintered laminate on the edges of the bottom half of the door. k. Observations of Room #601 on 11/01/16 at 4:58 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:14 PM revealed the door of Resident Room #601 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:49 AM revealed the door of Resident Room #601 had broken and splintered laminate on the edges of the bottom half of the door. l. Observations of Room #700 on 11/01/16 at 5:03 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:18 PM revealed the door of Resident Room #700 had broken and splintered laminate on the edges of the bottom	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 14 half of the door. Observations on 11/03/16 at 9:52 AM revealed the door of Resident Room #700 had broken and splintered laminate on the edges of the bottom half of the door. m. Observations of Room #706 on 11/01/16 at 5:04 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:19 PM revealed the door of Resident Room #706 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:54 AM revealed the door of Resident Room #706 had broken and splintered laminate on the edges of the bottom half of the door. 3. a. Observations of the recreation room door on the 100 hall across from Resident Room #102 on 11/01/16 at 5:09 PM revealed the door had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/02/16 at 4:20 PM of the recreation room door on the 100 hall across from Resident Room #102 revealed the door had broken and splintered laminate on the edges of the bottom half of the door. Observations on 11/03/16 at 9:52 AM of the recreation room door on the 100 hall across from Resident Room #102 revealed the door had broken and splintered laminate on the edges of the bottom half of the door.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 15 4. a. Observations on 11/01/16 at 5:20 PM of the smoke prevention doors on the 700 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors. Observations on 11/02/16 at 4:25 PM of the smoke prevention doors on the 700 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors. Observations on 11/03/16 at 9:55 AM of the smoke prevention doors on the 700 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors. 5. a. Observations on 11/01/16 at 5:15 PM of the wall in Room #410-A behind the resident's bed revealed 3 long scrapes gouged into the sheetrock. Observations on 11/02/16 at 4:30 PM of the wall in Room #410-A behind the resident's bed revealed 3 long scrapes gouged into the sheetrock. Observations on 11/03/16 at 9:58 AM of the wall in Room #410-A behind the resident's bed revealed 3 long scrapes gouged into the sheetrock. An interview and tour was conducted on 11/03/16 at 3:58 PM with the Maintenance Director and a Regional Maintenance Director. The Maintenance Director stated he was new to the	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 253	Continued From page 16 facility and had just started to work in the facility last week. The Regional Maintenance Director stated he had been in the facility once a week for the past 3-4 months until the facility had hired a Maintenance Director. The Maintenance Director explained the facility had requisition slips for staff to write out work orders for any repairs that needed to be made. He stated staff also stopped him in the hall when he made rounds and he received calls and messages on his phone to report things that needed to be repaired. He confirmed there were no current projects in the facility and he was just getting organized with general maintenance duties. He stated it was his expectation for staff to let him know the location and general problem for repairs that needed to be made and then he made the repairs. During the tour the Maintenance Director and the Regional Director acknowledged the broken and splintered laminate and wood on the doors and the damaged sheetrock and stated they were unaware the doors or the wall needed repair. During an interview on 11/03/16 at 4:20 PM with the Interim Administrator she acknowledged the broken and splintered laminate and wood on resident doors. She stated she expected staff to report damage to resident doors and walls to the Maintenance Director and she expected for maintenance to address the damage and fix them.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and physician interviews the facility failed to assess and respond to a change in condition when a residents eye enucleation (removal of the eye) began draining purulent drainage for 1 of 2 sampled residents (Resident #25). The findings included: Resident #25 was admitted to the facility on 09/30/16 with diagnoses that included chronic obstructive pulmonary disease (COPD), weakness, tracheostomy, dementia, seizures, pneumonia, and others. Review of the most recent comprehensive minimum data set (MDS) dated 10/12/16 revealed that Resident #25 was cognitively intact with unclear speech. No behaviors were identified. Resident #25 required extensive assistance of 2 person with bed mobility and transfers and required total assistance of one staff member for personal hygiene. Review of admission orders dated 09/30/16 from the hospital revealed no orders for a dressing to the right eye site. Review of an initial skin check dated 10/01/16 revealed nothing about Resident #25 ' s eye area or lack of a eyeball.	F 309	1.SBAR (Situation Background Assessment Response) completed and NP notified of change on 11/3/16 by Licensed Nurse. Nurse Practitioner assessed resident #25 on 11/3/16. 2.Current residents with dressings have the potential to be affected by the alleged deficient practice. Nurse Manager completed an audit of residents with dressings on 11/3/16 with no abnormal findings noted. 3.Licensed nursing staff will be re-educated by DON/Administrative RN by 11/30/16 on SBAR and notification to MD/NP. Nurse Manager will assess all residents with dressings 5 times weekly for 2 weeks for notification of changes in abnormal drainage. Nurse Manager will continue to assess residents with dressings for changes and notification weekly for 3 months. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18	F 309		

Observation on 10/31/16 at 5:09 PM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. Resident #25 was able to mouth a few words to me. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing contained no date indicating when it had been applied. The dressing was clean and dry.

Observation on 11/01/16 at 9:58 AM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. Resident #25 would not mouth any words to me and would not communicate using the dry erase board at bedside. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing contained no date indicating when it had been applied but appeared to be the same dressing that was in place yesterday as the edges were frayed. The dressing had a 50 cent piece size area of purulent drainage noted to the dressing.

Observation on 11/02/16 at 9:25 AM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. Resident #25 would not mouth any words to me and did communicate using the dry erase board at bedside. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing contained no date indicating when it had been applied but appeared to be the same dressing that was in place yesterday as the same edges were frayed. The dressing had 2 50 cent piece size areas of purulent drainage noted on the dressing. The surrounding area around the dressing was crusty with dried hard substance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19	F 309		

Observation on 11/02/16 at 11:47 AM of Resident #25 revealed he was in bed and non-verbal due to tracheostomy. Resident #25 would not mouth any words to me and did not communicate using the dry erase board at bedside. There was a dressing covering the right eye area and Resident #25 had a pair of dark sunglasses on. The dressing contained no date indicating when it had been applied but appeared to be the same dressing from earlier observation with the same frayed edges. The dressing had 2 50 cent piece size areas of purulent drainage noted on the dressing. The surrounding area around the dressing was crusty with dried hard substance.

Observation on 11/02/16 at 3:41 PM of Resident #25 revealed he was up in his wheelchair at bedside and remained non-verbal. The dressing covering his right eye area had been changed and was clean and dry. There was no date indicating when the dressing had been applied. The crusty substance surrounding the eye area has been cleaned as well.

Interview with Nurse #1 on 11/03/16 at 10:38 AM revealed that she routinely took care of Resident #25 and stated that Resident #25 was very demanding with staff and did become belligerent with staff at times. Nurse #1 confirmed that she had worked with Resident #25 on 11/01/16 and 11/02/16 and confirmed that she had changed the dressing to Resident #25' s righty eye area on 11/02/16 sometime after lunch. Nurse #1 stated she was not sure how often the dressing over his right eye area was scheduled to be changed. Nurse #1 stated she had noticed the green drainage on the dressing on 11/01/16 but "was going to wait and see" but stated she would go ahead and have the doctor look at it when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 20	F 309		

was in the facility.

Interview with the Assistant Director of Nursing (ADON) on 11/03/16 at 11:52 AM revealed that if the staff had noted the green drainage on 11/01/16 she would have expected them to immediately contact the physician and complete a report in the resident's medical record.

Interview with the Nurse Practitioner (NP) on 11/03/16 at 1:47 PM revealed that she had evaluated Resident #25 on 11/02/16 near the end of the business day. The NP stated this was a focused visit for Resident #25's complaints of insomnia, the NP stated she did not remove the dressing and did not evaluate the eye. The NP stated she was not aware of any purulent drainage that had come from the right eye area.

Interview with the physician on 11/03/16 at 2:59 PM revealed that she was fairly new to the facility and had been there for approximately 3 to 4 weeks. The physician stated that she had evaluated Resident #25 previously for respiratory distress and he was place on antibiotic therapy at that time. The physician stated that each time she had evaluated Resident #25 he had a patch covering the right eye area. The physician also stated that if the right eye area started draining purulent drainage that was a new problem for him and she would be expected to be notified so that she could assess the issue. The physician stated that Resident #25 was currently on Levaquin (antibiotic) for his pulmonary issues but Levaquin was not good for anaerobic bacteria which is what she would be concerned with purulent drainage from the eye area so the Levaquin would not cover that bacteria. The physician stated she would not culture the area due to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 risk of contamination but would use an empiric antibiotic that would cover the anaerobic bacteria. The physician again stated with the purulent drainage she would expect to be notified and put on the list to be seen. Interview with the Director of Nursing on 11/03/16 at 3:47 PM stated that she expected Nurse #1 to contact the physician the same day that she noticed the purulent drainage and document her findings in the medical record.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to trim a dependent residents fingernails for 1 of 3 residents sampled for activities of daily living (Resident #97). The findings included: Resident #97 was admitted to the facility on 09/03/15 with diagnoses that included quadriplegia C1-C4 incomplete, muscle spasms, contractures, and dysphagia. Review of the most recent quarterly minimum data set (MDS) dated 10/19/16 revealed that	F 312	1.Resident #97□s nails were trimmed by CNA on 11/2/16 and 11/3/16. 2.Current dependent residents who do not participate in showers or out of bed activity nail clinic have the potential to be affected by the alleged deficient practice. Nurse Manager completed fingernail audit on residents who do not participate in showers or activity nail clinic on 11/4/16.No areas of concern noted. 3.Staff will be re-educated on trimming lengthy nails by 11/30/16. Nurse Manager will complete an audit of all dependent residents that do not participate in showers or activity nail clinic 3 times a	12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 22 Resident #97 was cognitively intact and required total assistance with all aspects of activities of daily living (ADLs) including personal hygiene with one or two person assistance from staff. The MDS also indicated that Resident #97 had impairments to bilateral upper and lower extremities. Observation of Resident #97 on 10/31/16 at 4:44 PM revealed he was lying in bed with eyes open and fingernails were observed to be approximately ½ inch long on both hands. Resident #97 stated that he was a quadriplegic and could not move anything except his head in very small movements. Observation of Resident #97 on 11/02/16 at 10:05 AM revealed he was lying in bed with eyes open and his fingernails remained approximately ½ inch long on both hands. Observation of ADL care on 11/02/16 at 10:38 AM revealed Nursing Assistant (NA) #1 washed and dried Resident #97. NA #1 also completed perineal care and catheter care and placed a clean brief on Resident #97. Resident #97 fingernails remained approximately ½ inch long on both hands. When NA#1 had completed her bed bath she provided Resident #97 with a snack and a sip of water, then NA#1 gathered the soiled linen and trash and confirmed she was done with providing ADL care to Resident #97 and exited the room. Interview with NA#1 on 11/02/16 at 11:59 AM revealed that she routinely took care of Resident #97. NA#1 stated that she had to perform all ADLs for Resident #97 including nail care. NA#1 stated that Resident #97 did not go to the shower	F 312	week for 2 weeks and then weekly for 2 months. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by Nurse Manager for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(X4) ID PREFIX 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 23	F 312		

and only received bed baths. NA#1 further stated nail care is routinely completed on shower days or anytime we see they are "outrageously" long, we can use an orange stick to clean them if we need too. NA#1 stated she did notice during ADL care that Resident #97's nails were long but did not trim them, but she would go back and do it. NA#1 stated that Resident #97 had never refused to have nails trimmed to her knowledge and she would take care of it now.

Interview with the Assistant Director of Nursing (ADON) on 11/03/16 at 10:46 AM revealed that the NA's provided nail cleaning and trimming as long as the resident was not a diabetic, then the nurse has to trim them. The ADON stated that nail care was to be performed anytime staff noticed it needed to be done, it was something we routinely look for.

Interview with Resident #97 on 11/03/16 at 2:14 PM revealed that his nails were long and needed to be trimmed. Resident #97 stated that most of the time his wife trimmed his nails, not because he preferred her to do but because she would notice there were long and just took care of it for him. Resident #97 again stated that he did not care who trimmed his nails but they needed to be trimmed they were too long.

Interview with the Director of Nursing (DON) on 11/03/16 at 3:47 PM revealed that the activities department 1 to 2 times a month has a nail clinic where they clean and file nails and the NA's or nurses are to trim nails during showers or when providing routine care. The DON stated that if NA #1 had noticed that Resident #97's nails needed to be trimmed then she expected them to be trimmed at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 11/03/2016

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BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and resident and staff interviews the facility failed to secure the indwelling catheter tubing to prevent excessive tension or accidental displacement for 1 of 1 sampled residents for urinary catheters (Resident #97). The findings included: Resident #97 was admitted to the facility on 09/03/15 with diagnoses that included quadriplegia C1-C4 incomplete, muscle spasms, and neuromuscular dysfunction of the bladder. Review of the most recent quarterly minimum data set (MDS) dated 10/19/16 revealed that Resident #97 was cognitively intact and required total assistance with all aspects of activities of daily living (ADLs) including personal hygiene with one or two person assistance from staff. The MDS also revealed that Resident #97 had an indwelling catheter.	F 315	1.Resident #97□s catheter was secured with anchor on 11/2/16 by CNA. 2.Current residents with catheters have the potential to be affected by the alleged deficient practice. An audit was completed on 11/5/16 to ensure residents with catheters had securement of tubing by Nurse Manager. 3.Staff re-education on assuring catheter tubing is properly secured to be completed on 11/30/16 by DON/ADON. Nurse Manager will complete an audit of residents with catheters 5 times a week for 2 weeks then weekly for 2 months. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	12/1/16

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F 315	Continued From page 25	F 315		

Review of a care plan dated 10/26/16 read in part Resident #97 had an indwelling catheter related to neurogenic bladder and pressure ulcer. The goal of stated care plan was Resident #97 would be free from catheter related trauma through the review date. Interventions of the care plan included anchor catheter tubing to prevent excessive tension.

Observation of catheter care on 11/02/16 at 10:38 AM revealed that Nursing Assistant (NA) #1 un-anchored the catheter tubing from his right leg and cleaned the catheter using good clean technique and when Na#1 completed the cleaning she did not re-anchor the tubing to the residents right leg. After care was provided NA#1 collected the soiled linen and trash and confirmed the care was complete and exited Resident #97's room leaving the catheter tubing unanchored.

Interview with NA #1 on 11/02/16 at 11:59 AM revealed that she routinely took care of Resident #97 and had to perform all aspect of personal care for him including catheter care. NA#1 stated that she performed catheter care each time she provided incontinent care to Resident #97. NA#1 reported that in the past Resident #97 had a problem with his catheter and he frequently asked her to tighten the anchor to relieve any excess tension from the catheter tubing. NA#1 stated that she did not re-anchor the catheter tubing this morning after providing catheter care and she was shocked that Resident #97 did not say anything to her about it, but NA#1 stated she would go back in there and re-anchor the tubing like she should have done after she provided catheter care earlier that morning.

Interview with Nurse #1 on 11/03/16 at 10:46 AM

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F 315	Continued From page 26 revealed that Resident #97 had an indwelling catheter and he was very particular about the way it was anchored, if the catheter tubing was not anchored correctly Resident #97 reported that it was "clogging up." Nurse #1 stated that Resident #97's catheter tubing should be anchored at all times except when providing catheter care. Interview with Resident #97 on 11/03/16 at 2:14 PM revealed that when staff failed to anchor his catheter tubing the catheter would often start to "clog up" and I begin to feel bloated and routinely in the past this has caused me to run a fever and develop a urinary tract infection (UTI). Resident #97 stated he was aware when the catheter tubing was not anchored and I am able to ask the staff to come and anchor it like it should be which happened from time to time. Interview with the Director of Nursing (DON) on 11/03/16 at 3:47 PM revealed that she expected the catheter tubing to be anchored to one of Resident #97's legs at all times except when providing catheter care.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/1/16

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F 371	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean a fan that contained gray debris hanging from the metal grates on the front and back of the fan that was in use and located in a food preparation area next to clean pots and pans and the facility failed to clean a dirty microwave located in 1 of 2 nourishment rooms (700 hall). The findings included: 1. During the initial tour and observation of the kitchen on 10/31/16 at 2:53 PM a small fan was sitting on a rolling cart at the end of the tray line near clean pots and pans that were draining at the end of a 3 compartment sink. The fan was turned on and gray debris was visible and hanging from the metal grates on the front and back of the fan. During an observation on 11/02/16 at 11:16 AM a small fan was sitting on a rolling cart next to clean pots and pans that were drying at the end of the 3 compartment sink. The fan was turned on and air was blowing out of the front and back of the fan and the clean pots and pans were located next to the back of the fan. A buildup of gray debris was located on the front and back grates of the fan with the buildup of debris greater on the back of the fan. An observation and interview was conducted on 11/03/16 at 9:50 AM in the kitchen with the	F 371	1.Fan located in kitchen removed and cleaned by Dietary Manager on 11/3/16. Microwave located in 700 hall nourishment room cleaned on 11/3/16 by dietary staff. 2.Current residents have the potential to be affected by the alleged deficient practice. An audit of kitchen fans and nourishment room microwaves completed on 11/3/16 by Dietary Manager and Administrator. Equipment cleaned and sanitized. 3.Dietary staff to be re-educated on cleaning process for kitchen fans and nourishment room microwaves by 11/30/16. Dietary Manager/Dietary Staff to complete audit of microwaves and kitchen fans daily for 2 weeks then 3 times a week for 4 weeks and then weekly for 3 months. 4.Data obtained during the audit process will be brought to QAPI committee for 3 months by the Dietary Manager, at which time the QAPI committee will evaluate for trends, patterns and the effectiveness of the audit and determine if further auditing is needed.	

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F 371	Continued From page 28	F 371		

Dietary Manager and the District Manager. A small fan was observed sitting on a rolling cart that was parked at the end of the 3 compartment sink next to a drying rack that contained a large clean pot. The fan was turned off and a buildup of gray debris was visible on the front and back grates of the fan. The Dietary Manager explained the purpose of the small fan was to help cool the air temperatures when it got really hot in the kitchen. She stated there was no cleaning schedule in place to clean the fan but it should be cleaned as needed. She confirmed the fan had dust build up on the front and back of the fan and it should be removed from the kitchen and cleaned. She stated she had been focused on other things during the week and had not seen the dust buildup on the fan.

2. During an observation on 10/31/16 at 3:25 PM a microwave was sitting on a counter in the nourishment room on the 700 hall and inside the microwave there was dried food splatters on the sides and top surfaces.

During an observation on 11/02/16 at 3:01 PM of the microwave in the nourishment room on the 700 hall revealed it had dried and splattered food on the inside top surface.

During an observation on 11/03/16 at 10:11 AM of the microwave in the nourishment room on the 700 hall revealed it had dried and splattered food on the inside top surface.

During an interview on 11/03/16 at 10:15 AM with

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F 371	Continued From page 29 the Dietary Manager she confirmed environmental services was responsible for cleaning microwaves in the nourishment rooms. She further stated she had noticed the microwave in the nourishment room on the 700 hall was dirty on 10/31/16 and had told the Housekeeping Manager it needed to be cleaned. During an interview and tour on 11/03/16 at 10:21 AM with the Housekeeping Manager he confirmed housekeeping staff was responsible for cleaning microwaves in the nourishment rooms and verified the nourishment rooms were located on the 400 and 700 hallways. He stated it was his expectation for housekeepers to clean the microwave every day. During the tour he opened the door of the microwave in the nourishment room on the 700 hallway and confirmed the inside top of the microwave had dried and splattered food on the surface. He stated when housekeeping staff had cleaned the microwave they did not get the inside top surface cleaned. He stated it was his expectation for housekeeping staff to clean microwaves every day and they had to clean all the surfaces which included the top of the microwave. During an interview and tour on 11/03/16 at 10:28 AM with the Interim Administrator she confirmed the inside top surface of the microwave in the nourishment room on the 700 hall was dirty with dried and splattered food. She stated it was her expectation for the microwave to be cleaned.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		12/1/16

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F 431	Continued From page 30 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to remove expired medications from 1 of 4 medication carts.	F 431	1.The 2 vials of expired Phenergan were removed from med cart on 11/2/16. 2.Current residents have the potential to	

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F 431	Continued From page 31 The findings included: Review of a facility policy titled "Medication Pass and Medication Storage" dated December 2006 read in part medications are stored to maintain their integrity and to support safe administration of the correct medication to the correct resident, by the correct route and in the correct dose such as medications available for use are not expired, contaminated or unusable. Observation on 11/02/16 at 12:15 PM of the 300 hall medication cart revealed 2 vials of Phenergan 25 milligram (MG) per 1 milliliter (ml) that expired 07/2016 that were present on the cart in the top draw and available for use by the staff. Interview with the Certified Medication Aide (CMA) #1 on 11/02/16 at 12:20 PM revealed that the pharmacy representative had been there an hour earlier and been through his cart and removed other expired medication so he was not sure how they missed the expired Phenergan. The CMA #1 stated he did not give injections so he had not checked the expiration dates on those medications, he checked the dates on the medications he administered. Interview with the Director of Nursing (DON) on 11/03/16 at 3:47 PM revealed that night shift nurses are responsible for checking medication carts and medication rooms for expired medications. In addition to the night nurse the DON stated that she checked medication carts and medication rooms as did the unit managers and as an extra precaution the pharmacy representative checked the medication carts and	F 431	be affected by the alleged deficient practice. Facility wide audit of med carts was completed on 11/2/16 with no other expired medications noted. 3. Pharmacist re-educated Pharmacy Technician on auditing every medication vial on 11/21/16. DON/ADON to re-educate Licensed Nurses to audit all vials of medication for expiration date. Pharmacy Technician to audit all med carts every month for 3 months for expired medication vials. Administrative Nurse to audit medication carts 3 times a week for 4 weeks for expired medication vials, then weekly for 3 months. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	

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F 431	Continued From page 32 rooms. The DON stated that when a medication is discontinued they would go to the medication cart and remove the medication from the cart. The DON further stated that the pharmacy representative had just been through the carts and did not identify the expired Phenergan but her expectation was that all expired medication was removed from the medication cart and disposed of per facility policy.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		12/1/16

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F 520	Continued From page 33 This REQUIREMENT is not met as evidenced by: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in October 2015. This was for one recited deficiency originally cited in October 2015 on an annual recertification survey and subsequently recited on the current recertification survey. The deficiency was in the area of maintenance and housekeeping services. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: This tag is cross referred to: F 253: Based on observations and staff interviews the facility failed to label a urinal and a fracture bed pan in 2 resident bathrooms (Room #106 and #310) on 2 of 7 resident hallways, failed to repair 13 resident doors (Resident Room #103, #201, #205, #207, #305, #310, #311, #401, #405, #512, #601, #700 and #706) with broken and splintered laminate and wood on the edges of the bottom half of the doors (100, 200, 300, 400, 500, 600 and 700 halls), failed to repair 1 of 2 doors to the recreation room with broken and splintered laminate on the lower edges of the door (100 hallway), failed to repair a set of smoke prevention doors (700 hall) with broken and splintered laminate on the lower edges of the doors on 1 of 7 hallways and failed to repair a wall behind a resident's bed with deep gouges into the sheetrock (Room #410-A) on 1 of 7 resident hallways.	F 520	1.Administrator in serviced QAPI committee to maintain implemented procedures and monitor these interventions. In service completed 11/23/16 2.QAPI committee educated by Administrator on F520 on 11/23/16 as all residents residing in the facility has the potential to be affected. 3.Administrator to educate committee to maintain and implement procedures and monitor the interventions. DON has educated the management team and staff on auditing resident rooms for identified areas of splintered doors, wall gouges as well as labeling of urinals and bed pans 4.The Administrator will oversee the committee meeting and the contents to validate that the QAPI committee is reviewing all audits and the findings with discussion of identified areas to ensure facility maintains compliance on going. Committee will meet monthly for 3 months.	

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F 520	Continued From page 34 The facility was cited for F 253 in October 2015 for a soiled privacy curtain. On 11/03/16 at 5:02 PM the interim Administrator was interviewed about the facility's Quality Assurance Program. The interim Administrator reported that she had reviewed the statement of deficiencies upon coming to the facility and felt the facility was in compliance with F 253.	F 520		