| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 166 SS=D | 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br><br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their | F 166 | | |

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 166 | Continued From page 1<br>conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br><br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br><br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br><br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement | F 166 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 166 | Continued From page 2<br>Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to resolve a grievance and ensure the grievance investigation and resolution were provided in writing to 1 of 1 sampled resident (Resident #2).<br><br>The findings included:<br><br>Resident #2 was admitted to the facility on 09/16/16 with diagnoses that included chronic respiratory failure, weakness, displaced malleolar fracture of right leg, difficulty in walking and others.<br><br>Review of the most recent quarterly Minimum Data Set (MDS) dated 04/24/17 revealed that Resident #2 was cognitively intact and required extensive assistance to total dependence with activities of daily living.<br><br>Review of a grievance filed by Resident #2 on 03/06/17 revealed that the grievance was received by the Administrator. Resident #2's concerns were: Resident #2 waited to be changed from 9:00 AM to 11:00 AM and there was no supervisor in the building during the weekend. The "Action" of the grievance read in part, there was a supervisor in the building and she denied having any concerns from Resident | F 166 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 166 | Continued From page 3 | F 166 | | |

#2. The nursing staff was educated on responding to resident needs as soon as possible and to keep the resident informed. The staff was also educated on checking on residents before meal times to ensure faster services and increase resident satisfaction. The form indicated that Resident #2 was not satisfied with the resolution and the form was signed by the Administrator on 03/06/17.

An interview with Resident #2 was conducted on 06/06/17 at 10:27 AM. Resident #2 confirmed that he had filed the grievance on 03/06/17 after he called the facility "hot line". He added that after he had call the "hot line" the Administrator had come and spoken with him about his concerns. Resident #2 stated that after the Administrator came and listened to his concerns he had not heard any follow up from the grievance and no resolution had been reached.

An interview with the Administrator was conducted on 06/06/17 at 6:39 PM. The Administrator stated that Resident #2 was assigned an ambassador that checked on him frequently. He stated that Resident #2 often called the facility "hot line" and had multiple complaints each day and was very difficult to make happy. The Administrator stated that the "Actions" the facility took to handle the grievance were documented on the grievance form and he only provided follow up if the resident or family asked for it. The Administrator stated that he had attend the recent training on grievances but he only believed that follow up was only required if the resident or family asked for it. The Administrator stated that after the training he did start documenting some follow up notes on the grievance form but had not started doing follow

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 166 | Continued From page 4<br>up letters yet. | F 166 | | |
| F 253 SS=D | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident, and staff interviews the facility failed to empty a bedside commode and address a foul urine odor in 1 of 3 resident's room (Room #301) on 1 of 4 halls (300 hall).<br><br>The findings included:<br><br>An observation of Room #301 on 06/06/17 at 9:34 AM revealed a strong foul urine odor present in the room and outside in the connecting hallway. There was a bedside commode in the room that had urine present in it. Housekeeping staff was noted to be in the room next to Room #301.<br><br>Interview with the Housekeeping Aide on 06/06/17 at 9:50AM revealed that she was responsible for cleaning 5 rooms on the 300 including 301 and some of the commons areas in the facility. She stated she had emptied the trash and made a quick pass in room 301 and she would return after the breakfast meal to perform the complete clean of the room.<br><br>An observation of Room #301 on 06/06/17 at 11:22 AM revealed a strong foul urine odor present in the room and outside in the connecting hallway. There was a bedside commode in the | F 253 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 5 | F 253 | | |

room that had urine present in it. There was also a soiled brief laying on top of the bedside commode.

An observation of Nurse #1 was made on 06/06/17 at 12:00 PM. Nurse #1 responded to the call bell in Room #301 and was observed to empty the bedside commode and dispose of the soiled brief in the trash can. Before Nurse #1 exited the Room #301 she sprayed orange scented room deodorizing spray in Room #301.

An observation and interview with Director of Housekeeping (DOH) on 06/06/17 at 12:08 PM was conducted. The DOH confirmed that the room had a strong foul urine odor despite the scent of orange deodorizing spray.

An interview with the alert and oriented Resident #3 on 06/06/17 at 12:15 PM revealed that she resided in Room #301 and confirmed that she had used the bedside commode earlier that morning and staff had not emptied yet. She further stated she asked Nurse #1 to empty the bedside commode and to spray the deodorizing spray because her room smelled strongly of urine and although she did not have much sense of smell she could detect the odor.

An interview was conducted with Nurse #1 on 06/06/17 at 5:02 PM. Nurse #1 stated she had noticed the strong urine odor in Room #301 earlier when she emptied the bedside commode. She added that there was a soiled brief lying on top of the bedside commode and she believed that was the source of the odor. Nurse #1 stated she had sprayed orange scented room deodorizing spray to try and alleviate the strong urine odor.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 6<br><br>An observation of Room #301 on 06/06/17 at 5:08 PM revealed a strong foul urine odor in room. The odor was not present in the connecting hallway.<br><br>An interview with the Administrator on 06/06/17 at 5:47 PM confirmed that Room #301 had a foul urine odor that morning. He added that it was a little better this afternoon after housekeeping had cleaned the room but was still present. The Administrator added that they will have to take additional steps to try and alleviate the odor in Room #301 that may include removing everything from the room and washing it from top to bottom. | F 253 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly- | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 278 | Continued From page 7<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, physician, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the use of a ventilator for 1 of 3 sampled residents receiving respiratory services (Resident #1).<br><br>The findings included:<br><br>Resident #1 was readmitted to the facility on 05/05/17 with diagnoses that included: chronic respiratory failure, dependence on a ventilator, chronic diastolic heart failure, and obstructive sleep apnea. Resident #1 was discharged from the facility on 05/19/17.<br><br>Review of a physician order dated 05/05/17 revealed Respiratory Therapist (RT) or Nurse to place patient on the ventilator at night.<br><br>Review of a facility document titled Tracheostomy Daily Flow Sheet dated 05/11/17 read in part, Resident #1 used the ventilator at bedtime and as needed and listed the ventilator setting that were used when Resident #1 was placed on the | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 278 | Continued From page 8<br>ventilator.<br><br>Review of the most recent quarterly Minimum Data Set (MDS) dated 05/12/17 revealed that Resident #1 was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #1 required the use of oxygen, required suctioning, and received tracheostomy care. The use of a ventilator was not checked.<br><br>An interview was conducted with the RT on 06/06/17 at 1:32 PM. The RT stated that Resident #1 had carbon dioxide retention and a poor ejection fraction (percentage of blood that leaves the heart with each beat) of her heart and was going to require the use of the nocturnal (night time) ventilator for the rest of her life. The RT stated that Resident #1 was preparing to discharge home and he had arranged for home ventilator services. He added that he worked the day shift and when he would come to work he would remove Resident #1 from her ventilator for the day and then at night another staff member would put her back on her ventilator.<br><br>The MDS Coordinator was unavailable for interview on 06/06/17 at 2:54 PM.<br><br>An interview was conducted with MDS Nurse #1 on 06/06/17 at 2:54 PM. MDS Nurse #1 stated the facility coded the use of the ventilator under section O of the MDS. MDS Nurse #1 reviewed Resident #1 MDS dated 05/12/17 and stated she was unsure why it was not coded but she would find out.<br><br>A follow up interview was conducted with MDS Nurse #1 on 06/06/17 at 3:14 PM. MDS Nurse #1 | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 278 | Continued From page 9<br>stated that she had spoken to the MDS Coordinator at the facility via phone and stated "we not do code the use of the ventilator here because we do not get reimbursed for it, so we do not code them."<br><br>An interview with the Medical Doctor (MD) was conducted on 06/06/17 at 5:21 PM. The MD stated that Resident #1 lungs and respiratory status were "rock solid except Resident #1 required the use of the ventilator at night."<br><br>An interview was conducted with the Administrator on 06/06/17 at 6:39 PM. The Administrator stated that since he had been at the facility they have not coded the MDS to reflect the use of ventilators because they were told the ventilators were used just like a CPAP so they did not code the use of ventilators. He added staff were going to have to figure it out and code the MDS assessment accurately. | F 278 | | |
| F 490 SS=D | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, medical doctor, pulmonologist, and staff interviews the facility failed to ensure that they were not exceeding their capabilities of respiratory services for 1 of 3 sampled residents (Resident #1). | F 490 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 490 | Continued From page 10<br>The findings included:<br><br>Resident #1 was readmitted to the facility on 05/05/17 with diagnoses that included: chronic respiratory failure, dependence on a ventilator, chronic diastolic heart failure, and obstructive sleep apnea. Resident #1 was discharged from the facility on 05/19/17.<br><br>Review of a physician order dated 05/05/17 revealed Respiratory Therapist (RT) or Nurse to place patient on the ventilator at night.<br><br>Review of a facility document titled Tracheostomy Daily Flow Sheet dated 05/11/17 read in part, Resident #1 used the ventilator at bedtime and as needed and listed the ventilator setting that were used when Resident #1 was placed on the ventilator.<br><br>Review of the most recent quarterly Minimum Data Set (MDS) dated 05/12/17 revealed that Resident #1 was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #1 required the use of oxygen, required suctioning, and received tracheostomy care. The use of a ventilator was not checked.<br><br>An interview was conducted with the RT on 06/06/17 at 1:32 PM. The RT stated that Resident #1 had carbon dioxide retention and a poor ejection fraction (percentage of blood that leaves the heart with each beat) of her heart and was going to require the use of the nocturnal (night time) ventilator for the rest of her life. The RT stated that Resident #1 was preparing to discharge home and he had arranged for home ventilator services. He added that he worked the | F 490 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 490 | Continued From page 11 | F 490 | | |

day shift and when he would come to work he would remove Resident #1 from her ventilator for the day and then at night another staff member would put her back on her ventilator.

An interview with the Medical Doctor (MD) was conducted on 06/06/17 at 5:21 PM. The MD stated that Resident #1 lungs and respiratory status were "rock solid except Resident #1 required the use of the ventilator at night." She added that Resident #1 liked to be suctioned but did not require any medication for excess secretions and despite being on the ventilator she had never had any respiratory distress. The MD stated Resident #1 was actually as stable as possible on her ventilator and the facility was in the process of arranging discharge for Resident #1 with ventilator services because Resident #1 would require nocturnal ventilation for the rest of her life.

An interview with the Pulmonologist was conducted on 06/13/17 at 9:47 AM. The pulmonologist confirmed that Resident #1 required the use of the nocturnal ventilator. He stated that Resident #1 had chronic polyneuropathy with respiratory failure and her rejection fraction was 15%. The pulmonologist added that Resident #1 had a remote history of sleep apnea but he had no documentation of that. He added that she admitted to the facility with a tracheostomy and was prescribed the trilogy (type of ventilator) at night. He stated the trilogy ventilator was designed to be functional and portable that allowed residents to eventually be able to go home despite the need for a ventilator. He added that the trilogy technology allowed them to use the Ventilator as a traditional ventilator or as a continue positive airway pressure (CPAP)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |



| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

| (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 490 | Continued From page 12<br>that could be tailored to each individual patient and for Resident #1 that was the use of the ventilator portion of the machine. He also stated that they used a swisher valve that allowed the system to remain an open system and again could be tailored to the needs of the resident. The pulmonologist stated that Resident #1 was not stable enough to have her tracheostomy capped and a traditional mask applied at night. He added that "Resident #1 required the use of the ventilator to stay alive."<br><br>An interview was conducted with the Administrator on 06/06/17 at 6:39 PM. The Administrator stated that they did not admit residents that required the use of the traditional ventilator because they were not a traditional ventilator unit. The Administrator stated that when he came to the facility he was told that the ventilators were used just like a CPAP machine. He stated that the Breath program that allowed the facility to admit nocturnal ventilator patients was started prior to him coming to the facility and he had not changed anything. He added that he was told that all the ventilators were used in place of CPAP machines and so to his knowledge Resident #1's ventilator was used in that manner. | F 490 | | |
| F 520 SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services; | F 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 520 | Continued From page 13<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, medical doctor, and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April 2017 following a complaint | F 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |



| (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 520 | Continued From page 14 | F 520 | | |

investigation and subsequently recited in June 2017 on the current complaint investigation. The repeat deficiencies are in the areas of House Keeping and Maintenance (F253) and Resident Assessment (F278). These deficiencies were recited during the facility current complaint investigation. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program.

The findings included:

This tag is cross referred to:

1a. F253 Based on observations, resident, and staff interviews the facility failed to empty a bedside commode and address a foul urine odor in 1 of 3 resident's room (Room #301) on 1 of 4 halls (300 hall).

During the complaint survey of 03/23/17, this regulation was cited for failing to secure a commode to the floor for 7 months and a grab bar to the wall (Room 113) for a resident who used the bathroom independently for 1 of 10 resident bathrooms observed.

During the current complaint survey of 06/13/17, this regulation was cited for failing to empty a bedside commode and address a foul urine odor.

1b. F278 Based on record review, resident, physician, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the use of a ventilator for 1 of 3 sampled residents receiving respiratory services (Resident #1).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 06/13/2017 |



| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

| (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 520 | Continued From page 15<br>During the complaint survey of 03/23/17, this regulation was cited for failure to accurately assess a resident for a history of falls on an annual and quarterly Minimum Data Set for 1 of 13 sampled residents reviewed (Resident #9).<br><br>During the complaint survey of 06/13/17, this regulation was cited for failure to accurately code the Minimum Data Set to reflect the use of a ventilator for 1 of 3 sampled residents receiving respiratory services.<br><br>An interview with the Administrator was conducted on 06/06/17 at 7:00 PM. The Administrator stated that the Quality Assessment and Assurance Committee (QA) consisted of himself, the Director of Nursing, Medical Director, and all other department heads and the committee met on a monthly basis. He added that the committee continued to complete the audits for repeat deficiencies (F253 and F278) that were implemented in April 2017 and those have been going well. The Administrator stated that the coding error with the Minimum Data Set (MDS) was not intentional and they would just have to figure it out so the MDS assessment are completed accurately. | F 520 | | |