	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURV COMPLETE	
					С	
		345578	B. WING		03/07/2)24
VAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAR CI	REEK HEALTH CENTER			41 PIEDMONT ROW DRIVE HARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COM	(X5) MPLETIO DATE
E 000	Initial Comments		E 000			
F 000	conplaint investigatio 3/5/2024 to 3/7/2024 compliance with the r Emergency Prepared	ertification survey and n survey were conducted . The facility was found in requirement CFR 483.73, Iness. Event ID # QUKS11.	F 000			
su Ev in	survey were conducted					
F 623 SS=B		Before Transfer/Discharge	F 623		3/22	!/24
	§483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a c representative of the Long-Term Care Oml (ii) Record the reason discharge in the reside accordance with para and	before transfer. fers or discharges a hust- and the resident's he transfer or discharge and hove in writing and in a r they understand. The opy of the notice to a Office of the State budsman. hs for the transfer or lent's medical record in agraph (c)(2) of this section;				
	§483.15(c)(4) Timing (i) Except as specifie	of the notice. d in paragraphs (c)(4)(ii) and				
BORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ē	TITLE	(X6) D.	ATE
	ically Signed				03/2	E IOO

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/05/2024 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345578	B. WING		_	03/	, 07/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	_	
BRIAR CR	EEK HEALTH CENTER			041 PIEDMONT ROW DRI CHARLOTTE, NC 28210			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Content notice specified in par must include the follow (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request;	the notice of transfer or ider this section must be it least 30 days before the lor discharged. Ide as soon as practicable charge when- riduals in the facility would paragraph (c)(1)(i)(C) of riduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge,)(i)(B) of this section; hefer or discharge is ent's urgent medical needs,)(i)(A) of this section; or resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: hefer or discharge; of transfer or discharge; inch the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and the Office of the State	F 623				

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	-	ID HUMAN SERVICES MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391			
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345578	B. WING				C 07/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	EEK HEALTH CENTER				6041 PIEDMONT ROW DRIVE		
DRIAR CR	EER HEALTH CENTER				CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 623	and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individu §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prio to the State Survey A State Long-Term Caro the facility, and the re well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on record revi	y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility bients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at §	F	623	The statements made on this plan of		
	the facility, and the re well as the plan for th relocation of the resid 483.70(I). This REQUIREMENT by: Based on record revi interviews, the facility	sident representatives, as e transfer and adequate lents, as required at § is not met as evidenced			The statements made on this plan of correction are not an admission to and not constitute an agreement with the	do	

Facility ID: 170065

If continuation sheet Page 3 of 18

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/05/ FORM APPRC OMB NO. 0938-(OVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345578	B. WING		C 03/07/2024	ŧ
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
BRIAR CR	EEK HEALTH CENTER			6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE	TION
F 623	Continued From page	e 3	F 62	23		
		viewed for hospitalization		alleged deficiencies. To re compliance with all federa regulations the facility has take the actions set forth in	l and state taken or will n this plan of	
	3/31/2022 with diagn	nitted to the facility on oses including kidney nsion. The medical record nt #4 was her own		correction. The plan of cor constitutes the facility's all compliance such that all a deficiencies cited have be corrected by the dates ind	egation of lleged en or will be	
	responsible party. The admission Minim	. ,		F623 Notice Requirements	s Before	
	#4 to be cognitively in			Transfer/Discharge Resident #4 was discharge	ed on 3/19/24.	
	A nursing progress no documented Residen condition with a decre consciousness and lo	it #4 had a change in		All residents have the pote affected. On 3/22/24 hospital transfe	ers on all	
	#4 was transferred to	the hospital for evaluation.		current residents in the las were audited by Administra		
	documented Residen	cord MDS dated 2/24/2024 at #4 was readmitted to the a short-term hospital.		no discrepancies found du The Business Office Mana Services Director and Adm Coordinator will be educat	nger, Social hissions	
		onic medical record for I no written notice of transfer medical record.		Administrator, on the Tran Policy by 3/22/24.	sfer Notice	
	AM. Resident #4 exp hospital many times of had not received a not	rviewed on 3/5/2024 at 8:43 blained she had been in the over the past year, but she btice of transfer from the		The Business Office Mana Admissions Coordinator w responsible for timely revie written transfer/discharge The Administrator, Directo	ill be ew and issuing notifications. r of Nursing and	
	Director on 3/6/2024	ducted with the Admissions at 2:41 PM. The Admissions t she was unable to locate a		or designee will be respon auditing transfers and disc hospital weekly for 3 mont Administrator, Director of I designee will bring audits Quality Assurance Perform	harges to the hs. Nursing, or to monthly	

Facility ID: 170065

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	D. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		345578	B WING			С
	ROVIDER OR SUPPLIER	345578		TREET ADDRESS, CITY, STATE, ZIP CODE	03	/07/2024
NAME OF P	ROVIDER OR SUPPLIER			3041 PIEDMONT ROW DRIVE		
BRIAR CF	REEK HEALTH CENTER			CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 623	electronic record. The	e Admissions Director	F 623	Improvement Committee meetings.	At	
		think the facility sent the a notice of discharge		that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continu auditing is necessary to maintain	ied	
	1:49 PM. The Administration of dischar completed for Reside are transferred to the reported the lack of n	ge should have been nt #4 and all residents who hospital. The Administrator otification of discharge was I. The Administrator reported s responsible for the		compliance.		
F 625 SS=B		olicy Before/Upon Trnsfr	F 625			3/22/24
	§483.15(d)(1) Notice nursing facility transfe the resident goes on nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi	provide written information to nt representative that e state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ich must be consistent with is section, permitting a				

Facility ID: 170065

If continuation sheet Page 5 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION	(X3) DATE	
		345578	B. WING _				C 07/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				6041 F	PIEDMONT ROW DRIVE		
BRIAR CR	EEK HEALTH CENTER			CHAF	RLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	 (iv) The information s of this section. §483.15(d)(2) Bed-hot the time of transfer of hospitalization or ther facility must provide to resident representative specifies the duration described in paragrap. This REQUIREMENT by: Based on record revision of the facility notice to resident transfer of 1 resident reviewed (Resident #4). The findings included Resident #4 was adm 3/31/2022 with diagned disease and hyperten documented Resident representative. The admission Minim dated 12/5/2023 assect cognitively intact. A nursing progress not documented Resident condition with a decret consciousness and lot #4 was transferred to a section of the section of	<pre>pecified in paragraph (e)(1) Id notice upon transfer. At a resident for apeutic leave, a nursing o the resident and the re written notice which of the bed-hold policy oh (d)(1) of this section. is not met as evidenced ews, resident, and staff failed to provide a bed hold asferred to the hospital for 1 d for hospitalization it initted to the facility on poses including kidney usion. The medical record t #4 was her own um Data Set assessment essed Resident #4 to be pte dated 2/5/2024 t #4 had a change in</pre>	F 6	F B R Al af O c u m C A C A C A C A C A C A C A C A C A C	625 Notice of Bed Hold Policy efore/Upon Transfer esident #4 was discharged on 3/19/24 I residents have the potential to be fected. n 3/22/24 hospital transfers on all urrent residents in the last seven days ere audited by Administrator. There w o discrepancies found during the audi ne Business Office Manager, Social ervices Director and Admissions oordinator will be educated by the dministrator, on the Bed Hold Policy to 22/24. The Director of Nursing and of esignee will educate all licensed nurse cluding fultime (FT), part time (PT), p em (PRN) and agency, by 3/22/24 on e Bed Hold Policy. All staff not in erviced by 3/22/2024, will be required omplete in-service prior to working. the Business Office Manager and dmissions Coordinator will be	es ber	
		t #4 was readmitted to the		re	sponsible for timely review and issuir ritten Bed Hold Policy notifications. Th	•	

Facility ID: 170065

If continuation sheet Page 6 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/05/2024 M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		PLETED
		345578	B. WING			C / 07/2024
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAR CR	EEK HEALTH CENTER			041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 625		e 6 onic medical record for no bed hold notice was	F 625	Administrator, Director of Nursing an designee will be responsible for audi transfers and discharges to the hosp	ting	
	scanned into the med Resident #4 was inter AM. Resident #4 exp hospital many times of had not received a be facility for any hospital Nurse #1 was intervie	ical record. rviewed on 3/5/2024 at 8:43 lained she had been in the over the past year, but she ed hold notice from the	transfers and discharges to the hospit weekly for 3 months. Administrator, Director of Nursing, or designee will b audits to monthly Quality Assurance Performance Improvement Committee meetings. At that time the QAPI committee will evaluate the effectiven of the interventions to determine if continued auditing is necessary to maintain compliance.		bring ee	
	hold notice with a resi transferred to the hos					
	Director on 3/6/2024 a Director reported that bed hold notice for Re record. The Admission had completed a bed resident transfer to the	ducted with the Admissions at 2:41 PM. The Admissions she was unable to locate a esident #4 in the electronic ns Director explained she hold notice for a recent e hospital and she did not 4 had not be given a bed				
	-					
	1:49 PM. The Adminis notice should have be and all residents who hospital. The Adminis	s interviewed on 2/7/2024 at strator reported the bed hold een provided to Resident #4 are transferred to the trator reported the bed hold the nursing station desk				

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		MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COMF	E SURVEY PLETED
		345578	B. WING				C / 07/2024
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	EEK HEALTH CENTER			60	041 PIEDMONT ROW DRIVE		
DRIARON				С	HARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	e 7	É F	625			
		why the nurses were not					
		residents when they were					
	transferred to the host	-					
F 697	Pain Management		F	697			3/22/24
SS=G	CFR(s): 483.25(k)						
	§483.25(k) Pain Man						
	•	ure that pain management is					
	•	who require such services, sional standards of practice,					
		erson-centered care plan,					
	and the residents' go						
	-	Γ is not met as evidenced					
	by:						
		iew, resident interview, and			F697 Pain Management		
		cility failed to assess a					
		dminister pain medication			Resident #70 had a pain assessment		
	• • •	cian for 1 of 2 residents			completed by the Director of Nursing o	n	
	. ,	the resident complained of			3/7/24.		
	-	dent #70 experienced pain of (10 being the worst pain)			Resident #70's pain is controlled an is receiving medications per MD order.		
		2/2024 until her medication			Medications are in stock.		
		after she was readmitted to					
		ospital for a fractured left			All residents that receive pain medicati	ion	
	fibula.				have the potential to be affected.		
					On 3/22/24 the Director of Nursing and		
	Findings included:				designee completed a pain assessmer		
	D				on all current residents to ensure that p		
		Imitted to the facility on			needs are being met appropriately, and		
		as readmitted from the 4 with diagnoses of left fibula			audited their medications to ensure the are on hand in the facility. There were	•	
	•	repair and osteoarthritis.			concerns. The Director of Nursing and		
					designee will educate all licensed nurs		
	An admission Nursin	g Assessment dated			including fulltime (FT), part time (PT), p		
		stated Resident #70 had a			diem (PRN) and agency, by 3/22/24 or		
	left ankle fracture wit	h surgical repair, and she			pain scale and assessments, with an		
	received pain medica	ation,			emphasis on the evaluation and		
	Hydrocodone-Acetar		1		monitoring of pain levels for routine an		1

Facility ID: 170065

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PRINTED: 04/05/2024 FORM APPROVED

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· · /		· · · ·	IPLETED
						С
		345578	B. WING		0;	3/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				6041 PIEDMONT ROW DRIVE		
BRIAR CF	REEK HEALTH CENTER			CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 697	Continued From page	e 8	F 69	17		
	7:00 pm and denied			as needed medications. A	ll staff not in	
				serviced by 3/22/2024, will		
		cation orders stated she had		complete in-service prior to	o working. The	
		ninophen 5-325 milligrams		Director of Nursing or desi	•	
		every 6 hours as needed for		educate all licensed nurse	-	
	pain ordered by the p	ohysician on 1/11/2024.		fulltime (FT), part time (PT		
	Posidont #70's Modia	cation Administration Record		(PRN) and agency on the documentation of medicati		
	(MAR) for 1/2024 was			administration, pharmacy		
		ated her pain was assessed		ordering of medications, ca		
		ated at 0 on scale of 0 to 10		pharmacy to validate recei	-	
	on 1/11/2024 on the r	night shift; 0 on a scale of 0		admission orders, use of b	ack up	
		n the day shift; and 7 on a		medications and back up r		
	scale of 0 to 10 on th	-		staff not in serviced by 3/2		
		R further indicated Resident		required to complete in-se		
	#70 did not receive A	ninophen or any pain		working. This education w newly hired nursing staff ir		
	medications until she			newly filled fullsing start in		
		ninophen 5-325 milligrams		In clinical meeting daily, th	e Director of	
		pm and she rated her pain		Nursing or designee will re		
	at an 8 on a scale of	0 to 10.		admissions to ensure that	pain	
				assessments were comple		
	An admission Minimu	· · · · ·		pain medication available		
		18/2024 indicated Resident		administered if needed, or		
		ntact, rated her pain a 7 on a indicated her pain was		supervisor or designee wil months, then three times v		
		her ability to sleep. The		month. The Director of Nu		
		so indicated she received		designee will complete 3 r	•	
		tions for the reported pain.		assessments weekly to en		
				residents pain needs are b		
	During an interview w			appropriately, and medica		
	-	h she stated when she was		The audits will be complete		
	-	y on 1/11/2024 at 9:30 pm,		three months. The Directo	•	
		eft ankle that required cility did not have the pain		bring the results of the auc monthly Quality Assurance		
	medication that was			Improvement committee m		
		ninophen, and she was told		ongoing compliance. The		
		medication was not available		Nursing is responsible for		
		know when it would be		the acceptable plan of con		

Facility ID: 170065

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
						С
		345578	B. WING		0	3/07/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODI	E	
	REEK HEALTH CENTER			6041 PIEDMONT ROW DRIVE		
				CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 697	Continued From page	_ 0	F 69	7		
1 007		² 9 ¢70 stated she waited 12	F 09	Assurance Performance Impre	ovomont	
		dication that was ordered.		Committee is responsible for o		
	Resident #70 stated s			compliance.		
		ninophen at 7:00 pm before				
	leaving the hospital and Nurse #1 gave her Acetaminophen for pain at 1:00 am on 1/12/2024					
		er pain was an 8 on a scale				
	of 1 to 10. Resident	#70 stated the				
		ot relieve her pain and she				
		er ordered pain medication				
		t. She stated she was in				
		light and the next day until				
		odone-Acetaminophen at				
	-	4. Resident #70 stated she ight on 1/12/2024 but she				
	-	nt that could not speak for				
		ain for a long time like she				
		/12/2024. Resident #70				
		fractures in her left ankle,				
		elevate her left leg while in				
		opedic boot when she is out				
	of the bed.					
	Nurse #1 was intervi	ewed on 3/7/2024 at 2:06				
		esident #70 arrived at the				
		1/11/2024 and she admitted				
	•	rse # 1 stated Resident #70				
		etaminophen (a narcotic				
		ered for pain when she was plained to Resident #70 she				
		ne would be able to get her				
		urse #1 further stated she				
		cetaminophen from the				
	•	ers at 1:00 am, and Resident				
	#70 was upset becau					
	Acetaminophen for pa	-				
		ninophen. Nurse #1 stated				
	she would have giver	Resident #70 the				
		ninophen if it had arrived				

Facility ID: 170065

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/05/2024 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345578	B. WING				C / 07/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				60	041 PIEDMONT ROW DRIVE		
BRIAR CR	EEK HEALTH CENTER			С	CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	Resident #70 did not a again throughout the checked on her one ti She stated since she have been in much pa documented Resident the admission assess	ring the night. She stated ask for pain medication night and she stated she me and she was sleeping. was sleeping, she must not ain. Nurse #1 stated she t #70's pain when she did ment in the computer ot have Resident #70 rate	F	697			
	Nursing on 3/7/2024 a Nurse #1 should have pharmacy when Reside medication was not ave automated medication further stated if a medication the facility's automate the facility's pharmacy medication then the n 24-hour pharmacy the to obtain the medication stated he did not know administer Resident # Nurse #1 did not call to another medication w	dent #70's ordered pain vailable in the facility's n dispensing system. He lication is not available in d medication system and v cannot deliver the urse should have called the e facility has a contract with on and have a courier n. The Director of Nursing v why Nurse #1 failed to 570's medication or why the physician and see if as available in the n system would have been					
	interviewed and state called the back up ph an order that was ava automated medication	n system to give to Resident or stated she expected the					

Facility ID: 170065

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345578	B. WING				07/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAR CF	REEK HEALTH CENTER				041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755 SS=G	,		F	755			3/22/24
	drugs and biologicals them under an agreer §483.70(g). The facil personnel to administ	ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed					
	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.						
		onsultation. The facility n the services of a licensed					
	§483.45(b)(1) Provide aspects of the provision the facility.	es consultation on all on of pharmacy services in					
		shes a system of records of n of all controlled drugs in ble an accurate					
	order and that an acc is maintained and per	ines that drug records are in ount of all controlled drugs iodically reconciled. i is not met as evidenced					
	Based on record revi staff interviews the fa- medication ordered by	ew, resident interview, and cility failed to obtain pain y the physician for 1 of 2 70) when the resident was			F755 Pharmacy Resident #70 medications were audited 3/7/24 and are in stock.	Ł	

Facility ID: 170065

If continuation sheet Page 12 of 18

		MEDICAID SERVICES				<u>IO. 0938-03</u>	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED		
			A. BUILDING	G			
		345578	B. WING			С	
		345578	B. WING_			3/07/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAR CREEK HEALTH CENTER				6041 PIEDMONT ROW DRIVE			
	1			CHARLOTTE, NC 28210			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 755	Continued From page	- 12	F 75	55			
1 100	1.0						
		y after surgical repair of a left lent #70 experienced pain of		All residents that receive pa	in medication		
		(1- being the worst pain)		have the potential to be affe			
		2/2024 until her medication		On 3/22/24 the Director of N			
		1/12/2024 at 1:06 pm on		designee completed a pain	-		
	1/12/2024.			on all current residents to e			
				needs are being met appro	•		
	Findings included:			audited their medications to	-		
				are on hand in the facility, a	nd there were		
	Resident #70 was ad	mitted to the facility on		no concerns. The Director of	of Nursing or		
		as readmitted from the		designee will educate all lic	ensed nurses		
		ith diagnoses of left fibula		including fulltime (FT), part			
	fracture with surgical	repair and osteoarthritis.		diem (PRN) and agency on documentation of medicatio			
	An admission Nursing	g Assessment dated		administration, pharmacy p	rocedures for		
		stated Resident #70 had a		ordering of medications, cal			
		h surgical repair, and she		pharmacy to validate receiv	-		
	received pain medica			admission orders, use of ba			
	Hydrocodone-Acetan 7:00 pm and denied p	ninophen, at the hospital at pain.		medications and back up na staff not in serviced by 3/22	/2024, will be		
				required to complete in-serv			
		cation orders stated she had		working. This education will			
		ninophen 5-325 milligrams		newly hired nursing staff in	orientation.		
		every 6 hours as needed for					
	pain ordered by the p	hysician on 1/11/2024.		The Director of Nursing or o	-		
	Desident #701- M	action Administration Decard		review new admissions to e			
		cation Administration Record		medication availability in cli			
	(MAR) for 1/2024 was			daily, on weekends the sup			
		ated her pain was assessed ated at 0 on scale of 0 to 10		designee will review to ensu medication availability for ne	•		
		night shift; 0 on a scale of 0		for 2 months, then three tim			
		n the day shift; and 7 on a		one month. The Director of	•		
	scale of 0 to 10 on th			designee will complete 3 ra	-		
		R further indicated Resident		ensure pain medication is a			
		medication for pain relief until		audits will be completed we			
		odone-Acetaminophen 5-325		months. The Director of Nu			
		024 at 1:06 pm and she rated		the results of the audits to the			
	her pain at an 8 on a			Quality Assurance and Imp	-		
				committee meetings for ong		1	

Facility ID: 170065

		MEDICAID SERVICES					O. 0938-03	
· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345578	B. WING			С		
		545576		STREET ADDRESS, CITY, STATE, ZIP CODE			8/07/2024	
NAME OF PROVIDER OR SUPPLIER			6041 PIEDMONT ROW DRIVE					
3RIAR CR	EEK HEALTH CENTER			CHARLOTTE, NC 28210				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 755	Continued From page	. 12	F 75	EE				
1755			F /:	55	compliance. The Director of Nursing i	-		
	An admission Minimu	18/2024 indicated Resident			compliance. The Director of Nursing i responsible for implementing the	5		
	#70 was cognitively in			acceptable plan of correction. Quality				
	scale of 0 to 10, and i			Assurance Performance Improvement				
	frequent and affected			Committee is responsible for ongoing				
	MDS assessment als			compliance.				
	narcotic pain medicat	tions for the reported pain.						
	During an interview with Resident #70 on							
	3/7/2024 at 12:45 pm							
	admitted to the facility							
		eft ankle that required						
	•	cility did not have the pain						
	medication that was o	ninophen, and she was told						
	-	medication was not available						
	-	know when it would be						
	available. Resident #	70 stated she waited 12						
		dication that was ordered.						
	Resident #70 stated s							
	•	ninophen at 7:00 pm before						
		nd Nurse #1 gave her ain at 1:00 am on 1/12/2024						
	• •	done-Acetaminophen						
		not available, when she						
		s an 8 on a scale of 1 to 10.						
	Resident #70 stated s	she was in pain throughout						
		t day until she received						
		ninophen at 1:00 pm on						
	fractures in her left ar	#70 stated she had three						
	Nurse #1 was intervi	ewed on 3/7/2024 at 2:06						
	pm and she stated Re	esident #70 arrived at the						
		1/11/2024 and she admitted						
		rse # 1 stated Resident #70						
		etaminophen (a narcotic						
	. ,	ered for pain when she was						
	admitted, and she ex	plained to Resident #70 she						

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	MENT OF HEALTH AN S FOR MEDICARE & I					FOR	D: 04/05/2024 M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMF	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345578	B. WING			C 03/07/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAR CREEK HEALTH CENTER					041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	pain medications. Nu gave Resident #70 Ac facility's standing orde #70 was upset becaus Acetaminophen for pa Hydrocodone-Acetam she would have given Hydrocodone-Acetam from the pharmacy du An interview was cond Nursing on 3/7/2024 at Nurse #1 should have pharmacy when Resid medication was not av automated medication further stated if a medication further stated if a medication the facility's pharmacy medication then the n 24-hour pharmacy the to obtain the medication stated he did not know administer Resident # Nurse #1 did not call fa another medication an appropriate replace On 3/7/2024 at 3:26 p interviewed and state called the backup pha an order that was ava automated medication	e would be able to get her rse #1 further stated she betaminophen from the ers at 1:00 am, and Resident se she was given the ain instead of the inophen. Nurse #1 stated Resident #70 inophen if it had arrived iring the night. ducted with the Director of at 2:14 pm and he stated e called the backup dent #70's ordered pain vailable in the facility's in dispensing system. He lication is not available in d medication system and y cannot deliver the urse should have called the e facility has a contract with on and have a courier in The Director of Nursing w why Nurse #1 failed to 70's medication or why the physician and see if as available in the in system would have been ement.	F	755			

Facility ID: 170065

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S FOR MEDICARE & I	ID HUMAN SERVICES					MAPPROVED 0. 0938-0391	
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED C		
	345578	B. WING				07/2024	
ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
			6	041 PIEDMONT ROW DRIVE			
			c	CHARLOTTE, NC 28210			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						(X5) COMPLETION DATE	
		F	812			3/22/24	
§483.60(i) Food safet The facility must -	y requirements.						
 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. 							
standards for food se This REQUIREMENT by: Based on observation facility failed to label a discard expired food i and ensure resident r and pans were not sta	rvice safety. is not met as evidenced ns and staff interviews, the and cover cooked food, in the walk-in refrigerator, neal trays, baking sheets, acked wet for 1 of 2 kitchen			F812 Food Procurement, Store/Prepare/Serve-Sanitary No residents were found to have been affected.			
affect food served to i The findings included The facility kitchen wa 7:47 AM. An observa walk-in refrigerator an observed:	residents. as toured on 3/5/2024 at ation was conducted of the ad the following were			the potential to be affected. On 3/5/2024, the Corporate Dietary Quality Assurance Manager disposed of all expired items stored in the walk-in refrigerator. On 3/6/2024-3/15/2024, th Corporate Dietary Quality Assurance Manager educated the Food services Staff regarding proper ware washing an	of e		
	DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER REEK HEALTH CENTER SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I Food Procurement, St CFR(s): 483.60(i)(1)(1) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pi gardens, subject to co safe growing and food (iii) This provision doe facilities from using pi gardens, subject to co safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observatio facility failed to label a discard expired food i and ensure resident r and pans were not state observations. These pi affect food served to b The findings included The facility kitchen wa 7:47 AM. An observation affect food served to b The findings included	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345578 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and cover cooked food, discard expired food in the walk-in refrigerator, and pans were not stacked wet for 1 of 2 kitchen observations. These practices had the potential to affect food served to residents. <td colspan<="" td=""><td>OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI 345578 ROVIDER OR SUPPLIER 345578 B. WING REEK HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) F \$483.60(i) Food safety requirements. 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These practices had the potential to affect food served to residents. The findings included: The facility kitchen was toured on 3/5/2024 at 7.47 AM. An observation was conducted of the walk-in refrigerator and	OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345578 ROVIDER OR SUPPLIER 345578 B. WING ROVIDER OR SUPPLIER ID REEK HEALTH CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) F 812 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. F 812 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. F 812 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and cover cooked food, discard expired food in the walk-in refrigerator, and ensure resident meal trays, baking sheets, and pans were not stacked wet for 1 of 2 kitchen observations. These practices had the potential to affect food served to residents. The facility kitchen was toured on 3/5/2024 at 7.47 AM	DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIER DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210 REEK HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210 REEK HEALTH CENTER DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD (EACH CORRECTIVE (EACH CORRECTIVE	prependencies (N1) PROVIDER/SUPPLIER (P2) MUTTPLE CONSTRUCTION (P3) MUTUPLE (P3) complexed on supplier 345578 B. WING (P3) complexed on supplier 345578 B. WING (P3) complexed on supplier STREET ADDRESS, CITY, STATE, 2IP CODE 6041 PIEDMONT ROW DRIVE (P3) recent HEALTH CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 6041 PIEDMONT ROW DRIVE (PA) (P4,CH) CENTER (P4,CH) CENTER (P4) PROVERSITY PLAN OF CORRECTION (P4) (P4,CH) CENTER (P4) PROVERSITY PLAN OF CORRECTION (P4) (P4,CH) CENTER (P4) PROVERSITY PLAN OF CORRECTION (P4) (P4,CH) CENTER (P4) (P4) PROVERSITY PLAN OF CORRECTION (P4) (P4,CH) CENTER (P4) PROVERSITY PLAN OF CORRECTION (P4) (P4,CH) CENTER (P4) PROVERSITY PLAN OF CORRECTION (P4) (P4) (P4) (P4) (P4) (P4)

Facility ID: 170065

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345578	B. WING		0	03/07/2024		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
BRIAR CREEK HEALTH CENTER				6041 PIEDMONT ROW DRIVE				
				CHARLOTTE, NC 28210				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE		
F 812	Continued From page	e 16	F 81	2				
	1.0	amer pans on the top shelf		covering, sealing, labeling	g with name of			
		s cooked white colored		item and date, use by dat				
	meat in the pans that	were floating in pink colored		disposing of expired food	daily, proper air			
	liquid. The sheet on the			drying of items including				
	•	2 PM". The interim Dietary		baking sheets, pots and p				
		terviewed at the time of the reported that the cooling		in serviced by 3/22/2024,	-			
		dly cool food for storage.		to complete in-service pri This education will be pro	•			
		e turkey should have been		hired staff in orientation.	vided to newly			
		after cooling and she would						
	discard the pans of tu	-		The Kitchen Managemen	t team and/or			
				designee will complete ar				
		ed "tuna salad expires		walk-in refrigerator to ens				
		The DM explained the tuna		adhering to policy regard				
		en discarded on 3/4/2024 ain why it was not thrown		food, and uncovered or n identified areas of concer	•			
		I the tuna salad from the		corrected immediately an				
	refrigerator.			will be immediately discar				
	C C			be completed five (5) time	es weekly for 4			
		ing container had an open		weeks, then (3) times we	•			
	date of 2/3/2024. The			then twice weekly for 4 w				
		essing expired after 30 days		Kitchen Management tea				
	discarded on 3/4/2024	ssing should have been		designee will complete ar items are dried properly a				
		τ.		wet per policy. Any identi				
	d. The storage rack	s in the main kitchen were		concern will be corrected				
	-	on 3/5/2024. A stack of trays		and the staff members re	-educated.			
		als were noted to have		Audits will be completed				
	dripping water betwee	en each tray.		weekly for 4 weeks, then	•			
	o Doking shast	are noted to be an a stores-		for 4 weeks, then twice w	-			
	•	ere noted to be on a storage tacked wet together, as well		weeks. The Administrato				
		e DM was interviewed		ensure compliance. The l				
	•	n, and she reported that the		Administrator and/or desi				
		v temperature dishwasher		results of audits to the mo				
	that used a chemical	agent to sanitize the dishes		Assurance Performance	Improvement			
	-	perature was low, the pans		Committee meetings. At t				
	took longer to air dry.			QAPI committee will eval effectiveness of the interv				

Facility ID: 170065

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/05/2024 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	345578		B. WING			C 03/07/2024	
NAME OF PROVIDER OR SUPPLIER			•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
BRIAR CREEK HEALTH CENTER							
				C	HARLOTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 17	Í F	812			
	The DM was interviewed on 3/6/2024 at 4:04 PM and she explained the facility had conducted a mock survey late in February and multiple issues were identified in the kitchen and a plan of correction had been developed. The DM reported issues identified were late meal trays, cold food, missing menu items, and sanitation. The DM reported that training was expected to be completed on 3/7/2024. The DM reported that a booster heater was going to be added to the dish				determine if continued auditing is necessary to maintain compliance.		
	machine to help with drying pans. The DM explained that there had been a turnover in the kitchen staff and education was needed.						
	The Administrator was interviewed on 3/7/2024 at 1:49 PM. The Administrator explained there had been a recent turnover in the kitchen and issues were identified during the mock survey that the interim DM and corporate consultants were working together to provide training to improve the process in the kitchen. The Administrator reported that expired foods should be discarded, and all open foods should be labeled and dated. The Administrator explained that the booster heater would improve drying times for the pans and prevent wet stacking.						

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