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BRIAN CENTER HEALTH & RETIREMENT/LINCOLNTON	515 S GENERALS BOULEVARD LINCOLNTON, NC 28093

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E 000	Initial Comments An unannounced recertification survey was conducted on 12/13/2021 through 12/16/2021. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # HXFM11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted on 12/13/2021 through 12/16/2021. There was 1 allegation investigated and it was unsubstantiated. Event ID # HXFM11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge for 1 of 2 closed records reviewed for MDS accuracy (Resident #82). The findings included: Resident #82 was admitted to the facility on 09/09/2021 with diagnosis which included diabetes mellitus. Review of the discharge Minimum Data Set (MDS) dated 09/24/21 revealed Resident #82 was discharged to the community. A review of a nursing progress note dated	F 641	F 641 Accuracy of Assessments Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The MDS's for Resident #82 have been modified to reflect accurate coding of section A2100on 12-15-21 by the Resident Care Management Director (RCMD). On 12/15/21, the Administrator validated that the modification of resident	1/12/22

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

Electronically Signed | 01/07/2022

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F 641	Continued From page 1 09/24/21 at 5:58 AM revealed Resident #82 was transferred to the hospital due to an episode of shortness of breath. On 12/14/21 at 11:23 AM an interview was conducted with MDS Nurse #1. During the interview she reviewed the MDS record for Resident #82. She stated the MDS should have indicated the resident went to the hospital under Section A. The interview revealed the MDS had been coded in error. On 12/16/21 at 3:48 PM an interview was conducted with the Administrator. She stated Resident #82's MDS should have been coded that he went to the hospital and not the community. The interview revealed the MDS had been coded in error.	F 641	#82 MDS, with an ARD 9/24/21, was completed to correct coding of discharge location in section A2100. All residents with discharge location coding have the potential to be affected by the alleged deficient practice. An audit of all current residents having an MDS completed in the last 30 days will be completed to verify accurate coding of discharge location in Section A 2100. The audit was completed by the Resident Care Management Director (RCMD)on 1-11-2022 to ensure accurate coding of discharge locations sections "A2100" on the MDS assessment per the RAI manual. Corrections will be made as identified per the RAI manual guidelines The RCMD / Designee will document random MDS audits for coding accuracy for 3 completed MDS's per week for 4 weeks, then 2 completed MDS's per week for 4 weeks, then 1 completed MDS's per week for 4 weeks to ensure compliance is achieved and maintained. The MDS Coordinators were in-serviced on 12-28-21, by the Resident Care Management Director (RCMD) on the accurate coding of the MDS assessment per the RAI Administrator / RCMD will review results of the random MDS coding audits and those findings will be reported at the monthly QAPI meeting monthly until substantial compliance has been achieved. The Administrator will be responsible for the implementation of the	

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F 641	Continued From page 2	F 641	acceptable plan of correction. The date of compliance is 1/12/2022	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to administer supplemental oxygen as ordered for 1 of 1 resident reviewed for respiratory care (Resident #54). The findings Included: Resident #54 was admitted to the facility on 10/20/17. Her diagnoses included acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs). Resident #54 was care planned for COPD and history of pneumonia with oxygen dependence on 11/17/20. The interventions included administer oxygen as ordered, observe for signs and symptoms of respiratory distress and report to the Medical Doctor as needed (skin color, increased heart rate, restlessness, confusion etc.), oxygen	F 695	F 695 Respiratory Care Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Res #54 was placed on her O2 concentrator at 4 liters with deep breathing and no signs of distress. O2 sats increased to 93%. All residents on O2 have the potential to be affected by the alleged deficient practice for the administration of supplemental O2. All residents on O2 were immediately checked to validate that the O2 was being administered per MD	1/12/22

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F 695	Continued From page 3 at 4 liters (L) per minute via nasal canula (NC) continuous. Resident #54 had a quarterly Minimum Data Set (MDS) dated 11/22/2021 which revealed intact cognition and indicated Resident #54 received oxygen therapy. Resident #54's physician's orders dated 11/22/21 revealed an order for oxygen to be administered at 4 L(liters) per minute via nasal cannula continuous every shift for respiratory failure with hypoxia. An observation was completed of Resident #54 on 12/13/21 at 11:15 AM and at 3:58 PM which revealed the oxygen setting on 3.5 L per minute. The Resident showed no signs of distress. An observation made on 12/14/21 at 09:59 AM revealed Resident #54's in-room oxygen concentrator setting at 3 L per minute. Resident #54 was observed in her bed resting. She had her oxygen in her nares via NC. She did not show any signs or symptoms of distress. An observation made on 12/14/21 at 3:35 PM revealed the Resident sitting in her wheelchair with her oxygen applied via NC to her nares. The oxygen tube was hooked up to the portable oxygen tank set at 3 L per minute. Further observation revealed the portable oxygen tank indicator was in the red, which indicated the portable oxygen tank was empty. The in-room oxygen concentrator was observed to be running and was set at 3 L per minute. On 12/14/21 at 3:39 PM Resident #54 was interviewed and she reported no shortness of	F 695	order and to ensure that the O2 level in the tank, if in tank was in use, was at an adequate level. On 12-15-2022, the Director of Nursing initiated reeducation for all staff, including agency staff, prior to working, on the policy for supplemental 02 use, to ensure the following: O2 E tanks are checked to ensure 02 level in the tank is adequate, resident is placed on O2 concentrator when in resident rooms. Staff that returns resident to room will inform the nurse that resident is in the room, and has been placed on concentrator per physician□s O2 order. DON, Unit managers and Rehab Program Manager will conduct audits daily for 4 weeks, 3 times a week for 4 weeks, and 1 time a week for 4 weeks, that O2 is being administered per physician□s O2 order, the O2 is being connected to O2 concentrator when resident returned to room, and that residents out of their rooms on tanks have adequate O2 supply in tank. Education of the facility policy for supplemental O2 administration will also be added to new facility staff orientation and new agency staff orientation by the Staff Development Coordinator. The Administrator/Director of Nursing will present the results of these supplemental O2 administration audits to the monthly QAPI meeting for 90 days to evaluate the effectiveness of the plan. The QAPI committee will make changes and recommendations as indicated. The date of compliance is 1-12-2022	

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F 695	Continued From page 4	F 695		

breath or struggle to breath.

An interview was completed with Nurse #2 on 12/14/21 at 3:52 PM who stated she administered Resident #54 her anxiety medication prior to therapy services around 12:30 PM to 1:00 PM. She explained Resident #54 was on her in-room concentrator prior to her therapy session. Nurse #2 stated Resident #54's oxygen setting should have been set at 4 L per minute but did not visualize the setting on the in-room concentrator. Nurse #2 expressed she had not checked on Resident #54 since her therapy session. Nurse #2 verbalized that nurse aides were not allowed to manipulate oxygen settings. Nurse #2 explained she was trained to review physician orders to verify ordered amount of supplemental oxygen as well as check the medication administration record (MAR) for ordered amount of supplemental oxygen.

An observation and interview were completed on 12/14/21 at 4:00 PM with Nurse #1. Resident #54 was observed sitting in her wheelchair with her nasal cannula in her nares connected to her portable oxygen tank. Resident #54 did not show signs or symptoms of distress. Nurse #1 obtained a pulse oximetry (reading of the oxygen level in the blood) which read 80%. Nurse #1 immediately switched Resident #54 to her in-room oxygen concentrator and applied her nasal cannula to her nares. The in-room concentrator was adjusted from 3 L per minute to 4 L per minute. Resident #54 was instructed by Nurse #1 to take slow deep breaths and continue with deep breathing exercises. Resident #54's pulse oximetry was observed to register at 93% within 3 to 5 minutes at 4 L per minute via the in-room concentrator.

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F 695	Continued From page 5	F 695		

An interview with Nurse #1 was completed on 12/14/21 at 4:07 PM who stated she and Nurse #2 completed shift report at the end of first shift/ beginning of second shift. She explained Nurse #2 verbalized to her the oxygen setting for Resident #54 was not accurate. Nurse #1 was in the process of verifying the physician order and oxygen setting when the surveyor intervened.

An interview was completed on12/14/21 at 4:05 PM with Resident #54. She stated she felt fine. She was observed continuing her deep breathing exercises with the nasal cannula in her nares and her in-room concentrator was set at 4 L per minute.

An interview was completed with the Certified Occupational Therapy Assistant (COTA) on 12/15/21 10:27 AM who stated she worked with Resident #54 on 12/14/21 in the afternoon. The COTA explained Resident #54 was in the rehab Cardio-Pulmonary program offered at the facility. She stated Resident #54 had the portable oxygen tank in place with the setting at 3 L per minute. The COTA explained she checked the amount of oxygen in the portable tank throughout the therapy session and Resident #54 had sufficient oxygen in the portable tank. The COTA returned Resident #54 back to her room and she remained in her wheelchair connected to the portable oxygen tank. The COTA could not recall the exact time she returned Resident #54 to her room but stated between 2:45 PM and 3:00 PM. She further stated she did not recall the positioning of the portable oxygen tank indicator, but voiced Resident #54 had enough oxygen remaining in the portable tank. The COTA communicated if she had a resident that was on a portable oxygen

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F 695	Continued From page 6	F 695		

tank in or near empty (red zone) she would change the portable oxygen tank if the resident wanted to remain in their wheelchair or go out of their room. She further stated she would place the resident on their in-room concentrator if that was the resident's preference. The COTA expressed going forward she would switch the resident to the in-room concentrator after therapy sessions.

An interview with Nurse Aide (NA) #1 on 12/14/21 at 3:43 PM revealed she did a walk around to see her residents upon start of shift at 3:00 PM. The NA stated she received an update on Resident #54 today at shift change. NA #1 thought Resident #54 was connected to the in-room concentrator. NA #1 could not recall if the portable tank on the wheelchair was hooked up to the resident or not. She stated she always checked with the nurse for the current oxygen order to see if there were changes. NA #1 reported the previous week Resident #54's oxygen was set at 2 L per minute. NA #1 explained first shift might have put the resident on the portable oxygen tank for her shower today.

An interview and observation were completed with the Director of Nursing (DON) on 12/14/21 at 4:30 PM revealed Resident #54 had been at the facility for many years and had different oxygen orders. The DON stated that she would check Resident #54's orders but nursing should check oxygen every shift. The DON indicated with Resident #54's chronic condition, her oxygen saturation would not be like a well person with her oxygen in place. The DON explained Resident #54's oxygen saturation ranged between 90% and above with supplemental oxygen in place. An observation was completed of the December

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F 695	Continued From page 7	F 695		

2021 MAR with the DON which revealed Resident #54 typically was on the in-room concentrator. The DON communicated the facility would take an all-hands-on deck/ all staff approach to make sure that portable oxygen tanks were full and the proper setting was applied. The DON communicated the NAs could validate the oxygen settings with their nurses on their assigned units. The primary time to check oxygen settings would be when staff were checking the function and capacity of the portable oxygen as well spot checking throughout the shift. Nurses were trained to check oxygen according to physician order. In this instance, Resident #54 should have been placed back on the in-room concentrator when she returned to her room unless she desired to be on the portable oxygen tank.

A telephone interview was completed on 12/15/21 at 8:30 AM with the Physician. He stated Resident #54 had advanced chronic obstructive pulmonary disease. The Physician indicated he was glad that she had her oxygen in place, but the portable oxygen tank should have been full, or the in-room concentrator should have been connected. The oxygen saturation reading of 80% would not cause her harm because of her advanced disease state. The Physician indicated he would not want her to be in the high 90's but in the low 90's and 80's. Visibly, if she were in trouble staff would see a change in mentation and breathing pattern. The Physician further stated he would expect for the facility to identify the issue (oxygen not applied properly) and correct the issue (carrying out the physician order with correct oxygen setting).

An interview with the Administrator on 12/15/21 at 9:53 AM revealed that staff should follow the

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F 695	Continued From page 8 physician's orders related to supplemental oxygen.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 observations and staff interviews the facility failed to remove an expired medication from one of two medication carts inspected for medication storage (400 Hall Medication Cart). Findings included:	F 761	F761 Label/Store Drugs and Biologicals Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of	1/12/22

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F 761	Continued From page 9 An observation of the 400 Hall Medication Cart conducted on 12/16/21 at 9:39 AM revealed an insulin pen (Novolog flex pen 100/ milliliters) with an open date of 11/09/21 and a discard date of 12/07/21. Review of the Omnicare Insulin Storage Recommendations the facility kept on all their medication carts revealed a Novolog insulin pen was to be discarded 28 days after the initial open date. An interview conducted with Nurse #1 on 12/16/21 at 9:39 AM revealed she was responsible for the 400-hall medication cart. She stated she had not noticed the date on the insulin pen was expired. The interview revealed the last time the resident received a dose from the insulin pen was the night prior on 12/15/21 at 9:00 PM. She confirmed there was no other opened insulin pen for the resident in the medication cart. Nurse #1 stated the insulin pen should have been removed on 12/07/21. An interview conducted on 12/16/21 at 9:59 AM with Unit Manager #1 revealed the facility policy for insulin pens was for the insulin to be discarded 28 days after it was opened. She stated the initial opened date on the insulin pen was 11/9/21 and the discard date should have been 12/07/21. The interview revealed she had checked the medication cart the day before on 12/15/21 and had missed the expired insulin pen. She stated she would immediately remove the insulin pen from the medication cart and replace it with a new one from the refrigerator. An interview conducted with the Director of	F 761	correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The identified expired insulin pen was immediately removed from the med cart and replaced with a new insulin pen. All residents have the potential to be affected by the alleged deficient practice for medication storage. All remaining med carts and medication rooms were reassessed by the DON on 12-16-21, to ensure compliance with drug storage. Inservice on the facility policy for biological storage, expirations, dating of medications/biologicals and the process of removing it from the facility, was conducted by the DON on 12-15-2022. Pharmacy Consultant conducted reeducation for for all licensed nursing staff, all licensed agency staff, and all Medication Aides, on 1/11/22. Education of the facility policy for biological storage, expiration, will be added to new licensed nurses, agency staff and Medication aides orientation by the Staff Development Coordinator. A Med Cart Med Room Audit Tool was implemented and will be completed by Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Unit Coordinator once weekly for 12 weeks on all 4 medication carts and 2 medication rooms. Director of Nursing will present the results	

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F 761	Continued From page 10 Nursing (DON) on 12/16/21 at 10:10 AM revealed she had looked at the insulin pen that was on the 400-hall medication cart and stated it should have been discarded on 12/07/21. The interview revealed the facility policy was to discard the medication 28 days after the initial open date. She stated the carts were checked weekly and it was just missed by mistake. An interview conducted with the Administrator on 12/16/21 at 3:48 PM revealed the 400-hall medication cart had been checked the week prior. She stated the insulin pen was missed by mistake and should have been discarded on the 28th day after it had been opened.	F 761	of these drug storage audits to the monthly QAPI meeting to evaluate the effectiveness of the plan. The QAPI committee will make changes and recommendations as indicated. The date of compliance is 1/12/2022	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to maintain a functioning and sanitary environment in the kitchen as evidenced by a leaking sink drain for 1 of 2 sinks that caused standing water and brown debris on the second shelf of a food prep table. The findings included: An observation made on 12/15/21 at 11:20 AM revealed a leaking sink in a food prep area. Brown debris was observed under the sink, on the second level of the food prep table. The area contained visible standing water and a saturated	F 921	F921 Safe Sanitary Environment Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The Maintenance Director repaired the sink in the food prep area on 12-15-2021.	1/12/22

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F 921	Continued From page 11 folded wet towel with brownish and blackish stains. A corroded rubber seal was visible under the sink. When the sink was in use, visible water was observed leaking from the corroded seal to the second shelf of the food prep table. The Dietary Manager (DM) reported that the sink would leak sometimes, and that maintenance was aware of the leak. The DM was observed notifying the Maintenance Director on 12/15/21 at 11:25 AM. The Maintenance Director immediately came to the kitchen to assess the sink. The Maintenance Director agreed the sink was leaking and stated he would repair it. A review of the maintenance log for the kitchen on 12/15/21 at 3:39 PM revealed that on 11/01/21 notification was made that the sink was broken. The log was not signed off as completed by the Maintenance Director. An interview with the DM and the District Dietary Manager on 12/15/21 at 03:45 PM revealed the DM thought the sink would have been fixed and did not realize that the sink had not been repaired. The DM stated the Maintenance Director's normal practice was to immediately fix things. The District Dietary Manager stated the sink was not leaking a couple weeks ago when he was last in the kitchen. He explained the sink was used to retrieve water when staff was near the stove and ovens. An interview with the Maintenance Director on 12/16/21 at 11:42 AM revealed he became aware the sink was leaking when he entered the kitchen on 12/15/21. The Maintenance Director explained he checked the maintenance log	F 921	All other sinks in the kitchen were checked and were not leaking. All sinks have the potential to be affected by the alleged deficient practice. All other sinks in dietary, resident bath rooms and common areas throughout the facility were checked by the Maintenance Director on or before 12-31-2021 to ensure proper functioning. Maintenance Director will check dietary sinks, all resident bathroom sinks and all common area sinks weekly for 90 days. All facility staff, including agency, staff were inserviced on the process to report any issues on the Maintenance Log or contact Maintenance Director. The Maintenance Direct will check the Maintenance Log Monday thru Friday and repair the identified concerns. The Maintenance Director will complete the required monthly checks on TELS. The administrator will spot check the sink audits and the Maintenance Log weekly for 90 days to ensure and safe sanitary environment. The Administrator /Director of Nursing will present the results of Safe Sanitary Environment audits to the monthly QAPI meeting to evaluate the effectiveness of the plan for 90 days. The QAPI committee will make changes and recommendations as indicated. The date of compliance is 1-12-2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345250	A. BUILDING _____ B. WING _____	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/LINCOLNTON	**515 S GENERALS BOULEVARD LINCOLNTON, NC 28093**

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F 921	Continued From page 12 outside of the kitchen on a daily basis. The Maintenance Director explained the notation on the maintenance log dated 11/1/21 was for the sink handles due to continued leaking and he replaced the entire fixture. The Maintenance Director stated he did not check to see if leakage was occurring underneath the sink. The interview further revealed the prep table was not mounted, and the water drained directly into the floor drain. The Maintenance Director thought the table may have been moved and caused the gasket seal on the bottom of the sink to break. An interview with the Administrator on 12/16/21 at 3:35 PM revealed that when equipment was in disrepair, it should be fixed in a timely manner.	F 921		