STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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
E 000	Initial Comments An unannounced recertification survey and conplaint investigation survey were conducted 3/5/2024 to 3/7/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # QUKS11.	E 000		
F 000	INITIAL COMMENTS A complaint investigation and recertification survey were conducted 3/5/2024 to 3/7/2024. Event ID #QUKS11. The following intakes were investigated: NC00209557, NC00198028, NC00200601, and NC00213913. 1 of 15 complaint allegations resulted in a deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		3/22/24

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

Electronically Signed | 03/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 623	Continued From page 1	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews, the facility failed to notify the resident in writing of the reason for transfer to the hospital	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 623	Continued From page 3 for 1 of 1 resident reviewed for hospitalization (Resident #4). The findings included: Resident #4 was admitted to the facility on 3/31/2022 with diagnoses including kidney disease and hypertension. The medical record documented Resident #4 was her own responsible party. The admission Minimum Data Set (MDS) assessment dated 12/5/2023 assessed Resident #4 to be cognitively intact. A nursing progress note dated 2/5/2024 documented Resident #4 had a change in condition with a decreased level of consciousness and low blood pressure. Resident #4 was transferred to the hospital for evaluation. The entry tracking record MDS dated 2/24/2024 documented Resident #4 was readmitted to the facility after a stay at a short-term hospital. A review of the electronic medical record for Resident #4 revealed no written notice of transfer was scanned into the medical record. Resident #4 was interviewed on 3/5/2024 at 8:43 AM. Resident #4 explained she had been in the hospital many times over the past year, but she had not received a notice of transfer from the facility for any hospitalization. An interview was conducted with the Admissions Director on 3/6/2024 at 2:41 PM. The Admissions Director reported that she was unable to locate a notice of discharge for Resident #4 in the	F 623	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 Notice Requirements Before Transfer/Discharge Resident #4 was discharged on 3/19/24. All residents have the potential to be affected. On 3/22/24 hospital transfers on all current residents in the last seven days were audited by Administrator. There were no discrepancies found during the audit. The Business Office Manager, Social Services Director and Admissions Coordinator will be educated by the Administrator, on the Transfer Notice Policy by 3/22/24. The Business Office Manager and Admissions Coordinator will be responsible for timely review and issuing written transfer/discharge notifications. The Administrator, Director of Nursing and or designee will be responsible for auditing transfers and discharges to the hospital weekly for 3 months. Administrator, Director of Nursing, or designee will bring audits to monthly Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 623	Continued From page 4 electronic record. The Admissions Director explained she did not think the facility sent the resident or representative a notice of discharge for hospitalizations. The Administrator was interviewed on 3/7/2024 at 1:49 PM. The Administrator reported the notification of discharge should have been completed for Resident #4 and all residents who are transferred to the hospital. The Administrator reported the lack of notification of discharge was due to staff education. The Administrator reported the Social Worker was responsible for the notification of change. The Social Worker was not available for interview.	F 623	Improvement Committee meetings. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		3/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 625	Continued From page 5 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews, the facility failed to provide a bed hold notice to resident transferred to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #4). The findings included: Resident #4 was admitted to the facility on 3/31/2022 with diagnoses including kidney disease and hypertension. The medical record documented Resident #4 was her own representative. The admission Minimum Data Set assessment dated 12/5/2023 assessed Resident #4 to be cognitively intact. A nursing progress note dated 2/5/2024 documented Resident #4 had a change in condition with a decreased level of consciousness and low blood pressure. Resident #4 was transferred to the hospital for evaluation. The entry tracking record MDS dated 2/24/2024 documented Resident #4 was readmitted to the facility after a stay at a short-term hospital.	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer Resident #4 was discharged on 3/19/24. All residents have the potential to be affected. On 3/22/24 hospital transfers on all current residents in the last seven days were audited by Administrator. There were no discrepancies found during the audit. The Business Office Manager, Social Services Director and Admissions Coordinator will be educated by the Administrator, on the Bed Hold Policy by 3/22/24. The Director of Nursing and or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency, by 3/22/24 on the Bed Hold Policy. All staff not in serviced by 3/22/2024, will be required to complete in-service prior to working. The Business Office Manager and Admissions Coordinator will be responsible for timely review and issuing written Bed Hold Policy notifications. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 625	Continued From page 6 A review of the electronic medical record for Resident #4 revealed no bed hold notice was scanned into the medical record. Resident #4 was interviewed on 3/5/2024 at 8:43 AM. Resident #4 explained she had been in the hospital many times over the past year, but she had not received a bed hold notice from the facility for any hospitalization. Nurse #1 was interviewed on 3/6/2024 at 2:02 PM. Nurse #1 reported she did not send a bed hold notice with a resident when they were transferred to the hospital because she thought the Admissions Director was responsible for the bed hold notice. An interview was conducted with the Admissions Director on 3/6/2024 at 2:41 PM. The Admissions Director reported that she was unable to locate a bed hold notice for Resident #4 in the electronic record. The Admissions Director explained she had completed a bed hold notice for a recent resident transfer to the hospital and she did not know why Resident #4 had not be given a bed hold notice. During an interview with Nurse #2 on 3/7/2024 at 11:35 AM, Nurse #2 reported she had not sent a bed hold notice with any resident who was transferred to the hospital. The Administrator was interviewed on 2/7/2024 at 1:49 PM. The Administrator reported the bed hold notice should have been provided to Resident #4 and all residents who are transferred to the hospital. The Administrator reported the bed hold notice was in a file on the nursing station desk	F 625	Administrator, Director of Nursing and or designee will be responsible for auditing transfers and discharges to the hospital weekly for 3 months. Administrator, Director of Nursing, or designee will bring audits to monthly Quality Assurance Performance Improvement Committee meetings. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 625	Continued From page 7 and she did not know why the nurses were not sending a copy with residents when they were transferred to the hospital.	F 625		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to assess a resident's pain and administer pain medication ordered by the physician for 1 of 2 residents (Resident #70) when the resident complained of left ankle pain. Resident #70 experienced pain of 8 on a scale of 0-10 (10 being the worst pain) from 1:00 am on 1/12/2024 until her medication arrived twelve hours after she was readmitted to the facility from the hospital for a fractured left fibula. Findings included: Resident #70 was admitted to the facility on 1/11/2024 and she was readmitted from the hospital on 2/26/2024 with diagnoses of left fibula fracture with surgical repair and osteoarthritis. An admission Nursing Assessment dated 1/11/2024 at 9:18 pm stated Resident #70 had a left ankle fracture with surgical repair, and she received pain medication, Hydrocodone-Acetaminophen, at the hospital at	F 697	F697 Pain Management Resident #70 had a pain assessment completed by the Director of Nursing on 3/7/24. Resident #70's pain is controlled an is receiving medications per MD order. Medications are in stock. All residents that receive pain medication have the potential to be affected. On 3/22/24 the Director of Nursing and designee completed a pain assessment on all current residents to ensure that pain needs are being met appropriately, and audited their medications to ensure they are on hand in the facility. There were no concerns. The Director of Nursing and or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency, by 3/22/24 on pain scale and assessments, with an emphasis on the evaluation and monitoring of pain levels for routine and	3/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 697	Continued From page 8 7:00 pm and denied pain. Resident #70's medication orders stated she had Hydrocodone-Acetaminophen 5-325 milligrams one tablet by mouth every 6 hours as needed for pain ordered by the physician on 1/11/2024. Resident #70's Medication Administration Record (MAR) for 1/2024 was reviewed and the documentation indicated her pain was assessed each shift and was rated at 0 on scale of 0 to 10 on 1/11/2024 on the night shift; 0 on a scale of 0 to 10 on 1/12/2024 on the day shift; and 7 on a scale of 0 to 10 on the evening shift on 1/12/2024. The MAR further indicated Resident #70 did not receive Acetaminophen, Hydrocodone-Acetaminophen or any pain medications until she received Hydrocodone-Acetaminophen 5-325 milligrams on 1/12/2024 at 1:06 pm and she rated her pain at an 8 on a scale of 0 to 10. An admission Minimum Data Set (MDS) assessment dated 1/18/2024 indicated Resident #70 was cognitively intact, rated her pain a 7 on a scale of 0 to 10, and indicated her pain was frequent and affected her ability to sleep. The MDS assessment also indicated she received narcotic pain medications for the reported pain. During an interview with Resident #70 on 3/7/2024 at 12:45 pm she stated when she was admitted to the facility on 1/11/2024 at 9:30 pm, with fractures to her left ankle that required surgical repair, the facility did not have the pain medication that was ordered, Hydrocodone-Acetaminophen, and she was told by Nurse #1 that the medication was not available and Nurse #1 did not know when it would be	F 697	as needed medications. All staff not in serviced by 3/22/2024, will be required to complete in-service prior to working. The Director of Nursing or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency on the proper documentation of medication administration, pharmacy procedures for ordering of medications, calling of pharmacy to validate receiving of new admission orders, use of back up medications and back up narcotics. All staff not in serviced by 3/22/2024, will be required to complete in-service prior to working. This education will be provided to newly hired nursing staff in orientation. In clinical meeting daily, the Director of Nursing or designee will review new admissions to ensure that pain assessments were completed, and the pain medication available and administered if needed, on weekends the supervisor or designee will complete for 2 months, then three times weekly for one month. The Director of Nursing or designee will complete 3 random pain assessments weekly to ensure that residents pain needs are being met appropriately, and medication is available. The audits will be completed weekly for three months. The Director of Nursing will bring the results of the audits to the monthly Quality Assurance and Improvement committee meetings for ongoing compliance. The Director of Nursing is responsible for implementing the acceptable plan of correction. Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 697	Continued From page 9 available. Resident #70 stated she waited 12 hours for the pain medication that was ordered. Resident #70 stated she had a dose of Hydrocodone-Acetaminophen at 7:00 pm before leaving the hospital and Nurse #1 gave her Acetaminophen for pain at 1:00 am on 1/12/2024 when she reported her pain was an 8 on a scale of 1 to 10. Resident #70 stated the Acetaminophen did not relieve her pain and she asked Nurse #1 for her ordered pain medication again during the night. She stated she was in pain throughout the night and the next day until she received Hydrocodone-Acetaminophen at 1:00 pm on 1/12/2024. Resident #70 stated she made it through the night on 1/12/2024 but she did not want a resident that could not speak for themselves to be in pain for a long time like she was on the night of 1/12/2024. Resident #70 stated she had three fractures in her left ankle, and she continued to elevate her left leg while in bed and wear an orthopedic boot when she is out of the bed. Nurse #1 was interviewed on 3/7/2024 at 2:06 pm and she stated Resident #70 arrived at the facility at 9:30 pm on 1/11/2024 and she admitted her to the facility. Nurse # 1 stated Resident #70 had Hydrocodone-Acetaminophen (a narcotic pain medication) ordered for pain when she was admitted, and she explained to Resident #70 she did not know when she would be able to get her pain medications. Nurse #1 further stated she gave Resident #70 Acetaminophen from the facility's standing orders at 1:00 am, and Resident #70 was upset because she was given the Acetaminophen for pain instead of the Hydrocodone-Acetaminophen. Nurse #1 stated she would have given Resident #70 the Hydrocodone-Acetaminophen if it had arrived	F 697	Assurance Performance Improvement Committee is responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 697	Continued From page 10	F 697		

from the pharmacy during the night. She stated Resident #70 did not ask for pain medication again throughout the night and she stated she checked on her one time and she was sleeping. She stated since she was sleeping, she must not have been in much pain. Nurse #1 stated she documented Resident #70's pain when she did the admission assessment in the computer charting but she did not have Resident #70 rate her pain again during the shift.

An interview was conducted with the Director of Nursing on 3/7/2024 at 2:14 pm and he stated Nurse #1 should have called the back up pharmacy when Resident #70's ordered pain medication was not available in the facility's automated medication dispensing system. He further stated if a medication is not available in the facility's automated medication system and the facility's pharmacy cannot deliver the medication then the nurse should have called the 24-hour pharmacy the facility has a contract with to obtain the medication and have a courier deliver the medication. The Director of Nursing stated he did not know why Nurse #1 failed to administer Resident #70's medication or why Nurse #1 did not call the physician and see if another medication was available in the automated medication system would have been an appropriate replacement.

On 3/7/2024 at 3:26 pm the Administrator was interviewed and stated Nurse #1 should have called the back up pharmacy or the physician for an order that was available in the facility's automated medication system to give to Resident #70. The Administrator stated she expected the nursing staff to ensure all residents are comfortable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to obtain pain medication ordered by the physician for 1 of 2 residents (Resident #70) when the resident was	F 755	F755 Pharmacy Resident #70 medications were audited 3/7/24 and are in stock.	3/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 755	Continued From page 12 admitted to the facility after surgical repair of a left fibula fracture. Resident #70 experienced pain of 8 on a scale of 0-10 (1- being the worst pain) from 1:00 am on 1/12/2024 until her medication was administered on 1/12/2024 at 1:06 pm on 1/12/2024. Findings included: Resident #70 was admitted to the facility on 1/11/2024 and she was readmitted from the hospital on 2//2024 with diagnoses of left fibula fracture with surgical repair and osteoarthritis. An admission Nursing Assessment dated 1/11/2024 at 9:18 pm stated Resident #70 had a left ankle fracture with surgical repair, and she received pain medication, Hydrocodone-Acetaminophen, at the hospital at 7:00 pm and denied pain. Resident #70's medication orders stated she had Hydrocodone-Acetaminophen 5-325 milligrams one tablet by mouth every 6 hours as needed for pain ordered by the physician on 1/11/2024. Resident #70's Medication Administration Record (MAR) for 1/2024 was reviewed and the documentation indicated her pain was assessed each shift and was rated at 0 on scale of 0 to 10 on 1/11/2024 on the night shift; 0 on a scale of 0 to 10 on 1/12/2024 on the day shift; and 7 on a scale of 0 to 10 on the evening shift on 1/12/2024. The MAR further indicated Resident #70 did not receive medication for pain relief until she received Hydrocodone-Acetaminophen 5-325 milligrams on 1/12/2024 at 1:06 pm and she rated her pain at an 8 on a scale of 0 to 10.	F 755	All residents that receive pain medication have the potential to be affected. On 3/22/24 the Director of Nursing and designee completed a pain assessment on all current residents to ensure that pain needs are being met appropriately, and audited their medications to ensure they are on hand in the facility, and there were no concerns. The Director of Nursing or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency on the proper documentation of medication administration, pharmacy procedures for ordering of medications, calling of pharmacy to validate receiving of new admission orders, use of back up medications and back up narcotics. All staff not in serviced by 3/22/2024, will be required to complete in-service prior to working. This education will be provided to newly hired nursing staff in orientation. The Director of Nursing or designee will review new admissions to ensure pain medication availability in clinical meeting daily, on weekends the supervisor and/or designee will review to ensure pain medication availability for new admissions for 2 months, then three times weekly for one month. The Director of Nursing or designee will complete 3 random audits to ensure pain medication is available. The audits will be completed weekly for three months. The Director of Nursing will bring the results of the audits to the monthly Quality Assurance and Improvement committee meetings for ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 755	Continued From page 13 An admission Minimum Data Set (MDS) assessment dated 1/18/2024 indicated Resident #70 was cognitively intact, rated her pain a 7 on a scale of 0 to 10, and indicated her pain was frequent and affected her ability to sleep. The MDS assessment also indicated she received narcotic pain medications for the reported pain. During an interview with Resident #70 on 3/7/2024 at 12:45 pm she stated when she was admitted to the facility on 1/11/2024 at 9:30 pm, with fractures to her left ankle that required surgical repair, the facility did not have the pain medication that was ordered, Hydrocodone-Acetaminophen, and she was told by Nurse #1 that the medication was not available and Nurse #1 did not know when it would be available. Resident #70 stated she waited 12 hours for the pain medication that was ordered. Resident #70 stated she had a dose of Hydrocodone-Acetaminophen at 7:00 pm before leaving the hospital and Nurse #1 gave her Acetaminophen for pain at 1:00 am on 1/12/2024 because the Hydrocodone-Acetaminophen ordered for her was not available, when she reported her pain was an 8 on a scale of 1 to 10. Resident #70 stated she was in pain throughout the night and the next day until she received Hydrocodone-Acetaminophen at 1:00 pm on 1/12/2024. Resident #70 stated she had three fractures in her left ankle. Nurse #1 was interviewed on 3/7/2024 at 2:06 pm and she stated Resident #70 arrived at the facility at 9:30 pm on 1/11/2024 and she admitted her to the facility. Nurse # 1 stated Resident #70 had Hydrocodone-Acetaminophen (a narcotic pain medication) ordered for pain when she was admitted, and she explained to Resident #70 she	F 755	compliance. The Director of Nursing is responsible for implementing the acceptable plan of correction. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 755	Continued From page 14	F 755		

did not know when she would be able to get her pain medications. Nurse #1 further stated she gave Resident #70 Acetaminophen from the facility's standing orders at 1:00 am, and Resident #70 was upset because she was given the Acetaminophen for pain instead of the Hydrocodone-Acetaminophen. Nurse #1 stated she would have given Resident #70 Hydrocodone-Acetaminophen if it had arrived from the pharmacy during the night.

An interview was conducted with the Director of Nursing on 3/7/2024 at 2:14 pm and he stated Nurse #1 should have called the backup pharmacy when Resident #70's ordered pain medication was not available in the facility's automated medication dispensing system. He further stated if a medication is not available in the facility's automated medication system and the facility's pharmacy cannot deliver the medication then the nurse should have called the 24-hour pharmacy the facility has a contract with to obtain the medication and have a courier deliver the medication. The Director of Nursing stated he did not know why Nurse #1 failed to administer Resident #70's medication or why Nurse #1 did not call the physician and see if another medication was available in the automated medication system would have been an appropriate replacement.

On 3/7/2024 at 3:26 pm the Administrator was interviewed and stated Nurse #1 should have called the backup pharmacy or the physician for an order that was available in the facility's automated medication system to give to Resident #70. The Administrator stated she expected the nursing staff to ensure all residents are comfortable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 812 SS=E	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 preclude 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 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 the following were observed: a. A free-standing rack was labeled "cooling	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary No residents were found to have been affected. All residents residing at the facility have 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, the Corporate Dietary Quality Assurance Manager educated the Food services Staff regarding proper ware washing and food safety guidelines to include: food	3/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 812	Continued From page 16 rack" had 2 deep steamer pans on the top shelf of the rack. There was cooked white colored meat in the pans that were floating in pink colored liquid. The sheet on the cooling rack noted "turkey 3/2/2024 12:42 PM". The interim Dietary Manager (DM) was interviewed at the time of the observation, and she reported that the cooling rack was used to rapidly cool food for storage. The DM explained the turkey should have been covered and labeled after cooling and she would discard the pans of turkey. b. A container labeled "tuna salad expires 3/4/2024" was noted. The DM explained the tuna salad should have been discarded on 3/4/2024 and she was not certain why it was not thrown out. The DM removed the tuna salad from the refrigerator. c. A coleslaw dressing container had an open date of 2/3/2024. The DM reported open containers of salad dressing expired after 30 days and the coleslaw dressing should have been discarded on 3/4/2024. d. The storage racks in the main kitchen were observed at 8:10 AM on 3/5/2024. A stack of trays used for resident meals were noted to have dripping water between each tray. e. Baking sheets were noted to be on a storage rack, and they were stacked wet together, as well as steamer pans. The DM was interviewed during the observation, and she reported that the dishwasher was a low temperature dishwasher that used a chemical agent to sanitize the dishes and because the temperature was low, the pans took longer to air dry.	F 812	covering, sealing, labeling with name of item and date, use by dates and all staff disposing of expired food daily, proper air drying of items including resident trays, baking sheets, pots and pans. All staff not in serviced by 3/22/2024, will be required to complete in-service prior to working. This education will be provided to newly hired staff in orientation. The Kitchen Management team and/or designee will complete an audit of the walk-in refrigerator to ensure that staff are adhering to policy regarding no expired food, and uncovered or not labeled. Any identified areas of concern will be corrected immediately and affected items will be immediately discarded. Audits will be completed five (5) times weekly for 4 weeks, then (3) times weekly for 4 weeks, then twice weekly for 4 weeks. The Kitchen Management team and/or designee will complete an audit to ensure items are dried properly and not stacked wet per policy. Any identified areas of concern will be corrected immediately, and the staff members re-educated. Audits will be completed five (5) times weekly for 4 weeks, then (3) times weekly for 4 weeks, then twice weekly for 4 weeks. The Administrator will review the completed audits on a weekly basis to ensure compliance. The Dietary Manager, Administrator and/or designee will bring results of audits to the monthly Quality Assurance Performance Improvement Committee meetings. At that time the QAPI committee will evaluate the effectiveness of the interventions to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345578	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR CREEK HEALTH CENTER	6041 PIEDMONT ROW DRIVE CHARLOTTE, NC 28210

(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 812	Continued From page 17 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 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.	F 812	determine if continued auditing is necessary to maintain compliance.	