PRINTED: 09/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG				
		345179	B. WING				R-C 09/08/2017	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STR	REET ADDRESS, CITY, STATE, ZIP CODE			
DDIAN OF	ENTED LIEALTH AND DE	TIDE KKENT		752	E CENTER AVENUE			
BRIANCE	ENTER HEALTH AND RE	IREMENT		MO	ORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	× .	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
					F224		10/22/17	
{F 224}			{F 2	24}	, _ m _ T		-0/22/1/	
SS=E	MID I KEATMENT/NE	GLECT/MISAPPROPRIATN		:	1. On 9/5/17 thru 9	/8/17 root	doutidoo	
	§483.12 The resident has the right to be free from				Observed with In	. O. T. 1621	uent#130	
		ppropriation of resident			observed with lo	ng nans,	with brown	
property, and exploitation as defined in this				debris under the	nails. Re	esident #130		
	subpart. This includes				nails trimmed an	d cleaned	on 9/8/17.	
freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint								
		ne resident's symptoms.			Resident #69 was	i readmiti	ted to the	
	not required to treat ti	to resident a symptoms.			facility on 8/14/17	review o	f medical	
	483.12(b) The facility must develop and				records revealed	no order	for treatment	
implement written policies and procedures that:				:	to the pressure u	cer to lef	tear	
					Physician's order	ahtainad	on O le la a c	
		event abuse, neglect, and			pressure ulcer to	ostanieu Iostanieu	on 9/5/17 for	
	resident property,	its and misappropriation of		:	#69.	eit ear fo	or resident	
	(b)(2) Establish policie	es and procedures to		į	On 9/6/17 observa	tion of D		
	investigate any such a				revealed resident's	brief to	be heavy	
	(b)(3) Include training	as required at paragraph		:	with urine. Reside	nt #145 r	eceived	
	§483.95,				incontinent care ar	nd will red	ceive	
		is not met as evidenced			incontinent care ro	utinely	~~~~	
	by:	ns, record reviews and staff						
		neglected to implement the			2. Residents depende	nt on sta	ff for nail	
	correct treatment orde	= :			care have the poter	ntial to be	afforted	
	pressure ulcer (Reside				Current residents n	عران میرد	anected.	
		re (Resident #145), and			Amhassadara fara t	ans were	checked by	
		ail care (Resident #130) for			Ambassadors for cle	anliness	and length	
ļ	3 of 4 sampled reside	nts.			and service provide	d as need	led.	
	The findings included:			NA STATE OF THE ST	All residents with pr	essure ar	eas have	
	1 Booldont #00	most reportly readwitted to	****		the potential to be a	affected b	v the	
		most recently readmitted to 7. Review of Resident #69's			alleged deficient pra	ctice	7 4116	
	*	ed that he had been present			Administrative RN (MALARA	N 6 h a	
		through 08/08/17 and			Managor I hat o	ON,ADO	N,Nurse	
	again from 08/14/17 th	a jiha a kalana siya da kalanda ka kalanda ka kalanda ka		vesesively settes	Manager, Unit Coord	iinator) w	411	
ABORATORY [DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE	

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.

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	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUI ND PLAN OF CORRECTION IDENTIFICATION		1 ' '	TIPLE CONSTI NG		(X3) DATE SURVEY COMPLETED			
						R-C			
		345179	B. WING		09/08/2017				
	ROVIDER OR SUPPLIER ENTER HEALTH AND RE	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
{F 224}	F 224} Continued From page 1 diagnoses included hemiplegia/hemiparesis, sepsis, pressure ulcer of the sacrum, retention of urine, and others. Review of the most recent quarterly minimum data set (MDS) dated 07/31/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #69 required total assistance of 2 staff members for bed mobility and had 1 Stage 3 pressure ulcer and 1 Unstageable pressure ulcer. Review of a wound assessment by the Wound Nurse Practitioner (WNP) dated 08/01/17 indicated that Resident #69 had 4 stage 3 pressure ulcers. The locations of the wounds were: left heel, left ankle, left sacrum, and left ear. The recommended treatment to the left ear wound was calcium alginate and hydrocolloid dressing.		{F 2	.24}	complete an audit of all residents with pressure areas by 10/22/17 to ensure treatment initiated and Practitioner notification occurred. Residents dependent on staff for incontinent care have the potential to be affected. Observations made by Ambassadors of current residents requiring incontinent care and service provided as needed. Certified Nursing assistants will be re-				
					educated by DON or desig 10/22/17 regarding ADL ca trimming and cleanliness	nee by re to include of resident			
	hydrocolloid to left ea	of a physician order dated 08/01/17 read, olloid to left ear every Tuesday and ay for wound to left ear.			finger nails. All nursing sta educated regarding resider relation to ADL care and tr pressure ulcers.	nt neglect in			
	(TAR) dated 08/01/17 through 08/31/17 contained the following: hydrocolloid to left ear every Tuesday and Saturday for wound to left ear. The order date was 08/01/17 and the discontinue date was 08/14/17. Review of the physician orders from Resident #69's readmission to the facility on 08/14/17 revealed no order for the treatment to the pressure ulcer to the top of the left ear.			3.	 Nursing staff will be re-educated by Director of Nursing or designee r/t proper resident nail care. Licensed Nursing Staff will be educated by the 				
				Averant //Abbothprovist vices is A defective	Director of Nursing or designee r/t obtaining physician orders for Pressure Ulcer treatments. Nursing staff will be re-educated by Director of Nursing or				
	Review of the TAR da	ted 08/01/17 through			designee r/t proper Inconti	nent Care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
AND I LAN O	CONNECTION	IDENTIFICATION NOW DETC	A. BUILDI	NG		1
		345179	B. WING			R-C 09/08/2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
				7	52 E CENTER AVENUE	
BRIAN CE	ENTER HEALTH AND RE	TIREMENT		N	MOORESVILLE, NC 28115	
	DUMMADY CT	ATEMENT OF DESIGNATES	1/3		PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
(E 224)	0-5-5-			10.41	4. Administrative RN (DON,	\DON,Nurse
{F 224}	: -		{F 2	.24}	Manage, Unit Coordinator	l or designee
	08/31/17 revealed no documentation of the treatment to Resident #69's left ear during				_	
	i control of the cont	•	1		will audit all residents wit	'
Resident #69's stay in					ulcers for changes, notific	ation and
		7 at which point he was			active treatment 2 times a	week for 4
	discharged to the hospital.				weeks, then weekly x 2 m	onths.
	Review of the facility assignment sheet revealed				Administrative RN (DON, A	i
	that Nurse #6 was responsible for Resident #69 on 08/19/17 when the treatment was due to be				Managers) or designee wi	
		treatment was due to be	:		, ,	í
	completed.				random observations of 5	
	Observation and inter	view of Resident #69's left			incontinent care 2 times a	week x 4
		on 09/06/17 at 3:29 PM			weeks then weekly x 2 mc	onths.
		The left ear was noted to			Ambassadors will observe	5 residents'
		ored transparent covering		į	nails 2 times a week x 4 w	
		xygen tubing was resting on				
		covering. The TN stated			weekly x 2 months during	
	that the current treatm	ent for Resident #69 was			ensure cleanliness and pro	per length.
		prep that created a light				
		arent covering so you know			Data obtained during the a	audit process
		was covered with the skin			will be analyzed for patterns and t	rends and
		weekly treatment had been				e QAPI
į		morning on 09/05/17 just			•	•
	room for evaluation.	vas sent to the emergency			committee by the Director of Nurs	_
	TOOM TO EVARUATION.			i	months at which time the commit	tee will
	Attempts to interview	Nurse #6 on 09/07/17 at			evaluate the effectiveness of th	ie
	10:49 AM were unsuc			ì	interventions and determine if fur	ther auditing
						iner additing
	An interview was cond	ducted with the Treatment		'	is needed.	10/22/17
3	Nurse (TN) on 09/08/2	17 at 10:35 AM. The TN				10/22/17
		d incorrectly transcribed the				į l
		ent to Resident #69's top of				<u>;</u>
		at the WNP recommended				
	calcium alginate with I	•				
		colloid into the system. The				
	TN also confirmed tha					e gant topologico con construit and construit great group groups to the construit and construit and construit a
	The control of the co	ity on 08/14/17 all of his		anang gan		
İ	orders were removed	from the electronic system	1			1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345179	B. WING	B. WING		R-C 09/08/2017	
	ROVIDER OR SUPPLIER	ETIREMENT		752	EET ADDRESS, CITY, STATE, ZIP CODE E CENTER AVENUE DRESVILLE, NC 28115	· · · · · · · · · · · · · · · · · · ·	
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{F 224}	get entered back in were "just an hones verify that the treatr there was no order added that she had Resident #69's left." An interview was co Director of Nursing PM. The interim DC for all orders to be to	eatment to the left ear did not to the system and both errors at mistake." The TN could not ment was completed because for it in the system. She provided the treatment to ear on 08/15/17. Inducted with the Interim (DON) on 09/08/17 at 1:57 on stated that she expected ranscribed correctly into the swell as the correct treatment	{F 2	24}			
	04/27/17 for rehabil hospitalization for colleft side. Her other malignant neoplasm treatment, diabetes also had surgical re grafting to her right	vas admitted to the facility on itation following a erebral infarction affecting her diagnoses included history of nof brain with surgical mellitus, and epilepsy. She pair of embolus and skin arm with donor site to right healed and required dressing					
	Data Set (MDS) dat adequate hearing an speech, understood cognitively intact. R no behaviors, and n required extensive a for most activities of resident was freque	t #145's quarterly Minimum ed 08/03/17 revealed she had nd vision with glasses, clear and understands and was desident #145 had no moods, o rejection of care and desistance of 1 to 2 persons of daily living (ADL). The ntly incontinent of urine and of a tolleting program.			E SANGE E E SANGE ON E SANGE ON SANGE O		
Spiritalogia in propincia di Signi neglicie i	A review of Residen	t #145's admission Care Area		Assisting street	er kalander frankligt for det skilder for det skilder franklige frankligt for det skilder frankligt for det ka De skilder for det skilder van de skilder frankligt for de skilder for de skilder for de skilder for de skilde	inglaceting programme and an artist of the second	

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	345179		B. WING		_			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 752 E CENTER AVENUE MOORESVILLE, NC 281				
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{F 224}	Assessment (CAA) serevealed she was a who presented for redischarge plans were and oriented but had confusion that vary a since admission that screaming for assist not easily altered so psychiatric services management. She rewith bed mobility and bowel and bladder. A review of Resident 05/12/17 revealed shaving functional blather disease process malignant neoplasm Resident #145 was the breakdown due to in through the next revitate interventions include frequently and as neas needed after incomparted at the nurse's resident's room, the was at the nurse's deand stated she was abeen changed since at 10:30 AM. The rewheelchair down to resident #145 who was cognitively intact as well as the sident was a sident was a sound to resident was a soun	summary dated 05/10/17 new admission to the facility enabilitation and whose e uncertain. She was alert d presented with episodes of and has had some behaviors e included yelling and ance. Her behaviors were she had been referred to for counseling and medical required extensive assistance d was incontinent of both #145's Care Plan dated he was care planned for hadder incontinence related to les of cerebral infarction and hof the brain. The goal for hor remain free from skin continence and brief use hew date of 08/10/17. Hed changing the resident leded, and changing clothing hitinence episodes. Observation made on h06/17 at 4:11 PM that he desk and continued to the hobservation revealed she lesk requesting to be changed hosoaking wet and had not hose she got up in the wheelchair her room to be changed. Was assessed by the facility and wore a watch on her right hit NAs had not checked or	{F 2					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED R-C 09/08/2017	
		345179	B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	·	070072011	
	DOLAN OCNTED HEALTH AND DETIDERACHT			752 E CENTER AVENUE			
BRIAN CENTER HEALTH AND RETIREMENT				MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG			(X5) COMPLETION DATE	
{F 224}	Continued From pag	0.5	{F 22), I	, ,		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-41			
	•	ide (NA) #6 and NA #7 came					
		n at 4:15 PM and provided					
		he resident's pants were d wet to the touch and					
		vas removed and observed					
		e, with the inside contents					
	·	an instant smell of urine				ļ	
		f. NA #6 and NA #7 cleaned		T supplies			
	- -	um area using appropriate		4			
;	•	ed her legs and dried them					
	and applied a clean t	orief and clean pants. NA#6		***************************************			
!	wiped down her chair	r cushion and dried it so it		No.			
	would not smell or be	wet when she got back up					
		esident told NA #7 that she					
		efore she went to bed					
		after being wet so long and					
	-	d felt like she smelled like					
		her she would give her a					
	bath before bed.						
	A phone interview on	09/07/17 at 8:47 AM with					
İ		nad taken care of Resident					
1		09/06/17. She stated she					
		nt a wash up in the bed on					
		r hair, changed her brief and	!	***			
	•	wheelchair around 10:30	j	(P. P. A. 1996)			
	AM. NA #4 stated sh	-		***************************************			
		because she was up in her tated she checked with the		erannou.			
		eated she checked with the PM while she was out	The second secon				
İ		and the NA stated the				1	
		NA stated that she only had					
		nt once on her shift but she					
		e her more often. NA #4					
:		as a heavy wetter and would	İ			2	
		brief and pants if she wet					
		imes before being changed.	-				
		t the resident would usually					
		she was wet and needed to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	345179 B. WING		R-C 09/08/2017				
	ROVIDER OR SUPPLIER	RETIREMENT		STREET ADDRESS, CITY, STATE, ZIP COL 752 E CENTER AVENUE MOORESVILLE, NC 28115	DE		
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{F 224}	Director of Nursing their expectation we done every 2 hours 3. Resident #130 w 05/26/17 and readment hospitalization for codiagnoses included renal disease, deprenal disease,	208/17 at 1:59 PM with the and Administrator revealed as for incontinence care to be a or as needed. 208/16/17 following a liabetic ketoacidosis. Other a diabetes mellitus, end stage ession, dysphagia, dementia gastrostomy tube for a more formal than the dolor of the following a liabetic ketoacidosis. Other a diabetes mellitus, end stage ession, dysphagia, dementia gastrostomy tube for a more formal than the formal for ADL formal formal for ADL formal formal for ADL formal formal for ADL formal formal for ADL formal formal for ADL formal for ADL formal formal for ADL formal formal for ADL formal formal for ADL formal formal formal formal for ADL formal forma	{F 2:	24}			
	decreased mobility to improve his curre through the next re- interventions include	The goal was for the resident ent level of function in ADL view date of 11/30/17. The ed he preferred showers, assistance of 1 staff with			en frantziako erriziako er		

NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) (F 224) Continued From page 7 showering and required extensive assistance of 1 staff with personal hygiene and oral care. An observation of Resident #130 on 09/05/17 at 2:23 pm revealed he was sitting in his wheelchair at the end of the hall looking out the door. Observed his nails to be long, approximately ½ to ½ inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was). An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long and had brown debris under them.	(X3) DATE SURVEY COMPLETED R-C 09/08/2017	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 224] Continued From page 7 showering and required extensive assistance of 1 staff with personal hygiene and oral care. An observation of Resident #130 on 09/05/17 at 2:23 pm revealed he was sitting in his wheelchair at the end of the hall looking out the door. Observed his nails to be long, approximately ½ to ½ inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was). An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long		
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showering and required extensive assistance of 1 staff with personal hygiene and oral care. An observation of Resident #130 on 09/05/17 at 2:23 pm revealed he was sitting in his wheelchair at the end of the hall looking out the door. Observed his nails to be long, approximately ¼ to ½ inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was). An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long		
staff with personal hygiene and oral care. An observation of Resident #130 on 09/05/17 at 2:23 pm revealed he was sitting in his wheelchair at the end of the hall looking out the door. Observed his nails to be long, approximately 1/2 to 1/2 inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was). An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long	,,,,,,,	
9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long		
On 09/07/17 at 10:46 AM Resident #130 was lying on top of his bed with his clothes on and his arms wrapped around his head. Fingernails were still long and still had brown debris under the nails.		
On 09/08/17 at 10:43 AM Resident #130 was lying on top of his bed with his clothes on but easily aroused. Stated they still had not cut his nails and they were noted to have brown debris under the nails.		
On 09/08/17 at 11:02 AM an interview with NAs #4 and #9 revealed their showers consisted of washing the resident's whole body, shampooing their hair, shaving them, cleaning their ears, and providing nail care and mouth care. NA #4 stated she had given Resident #130 a shower on day shift before and provided this care. NA #4 stated		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345179	B. WING _	B. WING		09/	08/2017	
NAME OF F	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	ENTER HEALTH AND RE	TIREMENT			'52 E CENTER AVENUE			
				N	MOORESVILLE, NC 28115		:	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE	
{F 224}	Continued From page		{F 2:	- 224}				
		t with dirty nails she would			F241			
	÷	em if needed even if it was NA #4 stated she was		1 On $0/6/17$ observation of 0 .		cidant t	14 45	
	assigned to Resident			1. On 9/6/17 observation of Res				
	#9 interviewed about Resident #130s nails in his room and both stated they needed to be trimmed				revealed resident's brief to be heavy with urine. Resident #145 received incontinent care and will			
					receive incontinent care routinely.			
	and cleaned.				receive incontinent care routin	ely.		
	On 09/08/17 at 11:09 AM an interview with the Unit Manager revealed that her expectation was				2. Current residents requiring a	issistan	ce with	
j					incontinence care have the pot			
	1	for Resident #130's nails to be trimmed and			affected by the alleged deficient practice.			
	cleaned.				Residents dependent on staff for incontinent			
	On 09/08/17 at 12:08	PM an interview with the						
	Director of Nursing re			care have the potential to be at				
	for the residents to be cared for and their needs to be met on a daily basis. She stated it was her		İ		Observations made by Ambass			
					residents requiring incontinent	care an	id service	
		are be a part of bathing for ils should be trimmed and			provided as needed.			
	clean.	iiis stipula be untitued and			2 Nursing staff will be as adve-			
{F 241}	483.10(a)(1) DIGNIT\	AND RESPECT OF	{F 24	41}	3. Nursing staff will be re-educated to the staff will be re-educa			
SS=D	INDIVIDUALITY				of Nursing or designee r/t provi			
					respect specifically proper inco			
		reat and care for each and in an environment that			The Care plan and Kardex for Re			
		e or enhancement of his or	-		dependent on staff for incontin	ent care	e will be	
	•	gnizing each resident's	2000		updated by 10/22/17.			
	individuality. The facil							
	promote the rights of t				4. Resident Ambassadors (depa			
		is not met as evidenced			will monitor 5 residents during (daily vis	sits to	
	by: Based on observation	ns, resident and staff			ensure resident dignity and resp	ect is		
		reviews the facility failed to			maintained specifically r/t incon		care. Unit	
	treat 1 of 3 residents (Managers will make observations of staff providing dignity and respect specifically with			
	-	ot providing incontinence						
	care as needed on the day shift.				incontinent care 2 times a week		,	
	The findings included:			nagalyang	weekly x 2 months.		ers men	
	······································				Weenly X 2 Honens,	and a street means by helphy		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C		
		345179	B. WING			09	08/2017	
	ROVIDER OR SUPPLIER ENTER HEALTH AND RE	TIREMENT		75	TREET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVENUE 10ORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 241}	O4/27/17 for rehabilitation for cer left side. Her other di malignant neoplasmo treatment, diabetes ma depressive disorder, of embolus and skin gadonor site to right thig required dressing characteristic data Set (MDS) dated adequate hearing and speech, understood a cognitively intact. Remo behaviors, and no required extensive as for most activities of dresident was frequent stool and was not on Resident #145 received needed, insulin, antian needed, antidepressamedication as scheduled. A review of Resident # Assessment (CAA) surevealed she was a new ho presented for rehidischarge plans were and oriented but had pronfusion that vary an since admission that is screaming for assistant disruptive to other res	dmitted to the facility on ation following a ebral infarction affecting her agnoses included history of of brain with surgical nellitus, epilepsy, anxiety and She also had surgical repair grafting to her right arm with the which has not healed and inges. #145's quarterly Minimum to 08/03/17 revealed she had it vision with glasses, clear and understands and was sident #145 had no moods, rejection of care and sistance of 1 to 2 persons laily living (ADL). The ly incontinent of urine and a toileting program. The ded pain medication as not and anticoagulation and whose uncertain. She was alert presented with episodes of d has had some behaviors included yelling and	{F 2	41}	Data obtained during the audity analyzed for patterns and trent to Quality Assurance (QAPI) by Nursing for 3 months, at which committee will evaluate the exinterventions and determine it is needed to sustain compliance.	ds and the Ditention time to the fectives of t	reported rector of he ness of the	
	when they entered he	r room, but had not						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345179	B. WING_	B. WING		09/08/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
, , , , , , , , , , , , , , , , , , , ,				7	752 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RE	TIREMENT			MOORESVILLE, NC 28115		
	CLIMANACIOV CT	ATEMENT OF DEFICIENCIES	(1)	ID PROVIDER'S PLAN OF CORREC			(X5)
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFILE OF THE			COMPLETION DATE
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{F 241}	Continued From page	10	{F 2	41}		.,	
	displayed these beha	viors when visitors were					
	present. Her behavio	rs were not easily altered so					
	she had been referred	d to psychiatric services for					
	counseling and medic	cal management. She					
	required extensive as	sistance with bed mobility					
	and was incontinent o	of both bowel and bladder.					: :
	Resident #145 was cu	urrently taking antianxiety,					
	antidepressant and ar	ntipsychotic medication.					
	A review of Regident:	#145's Care Plan dated					
		e was care planned for					
		Ider incontinence related to					-
		s of cerebral infarction and					
		of the brain. The goal for	1			į	
	Resident #145 was to	-	1				
	•	ontinence and brief use					
	through the next revie						}
		I changing the resident					
		ded, and changing clothing					
	as needed after incon	· · · · · · · · · · · · · · · ·					
	During a continuous s	boonistian made on					
	During a continuous o Resident #145 on 09/						
		desk and continued to the				,	
		bservation revealed she	į				l
		sk requesting to be changed					
		paking wet and had not					
		he got up at 10:30 AM.					
	•	her wheelchair down to her					
		Resident #145 who was					
	•	y as cognitively intact and					
	•	ight arm, stated the first					
		cked or changed her after					
		wheelchair. She stated that					
		h of urine on her and she					
		tated that she smelled like					
		s smelled like urine to her					
		nelled like. Nurse Aide		3022755			
en et 11 de la 14 de en en en en en en en en en en en en en	makan kepada da kan manak bana bahan kepada da mada da mada da ke	me in the resident's room at				Anthony or a little property	es at a second s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	IG		R-C	
	345179 B. WING		B. WING			09/08/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE .		
			1	752 E CENTER AVENUE			
BRIAN CE	BRIAN CENTER HEALTH AND RETIREMENT			MOORESVILLE, NC 28115			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
				2.2			
{F 241}	Continued From page	2 11	{F 24	1 1}			
	•	d incontinence care. The	İ				
		soaked with urine and wet				į	
	to the touch and remo						
	removed and observe	ed to be heavy with urine,	Add the same				
		its balled and there was an					
		coming from the brief. NA	Í				
		d the resident's perineum					
		e technique and washed her					
		and applied a clean brief and					
	•	viped down her chair cushion					
		d not smell or be wet when					
	•	he chair. The resident told					
		d a bed bath before she					
		she felt dirty after being wet	1				
	-	t feeling and felt like she	70				
		I NA #7 told her she would					
	give her a bath before	e bea.					
	A phone interview on	09/07/17 at 8:47 AM with				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	NA #4 revealed she h	ad taken care of Resident	İ				
		09/06/17. She stated she	İ				
		t a wash up in the bed on					
İ		r hair, changed her brief and		1989			
	· ·	wheelchair around 10:30		5			
	AM. NA #4 stated she						
İ		because she was up in her					
		ated she checked with the	-				
ļ	resident before 3:00 F		Cultural Control of Co				
1	smoking on 09/06/17		ļ				
		NA stated that she only had					
-	=	t once on her shift but she					
		her more often. NA #4					
		is a heavy wetter and would					
		orief and pants if she wet					
1		mes before being changed.					
1		t the resident would usually		as exercises			
		he was wet and needed to					
rantaning transfer and the state of the stat	anne an mala e contrata e com reta a franta la caractería de la caractería de la caractería de la caractería de l	ed that even though the		671 Jago 1672 Constant San Constant Special Constant Spec			
	resident was incontine	ent she could tell them when					

		(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY COMPLETED		
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		345179	B. WING			1	08/2017		
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		***************************************		
DD1411.0F	-NTES (15 4 T) 4 MS SE	······································		CENTER AVENUE					
BRIAN CE	ENTER HEALTH AND RE	IIREMENI		MOC	DRESVILLE, NC 28115				
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	i 3 1						An Advantable manner		
{F 241}	Continued From pag	e 12	{F 2	41}					
	she was wet.			Annual Property Control					
	An interview on 09/0	8/17 at 1:59 PM with the		N. 4 14. (PART)					
	:	nd Administrator revealed		THE CONTRACTOR OF THE CONTRACT					
	their expectation was		4444						
	be maintained and in		THE PERSON NAMED IN						
	every 2 hours or as r			403			:		
{F 242}		F-DETERMINATION -	{F 2	42}			:		
SS=D	RIGHT TO WAKE OF	TOICES		F2	242				
	 (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: 			*** OPERATOR NOTATION OF THE PROPERTY OF THE P	1. A review of a kardex indicated Resident #91 preferred showers in the morning during the summer and showers in the evenings during the winter. Interview with Resident #91 on 9/7/17 revealed that her personal preferences concerning showers were not being followed. Resident #91's personal preference interview assessment was updated on 9/22/17 to reflect the resident's current shower preference. Kardex for resident #91 was updated at				
Based on observations, record reviews and resident and staff interviews the facility failed to honor a resident's choices regarding showers (Resident #91) and failed to honor a resident's choice to have his fingernails trimmed (Resident #130) for 2 of 3 residents sampled for choices. Findings included: 1. Resident #91 was admitted to the facility on			12 10000 200 200 200 200 200 200 200 200	this time. On 9/5/17 thru 9/8/17 Resi observed with long nails. with Resident#130 reveals resident does not like his long. Resident #130 receivnail care on 9/8/17 and Kardex/Preferences updat	Intervie ed that Fingerna red imm	w			
	U3/U1/14 and re-adm	itted on 12/07/14 with		AGENTA KONG AGENTA	is sexi references updat	× Meta-reconsisse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345179	B. WING	~		1	08/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
				752 E	CENTER AVENUE			
BRIAN CE	ENTER HEALTH AND RE	TIREMENT		MOORESVILLE, NC 28115				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 242}	depression. A review of the most Data Set dated 08/07 was cognitively intact The MDS also reveal extensive assistance A review of a facility of Preferences Evaluation Resident #91 receive was her preference to morning in the summethe winter. A review of a shower #91 received a shower during the evening or A review of a kardex in preferred showers in summer and showers winter. During an interview of Resident #91 she star	recent quarterly Minimum /17 revealed Resident #91 for daily decision making. ed Resident #91 required by 1 staff with bathing. locument titled Resident on dated 07/19/17 indicated d 2 showers a week and it o get a shower during the er and during the evening in book indicated Resident er on Tuesday and Friday	{F 24	2) 2.	Current residents have the p be affected by the alleged de practice. Administrative Staff(Department Heads) completed/updated all curre residents' personal preference interviews on 9/22/17 to ensure resident preferences are being and any changes to residents preference were noted and reference were noted and reference with this time. Service Director completed readmission resident Personal interview for accuracy. New resident's Kardex updated at to reflect current preference. Administrative Staff will be resident by 10/22/17 regarding resident preference interviews to include residents and changes in curresident's preference status. Information obtained during	nt ce ure curr ng hono c' esident Social new Prefere admissio this tim status. e-educa nt ude nev rent The	ent ired nce on ne	
	shower every day but shower every other da to her. She confirmed week in the evening a to her. She explained showers in the mornin because of the hot ter showers in the evening because it's cold. Showers	ng during the summer mperatures and preferred						

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		IPLE NG	(X3) DATE SURVEY COMPLETED		
			11. 00.00.		······································	R	-c
		345179	B. WING_			09/	08/2017
	ROVIDER OR SUPPLIER ENTER HEALTH AND RE	TIREMENT		75	TREET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVENUE NOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	Χ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 242}	Continued From page hot outside and then colder weather. During an interview of a Receptionist she conceptionist she conception of the assignment to compreferences evaluation over the form and ask preferences for each stated she had been to Director of Nursing with facility that residents week so she had door for Resident #91 and preferences for shower morning in the summer during the winter and preference evaluation. During an interview of Nurse Aide (NA) #9 stores to Resident #91 and showers 2 days a week second shift because book indicated. She calways cooperative with a bag of personal care shower.	evening showers during on 09/07/17 at 09:40 AM with infirmed she completed the Evaluation for Resident explained she was given inplete the resident in and was instructed to go the resident their question on the form. She old by a former Assistant in on longer worked at the evere to receive 2 showers a jumented 2 showers a week had documented her ers to be given during the er and during the evening had placed Resident #91's in a notebook. on 09/07/17 at 10:50 AM, ated she had provided care her routinely received sk during the evening on that was what the shower explained Resident #91 was th showers and usually had	{F-2	4.		t to the ny new be note were to cerns or and reg sadors at whe effective if furth	or ed on ith during n will be ported ich time eness of
	care to Resident #91 a days a week on secon what was written in the confirmed Resident #9 showers and told her	and she got a shower 2 and shift because that was e shower book. She also but was cooperative with when she had her bag of eady to go to the shower.					den effectiv den er kan kan kan kan kan kan kan kan kan kan

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	(X3) DATE SURVEY COMPLETED	
		345179	B. WING		1	R-C 1/ 08/2017	
	ROVIDER OR SUPPLIER ENTER HEALTH AND F	RETIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODI 752 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 242}	Continued From pa	ge 15	{F 2 ²	12)			
	interim Director of N	on 09/08/17 at 1:57 PM, the Nursing stated it was her f to honor resident's choices					
	interim Administrate for staff to ask the r if they wanted a she give them a shower staff should work it accommodate the r because this was the	on 09/08/17 at 2:56 PM, the or stated it was her expectation esident their preferences and ower every day staff should every day. She further stated out with the work load and esident's preferences neir home and they should eless there's was a reason the e given.					
	05/26/17 and readn hospitalization for d diagnoses included renal disease, depr	vas admitted to the facility on nitted on 08/16/17 following a iabetic ketoacidosis. Other diabetes mellitus, end stage ession, dysphagia, dementia gastrostomy tube for					
	Data Set (MDS) dat adequate vision and and usually underst and had no mood o required extensive a	nt #130's admission Minimum ted 08/23/17 revealed he had dhearing, usually understood teands, was cognitively intact repensively. Resident #130 assistance of 1 person for frequently incontinent of urine ent of stool.					
	Daily Living (ADL) c	nt #130's Care Area summary for Activities of lated 08/28/17 revealed he assistance of 1 to 2 persons					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	NULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		345179	B. WING _			1	-C 08/2017	
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, 752 E CENTER AVE MOORESVILLE,		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F-242}	for transfers, dressing and toilet use and red bed mobility. A review of Resident 08/30/17 revealed he self-care performance decreased mobility, to improve his currenthrough the next revieinterventions included required extensive as showering and requir staff with personal hy An observation of Re 2:23 PM revealed he at the end of the hall eating a cheese cracible long, approximate end of his fingertips a under his nails. The like his fingernails to be cut. Stated he had remember her name) when he had his last remember what day if the after breakfast with the self-care and of Research and to be cut.	g, personal hygiene, bathing quired limited assistance with #130's care plan dated was care planned for ADL edeficit related to his The goal was for the resident to level of function in ADL ew date of 11/30/17. The district he preferred showers, sistance of 1 staff with ed extensive assistance of 1 giene and oral care. Sident #130 on 09/05/17 at was sitting in his wheelchair looking out the door and ker. Observed his nails to by ¼ to ½ inch beyond the ind there was brown debris resident stated he did not be long and wanted them to did told the NA (could not but she did not cut them shower (could not it was). Sident #130 on 09/06/17 at was lying on top of his bed e covers pulled over his were noted to still be long	{F 2	12)			,	
	lying on top of his bed arms wrapped around	AM Resident #130 was I with his clothes on and his I his head. Fingernails were brown debris under the				ander of grandom, the segment of second or sec		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	0.401.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/20/17
147 11112 01 1	THO PIDELLY OF COURT AND CO.				52 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RET	rirement		M	IOORESVILLE, NC 28115		*
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 242}	Continued From page	17	{F 2	42}	,		
	lying on top of his bed easily aroused. State nails and they were no under the nails. On 09/08/17 at 11:02 #4 and #9 revealed the washing the resident's their hair, shaving the providing nail care and she had given Reside shift before and provide	AM Resident #130 was I with his clothes on but d they still had not cut his oted to have brown debris AM an interview with NAs eir showers consisted of s whole body, shampooing m, cleaning their ears, and d mouth care. NA #4 stated nt #130 a shower on day ded this care. NA #4 stated					
	clean them and cut the not their shower day. assigned to Resident #9 interviewed about	t with dirty nails she would em if needed even if it was NA #4 stated she was #130 today. NAs #4 and Resident #130s nails in his they needed to be trimmed					
77 (77 (80)		AM an interview with the d that her expectation was ails to be trimmed and					
Ī	Director of Nursing rev for the residents to be to be met on a daily be expectation that nail c every resident. She st	mmed nails should be	F 2	50			
SS=D				200,000			
			i	i			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES		<u> </u>		JIVID NO. 0830-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
					-	R-C
		345179	B. WING			09/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
BDIAN CE	ENTER HEALTH AND RE	TIPEMENT		752 E CENTER AVENUE		
BRIANCE	"IAITEX (IEWEITI MID) IVE			MOORESVILLE, NC 28115		
(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	ION SHOULD BE HE APPROPRIA	
				F250		
F 250	Continued From page	e 18	F 25	0		
	social services to atta practicable physical, well-being of each rea This REQUIREMENT by: Based on observatio interviews and record provide medically rela	is not met as evidenced in, resident, family and staff I review, the facility failed to ated Social Services referral for 1 of 1 sampled		1. On 9/6/17 Resi would not let h because her Me Observation of nails trimmed b Res #145 was se 9/12/17.	er see the edicaid wa her feet re out not file	Podiatrist as pending. evealed her toe ed on both feet.
	04/27/17 for rehabilitation for cer	dmitted to the facility on ation following a rebral infarction affecting her iagnoses included history of of brain with surgical		2. Residents that a of Podiatry serv be affected. An residents was common Management to needs.	rices have to audit of completed I	the potential to current diabetic by Nurse
	Data Set (MDS) dated cognitively intact, had required extensive as for most activities of common on 09/06/17 at 9:28 A her wheelchair going her room, she stated see the Podiatrist becomending. An observatoe nails trimmed but	nterview with Resident #145 M revealed the resident in back to her room. Once in the staff would not let her cause her Medicaid was tion of her feet revealed her not filed on both feet.		3. Re-education to by the Administration scheduling reconstruction on 9/15/17. Re-Nurses and Certify Director of Notes of 10/22/17 related in need of podial	rator r/t for esident poreducation ified Nursi ursing or d d to identing try service	ollow-through diatry needs to Licensed ing Assistants designee by fying residents es. The
)	ther family member did the		Certified Nursing		
	best he could with trin	nming her toe nalls. Ther nails had gotten so long		findings to Licen		
		could not wear her tennis		Nurses will comr	nunicate t	he needs to

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		2.15470					R-C	
		345179	B. WING		A CONTRACTOR OF THE CONTRACTOR		09/08/2017	
	PROVIDER OR SUPPLIER ENTER HEALTH AND RE	TIREMENT		7.	STREET ADDRESS, CITY, STATE, ZIP CODE 152 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
				the Social Services Director.				
F 250	Continued From page	∍ 19	F:	250		Zanana (Manana da Araba) ann antat	· · · · · · · · · · · · · · · · · · ·	
		oot to balance and she had			4. Director of Nursing or de	signee t	to	
	been having to wear a instead of her shoe.	a no slip sock on her foot			monitor 5 diabetic resid			
					needs by observations 2	x week	x 4	
		09/06/17 at 4:34 PM with ly member revealed the staff	į		weeks ,then weekly x 2 r	nonths.	1	
	at the facility were not	t taking care of the			Administrator will audit	the Soci	al	
	•	amily member stated the			Service scheduling of dia	betic po	odiatry	
	staff had told them the since she was diabeti	ey could not trim her nails ic.			appointments to ensure	follow t	hrough	
			weekly x 4 weeks then monthly x 2				-	
		Social Worker (SW) on I revealed that she was			months. The Administra	•		
	;	inating Podiatry visits for the			findings of the audits to		•	
	residents. She stated	d the process was for her to			committee monthly x 3 to			
		get consents signed on the	-		committee monuny x 3	Uueten	line the	
		i to be seen. She stated rrals from the nurses and			: 		:	
		nts that had thick nails that			need for additional mo	nitarina	and/or	
	the staff were unable				need for additional mo	HUHHE	anu/or	
	1	ed for their toe nails to be ated that she was aware that			education.			
	1	iabetic. The SW stated the						
ļ	family should not be re	esponsible for taking care of					10/22/17	
100		ted the facility should set up					i i	
1		the Podiatrist and take care						
	I .	tated she had not offered he resident when they were						
	at the facility on 08/25							
	An interview with the	Director of Nursing (DON)						
	and Administrator on (real and a second		'	
	,	ed all interventions on the			ex-constant			
		. They stated the NAs						
		ole body while providing						
		rse of any concerns. They dhave expected the nurses						
	,	nt #145's toe nails and						
And the second s	 Contract of the c	mily to feel obligated to trim	Service of the Servic	22.20,000			2000/21/20 000 12/10/20/20 000 12/10/20/20/20/20/20/20/20/20/20/20/20/20/20	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDIN		ı	R-C	
		345179	B. WING		09	/08/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	ENTER HEALTH AND RE	TIREMENT		752 E CENTER AVENUE			
				MOORESVILLE, NC 28115			
(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 CORI ({EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 250	Continued From page	20	F 2				
	have been referred to was diabetic and the the referral to the Poo 483.20(g)-(j) ASSESS	BMENT	F 2	F278 MDS accuracy			
SS=D	must accurately reflect (h) Coordination A registered nurse muse ach assessment with participation of health (i) Certification (1) A registered nurse the assessment is cor (2) Each individual whassessment must sign that portion of the assessment for Falsification	esments. The assessment of the resident's status. Inst conduct or coordinate of the appropriate professionals. Inst sign and certify that impleted. In completes a portion of the of and certify the accuracy of essment.		 On 9/6/17 Resident would not let her so because her Medica Observation of her nails trimmed but in Res #145 was seen 9/12/17. Residents that are cof Podiatry services be affected. An audresidents was comp Management to observeds. 	ee the Podiat aid was pend feet revealed ot filed on be by the podiat diabetic and i have the pot lit of current leted by Nurs	rist ing. I her toe oth feet. trist on n need tential to diabetic	
	(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or on 9/15/17 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.		3. Re-education to Soc by the Administrato for scheduling reside on 9/15/17. Re-edu Nurses and Certified by Director of Nursin 10/22/17 related to	r r/t follow-tlent podiatry cation to Lice I Nursing Assing or designe I dentifying re	hrough needs ensed istants e by esidents		
	adijadina digagangsi ya afijadini katalogida a pagipana da gilapata adapagini a ginada na fibongidi a padi Anaka tanangingan a katalogida da atau katalogida a ginada a da atau a da atau atau da atau da atau a da atau			in need of podiatry s	ervices. The	redatoja piljoje dilpitioja redjilo i regionida). Prijas i kristina i dela dilpitioja prijas i kristina prijas i kristina.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,			A. BUILDI	ING	j		R-C	
		345179	B. WING				/08/2017	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	00:201.	
*** **** * * *	110110 11110 11110 11110 11110				752 E CENTER AVENUE			
BRIAN CE	ENTER HEALTH AND RE	TIREMENT			MOORESVILLE, NC 28115			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE	
F 278	Continued From page	e 21	F:	27	8 Certified Nursing Assistant	s will re	port	
	· -	ment does not constitute a			findings to Licensed Nurse	s and Li-	censed	
	material and false sta	false statement.			Nurses will communicate t			
	1	T is not met as evidenced	1		the Social Services Director		43 CO	
	by: Based on observation	ons, record reviews, and staff			the social services Director			
		failed to accurately code the			4. Director of Nursing or desi	enee to		
	1	2 of 3 residents with a			monitor 5 diabetic residen			
	#38).	sident #69 and Resident				•	•	
	#00 <i>)</i> .				'	needs by observations 2x week x 4 weeks ,then weekly x 2 months.		
	The findings included	l :	aberralist in		·			
	1 Dooldont #60 was	most recently readmitted to			Administrator will audit the	e Social		
	I and the second	17. His diagnoses included			Service scheduling of diabe	etic pod	iatry	
	-	sis, sepsis, pressure ulcer of			appointments to ensure fo	llow thr	rough	
	the sacrum, retention				weekly x 4 weeks then mo		_	
	Design of the mont of	e e e et accantante minimum			months. The Administrato	•		
		ecent quarterly minimum d 07/31/17 revealed that			7.5.48.5 M			
		verely cognitively impaired			findings of the audits to the	e QAPI		
		king and had long/short term						
ļ		he MDS further revealed that						
		d total assistance of one						
		ting, had an indwelling			committee monthly x 3 to c			
		casionally incontinent of			need for additional monitor	ring and	l/or	
		as completed by MDS Nurse			education.	~	•	
	#1.					4	~ /22 /17	
	An interview was con-	ducted with MDS Nurse #1				T	0/22/17	
1	on 09/07/17 at 11:30 /							
		ompleted the assessment on						
		31/17. She stated that it was						
		e catheter leaked and urine						
	touched the skin or da		ļ					
		she coded that under urinary	1					
		on the MDS assessment.						
		ding instructions for H0300		100.053.0				
	MDS Nurse #1 acknow and stated she would	wledge there was an error		saagaya; Taxoo X				
- 1	. and stated she would	correct the error.			1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN O	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG_			
		345179	B. WING			İ	l-C /08/2017
MAME OF D	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/2017
IVAINE OF F	NOVIDER OR SOIT EIER				752 E CENTER AVENUE		
BRIAN CE	NTER HEALTH AND RE	TIREMENT	İ		MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CORRECTION OF			(X5) COMPLETION DATE
F 278	Continued From page	∋ 22	F 2	278			
	Director of Nursing (I on 09/08/17 at 1:57 F that she expected all accurately as possible condition of the reside 2. Resident #38 was the facility on 07/24/1 quadriplegia, neuropa	most recently readmitted to 7. His diagnoses included athic bladder, and others.					
	Review of the most recent comprehensive minimum data set (MDS) dated 07/31/17 revealed that Resident #38 was cognitively intact and required extensive assistance of 1 staff member for toileting. The MDS also indicated that Resident #38 had an indwelling catheter and an ostomy (including urostomy, ileostomy, and colostomy). H0300 urinary continence of the MDS was also coded as occasionally incontinent.						
	on 09/07/17 at 11:30 a confirmed she had confirmed she had confirmed she had confirmed she had so no 7/3 her practice that if the touched the skin or doundergarments then so continence (H0300) on MDS Nurse #1 confirmation urostomy and not an review of the coding in Nurse #1 acknowledges tated she would correct the statement of the confirmation of the coding in Nurse #1 acknowledges tated she would correct the statement of the coding in Nurse #1 acknowledges tated she would correct the statement of the coding in Nurse #1 acknowledges the confirmation of the coding in Nurse #1 acknowledges the confirmation of the coding in Nurse #1 acknowledges the coding in Nurse #1 ackn	Impleted the assessment on 1/17. She stated that it was a urostomy leaked and urine ampened the she coded that under urinary in the MDS assessment. The med that Resident #38 had in indwelling catheter. After instructions for H0300 MDS are there was an error and		en gonarras			
		M. The interim DON stated		Usogis yetsa hannananan			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345179	B. WING		,	R-C 09/08/2017	
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	accurately as possible condition of the reside	MDSs to be completed as eto reflect the current ent.	F 278	F282		and the second s	
(F 282) SS≃D	PERSONS/PER CAR (b)(3) Comprehensive The services provided as outlined by the cor must- (ii) Be provided by qu accordance with each care. This REQUIREMENT by: Based on observatio interviews the facility plan interventions by a residents feet (Resi the care plan and faile resident with long toe (Resident #145) as in 2 of 3 sampled resided The findings included Resident #57 most re facility on 06/13/17. H failure to thrive, traum dysphagia, dementia,	e Care Plans d or arranged by the facility, mprehensive care plan, alified persons in n resident's written plan of is not met as evidenced ns, record review and staff failed to implement care not applying bunny boots to dent #57) as instructed by ed to refer a diabetic nails to the podiatrist structed by the care plan for ints. cently readmitted to the lis diagnoses included adult natic subdural hemorrhage,	{F 282}	 On 9/6/17 Resident would not let her so because her Medic Observation of her nails trimmed but r Res #145 was seen 9/12/17. Residents that are of Podiatry services be affected. An auresidents was comp Management to obneeds. Re-education to So by the Administrate for scheduling residents. 	ee the Podia aid was pend feet reveale not filed on the by the podia diabetic and s have the podia dit of curren pleted by Nu serve for podia cial Service I or r/t follow	trist ding. d her toe both feet. etrist on in need btential to t diabetic arse diatry Director -through	
	data set (MDS) dated #57 was severely cog	ecent quarterly minimum 07/11/17 indicated Resident nitively impaired for daily nad long/short term memory		on 9/15/17. Re-ed Nurses and Certifie by Director of Nurs 10/22/17 related to in need of podiatry	d Nursing As ing or design o identifying	ssistants nee by residents	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.05.0			R-C	
		345179	B. WING _			09/08/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
201110		**************************************		75	52 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RET	TIREMENT		MC	OORESVILLE, NC 28115		
(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 APPROPE DEFICIENCY)	BE COMPLETION	
(5.000)	,	-	rr 0.		Certified Nursing Assista	nts will report	
{F 282}			{F 28	82}	findings to Licensed Nurs	es and Licensed	
	problems. The MDS fi Resident #57 required	d extensive assistance of 2			Nurses will communicate the needs to		
	staff members for bed	d mobility. No pressure on the MDS and Resident			the Social Services Direct		
i		on the MDS and Resident aviors during the reference			4. Director of Nursing or de	signee to	
	•				monitor 5 diabetic reside	nt for podiatry	
	, ,	order dated 06/29/17 read,			needs by observations 2	x week x 4	
	bunny boots on while	in beu.			weeks ,then weekly x 2 n		
		initiated on 07/20/16 and			Administrator will audit t		
		ead in part, Resident #57					
	-	re ulcer to his sacrum due and incontinence. The goal			Service scheduling of dia	· ' ' !	
		lesident #57 would show			appointments to ensure		
		wound decreasing in overall			weekly x 4 weeks then m	onthly x 2	
	size and depth by the	next review. The			months. The Administrat	or will report	
		are plan included bunny			findings of the audits to t	'	
	boots.				committee monthly x 3 to		
	Review of the treatme	ent administration record			commutee monthly x 5 to	determine the	
		through 09/30/17 read in		en une une une une une une une une une u	and for additional monit	raring and/or	
		while in bed every shift for			need for additional monit	Offing and/or	
		n). Each shift had been	į	Ì	education.		
1	applied to Resident #5	e bunny boots had been					
	applied to resident lie	, , , , , , , , , , , , , , , , , , ,	İ			10/22/17	
		sident #57 was made on	-			1	
		Resident #57 was in bed					
		on his feet. Bilateral heels	No constitue to the				
	were resting on the ma	attress creating an ttress. No bunny boots were	İ			***	
	located in Resident #5	· · · · · · · · · · · · · · · · · · ·				,	
1	1000100 1111111111111111111111111111111			PERSONAL PROPERTY.			
i		sident #57 was made on					
1		Resident #57 was in bed					
	-	n his feet. Bilateral heels					
	were resting on the maindentation on the mat	attress creating an ttress. No bunny boots were					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŀ		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345179	B. WING			l	-C 08/2017
	ROVIDER OR SUPPLIER	TIREMENT		7	TREET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F-282}	o9/07/17 at 11:28 AM with no bunny boots of were resting on the mindentation on the may were located in Resident An observation of Resident at 1:09 PM. with no bunny boots of were resting on the mindentation on the may were located in Resident An interview was consumed at 12:00 frequently cared for Resident and would routinely ended that if bed he was turned an and would routinely ended to had bunny boots and the resident. An interview was consumed and would routinely ended to had bunny boots and the resident. An interview was consumed and would routinely ended to the had bunny boots and the resident. An interview was consumed and bunny boots and the resident. An interview was consumed and bunny boots and the resident and the resident at 1:25 PM. Not frequently provided casted he had recently Resident #57 with the into his room on 09/07. Resident #57 had no he had not applied the he cared for Resident sometime he would us feet.	sident #57 was made on I. Resident #57 was in bed In his feet. Bilateral heels nattress creating an attress. No bunny boots lent #57's room or closet. sident #57 was made on Resident #57 was in bed on his feet. Bilateral heels nattress creating an attress. No bunny boots lent #57's room or closet. ducted with Nurse Aide (NA) 39 PM. NA #2 stated that he desident #57 was in the drepositioned frequently levate his feet on a pillow. ot believe that Resident #57 he had not applied them to	{F-2	82}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345179	B. WING			1	R-C 1 /08/2017
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVENUE NOORESVILLE, NC 28115	, 03	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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-282}	with no bunny boots of were resting on the many market of the many were located in Resident and interview was con 09/08/17 at 9:26 AM. fairly new at the facility Resident #57. She at NAs were responsible repositioning resident completed the tasks. Resident #57 had an bilateral feet when he applied them and she sure they were applies she expected the NA' bunny boots when he An interview was con Nursing (DON) and that 1:57 PM. The DON Resident #57's bunny discontinued when the an air mattress. The Despected all care plant as ordered.	Resident #57 was in bed on his feet. Bilateral heels nattress creating an attress. No bunny boots dent #57's room or closet. ducted with Nurse #1 on Nurse #1 stated she was ty but routinely cared for ded that both nurses and e for turning and its but generally the NAs Nurse #1 added that order for bunny boots to was in bed and the NAs would check and make ad correctly. Nurse #1 stated is to apply Resident #57's was in bed as ordered. ducted with the Director of the Administrator on 09/08/17 If stated that she thought that woots had been ey switched his mattress to DON further stated that she in interventions to be followed administration affecting her agnoses included history of	{F-2	282}			
	depressive disorder.						

MANE OF PROMIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT STREET ADDRESS, CITY, STATE, ZP CODE, 752 E CONTER AVENUE MODRESVILLS, REGULATORY OR LISC IDENTIFYING INFORMATION) GENERAL PROFILES AND A CONTENT OF DESCRIPTION OF THE AVENUE MODE SEVERAL PROFILES AND A COMPRECION OF THE AVENUE MODE SEVERAL PROFILES AND A COMPRECION OF THE AVENUE MODE SEVERAL PROFILES AND A CONTENT OF THE AVENUE MODE SEVERAL PROFILES AND A CONTENT OF THE AVENUE MAY DEPOSIT OF THE AVENUE MODE SEVERAL PROFILES AND A CONTENT OF THE AVENUE MODE SEVERAL PROFILES	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
MANG OF PROMOBER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT (A) D (A) D (B) SUBMENY STATE, AND OF DEPLICACES (EACH DETICACE WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL REQUIRED WASTS OF PRESCRIPE OF YELL APPROPRIATE (F 282) Continued From page 27 A review of Resident #145's quarterly Minimum Data Set (MDS) dated 080/317 revealed she was cophilively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). A review of Resident #145's admission Care Area Assessment (CAA) summary dated 06/10'17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain. She was alert and oriented but had presented with episodes of confusion that vary and had had some behaviors since admission that included yelling and screaming for assistance. She required extensive assistance with bed mobility, and most ADL and was incontinent of both bowel and bladder. A review of Resident #145's Care Plan dated 06/12/17 revealed she was care planned for having Diabetes Mellitus with goals for being free from any signs or symptoms of hypoglycemia through the next review date. The interventions included in part, "Educate resident/family/caregiver." Diabetes was a chronic disease and that compliance was essential to prevent complications of the disease. Review complications and prevention with the resident/family/caregiver and elicit a verbal understanding from the resident/family/caregiver.			345179				i
FREENX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (F 282) (F 282) Continued From page 27 A review of Resident #145's quarterly Minimum Data Sat (MDS) dated 08/03/17 revealed she was cognitively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). A review of Resident #145's admission Care Area Assessment (CAA) summary dated 05/10/17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain. She was alert and oriented but had presented with episodes of confusion that vary and had had some behaviors since admission that included yelling and screaming for assistance. She required extensive assistance with bed mobility, and most ADL and was incontinent of both bowel and bladder. A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having Diabetes Mellitus with goals for being free from any signs or symptoms of hypoglycemia, having no complications related to diabetes and being free from any signs or symptoms of hypoglycemia through the next review date. The interventions included in part, "Educate resident/family/caregiver. Diabetes was a chronic disease and that compliance was essential to prevent complications of the disease. Review complications and prevention with the resident/family/caregiver. The latest of the prevent complications of the disease. Review complications and prevention with the resident/family/caregiver and elicitia verbal understanding from the resident/family/caregiver, that nails should always be cut straight across, never cut corners and file rough edges with an emery board." "Refer to podiatrist/foot care nurse to observe/document foot care needs and to cut					752 E CENTER AVENUE	DE.	03/06/2011
A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she was cognitively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). A review of Resident #145's admission Care Area Assessment (CAA) summary dated 05/10/17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain. She was alert and oriented but had presented with episodes of confusion that vary and had had some behaviors since admission that included yelling and screaming for assistance. She required extensive assistance with bed mobility, and most ADL and was incontinent of both bowel and bladder. A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having Diabetes Mellitus with goals for being free from any signs or symptoms of hyperglycemia, having no complications related to diabetes and being free from any signs or symptoms of hypoglycemia through the next review date. The interventions included in part, "Educate resident/family/caregiver: Diabetes was a chronic disease and that compliance was essential to prevent complications of the disease. Review complications and prevention with the resident/family/caregiver and elicit a verbal understanding from the resident/family/caregiver, that nails should always be cut straight across, never cut corners and file rough edges with an emery board." "Refer to podiatrist/foot care nurse to observe/document foot care needs and to cut	PREFIX	(EACH DEFICIENT	CY MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLETION
long nails.	{F-282}	A review of Resident Data Set (MDS) date cognitively intact, ha required extensive a for most activities of A review of Resident Assessment (CAA) is revealed she was a who presented for redischarge plans were and oriented but had confusion that vary a since admission that screaming for assistance admission that screaming for assistance ADL and was incontibled being Diabetes Mel from any signs or sylhaving Diabetes Mel from any signs or sylhaving no complication being free from any shypoglycemia through interventions include resident/family/careguisease and that conprevent complication complications and president/family/careguinderstanding from that nails should alwinever cut corners an emery board." "Refer to observe/document."	t #145's quarterly Minimum and 08/03/17 revealed she was d no rejection of care and ssistance of 1 to 2 persons daily living (ADL). It #145's admission Care Area summary dated 05/10/17 new admission to the facility shabilitation and whose e uncertain. She was alert I presented with episodes of and had had some behaviors included yelling and ance. She required with bed mobility, and most ment of both bowel and I #145's Care Plan dated he was care planned for litus with goals for being free mptoms of hyperglycemia, ons related to diabetes and signs or symptoms of the next review date. The d in part, "Educate giver: Diabetes was a chronic inpliance was essential to s of the disease. Review revention with the giver and elicit a verbal the resident/family/caregiver, ays be cut straight across, d file rough edges with an r to podiatrist/foot care nurse	{F-2i	32}		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PERMO	CONNECTION	SERVICION NOWSELV.	A. BUILDI	NG_			
		345179	B. WING				-C ′08/2017
NAME OF F	ROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/2017
NAME OF F	ROVIDER OR SUPPLIER		Ī		52 E CENTER AVENUE		
BRIAN C	ENTER HEALTH AND RE	TIREMENT	1				
				N	MOORESVILLE, NC 28115		,
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{F 282}	Continued From pag	e-28	{F-2	82}			
	An observation and is	nterview with Resident #145					1
	on 09/06/17 at 9:28 A	AM revealed the resident in					
	her wheelchair going	back to her room. Once in					
		the staff would not let her					
	see the Podiatrist be	cause her Medicaid was not					
	effective. An observa	ation of her feet revealed her					
	toe nails trimmed but	not filed on both feet.					
	Resident #145 stated	her family member did the					
		mming her toe nails. She					
		rker brought a consent for					
		was first admitted, but told					
		o pay for the service and the					
	↓	ad not had the money to pay					
		she had not signed the					
		145 stated her nails had					
		toes that she could not					
		on her "good" foot to					
		been having to wear a no					
	-	instead of her shoe. She					
	_	per from out of state visited when toenails and cut them	į				
		get her foot in her shoe. She					
		mily member had to trim					
		vas admitted to the facility					
	because the staff wor						
	DOGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGG		į				
	A phone interview on	09/06/17 at 4:34 PM with					
	•	ly member revealed the staff	***************************************				
	at the facility were no						
		amily member stated the	į				
		ey could not trim her nails					
		ic and they could lose their					
		nails. The family member					
,		er a consent when she was					
		Podiatrist but told them they			The Property		
ĺ		her to see the Podiatrist			7.00		
		the money to pay so they					
*****************************		o cut them for her. The	.,				
		I she had been doing her		andro (e)ele Constituents	y promotiva programa por programa programa programa programa por programa programa programa por programa progra	ing spigning known pastyllinade Linear and a state of a state of a	estron erollinge krispien panin indopention of the notice of control of the second section of the second

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
				-		R	R-C	
		345179	B. WING			1	/08/2017	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE	1		
				7	752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND RE	TIREMENT			MOORESVILLE, NC 28115			
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{F 282}	Continued From page	<u>1</u> -29	{F-2	821				
(,		ney had not done them	, -	,				
	either.	ney had not done mem						
	An interview with the	Social Worker (SW) on						
	!	revealed that she was						
	responsible for coordi	nating Podiatry visits for the						
		the process was for her to						
	audit the charts and g	et consents signed on the						
		to be seen. She stated			***************************************			
		rals from the nurses and						
ļ		ts that had thick nails that						
	the staff were unable		!					
		ed for their toe nails to be						
		its to be seen were usually	-					
	* *	isus and information was						
		contact and they in turn						
		o let them know who was y were coming. The SW						
	-	145 had not been seen by						
		she had not signed the			}			
	consent when she wa	——————————————————————————————————————	İ					
		d that she had not offered			T and a second s			
	· · · · · · · · · · · · · · · · · · ·	e resident and she had not						
		rtunity to see the Podiatrist						
	when he was at the fa							
	08/30/17. The SW sta	ated that she was aware						
	that Resident #145 wa	as diabetic but had not been						
	told that she needed to	o see the Podiatrist. The						
	SW stated the Adminis	strator made the decision						
	about the services tha	t would be provided for						
	residents who were ur	nable to pay for them. She						
İ		t asked the Administrator						
	about paying for Resid							
		ated the family should not	į				<u> </u>	
	•	ng care of diabetic nails			STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL STEEL ST	į	ļ I	
	and stated the facility				**************************************		<u> </u>	
İ	• •	Podiatrist and take care of						
	the bill. The SW state							
	pending and once app	roved she could see the	1					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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11014F 05 0	DOMESTO OF CHESTIES	345179	B. WINO		STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	/08/2017	
NAME OF P	ROVIDER OR SUPPLIER				752 E CENTER AVENUE			
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{F 282}	Continued From page	÷30	{F-2	82}				
. ,	podiatrist. The SW s	tated she had not offered he resident when they were	,	•				
	the resident's family r trimmed Resident #14 but was not comfortal diabetic. Stated that member from out of to							
	PM revealed that Res	h NA #5 on 09/07/17 at 3:04 hident #145's family member is and NA #5 had not noticed hg.						
	PM who had been take on day shift for month noticed the residents stated if she had notic would have referred h she was diabetic. Nu	se #3 on 09/07/17 at 3:41 sing care of Resident #145 s revealed that she had not toe nails being long. She ted them being long she ter to the Podiatrist since rse #5 did not recall any of at the residents toe nails	The state of the s					
	on 09/07/17 at 5:15 P process for nails was resident while providir and consult the nurse NAs were not allowed diabetic resident but the nurse was unable	for the NA to assess the ng care from head to toe about any concerns. The		2,000 1,25,00				
energia con especial de la companio del la companio del la companio del la companio de la companio de la companio de la companio de la companio de la companio del la companio del la companio del la companio del la companio del la c	nurse should have as	sessed the resident's nails		garanga Shidi Suburu Suburi Suburu		myrnan e Maguma politiklari (asylijini la na lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka lauka	and the second s	

AND DUAN OF CODDECTION I IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	aware of Resident #1 was not aware that he stated that no one had if they had she would she was diabetic. An interview with Nurs AM revealed that she #145 on night shift for not noticed her long to NAs on night shift had nails being long. A phone interview with AM who worked full til had told Nurse #3 abd nails a couple of week told the nurse about h was not allowed to trir was diabetic. NA #3 s an inch beyond the tip complained about the shoe on her right foot. An interview with Nurs PM revealed that she NAs taking care of Re the resident had long the NAs had told her t nails she would have a placed on the list to be	Nurse Practitioner on revealed that she was not 45 having long toe nails and ar family had cut them. She dimentioned them to her but refer her to Podiatry since se #4 on 09/08/17 at 8:42 had taken care of Resident months and stated she had be nails. She stated the I not mentioned her toe in NA #3 on 09/08/17 at 9:18 me at the facility stated she but Resident #145's long toe as ago. NA #3 stated she er toe nails because she in them since the resident tated her nails were at least as of her toes and she in hurting when she had her		82}			
	and Administrator on (

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	FIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	1 55.55
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{F 282}	Continued From page	32	{F 2(F312	:
{F 312} SS=D	care plan be followed should look at the who care and notify the nu both stated they would to offer to trim Reside would not want the far her nails. The DON's have been referred to was diabetic and the Sthe referral to the Pod A phone interview on the family member frohad trimmed Resident visiting her last week. were approximately 1 her toes and were stahurting her to keep he nails. The family mem told Resident #145 co Podiatrist because she pay for it so he cut her shoe. 483.24(a)(2) ADL CAFDEPENDENT RESIDE (a)(2) A resident who is activities of daily living services to maintain gresonal and oral hyging This REQUIREMENT by: Based on observation interviews and record provide incontinence of (Resident #145) and not service to the should be continence of the should be should be continence of the should be careful and the should be continence of the should be careful and the should be caref	They stated the NAs one body while providing urse of any concerns. They deduced have expected the nurses not #145's toe nails and mily to feel obligated to trim tated Resident #145 should the Podiatrist since she SW should have completed diatrist. O9/08/17 at 3:44 PM with mout of town revealed he town the the theorem of the theorem o	{F 31	 On 9/5/17 thru 9/8/17 reside observed with long nails, debris under the nails. Resident with urine. Resident #145 incontinent care and will incontinent care routinely. Residents dependent on scare have the potential to Observations of current rewere made by Ambassade (department managers) a were provided as needed, dependent on staff for incontinent on staff for incon	with brown esident #130 care on 9/8/17. Resident #145 co be heavy 5 received receive // staff for nail o be affected. esidents nails ors nd services . Residents continent care offected. by at managers) ed as needed. ucated on by the Area inator or rsing staff will incontinent
1			n er versker er er er er er er er er er er er er e	Coordinator or designee b	v 10/22/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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(F 312)	Continued From page	33	{F-31	12}	4. Ambassadors (Departmer		
, ,				,	will observe 5 residents d		•
	The findings included	:			visits 2 times a week x 4 w	reeks, a	and
	1 Desident #145 was	andmitted to the facility on	then weekly x 2 months for proper				
	04/27/17 for rehabilita	s admitted to the facility on tion following a			care and incontinent care	needs.	The
		ebral infarction affecting her			findings will be document	ed on t	:he
		agnoses included history of			Daily Ambassador visit for	m and	
	malignant neoplasm o treatment, diabetes m		reviewed by the Administrator.				
	Data Set (MDS) dated cognitively intact, had required extensive as for most activities of d	ly incontinent of urine and	Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improveme (QAPI) team by the Administrator for 3 month at which time, the QAPI Committee will				orted vement
	A review of Resident Assessment (CAA) surevealed she was a newho presented for reh discharge plans were required extensive ass	#145's admission Care Area mmary dated 05/10/17 ew admission to the facility	to determine if additional auditing is ne to maintain compliance.			rventions necessary /22/17	
	05/12/17 revealed she having functional bladher disease processes malignant neoplasm o Resident #145 was to breakdown due to incothrough the next review Interventions included	der incontinence related to sof cerebral infarction and fithe brain. The goal for remain free from skin ontinence and brief use w date of 08/10/17. changing the resident ded, and change clothing as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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WANG OF T	NOTIBELL ON OUT FEEL				52 E CENTER AVENUE			
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{F 312}	-Gontinued-From-page	34	{F-3:	12}	,,			
,	• =	sident #145 on 09/06/17 at	The second secon	•				
		was at the nurse's desk	-					
		ged and stated she was						
		not been changed since she						
į	-	Resident #145 stated the						
		checked or changed her						
	after they got her up i	n the wheelchair. She			!			
	stated that she smelle	ed the stench of urine on her						
	and she needed a bat	th. Nurse Aide (NA) #6 and					İ	
İ		sident's room at 4:15 PM					İ	
	•	ence care. The resident's						
	•	touch and removed. Her						
		d observed to be heavy with						
		contents balled and there						
		of urine coming from the						
		#7 cleaned the resident						
	*	nnique and washed her legs					;	
		oplied a clean brief and					1	
	clean pants.							
j	A phone interview on	09/07/17 at 8:47 AM with						
	•	ad taken care of Resident						
	#145 on first shift on 0	9/06/17. She stated she						
	had given the residen	t a wash up in the bed on						
	09/06/17, combed her	hair, changed her brief and						
	assisted her up to the	wheelchair. NA #4 stated			¥ concentration			
	she did not change the	e resident at lunch time						
	because she was up i	n her wheelchair. NA #4						
		e resident before 3:00 PM	1					
		vas dry. The NA stated that						
		e the resident once on her						
		e resident was a heavy						
1		etimes soak her brief and	1] 			
	•	rief a couple of times before						
	being changed. NA#							
		let them know when she						
3		o be changed. She stated						
		esident was incontinent she						
on conservation of the second of the	could tell them when s	ne was wet.	a contrasto tenaminacen en	na neisea	g vana manang na geed bad manananana nashal enahabi naha abanal mabara nasa mana langula babba nasha bibabi da Tabar	commission and a state to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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		345179	B. WING			09/08/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Œ		
DOM N. CE	NYED HEALTH AND DE	TELET ET RAET RETE]	752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND RE	IREWENT		MOORESVILLE, NC 28115			
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(F.312)	Continued From page	÷-35	{F-31	2)			
	Director of Nursing and their expectation was done every 2 hours of 2. Resident #130 was 05/26/17 and readmit hospitalization for dia diagnoses included diagnoses included diagnoses included diagnoses more demandal disease, demen gastrostomy tube for A review of Resident Data Set (MDS) dated cognitively intact and Resident #130 require person for most ADL and their experson for most ADL and their experson for most ADL and their experson for most ADL and their experson for most ADL and their expectation was a series of their expectation was a se	s admitted to the facility on ted on 08/16/17 following a betic ketoacidosis. Other iabetes mellitus, end stage tia and placement of a feedings. #130's admission Minimum d 08/23/17 revealed he was had no mood or behaviors.					
	Daily Living (ADL) dat required extensive as for transfers, dressing	#130's Care Area ummary for Activities of ted 08/28/17 revealed he sistance of 1 to 2 persons i, hygiene, bathing and toilet ed assistance with bed					
	08/30/17 revealed he self-care performance decreased mobility. To improve his current through the next revieinterventions included required extensive as:	#130's care plan dated was care planned for ADL deficit related to his he goal was for the resident level of function in ADL w date of 11/30/17. The he preferred showers, sistance of 1 staff with					
	staff with personal hyg						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
				-		₹-C		
		345179	B. WING		09	/08/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
				752 E CENTER AVENUE				
BRIAN CE	ENTER HEALTH AND R	ETIREMENT		MOORESVILLE, NC 28115	•			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE		
{F 312}	Continued From pag	ge 36	{F.3	12}				
	2:23 PM and reveals wheelchair at the en nails to be long, app beyond the end of horown debris under he did not like his fir wanted them to be of (could not remember ut them when he have member what day). An observation of Reg:49 AM revealed he after breakfast with head. His fingernail and had brown debried on 09/07/17 at 10:40 observed lying on to on and his arms wratingernails were still debris under the nail linterview on 09/08/17 at 11:02 #4 and #9 revealed washing the resident their hair, shaving the providing nail care a she had given Resident.	esident #130 on 09/06/17 at a was lying on top of his bed the covers pulled over his s were noted to still be long is under the nails. 6 AM Resident #130 was p of his bed with his clothes around his head. His long and still had brown is. 7 at 10:43 AM with Resident as lying on top of his bed with asily aroused. He stated they hails and they were noted to note the nails. 2 AM an interview with NAs their showers consisted of the whole body, shampooing em, cleaning their ears, and and mouth care. NA #4 stated ent #130 a shower on day						
		ided this care NA #4 stated nt with dirty nails she would						
	ii one iourio a reside	nt with anth hans site would	1	1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345179	B. WING			····	R-C 09/08/2017	
NAME OF D	ROVIDER OR SUPPLIER	340110	J		EET ADDRE	SS, CITY, STATE, ZIP CODE	1 03/	00/2017
NAME OF P	ROVIDER OR SOFFEIER				E CENTER			
BRIAN CE	ENTER HEALTH AND RE	FIREMENT				LE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 312}	Continued From page	37	{F-31	12}				· · · · ·
{F 314} SS=G	clean them and cut the not their shower day. assigned to Resident #9 were asked about room and both stated and cleaned. On 09/08/17 at 11:09 Unit Manager reveale for Resident #130's necleaned. On 09/08/17 at 12:08 Director of Nursing refor the residents to be to be met on a daily be expectation that nail devery resident. 483.25(b)(1) TREATM PREVENT/HEAL PREVENT/HE	em if needed even if it was NA #4 stated she was #130 today. NAs #4 and Resident #130s nails in his they needed to be trimmed AM an interview with the d that her expectation was ails to be trimmed and PM an interview with the vealed her expectation was a cared for and their needs asis. She stated it was her eare be a part of bathing for MENT/SVCS TO ESSURE SORES Based on the sment of a resident, the at- care, consistent with s of practice, to prevent oes not develop pressure vidual's clinical condition y were unavoidable; and ssure ulcers receives		14}	1.	Management Resident#57 had physicion 6/29/17 for bunny boots bed. Resident#57 observ 9/8/17 without bunny boots Res #57 order for Bunny discontinued on 9/8/17 o	on whi ved 9/5, bots on Boots v lue to h	le in /17- in bed. vas naving
F F	professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			nas pronons partenas. Salas pagasantes pagasantes pagasantes pagasantes pagasantes pagasantes pagasantes pagasantes pagasantes pagas	â	Low Air Loss mattress pla and Kardex updated. Res pressure ulcer resolved o	ident #!	57
Ī								

	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(SURVEY PLETED
			7 05.125.				R	-C
		345179	B. WING				09/	08/2017
NAME OF P	ROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	ENTER HEALTH AND RET	TIREMENT		752 E CENTER AVENUE				
Brazar	TO THE PROPERTY OF THE PROPERT				MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
{F.314}	Continued From page	38	√{F.3	Resident #69 was readmitted to the				
` .		is not met as evidenced			facility on 8/28/17 rev			
	by:				records revealed no o	rder	for tre	eatment
	:	ns, record review, staff,			to the pressure ulcer	to lei	ft ear.	
		oner and medical doctor failed to prevent a Stage 2			Resident #69 physicia	ns or	der w	as
	pressure ulcer from w				obtained and implem	ente	d on 9	/5/17.
	pressure ulcer (Resid	ent #57) and to ensure the er was transcribed and			Care plan and Kardex			,
	•	ident with a pressure ulcer			Residents with pressu	re ul	cers h	ave the
	(Resident #69) for 2 of pressure ulcers.	f 4 residents sampled for		potential of being affe				
	production diocio.		will be conducted by the wound nu					
	The findings included:		and unit manager of physician orders for treatments of pressure ulcers by					
	4 Desident #E7 was	andmitted to the feetility on						
		eadmitted to the facility on es included adult failure to						s by
	thrive, traumatic subd				10/22/17 to ensure a			
	dysphagia, dementia,				transcription of the or			
	•	nd contracture of right/left			and Kardexes will be u	pdat	ed ref	lective
	knee.				of the current status of	fthe	reside	ent.
		cale for predicting pressure						
		indicated that Resident #57			Licensed nursing staff	will k	oe re-	
	was nigh risk for deve	loping a pressure ulcer.			educated by SDC or de	sign	ee rela	ited to
	Review of the most re	cent quarterly minimum			Wound Management			
	• • •	07/11/17 indicated that	į		assessment, documen		Ψ.	
		erely impaired for daily	-				,	
		nad long/short term memory Iso indicated that Resident			prevention and treatn			
	#57 required extensive				ulcers. Nursing Admir			ill
		ility and no pressure ulcers			review Skin Assessmer	ts dı	uring	
	were identified.				morning clinical meeti	ng fo	r com	oletion
	Review of a Head to T	na Skin Chark dated	ļ		and necessary follow u			
		sident #57's skin was intact			admissions will be revi			aical
	with no areas of break				administration will be 1641	aweu	a III CIII	iicdi
						agagayattaga		
and the second s	Treview of a Skin-VVee	kly Non-Pressure Condition		and the same		a, an great distribute de		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						R.	c	
		345179	B. WING_			09/	08/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
		TIDEALENIT		752 E C	ENTER AVENUE			
BRIAN CE	INTER HEALTH AND RET	IRENENI		MOORE	ESVILLE, NC 28115			
(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 APPROPRI		(X5) COMPLETION DATE	
					morning meeting ensuring	comple	etion ——	
{F 314}	{F.314} Continued From page 39			14}	of required skin assessme	nt and		
, ,	Record dated 08/31/1	7 indicated Resident #57		-	subsequent pressure ulcer	treatm	ents.	
	had an area of excoris	ation to the right buttock that			care plan, kardex updates			
		eters (cm) x 2.0 cm x 0.1						
		mily and physician were			Unit Managers/designee v			
	notified of the area on	08/31/17.			Treatment Administration			
	Review of a physician	order dated 08/31/17 read,			residents with pressure uld	ers 2 ti	nes a	
	Zinc Oxide ointment 2				week x 4 weeks, then weel			
	topically every day an	d night shift for skin			during morning clinical me			
	protectant.				follow up as needed.	eting ai	IC.	
	Review of a Skin-Mee	ekly Non-Pressure Condition			tollow up as needed.			
		7 indicated that the area of	 Nursing Administration or Wound Nurse will make weekly wound rounds 					
	excoriation to the righ	t buttock had resolved.						
	man taxaa da Olda Mara	John Mars Danseyer Countition			und rot	ınds		
		ekly Non-Pressure Condition 7 indicated that Resident			with Wound MD weekly x 3			
		essure skin condition with			current resident with press	ure ulce	rs	
		1/17. The record also stated			and ensure appropriate doc			
		at the facility and was			on the Weekly Pressure Ulc			
		e wound was located on the d 4.0 cm x 3.0 cm x 0.1 cm			, , , , , , , , , , , , , , , , , , , ,	er neco	rus.	
	and was a Stage 2.	14.0 GH x 5.0 GH x 0.1 GH			DON or designee will make			
		to a Constitution 18 forms			observations daily x 4 week	s and th	en	
	An observation and in Nurse Practitioner (W	terview with the Wound			weekly x 2 months of reside			
	wound was made on (
		ting in bed with eyes closed,			requiring pressure ulcer trea	itments	to	
		side to reveal his pressure			ensure treatments are being			
	ulcer to the sacral are				as ordered. Wound physicia	ın to roi	und	
	noted one on left butto				weekly with wound nurse ar			
		ne coccyx area. The WNP as one large wound and			needed changes for wounds	that me		
		ere parts of the wound that			not ho improving Division	urat m	ay	
	were a Stage 2 but wit		į		not be improving. Physician			
	slough noted to the an	ea on the right buttock the			responsible parties to be upo	dated or	n	
		ge 3. She recommended			resident pressure ulcer prog			
		the area Resident #57			week (v			
	was noted to be on an	air mattress.	-					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		LE CONSTRUCTION	(X3) DATE	SURVEY
AND I LAN O	Connection	I DENTI O'NION NOMBER	A. BUILDI	NG			
		345179	B. WING _			i	l-C /08/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					752 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RE	: IIREMEN I			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F-314}	Continued From pag	e 40	{F-3	14	Findings of these audits and		
(· · · · · ·	John Bag		ι, ~		observations to be reported	l by the	DON
	Review of a care pla	n revised on 09/05/17 read in			to the QAPI committee mor		
	part, Resident #57 h	ad a Stage 2 pressure ulcer					'
		decreased mobility and			months to determine the ne		
	-	al of stated care plan was d would show signs of			additional education and/o	•	
		e in overall size and depth by			monitoring.		
	. –	rventions of the care plan				10	/22/17
	included: pressure re						
		r, provide incontinence care	Company of the Compan				
		l, skin checks weekly per turn and reposition frequently					
		with 2 staff members.					
	Review of a Wound A	Assessment by the WNP					
		ated Resident #57 had a					
	_	sacral area. The size of the					
		9.4 cm x 0.1 cm with a small and tissue). The WNP					
İ		ium alginate and eclipse					
		essing) 2 times a week.					
		n order dated 09/05/17 read,					
	-	silicone super absorbent					
		very day shift for wound to					
	silicone super absorb	m alginate and cover with ent dressing.					
	An interview was con	ducted with the Treatment					
	Nurse (TN) on 09/06/	17 at 9:59 AM. The TN					
		ally deferred staging wounds					
		the letters behind her name					
		" She added that she was					
į		nurse and the WNP was in the staging of wounds.	1				
		ne had not been given any	-				
	protocols for wound s						
		d protocols the facility had in				and proceedings of the processor,	
		d that she only completed		Charles School C			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345179	B. WING _			R-C 09/08/2017	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
				752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND RE	TIREMENT		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE	
(F.314)	Continued From page 41		{F-3	(4)			
	the wound treatments	sonce a week and the hall	Ţ.,				
		em the other days. The TN					
	•	31/17 Resident #57 was					
		excoriation on his right					
		d as red/pink area but not					
		tated. She added that she					
	•	practitioner (NP) and					
	obtained a treatment	order and then when she					
	reassessed the woun	d on 09/04/17 the	į				
	excoriation was resolven	ved but she identified an	1	1000			
	area of pressure to Re	esident #57's coccyx area.					
		ere were 4 small areas of					
		er and all were open but that					
		tissue or no slough, but the					
		ely a Stage 2 pressure					
		t again the NP was notified					
		ment was obtained. The TN					
	stated that Resident #						
	•	ments and he was very rigid					
		positions on his back and					
		evelopment of the pressure					
		. She also stated she had					
		y for positioning and they pes of pillows and wedges					
	to reposition Resident	•					
	to reposition residem	1 #07 frequently.					
ļ	An observation of Res	sident #57 was made on					
and the second		. Resident #57 was up in a					
	geri chair in the activit	_		2003			
	•	ns of Resident #57 made					
	from 09/05/17 through	n 09/08/17 revealed he was					
		on 09/06/17 at 10:32 AM					
	•	ations were made Resident					
	#57 was resting in bed	d.					
	A - Y-I Y-	F					
1		ducted with the Medical	1				
	, ,	/17 at 11:18 PM. The MD					
		I was her point person and					
annimetanijominik	that she rounded wee	kly on the residents with		ana magali ka amada bannaka banniin ka kitatana jummaka manaka ka kini ka ka kini mada kana kini ka kini kini ban kini ban kini ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka ka kini ka kini ka ka kini ka ki	. retario a constitui e e e e e e e e e e e e e e e e e e e	populario anno del la la como la seguina de la como la como la como la como la como la como la como la como la	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345179	B. WING			1	/08/2017
NAME OF P	ROVIDER OR SUPPLIER	I		8	STREET ADDRESS, CITY, STATE, ZIP CODE		
			752 E CENTER AVENUE		52 E CENTER AVENUE		
BRIAN CE	NTER HEALTH AND RE	HREMENT		N	MOORESVILLE, NC 28115		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F.314}	Continued From page	e.42	{F-3	14}	u (g. An chi hi hi mahada ad hi hi ha ad a shaha ana ga ka ana da an ka a shaha an ga ka a shaha a sha		
	they would go through the orders and review	hat at the end of the day that h the wounds and go over the TN's documentation of					
	heavily on the TN and	stated that she relied very I the WNP for staging of the					
	1	ed that was "very surprised d a wound." She added that					
		nt #57 was always in the					
ļ		nospitalization he was never					
ļ		ten had to go and seek him					00000
A PARTIE	stated that Resident #	ing to evaluate him. The MD					
	wounds and was nutri	· · · · · · · · · · · · · · · · · · ·					
		l it was very "unusual for					
		as quickly as his wound did."					
-	An interview was cond	ducted with Nursing 09/06/17 at 12:39 PM. He					
		ly provided care to Resident					
		He stated that Resident					
		e with his activities of daily					
		his shift he would try to turn					
		ours side to side and on his					
		at Resident #57 was very					
j		and repositioning and he					
***************************************	would use pillows that	were in his room to					
ĺ	position him.		1				
	An interview was cond	ducted with NA #8 on					
		NA #8 confirmed that she					
	worked 3rd shift at the						İ
ļ	Resident #57 frequent				1 Solver		
	Resident #57 required						
		and she would check and					
ļ		ne night. She added that she generally would turn					
	Resident #57 2-3 time						
	Observation of wound	care for Resident #57 was		en de la companya de la companya de la companya de la companya de la companya de la companya de la companya de La companya de la companya de la companya de la companya de la companya de la companya de la companya de la co		egyanasi kamana kanaya ya misaana. Cayanasi piyanasi haliyanga kanadan Mahamanasi kana kanada kanada kanada kanada	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			N. BOILDIN		-	R-C		
		345179	B. WING			09/08/2017		
NAME OF P	ROVIDER OR SUPPLIER	1	-	STREET ADDRESS, CITY, STATE, ZIP CO	DE			
				752 E CENTER AVENUE				
BRIAN CE	NTER HEALTH AND RE	TIREMENT		MOORESVILLE, NC 28115				
(X4) ID PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTIO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	REGULATORY OR I	SC (DENTIFYING INFORMATION)	TAG	DEFICIENCY				
(E 31/1)	Continued From page	9.43	{F-31	IAN.				
(1 01-1)			Įi O	''''				
		3:21 PM with the facilities						
		s resting in bed with eyes rbal indicators of pain. He						
	was turned onto his ri							
		e 3 areas were cleaned with						
		new dressing applied. The						
		ck continued to have a						
		ph present. Resident #57						
	was noted to be on ai							
	1100 110100 10 00 011 01	, main 555,						
	A follow up interview	was conducted with TN on						
	•	The TN confirmed that she						
	did not know what hap	ppened to cause Resident						
		m a Stage 2 to a Stage 3.						
	She again confirmed	_						
		on 09/04/17 it was "clearly a						
		ed that she believed that it						
	was combination of th	ings that may have						
	contributed to the dete	erioration of the wound						
	including his position	of choice and his frequent						
	bowel movements. Sh	ne stated that some fecal						
	matter may have gotte	en into the dressing and that						
	it may have impacted	the wound. The TN added						
		d would deteriorate very						
		was very sick but this was						
	not the case with Res	ident #57.						
		ducted with the WNP on						
		. The WNP indicated that at	***					
	times the TN was not	sure how to classify a	***************************************					
	wound and she would					100		
		stage of a wound. She						
	confirmed that Reside		ļ					
		as treating as one large	1					
į		area on the right buttock						
		f slough she would classify						
		The WNP added that the						
		h could-happen very quickly						
ngunen mengepanning menghankan kepital (kila) (kila) Manahan di kelada di kadalan di mendalah di kelada di mengalah di kelada di mengalah di kelada di mengalah di Mengalah di mengalah di kelada di mengalah di mengalah di mengalah di mengalah di mengalah di mengalah di men	and depended on the	underlying tissue, whether	A Control of the Cont		renomen er en er () en jagreng er op gûned it ûnderlijk Enrichtiekelê ûn. Lines () is die sty'n Lines () an die an die stier () andere als eines as tier ().	garaga magamagan da paraga ya pagamaga na nafilianda ya Nafigiana da Afrika (da da da da da da da da da da da d La serienza da da da da da da da da da da da da da		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345179	8. WING_			R-C 09/08/2017	
NAME OF D	ROVIDER OR SUPPLIER	343178		STREET ADDRESS, CITY, STATE, ZIP CODE		09/00/2017	
MANIE OLER	NOVIDER OR GOL LIER			752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND RE	TIREMENT		MOORESVILLE, NC 28115			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 314}	Continued From page	3-44	{F-31	4}			
	or not the resident was continence status, an status. She further statissue and can develop than 24 hours and sh	as off loading the pressure, d the resident's nutritional ated that slough is dead op quickly sometimes in less e was not alarmed by the ent on Resident #57's right					
	cared for Resident #5 stated that Resident # with most tasks include #5 stated that during generally turn Reside	ducted with NA #5 on NA #5 stated she routinely 7 when she worked. She #57 required total assistance ding feeding and turning. NA her 8 hours shift she would nt #57 2-3 times and she that were on his bed to					
	of Nursing (DON) on interim DON stated sl facility for a short peri had a chance to asse the facility. The interir she did not see woununless they were a Ke develop as the patien stated that she expeceverything they could from getting worse, in	to keep identified wounds cluding frequent turning and t incontinent care, and					
o 11 200 12 1000 100 100 100 100 100 100	the facility on 08/28/1 medical record reveal in the facility 08/01/17 again from 08/14/47-tl	most recently readmitted to 7. Review of Resident #69's ed that he had been present through 08/08/17 and hrough 08/22/17. His emiplegia/hemiparesis,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A, BUILDIN		R-C		
		345179	B. WING _		0	9/08/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
DOIAN CE	NTED HEALTH AND DE	TIDESSENIT		752 E CENTER AVENUE			
BRIANCE	ENTER HEALTH AND RE	IIREMENT		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
(F.314)	Continued From page	9.45	(F-31	4}			
	sepsis, pressure ulce urine, and others.	r of the sacrum, retention of					
	data set (MDS) dated Resident #69 was set for daily decision mak memory problems. The Resident #69 required members for bed mot pressure ulcer and 1 le Review of a wound as Nurse Practitioner (Windicated that Resider pressure ulcers. The lewere: left heel, left and ear. The recommende wound was calcium aid dressing. Review of a physician hydrocolloid to left ear Saturday for wound to Review of the Treatmet (TAR) dated 08/01/17 the following: hydrocolloid to left ear Saturday for wound to was 08/01/17 and the 08/14/17.	and #69 had 4 stage 3 docations of the wounds kle, left sacrum, and left ed treatment to the left ear liginate and hydrocolloid order dated 08/01/17 read, r every Tuesday and eleft ear. ent Administration Record through 08/31/17 contained r every Tuesday and eleft ear. The order date discontinue date was an orders from Resident the facility on 08/14/17 the treatment to the					
4	Review of the TAR dat						
1	or the fritt dat	ac colo ir ir anough	i			J	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345179	B. WING			09/	08/2017
NAME OF P	ROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE		
	-	rin raserator			752 E CENTER AVENUE		
BRIANCE	ENTER HEALTH AND RET	HREMENT			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F.314).	Continued From page	4.46	{F-3	14	1/20/10/20/20/20/20/20/20/20/20/20/20/20/20/20		
	08/31/17 revealed no	treatment was ordered or					
	provided to the left ea	r during Resident #69 stay					
		08/14/17 and 08/22/17 at					
	which point he was di	scharged to the hospital.					
	•	assignment sheet revealed	1				
		ponsible for Resident #69					
	completed.	treatment was due to be					
ļ	completed.		!				
	Observation and inter-	view of Resident #69's left					
	ear wound was made	on 09/06/17 at 3:29 PM	!				
	with the Treatment Nu	rse (TN) present. The left					
	ear was noted to have						
		he wound bed. The oxygen					
	tubing was resting on	· ·					
	covering. The TN state		į				
		t #69 was weekly marathon					
	skin prep that created	o you know that the entire					
	wound was covered w	-					
İ		tment had been completed					İ
	early in the morning or						
ļ	, ,	t to the emergency room					
	for evaluation.		-				
	A						
	Attempts to interview f 10:49 AM was unsucc	Nurse #6 on 09/07/17 at			**************************************		
	TO TO FIRE WAS UNSUUD	oogia(,					
	An interview was cond	ucted with the TN on					
	09/08/17 at 10:35 AM.	The TN confirmed that she					
	had incorrectly transcri	ibed the initial order for					
		#69's top of left ear. She					
	stated that the WNP re						
	_	oid and she entered just					
	•	e system. The TN also			• • • • • • • • • • • • • • • • • • •		-
		esident #69 readmitted to					
	the facility on 08/14/17			oner, e constante			
	removed the electronic	system and the order for	or colored to February	ww.CC		olmeimaenikki örist	and the second s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345179	B. WING			ł	-C 08/2017
	IDER OR SUPPLIER	TREMENT		752	REET ADDRESS, CITY, STATE, ZIP CODE LE CENTER AVENUE PORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFE TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 314} C	ontinued From page	.47	-{F-3	14}			anders of decidence for them, as decidence supposes designing
tre inf ho tre on sh ha be ide #6 mi Ar Di PN for ele an wa dis the \$SS=D (b) pro an (i) wit to p me (ii) app arm	eatment to the left eate to the system and be conest mistake." The eatment was completed for it in the system and other member and other member and been auditing the eatween 08/19/17 and entify the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of treating the lack of the lac	ar did not get entered back oth errors were "just an TN could not verify that the sted because there was not em. She further stated that it is of the management team treatment orders daily 108/22/17 and she did not extrement order for Resident in was just an honest further with the Interim ON) on 09/08/17 at 1:57 stated that she expected inscribed correctly into the extractional further explained that charged to the hospital it is at all orders be re-entered correctly when illity. (i)(i)(j) TREATMENT/CARE Susure that residents receive exare to maintain mobility the facility must: and treatment, in accordance dards of practice, including ins from the resident's and the resident in making	F3	328 F3	1. On 9/6/17 Resident#145 st staff would not let her see Podiatrist because her Med pending. Observation of he revealed her toe nails trimm filed on both feet. Res #145 by the podiatrist on 9/12/1	the licaid w er feet ned but was se	as : not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345179	B. WING		R-C 09/08/2017
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	The facility must ensurequire colostomy, unservices, receive such professional standard comprehensive perso the resident's goals a (g)(5) A resident who receives the appropriato prevent complicational comprehensive personal resident who neceives the appropriato prevent complicational resident who make a presentational resident who neceives the appropriational resident who neceives the appropriational resident who neceives and preferences (i) Respiratory care, in and tracheal suctioning that a resident who neceives and preferences of the personal standards comprehensive personal standards comprehensive personal resident who has a p	rostomy, or ileostomy care. ure that residents who reterostomy, or ileostomy h care consistent with ds of practice, the on-centered care plan, and and preferences. It is fed by enteral means ate treatment and services ations of enteral feeding ed to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers. Parenteral fluids must be ent with professional and in accordance with comprehensive e plan, and the resident's s. Including tracheostomy care and tracheal d such care, consistent with as of practice, the in-centered care plan, the oreferences, and 483.65 of accility must ensure that a osthesis is provided care stent with professional	F-3;	28. Resident that are diabeti of Podiatry services have to be affected. An audit diabetic residents was co Nurse Management to obe podiatry needs. 3. Re-education to Social Services by the Administrator r/t for scheduling resident poon 9/15/17. Re-education Nursing staff and Certified Assistants by Director of Nursing residents in new services. The Certified Nurwill report findings to licen and licensed nurses will cothe needs to the Social Servicetor.	the potential of current mpleted by oserve for rvice Director ollow-through odiatry needs in to Licensed I Nursing Jursing or ted to ed of podiatry sing Assistant used nurses mmunicate
enigenia)journegeneralijus (sametimenistis			aparoni senso proprio ancientario		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		345179	B. WING	B. WING		Lindanan	09/08/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
					752 E CE	ENTER AVENUE			
BRIAN CE	NTER HEALTH AND RE	TIREMENT			MOORE	SVILLE, NC 28115			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 328	-Continued From pag	e-49	F	F 328 4. Director of Nursing or designee to					
	prosthetic device.					monitor 5 diabetic resident	for poo	diatry	
	, ·	T is not met as evidenced			needs by observations weekly x 4				
	by:						,		
		on, resident, family and staff				then monthly x 2 months.			
		d review, the facility failed to ces for 1 of 1 resident				Administrator will audit the			
		ewed for diabetic foot care.				Service scheduling of diabe	tic pod	iatry	
	((tooloon in the) form					appointments to ensure fol			
	The findings included:					weekly x 4 weeks then mor			
	_ ,, ,,,,,					Weekly X 4 Weeks their mor	will ro	nort	
	Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her					months. The Administrator		ροιτ	
						findings of the audits to the	. QAPI		
		liagnoses included history of						:	
	malignant neoplasm					committee monthly x 3 to 0	leterm	ine	
	treatment, diabetes r	nellitus, and epilepsy.			O Salada	committee monthly x 3 to 3	nitarin	7	
		and area.				the need for additional mo	HILOHII	Ď	
		#145's quarterly Minimum d 08/03/17 revealed she was				and/or education.			
		d no rejection of care and				·			
	-	ssistance of 1 to 2 persons					10/22	2/17	
	for most activities of		Ì					1	
		#145's Care Plan dated			ļ				
		e was care planned for itus. The interventions							
		er to podiatrist/foot care							
	•	ument foot care needs and							
	to cut long nails."								
	A = = = = = = = = = = = = = = = = = = =	otomiou with Most-Josef 44 45							
i		nterview with Resident #145 M revealed the resident in							
		back to her room. Once in							
		the staff would not let her							
	see the Podiatrist bed	cause her Medicaid was							
1		tion of her feet revealed her							
3	toe nails trimmed but		Ì						
		her family member did the		enerver Gradyansa Gradyansa					
	pest ne could with trir	nming her toe nails last							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
					ļ ,	R-C	
		345179	B. WING		09	/08/2017	
	ROVIDER OR SUPPLIER ENTER HEALTH AND RE	FIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 328	-Continued-From-page	3.50	F 32	8	***************************************		
	week. Resident #145 so long on her toes the tennis shoe on her "gishe had been having her foot instead of her member from out of sand saw her toenails could get her foot in her toes and saw her toenails could get her foot in her toes and saw her toenails could get her foot in her toes and saw her toenails could get her foot in her toes and get her foot in her toes and get her foot in her toes and get her toes and get her toes and get her toes and get her the staff were unable residents were referred trimmed. The SW stares ponsible for taking stated the facility show with the Podiatrist and SW stated she had not to the resident when the toes and Administrator on the terminal of the stated they expected care plan be followed. Should look at the who care and notify the numboth stated they would to offer to trim Resider would not want the far her nails. The DON states and notify the DON states and the poon states are plan be followed.	is stated her nails had gotten hat she could not wear her cood" foot to balance and to wear a no slip sock on rishoe. She stated a family tate visited her last week and cut them for her so she er shoe. Social Worker (SW) on revealed that she was nating Podiatry visits for the interpretation of the to be seen. She stated that had thick nails that to cut and all diabetic and for their toe nails to be ted the family should not be care of diabetic nails and all diset up an appointment of take care of the bill. The pot offered Podiatry services they were at the facility on the They stated the NAs ole body while providing rise of any concerns. They is have expected the nurses and that the total stated the nurses and the Has's toe nails and mily to feel obligated to trim tated Resident #145 should					
		the Podiatrist since she SW should have completed					

OLIVILI	O I ON MEDICANE &	WEDIO/ ND OF KAIOFO	·					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED				
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		345179	B. WING	09/08/2017				
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CE	ENTER HEALTH AND RE	TIREMENT	1	62 E CENTER AVENUE MOORESVILLE, NC 28115				
				-	(X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (PROFIX (EACH CORRECTIVE ACTION SHOULD BE COMPITAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 328	Continued From page	3-51	F 328	F371				
	the referral to the Poo							
	483.60(i)(1)-(3) FOOE	PROCURE,	{F 371}	Dietary Sanitation				
SS=E	STORE/PREPARE/SI	ERVE - SANITARY		1. Observation in the kitche	n revealed a			
	(i)(1) - Procure food fr	om sources approved or						
		ry by federal, state or local		metal trash can at a hand				
	authorities.			with multiple gnats and s				
	(i) This may include fo	ood items obtained directly	around the lid of the trashcan. Staff					
	from local producers, subject to applicable State			had discarded food in tra	sh can. Trash			
and local laws or regulations.			can was emptied and clea	aned.				
	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility		On 9/5/17 during observation a fly was					
		oduce grown in racility empliance with applicable	flying around the open containers of					
	safe growing and food		food on the tray line. No fly lights or fly					
	(iii) This provision doe	es not preclude residents	fans to repel flies.					
	from consuming foods	s not procured by the facility.		·				
	(i)(2) Store propers	distribute and serve food in		Dietary Staff failed to disc	card 7			
		essional standards for food		containers of honey thick	tened water			
	service safety.			that were expired from n	ourishment			
	(3/2) Hove a policy re-	garding use and storage of		room refrigerator.				
		ents by family and other	į	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Ì	visitors to ensure safe			No residents were cited i	n this alleged			
	handling, and consum This REQUIREMENT	ption. is not met as evidenced		deficient practice.				
	by: Based on observation	ns and staff interviews the		2. The trash can in the Kitch	nen underneath			
		lies out of the kitchen area	-	the sink was immediately emptied and				
		and meal service and		cleaned by the Dietary N				
		tainers of honey thickened		-				
	room refrigerators (70	d in 1 of 2 nourishment 0 hall).		was placed on the trash of				
	goratoro (10	- ··-··/·		Towels Only" and the kit				
	Findings included:			educated by the Dietary	Manager. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			R-C	
		345179	B. WING _			09/08/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				75	52 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RET	TIREMENT		M	OORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION			
(E 371)	Continued From page	. 52	ic o	741	7 outdated thickened lic		
	-continued From page	92	{F-3	<i>i</i> 13	immediately removed fr	om the	
1. During an observ		tion on 09/05/17 at 11:10			nourishment room. Doo	r to Service Hall	
		room at the door which	į		to remain closed to prev	ent flies from	
opened into the kitchen lights or fly fans to repe		en revealed there were no fly pel flies.			entering from the outsic	e door.	
	During an observatior			3. Dietary staff will be in-se	erviced to		
	on a kitchen tour revealed a metal trash can at a hand washing sink with multiple gnats and small flies flying around the lid of the trashcan. A food preparation table was approximately 3 feet away				report any pest sighting	in the	
					maintenance log by 10/22/17.		
					maintenance log by 10/.		
	from the trash can and				4 Fly lights installed with	in the kitchen	
		e were 4 sandwiches with 2		1	• •	ini the kitchen	
		read with a slice of cheese			and dining room.		
		laying exposed to air. A fly			Now the contain and and by		
	was observed flying o circling over the food p	ver the sandwiches and			New fly curtain ordered b		
	Circuity over the lood	preparation table.			Maintenance Director and	will be	
	On 09/05/17 the lunch	n meal service was			installed when available.		
	observed with the Foo	d Service Director. During					
		05/17 at 11:59 AM a fly was			Service door leading into t	he kitchen	
		n containers of food on the			was repaired 9/30/17.		
	tray line. The Food Se acknowledged the fly						
	observed at the end o						
	coffee and tea dispens			-			
				0.00	4. The Dietary Manager or d	esignee will	
		on 09/05/17 at 12:06 PM 2			monitor the nourishment		
		d the plate covers stacked ne and one of the flies		ĺ			
		of the plate covers. The			refrigerators for stored th		
	Food Service Director				liquids daily x 4 weeks, we	ekly x 2	
	surveyor the fly was o	n the plate covers above			months. Dietary Manager	or designee	
		d on the tray line and the	1000		will audit trashcan in kitch	-	
		picked up the plate cover	•				
		vashing area of the kitchen. observed on a plate cover			underneath sink 2 times a		
		and the open containers of	**		weeks, then weekly x 2 mg	onths.	
		additional observations		paulabjes 12 circuction 7.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345179	B. WING			09	/08/2017
NAME OF P	ROVIDER OR SUPPLIER	· · · ·		(STREET ADDRESS, CITY, STATE, ZIP CODE		
		Pro Devines Pro Pro A Branco Laur		7	752 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND	RETIREMENT		ħ	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	the lid of the trash- which was approx preparation table a the tray line. During an interview Food Service Dire- surveyor of the flie the hand washing unaware there wel can and would hav was served. She was routinely by staff be service to place us had washed their if During an observations reveal flies were observed the back door of the observations reveal fly fans at this door During an observations revealed there was on the service hall the dumpsters. An interview was c PM with the Food S District Food Service Food Service Direct recertification surve installed 2 fly lights confirmed 1 light w the office on one si one was attached t	d small flies were flying around can at the hand washing sink imately 3 feet from the food and open containers of food on w on 09/05/17 at 12:08 PM the ctor was informed by the s and gnats at the trash can at sink. She stated she was re flies and gnats at the trash we staff empty it after the food verified the trashcan was used efore, during and after meal sed paper towels in it after they nands. Ition on 09/06/17 at 12:30 PM d in the service hallway when e kitchen was opened. Further alled there were no fly lights or	{F.3	7.1}	Dietary Staff will monitor fo	n weekl ort any ntenand more based of process ends an e by the at which te the ns and	y x 2 ce. on will d
i	•	lights had helped some but					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	A. BUILDING		
					F	₹-C
		345179	B. WING		09	/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	:	
				752 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RE	TIREMENT		MOORESVILLE, NC 28115		
	CUMMANDACT	ATTACKE OF DETECTACEO		DROVIDER'S DI ANI OF COL	PECTION	(X5)
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
(F.371)	Continued From page	ə.54	{F.3	7.1}		
	flies were still comina	into the kitchen. She				
	confirmed no fly lights					
		door of the kitchen on the				
)	main dining room next to the				
	!	xplained the doors at the				
	main dining room and	•				
	-	frequently by staff during	1			
		ated it was her expectation				
		ept away from the food				
		the tray line when food				
		ood containers were open.				
	The District Food Ser	vice Manager confirmed it				
		eep flies out of the kitchen				
		door which opened to the				
	courtyard where resid	lents went out to smoke and	İ			
	-	ervice hall where staff went				
	out to smoke and deli-	veries of food and supplies				
	were brought in through	gh the door. The District				
ļ	Food Service Manage	er stated she was unaware				
	of the flies and gnats	at the trashcan under the				
	hand washing sink in	the kitchen. The Food				
	Service Director state	d she emptied the trashcan		a co		
	after lunch was served	d on 09/05/17 and someone		V-		
	must have put someth	ning in the trash can that				
	had attracted the flies	and gnats. She stated it				
		or the cook to empty the				
	trash can and put a ne	ew bag in it after it was				
	emptied. She further	stated she expected for				
	nothing to be placed in	n the trashcan that would				
	attract flies and it shou	uld only be used to discard				
	paper towels after stat	ff washed their hands.				
	District and forten day of	00/00/47 -4 4.67 D8445 -				
		n 09/08/17 at 1:57 PM the		**************************************		
İ		was her expectations for				
		empty garbage regularly				
		doors closed as much as				
	possible to prevent flie					
		tated she would expect for			antigana pananga ya kaka panana nangara ya manana ar ganaga ya mana Oganaga a farina a kaganaga ya manana a manana ya ganga a panganaga ganana	
amentaria erra arranda erranda erranda de de de de de de de de de de de de de	mes to be kept away fi	rom all areas with open	anag na taona na anakahatahatahatah	an ann agus an an an an talain an an an talain an an talain an talain an talain an talain an talain an talain d I	consequences and production of production for the second of a street of the second of the second of the second	and the second s

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345179	B. WING		R-C 09/08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	03/00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
{F 371}	Continued From page containers of food.	1.55	{F.3:	7.11}	
	700 unit was made or cups of honey thicken "use by" date of 07/10 refrigerator. An interview was cond Service Director (FSD The FSD stated she was position. She stated thin-serviced her staff or items and how to use "method. The FSD stanourishment rooms or identify the out of date dietary staff routinely to nourishment room and refrigerator and the numer in the refrigerator as the stated that the expired	ducted with the Food b) on 09/06/17 at 10:27 AM. vas fairly new to her nat on 07/31/17 she had in the process of storing the "first in first out need she monitored the na daily basis but did not need water. She added that the cook boxes of water into the displaced them on top of the ursing staff would put them ney needed them. She I water should have been digiven to her so she could operly. No other food			
{F 431} SS=D	to not be out of date at to be checked and log 483.45(b)(2)(3)(g)(h) ELABEL/STORE DRUG	3/17 at 1:57 PM. The nat she expected the water and the nourishment rooms ged daily. DRUG RECORDS, S & BIOLOGICALS de routine and emergency to its residents, or obtain	{F 43	F431 – 483.45 Drug Record Drugs & Biologicals	s, Label/Store

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUC		(X3) DATE SURVEY COMPLETED
		345179	B. WING _			R-C 09/08/2017
	ROVIDER OR SUPPLIER ENTER HEALTH AND RE	FIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		ER AVENUE	
(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 BI ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F.431}	§483.70(g) of this par unlicensed personnel law permits, but only supervision of a licens. (a) Procedures. A fact pharmaceutical service that assure the accuradispensing, and admit biologicals) to meet the consultation of the supervision of all controls of the	sed nurse. cility must provide es (including procedures ate acquiring, receiving, nistering of all drugs and e needs of each resident. con. The facility must services of a licensed em of records of receipt and colled drugs in sufficient curate reconciliation; and ug records are in order and controlled drugs is lically reconciled. and Biologicals. used in the facility must be with currently accepted is, and include the and cautionary expiration date when and Biologicals. State and Federal laws, all drugs and biologicals in under proper temperature and yauthorized personnel to	₹ F. 4\$	2. 3. Date be a rep	Based on observations interviews the facility is medications in the originary for 3 of 5 medication of found in the 100, 300 a medication carts were is removed by the DON of 100% audit of all medicompleted by DON or 9/15/17 to ensure no lonoted. Licensed nurses will be DON or designee on dimedications by 10/22/1 medication carts were oput in place on 9/28/17. Floor nurses will perform daily x 4 weeks, then we months. Director of Nurses are compliance. It obtained during the augustality and the patterns and orted to Quality Assurant Director of Nursing for	failed to store inal packaging arts. Loose pills and 500/600 immediately or designee. cation carts were designee by ose pills were re-educated by scarding loose 7. New ordered and were react audits eekly x 2 rsing or weekly checks x nsure didt process will a trends and ce (QAPI) by

AMME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT AMME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT AND CONCESSULE, No. 28115 SUMMARY STREEM TO BEPTGENOES MORESVILE, No. 28116 ACCOMMENDATE, NO. 18 OF PROVIDERS PRANT OF COMPETION ON THE PROPRIET AND PROVIDERS PRANT OF COMPETION ON THE PROPRIET AND PROPRIETS PRANT OF COMPETION ON THE PROPRIET AND PROPRIETS PRANT OF COMPETION ON THE PROPRIETS		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
INMAE OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT AND CRESTILLE, NC. 23115 CALID CHARLES AND CORRECTION CHARLES AND CONTRECTION CAN DEPART TO CONTRECT OR PROCEDURE BY PULL HEGGLALORY OR LSC IDENTIFYING INFORMATION (E. 431). Continued From page 57 (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 store medications in the original packaging for 3 of 5 medication carts (100 cart, 300 cart, 500/600 cart) that were noted to have loose pills in the drawers. The findings included: 1a. An observation of the 100 hall medication cart was made on 09/05/17 at 3:05 PM. Nurse #2 responsible for the medication cart was proceed to see and not in the original package; 1 blue/white capsule, 3 round yellow pills, 4 oblong grey pills, 4 red rectangular pills, 1 beige round pill, 1 white round pill, and 1 blue round pill. The loose pills were given to Nurse #2 on 09/05/17 at 3:05 PM. Nurse #2 to 09/05/17 at 3:						R-C
STATE CENTER HEALTH AND RETIREMENT TSEE CENTER AVENUE MOORESVILE, NC 28115			345179	B. WING		09/08/2017
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (F.431) Continued From page 57. (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 1975 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 falled to store medications in the original packaging for 3 of 5 medication carts (100 cart, 300 cart, 500/600 cart) that were noted to have loose pills in the drawers. The findings included: 1a. An observation of the 100 hall medication cart was made on 98/05/17 at 3:05 PM. Nurse #2 responsible for the medication cart was present during the observation. In the second large drawer of the medication cart was present during the observation, in the second large grey pills, 4 red rectangular pills, 1 beige round pill, 1 white round pill, and 1 blue round pill. The loose pills were given to Nurse #2 on 08/05/17 at 3:05 PM. Nurse #2 stated that this was her first time working the 100 hall medication cart but the drawer swere so packed when she pulled cards of medications out the drawer the bubble packaging popped and the loose pills would fall into the drawer. Nurse #2 could not identify the pills and she stated she would.			TIREMENT	1 -	752 E CENTER AVENUE	
(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 store medications in the original packaging for 3 of 5 medication carts (100 cart, 300 cart, 500/600 cart) that were noted to have loose pills in the drawers. The findings included: 1a. An observation of the 100 hall medication cart was made on 09/05/17 at 3:05 PM. Nurse #2 responsible for the medication cart was present during the observation. In the second large drawer of the medication cart the following was noted loose and not in the original package: 1 blue/white capsule, 3 round yellow pills, 4 obloing grey pills, 4 red rectangular pills, 1 beige round pill, 1 white round pill, and 1 blue round pill. The loose pills were given to Nurse #2. An interview was conducted with Nurse #2 on 09/05/17 at 3:05 PM. Nurse #2 stated that this was her first time working the 100 hall medication cart but the drawers were so packed when she pulled cards of medications out the drawer the bubble packaging popped and the loose pills would fall into the drawer. Nurse #2 could not identify the pills and she stated she would.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION
was her first time working the 100 hall medication cart but the drawers were so packed when she pulled cards of medications out the drawer the bubble packaging popped and the loose pills would fall into the drawer. Nurse #2 could not identify the pills and she stated she would	{F 431}	Continued From page (2) The facility must p permanently affixed or controlled drugs listed Comprehensive Drug Control Act of 1976 ar abuse, except when th package drug distribut quantity stored is minit be readily detected. This REQUIREMENT by: Based on observation facility failed to store in packaging for 3 of 5 m 300 cart, 500/600 cart loose pills in the drawd The findings included: 1a. An observation of was made on 09/05/17 responsible for the meduring the observation drawer of the medicati noted loose and not in blue/white capsule, 3 in grey pills, 4 red rectan pill, 1 white round pill, loose pills were given.	rovide separately locked, ompartments for storage of in Schedule II of the Abuse Prevention and and other drugs subject to be facility uses single unit tion systems in which the small and a missing dose can is not met as evidenced as and staff interviews the predications in the original predication carts (100 cart, at 3:05 PM. Nurse #2 dication cart was present at In the second large on cart the following was the original package: 1 round yellow pills, 4 oblong gular pills, 1 beige round and 1 blue round pill. The to Nurse #2.		which time the committee effectiveness of the interve determine if further auditin	ntions and g is needed to
	a service proposed proposed services and services and services services and services services and services services and services and services are services as services and services are services and services are services and services are ser	was her first time work cart but the drawers w pulled cards of medica bubble packaging popwould fall into the drawidentify the pills and sh	ing the 100 hall medication ere so packed when she itions out the drawer the ped and the loose pills ver. Nurse #2 could not ne stated she would			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245470	B. WING		R-C	
NAME OF PROVIDER OR SUPPLIER	345179	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/08/2017	
			752 E CENTER AVENUE		
BRIAN CENTER HEALTH AND RE	FIREMENT		MOORESVILLE, NC 28115		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
{F 431} Continued From page	58	{F.4	31)		
b. An observation of the was made on 09/05/1 responsible for the meduring the observation drawer of the medicate noted loose and not in oblong white pills and loose pills were given Director of Nursing (Alfor the 300 half medication has a concent and the state of the state of the state of the state of the state of the state of the state of the state of the medication cart. The incomparison of the state of the state of the medication of the state of the state of the medication drawer of the medication of the state of the	the 300 hall medication cart 7 at 3:26 PM. The nurse edication cart was present in. In the second large ion cart the following was in the original package: 2 2 oblong blue pills. The to the interim Assistant DON) who was responsible ation cart. ducted with the interim 3:26 PM. The interim was his first day working in cart and he was unsure escame loose in the interim ADON stated he pills and he would dispose the 500/600 hall medication 05/17 at 3:47 PM. Nurse #1 indication cart was present in. In the second large ion cart there was 1 red ionse and not in the original pill was given to Nurse #1. The #1 was conducted on Nurse #1 stated she could ation and that she would				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345179	B. WING			09/	/08/2017
	ROVIDER OR SUPPLIER ENTER HEALTH AND RE	TREMENT		7	STREET ADDRESS, CITY, STATE, ZIP CODE 152 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F.431}	Continued From page	59	{F-4	31}		t de la descripción de la descripción de la dela de la dela dela dela dela de	
{F 490} SS=G	become foose in the c cart. 483.70 EFFECTIVE	e size to store the ginal package and not trawers of the medication ESIDENT WELL-BEING	{F 4	90}			
	483.70 Administration A facility must be adm enables it to use its re efficiently to attain or r practicable physical, n well-being of each res This REQUIREMENT by: Based on observation resident, staff and phy facility's administration resources effectively to	inistered in a manner that sources effectively and naintain the highest nental, and psychosocial ident. is not met as evidenced is, record reviews and sician interviews the failed to utilize its innert and sustain			 Refer to: F224, F241, F24 F312, F314, F328, F371, F F278, F250, F520 Refer to: F224, F241, F24 F312, F314, F328, F371, F278, F250, F520 	:431, F! 12, F28	514, , 2,
	have repeated deficier the care and needs of of 14 sampled residen #130, #91 and #57). The neglect, dignity, choice plan interventions, activaccuracy of medical resident from the resident from the resident with the resident #145), neglection (Resident #145), resident #1	es, implementation of care vities of daily living, cords and pressure sores. Based on observations, ff interviews the facility the correct treatment h a pressure ulcer ted to provide incontinent and neglected to provide	3. The District Director of Cand QIO will educate Adabout utilizing resources to implement and susta correction to ensure the does not have repeated by reviewing audits and corrective action as nee 4. The Administrator will reaudits completed by Facidally x 4 weeks, and then		ministra effection plans facility deficien mplant ed. view ty Staff	otor vely of ncies ing	
1	nail care (Resident #13 residents.	bu) for 3 of 4 sampled			months.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
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		345179	B. WING	······································		09/08/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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DRIAN CI	ENTER HEALTH AND RE	HISEMENT		MOORESVILLE, NC 28115		
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{E.490}	Continued From page)-60	{F 490			
(149 U)-	2. Cross refer to F-24 resident and staff inter the facility failed to tree (Resident #145) in a comproviding incontinence shift. 3. Cross refer to F-24 record reviews and rest the facility failed to how regarding showers (Resident #15 sampled for choices. 4. Cross refer to F-282 record review and staff failed to implement ca applying bunny boots (Resident #57) as inst failed to refer a diabetinalls to the podiatrist (instructed by the care residents. 5. Cross refer to F-312 resident and staff inter the facility failed to produce the facility failed	1: Based on observations, rviews and record reviews at 1 of 3 residents dignified manner by not e care as needed on the day. 2: Based on observations, sident and staff interviews nor a resident's choices esident #91) and failed to pice to have his fingernails 30) for 2 of 3 residents. 2: Based on observations, if interviews the facility re plan interventions by not to a residents feet ructed by the care plan and ic resident with long toe. Resident #145) as plan for 2 of 3 sampled. 2: Based on observations, views and record reviews vide incontinence care for lent #145) and nail care for lent #130) reviewed for.		Data obtained during the analyzed for patterns and to the QAPI committee by Nursing for 3 months at w committee will evaluate t interventions and determ is needed.	trends and the the time the time the time the time the time the time the the the the the the the the the th	nd reported ctor of e the iveness of the
	from worsening to a St	age-3 pressure-ulcer				
istoromasitzidadil	(Resident #57) and to	ensure the correct	trans productions is the advantage attended.		ANTONIO PROPERTINA PROPERTINA ANTONIO PROPERTINA AN	

FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAY	ΞΥ
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Total Center Health and retirement Total Center Avenue	17
CA4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFY INFORMATION TAG REGULATORY O	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (F. 490) Continued From-page 61— (F- 490) treatment order was transcribed and implemented for a resident with a pressure ulcer (Resident #69) for 2 of 4 residents sampled for pressure ulcers. 7. Cross refer to F-371: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service and failed to discard 7 containers of honey thickened water that were expired in 1 of 2 nourishment room refrigerators (700 hall). 8. Cross refer to F-431: Based on observations	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 490) Continued-From-page 61 treatment order was transcribed and implemented for a resident with a pressure ulcer (Resident #69) for 2 of 4 residents sampled for pressure ulcers. 7. Cross refer to F-371: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service and failed to discard 7 containers of honey thickened water that were expired in 1 of 2 nourishment room refrigerators (700 hall). 8. Cross refer to F-431: Based on observations	
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nourishment room refrigerators (700 hall). 8. Cross refer to F-431: Based on observations	
8. Cross refer to F-431: Based on observations	
and staff interviews the facility failed to store	
medications in the original packaging for 3 of 5	
medication carts (100 cart, 300 cart, 500/600 cart	i
that were noted to have loose pills in the drawers.	
9. Cross refer to F-514: Based on observations,	
record reviews and staff interview the facility	
failed to accurately document a pressure ulcer on	
the Skin-Weekly Pressure Ulcer Record for 1 of 4	
residents sampled for pressure ulcers (Resident	
#57).	
During on interview on 00/00/47 at 1:57 PM, the	
During an interview on 09/08/17 at 1:57 PM, the interim Director of Nursing stated she had only	
been in the facility for less than a week. She	
explained it had been her priority to review the	
plan of correction created by former	
administration and she was still in the process of	
getting to know staff and residents and	
understand process and procedure in the facility.	
She stated there was a lot of work that needed to	
be done to get the deficiencies corrected.	
During an interview on 07/14/17 at 2:37 PM, the	
interim Administrator stated she had only been at	
the facility for a couple of weeks and was still	kalendragen kontraktioner s kalendragen kontraktioner s

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345179	B. WING			09.	/08/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH AND RE	TIREMENT	ļ		E CENTER AVENUE		
Ditirate Gr				MO	ORESVILLE, NC 28115		
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{F 490}	Continued From page	3-62	√F-4	901	1.00000 FIFE OR D. D. D. D. D. D. D. D. D. D. D. D. D.		
{F 514} SS=D	trying to figure out protection to the facility. She explaid plans of correction created and initiative the facility she was consumpted to the facility she was consumpted to the corrective measures in correct the citations with the follow-up survey. The follow-up	th her limited knowledge of concerned there had not been acility staff to implement the nother had not been acility staff to implement the nother had not been acility staff to implement the nother had not correction to which were being recited on She stated more work would wreet the deficiencies. TE/ACCURATE/ACCESSIB In accepted professional es, the facility must write and each resident that Ented; In and In anized In must contain- In to identify the resident; Indent's assessments; In the plan of care and services	{F 5				
		e plan of care and services	V T I JOSEP AND IN THE STREET OF THE STREET				
	(iv) The results of any	preadmission screening	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	carried to the			
						Silver of the Control	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						
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	ROVIDER OR SUPPLIER	TIREMENT	1	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		ER AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 514}	Continued From page	9-63	{F-5	14}_			and the halo of the desire which are the second as	**************************************
	and resident review e determinations condu	cted by the State;	The state of the s			F514		
	services reports as re This REQUIREMENT by: Based on observation interview the facility fa a pressure ulcer on th Ulcer Record for 1 of pressure ulcers (Resident #57 was rea 06/13/17. His diagnos thrive, traumatic subd dysphagia, dementia, pulmonary disease, at knee. Review of the most re data set (MDS) dated Resident #57 was sev decision making and r problems. The MDS a #57 required extensive	ogy and other diagnostic quired under §483.50. is not met as evidenced is, record reviews, and staff ailed to accurately document be Skin-Weekly Pressure 4 residents sampled for dent #57). idmitted to the facility on its included adult failure to ural hemorrhage,			 2. 3. 	Pressure Ulcer on a Week Pressure Record versus a Pressure Ulcer Record. R wound documentation w immediately to reflect wo the time and documented Pressure Ulcer Record. R wound has now resolved.	esident as corre and sta d on We esident licer ha An audi r currer cers wa se on 9 ted as	/ #57 ected atus at eekly t #57 ve the it of nt as /15/17.
	Review of a Skin-Weekly Non-Pressure Condition Record dated 09/04/17 indicated that Resident #57 had a new non pressure skin condition with an onset date of 09/04/17. The record also stated			02000	• *************************************	proper documentation spowounds (Pressure/Non-Pr Records).		y tO
	the area was acquired	at the facility and was						

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	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CON	IPLETED				
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1144P OF F	PAYAATA AD OUDDUITS	345179	B. WIING	STREET ADDRESS, CITY, STATE, ZIP CODE	09	0/08/2017				
NAME OF F	ROVIDER OR SUPPLIER			752 E CENTER AVENUE						
BRIAN C	ENTER HEALTH AND RE	TIREMENT		MOORESVILLE, NC 28115						
	OLUMBADY OT	ATEMENT OF DESIGNATED		PROVIDER'S PLAN OF CORRECT	TION	. 0/6				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE				
{F 514}	Continued From page	e 64	{F 514	}4. Director of Nursing a	ad/or-desi	enee will				
	· ·	The wound was located on		audit wound docume						
	i	sured 4.0 centimeters (cm) x								
	3.0 cm x 0.1 cm and	was a Stage 2.	week x 4 weeks, then weekly x 2							
	;	ducted with the Treatment		months during clinica	i meeting.					
	, ,	17 at 9:59 AM. The TN assessment of Resident #57		Data obtained during the aud	it process	will be				
	,	tified the area of pressure		analyzed for patterns and tre						
	and she fully assesse	d the wound including	to Quality Assurance (QAPI) by the Resident							
		g the wound. She added		•	=					
	that she notified the fa			Care Management Director for						
	practitioner and obtained and initiated a treatment. The TN stated that she documented			that time the QAPI committe	ટ will evalા	uate the				
	the assessment on th			effectiveness of the intervent	ions to de	termine				
		port and that was a mistake	if auditing is necessary to maintain compliance.							
		n the Skin Weekly Pressure		,,		•				
		led that facility had recently complete Skin Weekly		1.	0/22/17					
	: · · · · · · · · · · · · · · · · · · ·	ls for residents that were		L.	)   22   11					
	not being followed by									
	practitioner and when									
		ent #57 she just mistakenly								
	used the wrong asses	sinent.								
	An interview was cond	fucted with the interim								
		ON) on 09/08/17 at 1:57								
		stated she expected all		B. Colored						
		as accurate as possible sment to be used to reflect								
	the type of wound that									
{F 520}	483.75(g)(1)(i)-(iii)(2)(	i)(ii)(h)(i) QAA	{F 520	}						
SS=G	COMMITTEE-MEMBE	ERS/MEET								
}	QUARTERLY/PLANS									
	(g) Quality assessmer	nt and assurance.								
	(1) A facility must mair	ntain a quality assessment								
********************************	and assurance commi		, 1 - 4, 1 Tray and payer are ne produce and produce and pro-		yanganang engelaga i yanganggi baharan 1969 sa	27.44 st 141.2000000 Sensitivity (10.500) street in meen st 150.				
			CONTROL OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE 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CENTER	13 I OK MEDICAKE &	MEDICAID SEKAICES			ONID NO. 0000-0001
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		345179	8. WING		09/08/2017
	(EACH DEFICIENC	TIREMENT  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	75	REET ADDRESS, CITY, STATE, ZIP CODE  2 E CENTER AVENUE  OORESVILLE, NC 28115  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
/E 5201	Continued From page	2.65	{F 520}	F – 520 (483.75)	
1	minimum of:	3-00	(1 020)		
	(i) The director of nur- (ii) The Medical Direction (iii) At least three other staff, at least one of wadministrator, owner, individual in a leaders	tor or his/her designee; er members of the facility's /ho must be the a board member or other		<ol> <li>Facility Administrator cond Assurance and Improvement of meeting on 9/13/2017 to disc survey citations from survey e</li> <li>All residents residing in the potential to be affected.</li> </ol>	Committee uss the current xit on 9/8/17
	<ul> <li>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</li> <li>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</li> <li>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</li> </ul>			3. The Director of Regulatory reeducated the Interdisciplina members of the Quality Assuration Improvement Committee by 9 accurately reporting and revising plans as well as developing and new action plans to assure star compliance in the facility. The contacted and will set up addit for facility staff related to the Oprocess.	ry team and ance and /12/17 regarding ing current action dimplementing a te and federal QIO has been ional education
	by: Based on observation and physician intervie	e used as a basis for  is not met as evidenced  is, record reviews and staff ws-the-facility's Quality		4. The Interdisciplinary Team facility Medical Director will me monthly to conduct the facility Assurance and Performance Im	eet at least 's Quality
	Assessment and Assu	rance Committee failed to			

		1	<del></del>				γ	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
			11.001.00.				R-C	
		345179	B. WING				09/08/2017	
NAME OF F	PROVIDER OR SUPPLIER	.1	1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		1 03/00/2017	
					E CENTER AVENUE			
BRIAN C	ENTER HEALTH AND RE	TIREMENT			DRESVILLE, NC 28115			
0/1/15	STIMMADY S.	SATEMENT DE DESIDIENICIES			PROVIDER'S PLAN OF CORR	ECTION	/V63	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD B		
ie esui	Cantinuad Eram nan	• 66	·		meeting. Should any inter	discip	linary team	
{i:020}-	Continued From pag		{F-5	20}	member find that the facil	ity ma	y need an	
	1	d procedures and monitor nat the committee put into			Adhoc Quality Assurance a	ind Pe	erformance	
	!	016 following a recertification	:		Improvement meeting for			
	! '	/. The facility was recited in					' '	
		ertification and complaint			issue, the Administrator w	ill org	anize a meeting	
	survey and subsequently recited on the current				and notify all team membe	ers in	order for a	
follow up survey for failure to maintain compliance. The repeat deficiencies are in the areas of neglect (F-224), dignity (F-241), choices					revision to any present action plan or for a n			
				1	for a new action plan in or			
	(F-242), provide services by qualified persons			1	·			
	according to the care plan (F-282), activities of			1	compliance in the facility.		· ·	
		ressure ulcers (F-314),			monitoring will take place	at eac	ch Quality	
		371), medication storage	1		Assurance and Performand	e Imp	rovement	
		on (F490) and accuracy of			meeting monthly and any a	Adhor	meetings held	
		14). These deficiencies ne facility's current follow up		•	meeting menting and any ,	101100	meetings field.	
	=	d failure of the facility during			This monitoring tool will	be sig	gned off by each	
	,	ecord show a pattern of the	2		Interdisciplinary team m	embe	r after each	
		istain an effective Quality			meeting accepting and a			
	Assurance Program.		:					
	Finalisms in stead of				monitoring and revisions		•	
	Findings included:				Quality Assurance and Pe	erforr	nance	
	1a. This tag is cr	oss referred to F-224	:		Improvement committee	e. The	District Director	
	_	servations, record reviews	1		of Operations or designe			
	and staff interviews th	ne facility neglected to					•	
	=	t treatment order for a	İ		QAPI meeting minutes at	t least	monthly x 3	
ĺ		ure ulcer (Resident #69),	į		months. 10/22/17			
		ncontinent care (Resident	1	1	·			
	#145), and neglected	•		-				
	(INESIDERIE# 100) 10F 3	of 4 sampled residents.		CHIANGE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF T				
İ	F-224 Neglect was or	iginally cited during the						
		mplaint survey of July 14,		İ				
ĺ		y neglected to assess and						
ļ	provide treatment for							
	neglected to clean an							
	residents finger nails							
various de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de la description de l	(Resident # 69). The	facility neglected to assess	to complete the following of the contraction of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the following of the follo	en verne fareteer	o antenna ambiga antanàna amin'ny fivondrona ao amin'ny faritra dia mandritra dia mandritra dia dia dia dia di Ny faritr'ora no ao amin'ny faritr'ora ny taona ao amin'ny faritr'ora na ao amin'ny faritr'ora ao amin'ny fari	a and property of the same of the	and the state of the production of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state	

NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND RETIREMENT  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 520) Continued From page 67  and seek treatment for Resident #69 which regulated in a decline of the pressure ulcer.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONS	STRUCTION	COM	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND RETIREMENT  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 520) Continued From page 67 and seek treatment for Resident #69 which			345179	B. WING				
REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  (F 520)  Continued From page 67 and seek treatment for Resident #69 which			TIREMENT		752 E C	ENTER AVENUE	<u> </u>	
and seek treatment for Resident #69 which	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	SHOULD BE COMPLE	
resulted in a decline of the pressure ulcer condition from redness upon admission on 06/15/17 to black necrotic tissues on 06/25/17.  b. This tag is cross referred to F-241 Dignity: Based on observations, resident and staff interviews and record reviews the facility failed to treat 1 of 3 residents (Resident #145) in a dignified manner by not providing incontinence care as needed on the day shift.  During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to dress dependent residents in a dignified manner for 2 of 3 residents sampled for dignity (Resident #69 and Resident #99).  c. This tag is cross referred to F-242 Choices: Based on observations, record reviews and resident and staff interviews the facility failed to honor a resident's choices regarding showers (Resident #91) and failed to honor a resident's choice to have his fingernals trimmed (Resident #130) for 2 of 3 residents sampled for choices.  During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to honor a resident's choice to have a shower every day for 1 of 4 residents sampled for choices (Resident #91).  d. This tag is cross referred to F-282 Services by qualified persons according to the care plan: Based on observations, record review and staff interviews the facility failed to implement care plan interventions by not applying bunny boots to a residents feel (Resident #57) as instructed by the care plan and falled to refer a	{F 520}	and seek treatment for resulted in a decline of condition from redness 06/15/17 to black need to b. This tag is cross Based on observation interviews and record treat 1 of 3 residents dignified manner by no care as needed on the During the recertificat July 14, 2017, the fact dress dependent resident and Resident #95 c. This tag is cross Choices: Based on obtain and resident and staff to honor a resident's of (Resident #91) and fact choice to have his fing #130) for 2 of 3 resident July 14, 2017, the fact honor a resident's chouse to have his fing #130) for 2 of 3 resident (Resident #91).  d. This tag is cross Services by qualified pare plan: Based on cand staff interviews the care plan intervention boots to a residents fer	or Resident #69 which of the pressure ulcer as upon admission on protic tissues on 06/25/17.  The series of the F-241 Dignity: the resident and staff are resident and staff are resident and staff are resident #145) in a providing incontinence the day shift.  The series of the facility failed to (Resident #145) in a providing incontinence the day shift.  The series of the facility failed for dignity (Resident B).  The series of the facility failed choices regarding showers alled to honor a resident's gernails trimmed (Resident ents sampled for choices.  The sampled for choices of the sampled for choices are sampled for choices.  The sampled for choices of the sampled for choices are sampled for choices.  The sampled for choices of the sampled for choices are ferred to F-282 persons according to the posservations, record review the facility failed to implement as by not applying bunny the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as by not applying bunny the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as by not applying bunny the facility failed to implement as by not applying bunny the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility failed to implement as the facility fai	{F-5	20}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345179	B. WING			1	R-C 9/ <b>08/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		L	:	STREET ADDRESS, CITY, STATE, ZIP CODE		0,00,201,
				1	752 E CENTER AVENUE		
BRIAN CE	:NTER HEALTH AND RE	TIREMENT		ا	MOORESVILLE, NC 28115		
(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 CORRECTIVE (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 520}	Continued From page	<b>.</b> 68	{F-6	5201			
(i 02.0)			, ,	,20	,		:
	diabetic resident with	<del>-</del>					
	care plan for 2 of 3 sa	145) as instructed by the					1
	cate plan for 2 of 3 Sc	impied residents.					
	During the recertificat	ion and complaint survey of					
	-	ility was cited for failure to					1
		nterventions by not dressing					
		is instructed by the care					
		d residents (Resident #69).					İ
:	e This tan is cros	ss referred to F-312	į				
	Activities of Daily Livin						
	-	t and staff interviews and					
	record reviews the fac						
	incontinence care for	1 of 3 residents (Resident	2				
	#145) and nail care for	r 1 of 3 residents (Resident	200				
	#130) reviewed for ac	tivities of daily living.	LANGE OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PER				
į	F-312 was originally of	ited during the					
		of November 3, 2016 for					
		dent residents fingernails					
		mpled for activities of daily					
		F-312 was cited again					
		on and complaint survey of					
	July 14, 2107 for failule dependent residents f						
		activities of daily living					
	(Resident # 69).	donvinos or dany riving					
	f This tag is cros	s referred to F-314 Pressure					
	<del></del>	ervations, record review,					<b> </b>
		ractitioner and medical					
	•	acility failed to prevent a					
		r from worsening to a Stage					į <b>I</b>
}		ident #57) and to ensure the					<b> </b>
İ		er was transcribed and	100				<b> </b>
	•	ident with a pressure ulcer					j
	(Resident #69) for 2 o	f 4 residents sampled for					
	pressure ulcers.			er menerintelijkij et maneritelijkij			

ASD PLAN OF CORRECTION    A SILLIDINO   SILVENT   A SILLIDINO   CRC		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		E CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND RETIREMENT    PRIVATE OF PROVIDER OR SUPPLIER	AND FLAN OF	CORRECTION	IDEA III TOM TOM NOMBER.	A. 8UILDI	ING			
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PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REPTENDED TO THE APPROPRIATE DEPTICATION YOU.  (F-520) Continued From page 69  During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to assess and provide treatment to prevent development of pressure ulcer for one of four sampled residents (Resident #89.) The resident was readmitted on 06/15/17 to the facility with a reddened area on left heel. The area on the left heel was not reassessed until 06/25/17 at which time the left heel area was black in color.  g. This tag is cross referred to F-371 Kitchen Sanitation: Based on observations and staff interviews the facility failed to keep files out of the kitchen area during food production and meal service and failed to discard 7 containers of honey thickened water that were expired in 1 of 2 nourishment room refrigerators (700 hall).  F-371 was originally cited during the recentification survey of November 3, 2016 for failure to clean a fan that contained gray debris hanging from the metal grates on the front and back of the fan that was in use and located in a food preparation area next to clean pots and pans and the facility failed to clean a dirty microwave located in 1 of 2 nourishment rooms (700 hall).  F-371 was cited again during the recentification and complaint survey of July 14, 2017 for failure to keep files out of the kitchen area during food production and meal service, failed to discard opened containers of milk that were not dated when opened and failed to remove 3 cartons of ice cream from the floor of the walk in freezer.  In This tag is cross referred to F-431 Drug Storage: Based on observations and staff interviews the facility failed to store medications in	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL'I A. BUILDII	IULTIPLE CONSTRUCTION (X3) DATE SI LDING			
		345179	B. WING _				R-C / <b>08/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
•				;	752 E CENTER AVENUE		
BRIAN CE	ENTER HEALTH AND RET	FIREMENT		į	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 500)		70	(= =	001			
{F 52U}	Continued From page			20)	<b>}</b>		
	(100 cart, 300 cart, 50 to have loose pills in t	00/600 cart) that were noted the drawers.			,		
	F-431 was originally o	ited during the					
	recertification survey	of November 3, 2016 for					
	failure to remove expi	red medications from 1 of 4					
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		vey of July 14, 2017 for					
	failure to keep medica						
		nedications cart (100 cart, 0 cart, 500/600 cart and 700	İ				
		to have loose pills in the					
	•	discard expired/undated					
		dication carts (100 cart and					
	400 cart).						
	i. This tag is cros	ss referred to F-490	NAME OF TRANSPORT				
	Administration: Based	on observations, record					
	reviews and resident,	staff and physician					
	•	administration failed to	İ				
		fectively to implement and					
	•	ction to ensure the facility					
	•	deficiencies in services to needs of residents in the	İ				
	-	pled residents (Resident					
		and #57). These areas					
		ity, choices, implementation					
		ons, activities of daily living,					
		ecords and pressure sores					}
	which resulted in the f	acility's failure to prevent a					
Ì	· ·	r from worsening to a Stage					
	3 pressure ulcer and t						
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		nt in the kitchen and to					
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED		
		345179	B. WING				R-C 09/08/2017
	ROVIDER OR SUPPLIER			752 E C	r ADDRESS, CITY, STATE, ZIP CODE SENTER AVENUE ESVILLE, NC 28115	, , , , , , , , , , , , , , , , , , ,	7370372017
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{F-520}			{F 5	20}			
	manage the care and building for 4 of 6 resi #93, #29, #147, and #	needs of residents in the dents sampled (Resident 69).					
	of medical records: Be record reviews, and s failed to accurately do the Skin-Weekly Pres	s referred to F-514 Accuracy ased on observations, taff interview the facility ocument a pressure ulcer on sure Ulcer Record for 1 of 4 pressure ulcers (Resident		THE COLUMN TWO PROPERTY OF THE COLUMN THE PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPERTY OF THE COLUMN TWO PROPER			
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