PRINTED: 04/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345243	B. WING _				/-C /13/2018
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212			16/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH		OULD BE COMPLETION	
F 580 SS=D	CFR(s): 483.10(g)(1 §483.10(g)(14) Notif (i) A facility must immonsult with the resiconsistent with his orepresentative(s) who (A) An accident involves in injury and physician intervention (B) A significant charmental, or psychosodeterioration in head status in either life-that clinical complication (C) A need to alter to a need to discontinuate treatment due to advocommence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii). (iii) When making no (14)(i) of this sectionall pertinent informatics available and proving physician. (iii) The facility must resident and the resident and the resident and the resident and the resident and regulation (e)(10) of this section (iv) The facility must resident and the res	fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident then there is- living the resident which has the potential for requiring on; onge in the resident's physical, orial status (that is, a th, mental, or psychosocial breatening conditions or ors); reatment significantly (that is, we an existing form of overse consequences, or to orm of treatment); or ornsfer or discharge the cility as specified in tification under paragraph (g) or, the facility must ensure that tion specified in §483.15(c)(2) orided upon request to the also promptly notify the ident representative, if any, or or roommate assignment ons as specified in paragraph ons. orecord and periodically (mailing and email) and	F	580			4/18/18
APODATODY	DIDECTOR'S OR PROVINCE	VSUPPLIER REPRESENTATIVE'S SIGNATUR	DE		TITI F		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/06/2018

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345243 B. WIN			R-C 03/13/2018		
	ROVIDER OR SUPPLIER	B/CH	STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 580	that is a composite di §483.5) must disclosi its physical configura locations that comprispart, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record reviacility failed to notify physician after the rea non-invasive mechaloxygen as ordered by found deceased for 1 respiratory services (Findings included: Resident #1 was read 12/19/15 with diagnorespiratory failure, hediabetes and chronic disease. Resident #1 03/06/18. A review of the most Data Set (MDS) date	osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced iew and staff interviews the the resident's primary sident was not connected to anical ventilator to provide y the physician and was of 3 residents sampled for Resident #1). dmitted to the facility on ses which included: art failure, hypertension, obstructive pulmonary expired at the facility on recent quarterly Minimum d 01/02/18 revealed	F 580	"Preparation and/or execution of this of correction does not constitute admission or agreement by the provice the truth of the facts alleged or conclusions set forth in the statement deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of fect and state law." F580 Notify of Changes 1. At 10:47pm on 3/6/18, Nurse #1 Nurse #2 responded to resident #1's following report of change of condition from NA#1. Resident #1was noted to unresponsive. Nurse #2 exited reside #1's room to obtain the crash cart. At 10:55pm Nurse #1 checked resident's advanced directives and noted reside	der of of suse deral and room be nt		
	daily decision making extensive assistance daily living. The MDS #1 required oxygen a	cognitive impairment for and required limited to from staff with activities of further revealed Resident and suctioning and had a ntilator was not checked on		was a DNR. At 11:00pm Nurse #1 a Nurse #2 assessed resident #1's vital signs and Vital signs were absent. At 11:03pm the Director of Nursing was notified of resident #1's death. On 3/Nurse #1 did not notify Resident #1's primary physician. The Nurse Practitions and a ware on 3/7/18 and the	6/18		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			l R	-C
		345243	B. WING			03/13/2018	
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN OF	NTED HEALTH & DEHA	D/OLL		59	939 REDDMAN ROAD		
BRIAN CE	NTER HEALTH & REHA	В/СН		CHARLOTTE, NC 28212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	2	F	580			
	A review of a physicia	an order dated 07/17/17			Primary physician was made aware of		
	indicated non-invasive mechanical ventilator at				incident by the Director of Nursing 3/9/	18.	
	bedtime.				2. Residents with a change of conditi	on	
					resulting in death have the potential to		
	A review of a Treatme	ent Administration Record			affected. The Nurse Managers conduc	ted	
		through 03/31/18 indicated			an audit of residents who have expired	in	
	Respiratory Therapy	. ,			the facility during the last 30 days to		
	Resident #1 on non-invasive mechanical ventilator at bedtime and the time for application				ensure notification was made to the		
					Primary Physician following the resider	it's	
was 9:00 PM.					death. This audit was completed by		
	A review of a DT note	e dated 03/07/18 at 10:06			4/18/18. Any opportunities were		
		revealed Nurse #1 informed			corrected by the Nurse Managers by 4/18/18		
		#1 had passed away in the			3. The Areas Staff Development		
		ated RT #1 asked Nurse #1		Manager and Nurse Manager re-educa			
		Nurse #1 stated Nursing		licensed nurses regarding the facility's			
		Resident #1 to bed around			policy for Notification of Changes to		
		turned to Resident #1's			include: Notification to MD for Change	in	
	room again at 10:55 F	PM and found Resident #1			Condition and Death. This education v	/as	
		further indicated RT #1			completed by 4/18/18.		
	asked Nurse #1 if Re	sident #1 was placed on			4. The Director of Nursing and Nurse		
	·	vith oxygen or was he placed			Managers will review the 24 hour report to		
	on his nocturnal non-				identify resident with changes in condit	ion	
		The note revealed Nurse #1			3 times per week for 12 weeks and		
	_	otten there yet due to her			ensure proper notification was made to		
	•	he was unsure if he was on			the Physician for residents with change		
	his tracheostomy coll				Data obtained during the audit process		
		. The note further revealed on-invasive mechanical			will be analyzed for patterns and trends and reported to Quality Assurance	,	
	ventilator event log w				Performance Improvement (QAPI) tear	n	
		ical ventilator was powered			by the Administrator for 3 months, at		
	on at 10:51 PM and s				which time, the QAPI Committee will		
		• •			evaluate the effectiveness of the		
	During an interview o	n 03/08/18 at 3:06 PM,			interventions to determine if additional		
	_	he worked second shift on			auditing is necessary to maintain		
	03/06/18 and was ass	signed to provide care to			compliance.		
		plained at approximately					
	10:55 PM on 03/06/1	8 NA #1 and NA #3 reported			Date of Compliance: 4/18/18		
	to her Resident #1 wa	as in bed and his tongue was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		
		345243	B. WING_			R-C 03/13/2018	
	ROVIDER OR SUPPLIER			5939 REI	ADDRESS, CITY, STATE, ZIP CODE DDMAN ROAD OTTE, NC 28212	1 03	713/2016
(X4) ID PREFIX TAG	(EACH DEFICIEI	EIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 580	#1's room and he we the NAs to get the owner when she entered it have his oxygen or was accessible to hooked up his non-and turned it on and to see if Resident # (DNR) order. She was sure he had a returned to Resider ventilator off. Nurs pronounced Resider and then she called Resident #1 had exnot call the resident on-call physician sereceived palliative of supposed to call the A review of a change situation, Background Recommendation (indicated on 03/06/was found without servealed Resident signs and none we had a DNR order. The Director of Nurs notified of Resident During an interview DON explained Nur 03/06/18 after she breathing and told in She stated Nurse #	e #1 stated she ran to Resident vas unresponsive and she told crash cart. Nurse #1 stated Resident #1's room he did not and she could not recall if it him. She explained she invasive mechanical ventilator did then left the room to check that a Do Not Resuscitate further explained when she DNR order in place she not #1's room and turned the e #1 stated she and Nurse #2 ent #1 deceased at 11:00 PM did palliative care and told them expired. She confirmed she did the trice she thought she was em. The document for the document titled and, Assessment, and SBAR) dated 03/09/18 at 10:55 PM Resident #1 signs of life. The document #1 was assessed for vital re present and Resident #1 The document further revealed sing (DON) and family were at #1's death. The on 03/09/18 at 12:08 PM, the rese #1 had called her on found Resident #1 was not her Resident #1 had expired. It told her she had called lid not say she had called	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345243	B. WING		R-C 03/13/2018	
	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	03/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 580	current Medical Direct facility and today was facility. He stated the available 24 hours a staff were expected to a resident's change it expired. He stated if care services the nur resident's primary photo notify them. During a follow up in AM, the DON stated a resident had a char resident had a char resident had a char resident received nurse should call the call the resident's pri	on 03/12/18 at 11:41 AM, the ctor stated he was new in the sonly his third time in the ere was physician coverage day and after hours nursing to call the on-call service for a condition or if they had a resident received palliative rise should still call the ysician or the on-call service terview on 03/13/18 at 10:52 it was her expectation when	F 58			

CENTERS FO	OR MEDICARE & MEDICAID SERVICES		_	"A" FORM					
STATEMENT OF	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY					
NO HARM WIT	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs AND	NFs	345243	B. WING						
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE	•					
		5939 REDDMAN							
BRIAN CEN	TER HEALTH & REHAB/CH	CHARLOTTE, N	NC						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE	ZIES							
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable inform (i) A facility may not release information (ii) The facility may release information the	nation. that is resident-identif	-	a					
	contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.								
	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized								
	§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety								
	as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.								
	§483.70(i)(4) Medical records must be ret (i) The period of time required by State la (ii) Five years from the date of discharge	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.							
	§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State:								

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The above isolated deficiencies pose no actual harm to the residents

CENTERS F	OR MEDICARE & MEDICAID SERVICES			"A" FORM						
STATEMENT C	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY						
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	_ COMPLETE:						
FOR SNFs ANI) NFs	345243	B. WING	3/13/2018						
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, 0	CITY, STATE, ZIP CODE	•						
BRIAN CE	NTER HEALTH & REHAB/CH		5939 REDDMAN ROAD CHARLOTTE, NC							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	TIES								
F 842	Continued From Page 1									
	(v) Physician's, nurse's, and other licensed (vi) Laboratory, radiology and other diag. This REQUIREMENT is not met as evid Based on record review, staff and current accurate medical record by not document medical records (Resident #1).	nostic services reports lenced by: Medical Director inte	as required under §483.50.	ate						
	The findings included:									
		Resident #1 was readmitted to the facility on 12/19/15 with diagnoses that included: respiratory failure, heart failure, hypertension, diabetes mellitus, and chronic obstructive pulmonary disease.								
	Review of a Situation, Background, Assessment, and Recommendation (SBAR) dated 03/09/18 indicated that on 03/06/18 at 10:55 AM Resident #1 was found without signs of life. Resident #1 was assessed for vital signs and none were present. The Director of Nursing (DON) and family were notified of Resident #1 's death. The SBAR was not a part of Resident #1 's medical record.									
	Review of Resident #1's medical record on 03/08/18 at 10:00 AM revealed no documentation of Resident's passing or the events leading up to his death.									
	An interview was conducted with Nurse #1 on 03/08/18 at 3:06 PM. Nurse #1 confirmed that she was working with Resident #1 on 03/06/18 on 2nd shift. Nurse #1 stated that she pronounced Resident #1 dead at 11:00 PM but had failed to document the event in the medical record because she ran out of time at the end of her shift.									
	An interview was conducted with the current Medical Director (CMD) on 03/12/18 at 11:41 AM. The CMD director stated the he expected Nurse #1 to document in the medical record exactly what happened and the details that lead up Resident #1 passing away which included the notification of the family and Medical Director.									
	An interview was conducted with the Director of Nursing (DON) on 03/13/18 at 10:52 AM. The DON stated that they had been conducting audits of medical records to check for accuracy and had not identified any issues. She confirmed that Nurse #1 did not document the event in the medical record and stated "we have been stressing the importance of documenting everything." The DON added that the facility was going through a cultural change and has had some challenges and getting the staff to document was one of them. She added that a lot of times the staff would wait until the end of their shift to document and then they would simply run out of time because they had other places to be. She added that she has instructed the staff that when something occurred to stop as soon as possible and document the event so we were not left wandering what took place. The DON again stated that she expected Nurse #1 to document the events of Resident #1 in the medical record.									

PRINTED: 03/28/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345243	B. WING _	B. WING		C 03/13/2018	
	ROVIDER OR SUPPLIER	в/СН		5	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD CHARLOTTE, NC 28212	1 03/	13/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	A complaint survey w 03/08/2018 through 0 Jeopardy was identified	3/13/2018. Immediate					
	of (J).	600 at a scope and severity 656 at a scope and severity					
	CFR 481.25 at tag F-0 of (J).	695 at a scope and severity					
	Tags F-600 and F-699 Quality of Care.	5 constituted Substandard					
	was removed on 03/1 survey was conducted complaint survey. The on 03/10/18 and retur 03/12/18 to continue of	conducting the partial the survey concluded on					
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F	600			
	Exploitation The resident has the reglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 600	§483.12(a) The facil §483.12(a)(1) Not us physical abuse, corp involuntary seclusion This REQUIREMEN by: Based on record re Therapist, former Mand current Medical facility neglected to non-invasive mecha oxygen as ordered be residents sampled for (Resident #1). When staff without the phy mechanical ventilate facility also neglecte for a dependent resi sampled for activitie Immediate Jeopardy Resident #1's oxyge transferring him to b and #3 and they tolo connected to his nor ventilator. Nurse #1 medications and neg	se verbal, mental, sexual, or poral punishment, or n; T is not met as evidenced view, staff, Respiratory edical Director, Pulmonologist Director interviews, the connect a resident to a nical ventilator to provide by the physician for 1 of 3 or respiratory services in Resident #1 was found by sician ordered non-invasive or he was deceased. The id to perform incontinent care dent for 1 of 3 residents is of daily living (Resident #6). If began on 03/06/18 when are was removed before ed by Nurse Aide (NA) #1 if Nurse #1 he was ready to be in-invasive mechanical was passing her night time glected to stop passing her	F 6	·				
	non-invasive mecha approximately 45 midiscovered Residentalerted Nurse #1. Nuneglected to place Formation non-invasive mechales in the place of the	inutes later NA #1 and NA #3 t #1 was not breathing and urse #1 realized she had						

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		345243	B. WING	B. WING		C 03/13/2018	
	ROVIDER OR SUPPLIER	В/СН		5	STREET ADDRESS, CITY, STATE, ZIP CODE 1939 REDDMAN ROAD CHARLOTTE, NC 28212		10,2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 600	#1 deceased. Immed on 03/13/18 when the implemented an acce compliance. The facil compliance at a lowe (no actual harm with minimal harm that is a complete staff educat systems put into place respiratory devices as The facility was cited scope and severity le Findings included: 1. Resident #1 was respiratory 12/19/15 with diagnost failure, heart fa	and pronounced Resident diate jeopardy was removed a facility provided and eptable credible allegation of ity remains out of a scope and severity of D potential for more than not immediate jeopardy) to cion and ensure monitoring are are effective for applying a ordered. at F600 for example #2 at a evel of D. eadmitted to the facility on sees that included: respiratory enypertension, diabetes and almonary disease. Resident lity on 03/06/18. In initiated 01/05/16 and evealed in part, Resident #1 trach) related to a different the goals were Resident #1 equal breath sounds have no signs or symptoms riew date. The interventions exygen via trach collar and ititated 01/05/16) and e placed on a non-invasive at night as ordered (initiated	F	600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345243	B. WING			C 03/13/2018		
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F 600	Data Set (MDS) date Resident #1 had mild daily decision making extensive assistance daily living. The MDS behaviors or rejection required oxygen and tracheostomy during period but ventilator MDS. A review of a Treatm (TAR) dated 03/01/18 RT/Nursing to place mechanical ventilato application was 9:00 A review of a Respiradated 03/07/18 at 10 revealed Nurse #1 in #1 had passed away indicated RT #1 asked and Nurse #1 stated Resident #1 to bed a returned to Resident PM and found Resident #1 was plan with oxygen bled in concturnal non-invasion.	recent quarterly Minimum and 01/02/18 revealed a cognitive impairment for grand required limited to from staff with activities of a further revealed no in of care and Resident #1 suctioning and had a the assessment reference use was not indicated on the ent Administration Record a through 03/31/18 indicated Resident #1 on non-invasive rat bedtime and the time for PM. Satory Therapy (RT) note 1:06 AM signed by RT #1 formed RT #1 that Resident in the night. The note end Nurse #1 what happened Nursing Assistants (NAs) put round 10:15 PM and they #1's room again at 10:55 ent #1 deceased. The note	F	500				
	pass so she was uns tracheostomy collar of mechanical ventilato							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		TRUCTION	(X3) DATE SURVEY COMPLETED		
		345243	B. WING			C		
NAME OF D	ROVIDER OR SUPPLIER	343243	B: Willo	STDEET	ADDRESS, CITY, STATE, ZIP CODE	03/	13/2018	
NAME OF FI	ROVIDER OR SUFFLIER				EDDMAN ROAD			
BRIAN CE	NTER HEALTH & REHAI	В/СН			OTTE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 600	Continued From page 4		F	800				
	on at 10:51 PM and s	ical ventilator was powered topped at 10:57 PM. The vas no as needed (PRN) RT						
	#1 confirmed Resider failure and was ventile stated Resident #1 we would sporadically tall but he was not able to ventilator. RT #1 expl 03/07/18 at 5:20 AM awas up in his wheelch him a new tank of oxy not. RT #1 stated he Resident #1 was and deceased. He explains stable and had not be oxygen needs and wat times a day. RT #1 s #1 what happened ar approximately 10:15 I requested to go to be and they went back to and he was deceased asked Nurse #1 if Resident was the non-invasive mechan tracheostomy collar at the non-invasive mechan trach	ained he arrived to work on and generally Resident #1 hair waiting for the RT to get yen but on this day he was questioned Nurse #1 where Nurse #1 stated he was ned Resident #1 was very sen sick, had no increased as only suctioned maybe 1-2 tated he questioned Nurse nd she explained at PM on 03/06/18 Resident #1 d so the NAs put him to bed or check on him at 10:55 PM d. RT #1 further stated he sident #1 had been on his ical ventilator or his and she stated he was not on chanical ventilator because medications and had not up yet. He explained he sive mechanical ventilator and centilator had been turned on ew minutes. RT #1 stated						
	and they went back to and he was deceased asked Nurse #1 if Res non-invasive mechan tracheostomy collar a the non-invasive mec she was still passing had time to hook him checked the non-inval log inside the monitor discovered that the ve and off within just a fet there was no RT in the	c check on him at 10:55 PM d. RT #1 further stated he sident #1 had been on his ical ventilator or his ind she stated he was not on hanical ventilator because medications and had not up yet. He explained he isive mechanical ventilator on the ventilator and entilator had been turned on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345243	B. WING			C 03/13/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	I	03/13/2016
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	RT #1 stated the nursiplace residents on the ventilator in the abse. During an interview of #1 stated she routine #1 and confirmed she 03/06/18 on second s	Resident #1 to his ical ventilator as ordered. See had been trained to be non-invasive mechanical ince of an RT. In 03/09/18 at 3:43 PM, NA by provided care for Resident be provided care for him on shift. NA #1 explained at 9:50 ber with placing Resident #1 ter Resident #1 was placed provided, she handed bell, urinal, and oxygen ated Resident #1 was able and she handed him the are if he placed it on himself bed she and NA #3 left and returned 35-45 minutes #1's call light was on. She NA #3 entered Resident do he was not breathing but and on his oxygen or not. In called Nurse #1 to the room and Resident #1 was not Do Not Resuscitate (DNR) and she left the room. In 03/08/18 at 3:27 PM, NA wided care for Resident #1 and shift. NA #3 explained at M to 10:00 PM she and NA	F 6	00		
	told Nurse #1 he was for her to hook him u	out Resident #1 to bed she in the bed and was ready to his machine. She imately 30-45 minutes later				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345243	B. WING		C 03/13/2018
	ROVIDER OR SUPPLIER	ΔB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 600	#1 entered his room Resident #1 had graf hand and had turned off the side of the be legs back in the bed the room they notice rising or falling so the explained Nurse #1 of checked his vital sign to take a deep breath was in the room. NA Resident #1 had bee because Nurse #1 w During an interview of Nurse #1 confirmed of Resident #1 on 03/06 #1 explained Reside on 03/06/18 and had had his oxygen in pla tracheostomy collar. 10:55 PM on 03/06/1 Resident #1 was in be hanging out. Nurse of Resident #1's room of and she directed the Nurse #1 stated whe room he did not have recall if it was access up his non-invasive r turned it on and then if Resident #1 had a when she was sure r she returned to Reside	ht was on and she and NA to see what he needed and bbed the hand rail with his I himself so that his legs were d. She stated NA #1 put his and as they turned to leave d that his chest was not ey ran to get Nurse #1. She came into the room and has and Resident #1 appeared hat one point when Nurse #1 #3 stated she was not sure if an hooked up to his ventilator has responsible for that.	F 60		
	mechanical ventilato	e him on his non-invasive r because she was passing #1 stated she had not had			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	'	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 7	F 6	500			
F 600	time to provide trache generally when she were non-invasive mechan stated Resident #1 hout because she had were not on. Nurse # pronounced Resident During an interview of Nurse #2 stated she 03/06/18 and late in the Nurse #1 to Resident she went with Nurse and when she entered was lying in bed and him. She further stath had his oxygen in platten non-invasive mechan for a pulse but could Nurse #1 left the room chart and then return confirmed he had a During an interview of former Medical Direct been Resident #1's part of the product of the product of the pronounced decease During an interview of former Medical Direct been Resident #1's part of the product of	eostomy care and that was yould have put him on the hical ventilator. She further ad alarms on his ventilator not hooked him up yet they 1 stated she and Nurse #2 t #1 deceased at 11:00 PM. In 03/08/18 at 5:06 PM, worked on second shift on the evening a NA called t #1's room. She explained #1 to Resident #1's room he seemed to have no life in ed she could not recall if he ice or if he was hooked to chanical ventilator but she a pulse oximeter. She returned to Resident #1 on the hical ventilator and checked not find a pulse. She stated in to check Resident #1's ed to the room and DNR order and Nurse #1 off. She further stated they sounds for 3-5 minutes but Resident #1 was					
	see him very often be tracheostomy and no	lained she did not have to ecause he was stable with a n-invasive mechanical ned at night Resident #1					

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F 600	mechanical ventilator was a traditional vent Resident #1 did not he ventilator connected to his death along wit disease, and hyperte stated she would exphis oxygen in place a his non-invasive mechanical very independent on a non-invasive mechanical very independent on a non-invasive mechanical very independent on a non-invasive mechanical ventilation at night an non-invasive mechanical ventilator at night to see (breathing). During an interview of current Medical Direction only his third time in the met with Resident #1 his wheelchair on a postated he was not farm mechanical ventilator left the management Pulmonologist who vibasis. The CMD states	poport of the non-invasive which to her knowledge ilator. The FMD stated if ave his oxygen on or his that could have contributed h his heart disease, lung nsion. The FMD further ect for Resident #1 to have nd for him to be hooked to hanical ventilator as n 03/09/18 at 2:51 PM, the Resident #1 was very stable to but had chronic respiratory ent tracheostomy and he nocturnal (at night) iical ventilator. The ned Resident #1 required the iical ventilator as back up d anyone who required the iical ventilator was ventilator if Resident #1 was n-invasive mechanical support his ventilations n 03/12/18 at 11:41 AM, the etor (CMD) stated this was he facility but he recalled he while he was sitting up in revious visit. The CMD inliar with the noninvasive is used in the facility and he of those devices up to the sited the facility on a weekly ed it was his expectation for sician orders and they	F	500			

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345243	B. WING _			C 03/13/2018	
	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	.	00/10/2010	
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F 600	Continued From page	e 9	F 6	500			
	He further stated it woommunicate any iss Pulmonologist. During an interview of Director of Nursing (Exequired the use of noit was usually placed to assist him with bread to assist him with bread to assist him with bread and she gave Now what she needed to of Nurse #1 did not combine all the facts in redeath. The DON furth expectation for Nurse non-invasive mechant the physician.	on 03/09/18 at 12:07 PM, the DON) stated Resident #1 on-invasive life support and on him when he went to bed athing. The DON explained ted her on the evening of d Resident #1 had passed Nurse #1 directions as to do. The DON stated that inmunicate with her at that egards to Resident #1's					
		aled the immediate cause of					
	Compliance	Credible Allegation of F600 Neglect					
	The Resident ide alleged deficient prace	entified to be affected by the stice.					
	medication to resider experienced no distre condition. Resident # and drink without pro	Nurse #1 administered at #1. Resident #1 ass or change in his baseline at swallowed his medication blems. At 9:50pm Nurse ide #3 assisted resident #1					

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	ROVIDER OR SUPPLIER	:HAB/CH		STREET ADDRESS, CITY, STATE, ZIP CO 5939 REDDMAN ROAD CHARLOTTE, NC 28212		3/13/2010	
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F 600	Aide #3 transferrer from the chair to the thair to the call light was on. The thair	ad. Nurse Aide #1 and Nurse d resident #1 via sit to stand lift he bed. NA #1 placed resident urinal within reach. NA#1 and h. At 10:45pm NA#1 exited room and noted resident #1's NA #1 noted that resident #1 ff of the bed and the call bell in vent around the bed to address dent #1's tongue was protruding NA #1 stated resident's color went to the door of resident #1's or help. NA #3 ran to the nurses' at 10:47pm Nurse #1 and hed to resident #1's room. Nurse to the resident #1's room to obtain the sident #1's room to obtain the sident #1's room to obtain the sident #1's vital signs and he defended the head to resident #1's vital signs and he beent. At 11:03pm the Director was sent to the NC Health Care S by the Administrator on this event. The police were ministrator on 3/10/18. The NC was notified via email on	F	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 3/13/2018	
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F 600	physician orders to a system. The IDT deresult of a lack of RT Further Root Cause A regarding the admiss tracheostomies required that no reside required that no reside requiring ventilation with tracheostomies or required that no reside requiring ventilation with scriteria error and 1 resident radd ventilation assists status while remaining. 2. Residents with the alleged deficient promotes and the alleged deficient promotes of the series of the	rse #1 failing to follow the oply the Astral ventilation termined this event was the staffing on 2nd shift. Analysis was conducted ion of residents with ring ventilation assistance. Incted with the Administrator, Respiratory therapist and entative by the Division Team requirements for residents on 6/16/17. This education ents with tracheostomies, would be admitted to the nace 6/16/17, 4 residents as, have been admitted in eccived physician's order to ance due to a decline in g in the facility The potential to be affected by practice. The acheostomies requiring a have the potential to be add deficient practice. The dit was completed by the national to the national staff of the potential to be add the potential to be add deficient practice. The potential to be add deficient practice. The potential to be add deficient practice of the potential to be add deficient practice. The potential to be add deficient practice. The potential to be add deficient practice of the potential to be add deficient practice. The potential to be add deficient practice of the potential to be add deficient practice. The potential to be add deficient practice of the potential to be add deficient practice. The potential to be add deficient practice of the potential to be add deficient practice.	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345243	B. WING				C 43/2048	
NAME OF P	ROVIDER OR SUPPLIER	0.102.10	1	STREET ADDRESS, CITY, STATE, ZIP CO	 DDE	1 03/	13/2018	
				5939 REDDMAN ROAD				
BRIAN CE	NTER HEALTH & REHA	В/СН		CHARLOTTE, NC 28212				
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 600	re-educated licensed Abuse and Neglect P 3/10/18. Beginning 3/ allowed to work until this education also in awareness that failure equipment and service care and oxygen admitted physician, can constituent NHA and DON will have to any deviation from "On 3/10/18 the E Services provided ed Interdisciplinary Team facility's admission caresident requiring reseducation includes the	Jursing and Nurse Managers nurses and nurse aides on revention beginning on 10/18 No staff will be the training is complete. Included ensuring staff to to provide respiratory the such as tracheostomy hinistration as ordered by the state resident neglect. The tave a no tolerance approach the policy. District Director of Clinical function to the in (IDT) regarding the apabilities with a focus on piratory assistance. This is e following: piratory referrals and levels arequired garding referrals with	Fé	DEFICIENCY	2			
	offering placementNo ventilation assists Astral/Trilogy or other " On 3/9/18 Respir Managers re-educate facility's policy for Recare to include suction completing a respirate " On 3/9/18 the Nuthe Nurse Aides on recessions with trached administration to include when oxygen is not a	ratory Therapist/Nurse and licensed nurses using the spiratory/Tracheostomy oning, applying t-collar, and ory assessment. urse Managers re-educated eporting observations of ostomies requiring oxygen ude notification of the nurse						

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(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	will be educated by the facility's policy for Recard Care during the orient "All licensed nurse educated annually, be continued proficiency care utilizing the facilical Respiratory/Tracheos "The Director of Nill review new admic clinical meeting to varespiratory equipmer according to the physe "The Director of Nill audit 10 residents equipment weekly for respiratory equipmer physician's orders. "The Director of Nof this morning during and the committee was needed. "The facility will not tracheostomies that it Astral or other system assistance. All refer be reviewed by the Discrete (DDCS) and for only those approved.	cation after 3/9/18. Seed nurses and nurse aides) he Nurse Manager on the spiratory/Tracheostomy itation process. es and nurse aides will be y the Nurse Manager, for y in respiratory/tracheostomy ity's policy for stomy Care. Nursing or Nurse Managers essions daily during the lidate physician ordered it is available and applied esician's orders. Nursing or Nurse Managers es requiring respiratory y 12 weeks to ensure et applied according to the lursing will report the results g the weekly QAPI meeting ill make recommendations o longer admit residents with require the use of the Trilogy, has that provide ventilation rals with tracheostomies will district Director of Clinical displacement will be offered and by the DDCS. istrator is responsible for ceptable plan of correction.	F 6				
		was removed on 03/13/18 at g staff interviews revealed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345243	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		03/13/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	respiratory devices, and suctioning of reconfirmed staff had how to properly care provide care accord staff interviews also required use of nonventilators had been 2. Resident #6 read 04/08/16 with diagne esophageal reflux dichronic obstructive provide that Reside impaired and require staff member with to revealed that Reside incontinent of bowel care was noted durit period. A continuous observe #6 on 03/08/18 from Resident #6 was ob with a gown on that lower abdomen and noted immediately uroom. There was a licolored soft non for Resident #6's legs the mid-thigh region. The colored soft non for #6's abdomen just a of Resident #6's bed	ducation on the application of use of respiratory equipment sidents. The interviews also received training regarding for tracheostomies and to ing to physician's orders. The revealed that residents who invasive mechanical discharged from the facility. mitted to the facility on oses that included gastro isease, history of ileus, and	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345243	B. WING				C 13/2018	
	ROVIDER OR SUPPLIER	в/сн	•	593	REET ADDRESS, CITY, STATE, ZIP CODE 39 REDDMAN ROAD HARLOTTE, NC 28212			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	wanted a cup of coffee were noted to pass be the observation. Durit observation the facilitic knocked on Resident room and was observation. Nursing Assist enter Resident #6's rexited the room. She with a bag of linen surfices with a bag of linen surfices. The room and noted the pand asked the house. An interview was cornog/08/18 at 10:32 AN was caring for Reside with him and his need going to start an incomend of the hall and work Resident #6 and work in approximately 20 to An observation of Re 03/08/18 at 10:53 AN bed with a blanket the extremities. There was detected out in the hall Resident #6's room. In non-formed stool was lower abdomen just a of light brown colored to ooze down between	rinated on himself and se. Numerous staff members y Resident #6's room during ng the continuous ty's Social Worker (SW) s #6's door and entered the wed to cover Resident #6's n a blanket and exit the ant (NA) #2 was observed to com and turn around and returned a few minutes later applies, she entered Resident the linen supplies and exited #6's roommate entered the coudle of fluid on the floor keeper to mop it up. If NA #2 confirmed that she ent #6 and was very familiar ds. NA #2 indicated she was intinent round at the other ork her way towards ald be providing care to him o 30 minutes. If Sident #6 was made on of the Resident #6 was resting in at covered his lower as a strong fecal odor now	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 600	Resident #6's room provide incontinen heavily prevalent in #6's room. Upon e # 2 stated "he had observed to provid #6 and to remove heavily soiled with matter. No skin bre Resident #6's buttered but the skin was mattress had a largindicating the blue Resident #6 indicaturinated all over hid dress Resident #6 wheelchair. A follow up intervision 03/08/18 at 11:: she was working the was running behin Resident #6 was us arrived to work but stated that she had him at around 8:00 arriving and she w NA #2 stated that she had him at around she w NA #2 stated that she had him at around she w NA #2 stated that she had him at around she w NA #2 stated that she had him at around she w NA #2 stated that she had been becember 2017. The had 4 to 5 NAs	age 16 s made of NA #2 entering n on 03/08/18 at 11:19 AM to t care. The fecal odor was now n the hallway and in Resident intering Resident #6's room NA a huge blow out." NA #2 was e incontinent care to Resident the linen from his bed that was light brown colored fecal eakdown was noted to ock areas, they were slightly as intact. Under the sheet the ge ring that was darker in color mattress was wet. Again ted that he had defecated and mself. NA #2 was observed to and place him in his ew was conducted with NA #2 21 AM. NA #2 explained that he whole hall by herself and d. She stated that generally p and dressed when she today he was not. NA #2 d provided incontinent care to 0 AM prior to his breakfast tray as just now getting back to him. when she delivered linen m earlier she had not noted the y when she arrived to provide 6 did she detect the fecal odor. conducted with the Unit 03/09/18 at 10:23 AM. The UM en in her current role since 'he UM explained that generally so on her unit each day and same. She indicated that the	F	500			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED		
		345243	B. WING _				C / 13/2018
	ROVIDER OR SUPPLIER	AB/CH		5939	EET ADDRESS, CITY, STATE, ZIP CODE REDDMAN ROAD ARLOTTE, NC 28212	1 00	710/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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 600	did not have the entexplained that the 2 herself made round day looking for thing incontinent care. She were able to alert the incontinent and need residents including checked and change unacceptable that Facility of the thicked and change unacceptable that Facility of the thing and the thing and the thing of the thing lights being answered that and looked for thing lights being answered that the thing of	d on 03/08/18 and that NA #2 lire hall by herself. The UM nurses on the unit and s sporadically throughout the gs that needed to be done like lie added that some residents lie staff that they were ded to be clean up but some Resident #6 were routinely led. The UM stated that it was lesident #6 laid in bed that land that care should have an sooner. Inducted with the Charge 2/18 at 12:38 PM. The CN responsible for overseeing where Resident #6 resided. Is she rounded daily on the unit lies like beds being made, call led, linens were clean, full king sure staff was offering ts. The CN stated that on wledge the unit was fully ly l	F	500			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	В/СН	<u> </u>	5	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD CHARLOTTE, NC 28212	1 001	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 608 SS=D	noticed he was uncovover his legs" and exicover as soon as possing resident heavily soiled was left soiled. She in unacceptable for Resover an hour. Reporting of Reasona CFR(s): 483.12(b)(5)(5)(5)(5)(6)(5)(5)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	nim up. She stated "I just vered and I threw the blanket ted his room. ducted with the Director of /13/18 at 10:52 AM. The expected NA #2 to provide ible and to never leave any d for as long as Resident #6 indicated that was ident #6 to lay soiled for able Suspicion of a Crime (i)-(iii) by must develop and icies and procedures that: reporting of crimes funded long-term care ive with section 1150B of the procedures must include the following elements. It is covered individuals, as 50B(a)(3) of the Act, of that it to comply with the following its. It is invidual shall report to the even more law enforcement all subdivision in which the reasonable suspicion of a ividual who is a resident of, form, the facility.		600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		ATE SURVEY DMPLETED
		345243	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	l '	03/13/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 608	(ii) Posting a conspirights, as defined at Act. (iii) Prohibiting and defined at section 17 This REQUIREMEN by: Based on record refacility failed to ident and procedure to no report to law enforce crime when a reside non-invasive mecha oxygen as ordered befound deceased for respiratory services Findings included: A review of a facility Neglect Prohibition of 2017 indicated in painmediately investigated in the situations of a trisk of occurring, and Response indicated in painmediately investigated in the situations of the situations of the situations of the situation of the si	ult in serious bodily injury. cuous notice of employee section 1150B(d)(3) of the preventing retaliation, as 150B(d)(1) and (2) of the Act. T is not met as evidenced view and staff interviews the ify neglect and follow policy tify the state agency and ement the suspicion of a nt was not connected to a nical ventilator or provide by the physician and was 1 of 3 residents sampled for (Resident #1). document titled Abuse and with a revised date of August rt Facility supervisors will ate and correct reported or n which abuse or neglect is A section labeled Reporting ated in part the facility will of abuse and neglect to the Survey Agency and law s. admitted to the facility on bees that included: respiratory hypertension, diabetes and bullmonary disease. Resident	F 60	8		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345243	B. WING _			1	C 13/2018
	ROVIDER OR SUPPLIER			5939	PEET ADDRESS, CITY, STATE, ZIP CODE 9 REDDMAN ROAD ARLOTTE, NC 28212	1 03/	13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 608	Continued From page Resident #1 had mild	e 20 cognitive impairment for	F	808			
	daily decision making extensive assistance daily living. The MDS #1 required oxygen a	and required limited to from staff with activities of further revealed Resident nd suctioning and had a stillator was not checked.					
		an order dated 07/17/17 e mechanical ventilator at					
	dated 03/07/18 at 10: revealed Nurse #1 in: #1 had passed away indicated RT #1 aske and Nurse #1 stated Resident #1 to bed at returned to Resident PM and found Reside further indicated RT # Resident #1 was place with oxygen bled in o nocturnal non-invasiv ordered. The note rev had not gotten there is pass so she was unsitracheostomy collar of mechanical ventilator RT #1 checked the no ventilator event log w non-invasive mechan on at 10:51 PM and si	d Nurse #1 what happened Nurse Aides (NAs) put round 10:15 PM and they #1's room again at 10:55 ent #1 deceased. The note #1 asked Nurse #1 if red on tracheostomy collar rows he placed on his e mechanical ventilator as realed Nurse #1 stated she red to her medication roure if he was on his ron-invasive. The note further revealed on-invasive mechanical hich indicated the rical ventilator was powered ropped at 10:57 PM.					
	#1 confirmed Resider failure and was ventil #1 explained he arrive	n 03/08/18 at 12:52 PM, RT nt #1 had chronic respiratory ator dependent at night. RT ed to work on 03/07/18 at ly Resident #1 was up in his					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG _		، ا	C
		345243	B. WING				13/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REH	AB/CH		5	939 REDDMAN ROAD		
BINIAIN CL	INTERTIERE IT & REIT	AB/OII		C	CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 608	tank of oxygen but of stated he questioned #1 was and Nurse #1 he explained Reside had not been sick, heeds and was only day. RT #1 stated he happened and she to 10:15 PM on 03/06/go to bed so the NA went back to check was deceased. RT Nurse #1 if Residen non-invasive mechatracheostomy collar the non-invasive mechatracheostomy and the pass and connected non-invasive mechatracheostomy and interview Nurse #1 explained usual self on 03/06/wheelchair and had liters through a tracatracheostomy at the pass and connected non-invasive mechatracheostomy and the pass and connected non-invasive mechatracheostomy and the pass and connected non-invasive mechatracheostomy and connected	for the RT to get him a new on this day he was not. RT #1 and Nurse #1 where Resident #1 stated he was deceased. ent #1 was very stable and had no increased oxygen a suctioned maybe 1-2 times a requestioned Nurse #1 what explained at approximately 18 Resident #1 requested to as put him to bed and they on him at 10:55 PM and he #1 further stated he asked at #1 had been on his anical ventilator or his and she stated he was not on echanical ventilator because g medications and had not m up yet. He explained he vasive mechanical ventilator and ventilator had been turned on few minutes. RT #1 stated the building that night and ve stopped her medication	F	608			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345243	B. WING			C 3/13/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 5939 REDDMAN ROAD CHARLOTTE, NC 28212		3/13/2016	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 608	on and could not rand she hooked uventilator and turn to check to see if I Resuscitate (DNR she was sure he had time to Reside ventilator off. She had time to place mechanical ventilator off. She had time to provide tragenerally when sh non-invasive mechanical ventilator off. She had time to provide tragenerally when sh non-invasive mechanical ventilator of the stated Resident # but because she had the were not on. Nurse pronounced Resident During an interview Director of Nursing contacted her on the reported Resident gave Nurse #1 director of the DON strager of the pool of t	m he did not have his oxygen ecall if it was accessible to him p his non-invasive mechanical ed it on and then left the room Resident #1 had a Do Not) order. She explained when had a DNR order in place she ent #1's room and turned the further explained she had not him on his non-invasive hator because she was passing ee #1 stated she had not had cheostomy care and that was ee would have put him on the nanical ventilator. She further thad alarms on his ventilator had not hooked him up yet they ee #1 stated she and Nurse #2 lent #1 deceased at 11:00 PM. We on 03/09/18 at 12:07 PM, the g (DON) stated Nurse #1 had he evening of 03/06/18 and #1 had passed away and she ections as to what she needed hated that Nurse #1 did not her at that time all the facts in	F	508			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` ') DATE SURVEY COMPLETED
		345243	B. WING_			C 03/13/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	<u> </u>	03/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 608	what had happened questions regarding 10:06 AM. She exp had happened she fit the State Agency an 03/10/18. She state to everyone and Nur the severity of things going to have be mo investigation when ir resident and they we on top of it. During a follow up in AM, the new Administ practice to file report according to policy a	ne was not made aware of until the surveyors asked the RT note on 03/06/18 at lained after she realized what led the 24 hour report with d notified law enforcement on d it had been a reality check ses sometimes forgot about s. She stated they were are	F 6	08		
F 641 SS=D	crime. Accuracy of Assessr CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mu resident's status. This REQUIREMEN by: Based on record reformer Medical Direct interviews the facility Minimum Data Set (I) ventilator for 4 of 4 s received respiratory non-invasive mechal		F 6	41		

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345243	B. WING _		C 03/13/2018
	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CO 5939 REDDMAN ROAD CHARLOTTE, NC 28212	
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 641	Continued From page	e 24	F 6	41	
	12/19/15 with diagnor respiratory failure, he diabetes and chronic disease. A review of the most Data Set (MDS) date Resident #1 had mild daily decision making extensive assistance daily living. The MDS #1 required oxygen a tracheostomy during period but ventilator vMDS. A review of a physicia indicated non-invasiv bedtime. During an interview of Respiratory Therapis had chronic respiratory dependent at night. During an interview of former Medical Direct been Resident #1's p 02/28/18 and Resider which required the us at night Resident #1 as	art failure, hypertension, obstructive pulmonary recent quarterly Minimum d 01/02/18 revealed cognitive impairment for and required limited to from staff with activities of further revealed Resident and suctioning and had a the assessment reference was not checked on the an's orders dated 07/17/17 e mechanical ventilator at an 03/08/18 at 12:52 PM, at (RT) #1 stated Resident #1 ry failure and was ventilator an 03/08/18 at 4:41 PM, the cor (FMD) stated she had hysician until approximately at #1 had a tracheostomy are of oxygen. She explained also required the extra vasive mechanical ventilator			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345243	B. WING		C 03/13/2018
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 641	Pulmonologist stated and independent but failure with a perman was dependent on a non-invasive mecha pulmonologist expla non-invasive mecha ventilation at night a non-invasive mecha dependent. During an interview former Administrator ventilators in the facility assist a Resident Ca (RCMD) with MDS be facility. She further time approximately of present time she was at the facility. She si ventilators on reside because she had be not use ventilators as she had questioned machines and was to ventilators according stated she then talked machines but was to non-invasive mecha continuous positive the Bi-level positive machines. She state	on 03/09/18 at 2:51 PM, the discrete Resident #1 was very stable to had chronic respiratory ment tracheostomy and he mocturnal (at night) mical ventilator. The fined Resident #1 required the mical ventilator as back up and anyone who required the mical ventilator was ventilator. On 03/09/18 at 6:06 PM the estated they did not use dility. On 03/12/18 at 11:23 AM, the explained she had been as a couple of days a week to be a couple of days a week to be a stated they did not use did not code and the stated she did not code and the stated she did not code and the facility. She explained the RCMD about the cold the facility did not use did to respiratory therapy. She and with RT #1 about the	F 64		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345243	B. WING_				C 13/2018
	ROVIDER OR SUPPLIER	В/СН		5939	EET ADDRESS, CITY, STATE, ZIP CODE REDDMAN ROAD ARLOTTE, NC 28212	1 03/	13/2010
(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 641	Continued From page	e 26 erified ventilator was not	F 6	641			
	coded on the MDS fo	r Resident #1. She stated it or the MDS to be complete					
	current Administrator called by corporate st	n 03/13/18 at 10:52 AM, the explained she had been aff to come to the facility on she was just learning about					
	facility had used but it resident's MDS to be further stated after re-	hanical ventilators the t was her expectation for the coded accurately. She view of RT notes which					
	indicated ventilator se should be coded for v	ettings the resident's MDS entilator.					
	12/05/17 with diagnos	eadmitted to the facility on ses which included acute ry failure with hypercapnia exide in the bloodstream).					
	indicated to place on	n order dated 12/05/17 non-invasive mechanical in respiratory distress.					
	Data Set (MDS) dated Resident #9 had mild daily decision making	recent quarterly Minimum d 12/21/17 revealed cognitive impairment for and required extensive nembers with activities of					
	required oxygen, suct	indicated Resident #9 ioning, and had a the assessment reference vas not checked on the					
	Respiratory Therapist	n 03/08/18 at 12:52 PM, : (RT) #1 stated Resident #9 ry failure and was ventilator					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345243	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	I	03/13/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Pulmonologist stated tracheostomy and country and country and country and country and she required the ventilator at night an "superior form of ver resident who required mechanical ventilator and the settings that not available on the airway pressure (Cpairway pressure (Bi-During an interview former Administrator ventilators in the factor of the facility assist a Resident Ca (RCMD) with MDS befacility. She further time approximately controlled because she had be not use ventilators as she had questioned	on 03/09/18 at 2:51 PM, the did Resident #9 had a build not be weaned from it enon-invasive mechanical did described the device as a nitilation." He explained any end the non-invasive or was ventilator dependent Resident #9 required were traditional continuous positive ap) or the Bi-level positive pap) machines.	F 6			
	stated she then talked machines but was to non-invasive mecha continuous positive	to respiratory therapy. She ed with RT #1 about the old at that time the nical ventilators were used as airway pressure (C-pap) or airway pressure (Bi-pap)				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345243	B. WING		C 03/13/2018	
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	03/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 641	told by RT #1 she comechanical ventilator resident's MDS and coded on the MDS for was her expectation and accurate. During an interview of current Administrator by corporate staff to 03/09/18. She state the non-invasive me facility had used but resident's MDS to be further stated after resindicated ventilators should be coded for 3. Resident #10 was 02/23/18 with diagnor Parkinson's disease tracheostomy and detail (MDS) dated 03/02/2 was cognitively intact the MDS further indextensive assistance toileting and hygiene Resident #10 require had a tracheostomy reference period but on the MDS. A review of a physicidated 02/26/18 indice ventilator dependent	ed based on what she was oded the non-invasive ars as C-pap/Bipap on the verified ventilator was not or Resident #9. She stated it for the MDS to be complete on 03/13/18 at 10:52 AM, the restated she had been called come to the facility on deshe was just learning about chanical ventilators the it was her expectation for the excited accurately. She eview of RT notes which settings the resident's MDS ventilator.	F 64			

	DF DEFICIENCIES CORRECTION			, ,	(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		30.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	e 29 respiratory failure and need	F 6	341		
	for mechanical ventil A review of a physici					
	distress.	d as needed for respiratory on 03/08/18 at 12:52 PM,				
	Respiratory Therapis	et (RT) #1 stated Resident piratory failure and was				
	Pulmonologist explaid Parkinson's disease Resident #10 might in decannulation (remostated Resident #10 mechanical ventilated device as a "superior added that any resided non-invasive mechanical ventilated dependent and the sequired were not avacontinuous positive as	not be a good candidate for val of his tracheostomy). He required the non-invasive r at night and described the form of ventilation." He				
	During an interview of	on 03/09/18 at 6:06 PM the stated they did not use lity.				
	MDS Coordinator ex coming to the facility assist a Resident Ca (RCMD) with MDS b	on 03/12/18 at 11:23 AM, the plained she had been a couple of days a week to re Management Director ut he had recently left the explained she was hired full				

AND DI AN OF CORRECTION IDENTIFICATION NI IMPER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	ΔB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	present time she was at the facility. She si ventilators on resider because she had be not use ventilators as she had questioned machines and was to ventilators according stated she then talked machines but was to non-invasive mechanicontinuous positive at the Bi-level p	s weeks ago and at the steep the only MDS staff member tated she did not code ints MDS at the facility en told by the RCMD they did at the facility. She explained the RCMD about the old the facility did not use into respiratory therapy. She ad with RT #1 about the lid at that time the inical ventilators were used as airway pressure (C-pap) or airway pressure (Bi-pap) and based on what she was added the non-invasive in the second of the MDS to be set. In 03/13/18 at 10:52 AM, the instated she had been called come to the facility on it is stated she had been called the facility on it is stated she had been called the facility on it is stated she had been called the facility on it is stated she had been called the facility on it is stated she had been called the facility on it is stated she had she is stated she had she is stated she had s	F6			
	02/09/18 with diagnorespiratory failure, character disease and tracheo	s admitted to the facility on uses which included acute aronic obstructive lung stomy.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345243	B. WING				C 13/2018
	ROVIDER OR SUPPLIER	В/СН		5	STREET ADDRESS, CITY, STATE, ZIP CODE 1939 REDDMAN ROAD CHARLOTTE, NC 28212		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	daily decision making Resident #11 required transfers but extensive mobility, dressing, toit MDS also indicated Froxygen, suctioning, a during the assessment ventilator was not chee. A review of a Pulmon 02/16/18 indicated Renon-invasive mechan. A review of a physicial indicated to place on ventilator at night and distress. During an interview of Respiratory Therapist #11 had chronic respiratory Therapist #11 had chronic respiratory an interview of Pulmonologist explain back and forth to the changes in his condit non-invasive mechanical ventilator and the settings that not available on the trainway pressure (C-pairway pressure (Bi-pairway pressure (Bi	It was cognitively intact for it. The MDS also indicated diminimal assistance with reassistance with bed leting and hygiene. The Resident #11 required and had a tracheostomy interference period but recked on the MDS. cologist progress note dated resident #11 needed the ical ventilator to live. It is order dated 03/01/18 non-invasive mechanical if as needed for respiratory In 03/08/18 at 12:52 PM, at (RT) #1 stated Resident reatory failure and was at night. In 03/09/18 at 2:52 PM, the need Resident #11 kept going hospital because of ion and he required ical ventilation at night. He reasive mechanical ventilators if ventilation." He explained uired the non-invasive was ventilator dependent Resident #11 required were readitional continuous positive ap) or the Bi-level positive	F	641			

TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345243	B. WING		C 03/13/2018	
ROVIDER OR SUPPLIER	AB/CH	STREET ADDRESS, CITY, STATE, ZIP COD 5939 REDDMAN ROAD CHARLOTTE, NC 28212		·	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETION	
former Administrato ventilators in the factor ventilators in the factor ventilators in the factor ventilators in the facility. Some substitution of the facility. She further time approximately present time she was at the facility. She substituted where the ventilators on reside because she had be not use ventilators are she had questioned machines and was a ventilators according stated she then talk machines but was to non-invasive mechanical ventilators. She stated by RT #1 she comechanical ventilator resident's MDS and coded on the MDS at the was her expectation of the model of the	on 03/12/18 at 11:23 AM, the explained she had been as a couple of days a week to be are Management Director but he had recently left the explained she was hired full as weeks ago and at the explained she did not code ents MDS at the facility been told by the RCMD they did at the facility. She explained the RCMD about the cold the facility did not use go to respiratory therapy. She ed with RT #1 about the bold at that time the cold at that time the cold at the time the cold at the rore time to the rore array pressure (C-pap) or airway pressure (Bi-pap) the dead on what she was coded the non-invasive ors as C-pap/Bipap on the verified ventilator was not for Resident #11. She stated on for the MDS to be atte.	F 641			
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER) Continued From page former Administrato ventilators in the facility assist a Resident Ci (RCMD) with MDS facility. She further time approximately present time she was at the facility. She siventilators on reside because she had be not use ventilators as she had questioned machines and was to ventilators according stated she then talk machines but was to non-invasive mechanical ventilators according to the Bi-level positive the Bi-l	CORRECTION IDENTIFICATION NUMBER:	A BUILDING 345243 B. WING ROVIDER OR SUPPLIER NTER HEALTH & REHAB/CH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 former Administrator stated they did not use ventilators in the facility. During an interview on 03/12/18 at 11:23 AM, the MDS Coordinator explained she had been coming to the facility a couple of days a week to assist a Resident Care Management Director (RCMD) with MDS but he had recently left the facility. She further explained she was hired full time approximately 3 weeks ago and at the present time she was the only MDS staff member at the facility. She stated she did not code ventilators on residents MDS at the facility because she had been told by the RCMD they did not use ventilators at the facility. She explained she had questioned the RCMD about the machines and was told the facility did not use ventilators according to respiratory therapy. She stated she then talked with RT #1 about the machines but was told at that time the non-invasive mechanical ventilators were used as continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines. She stated based on what she was told by RT #1 she coded the non-invasive mechanical ventilators as C-pap/Bipap on the resident's MDS and verified ventilator was not coded on the MDS for Resident #11. She stated it was her expectation for the MDS to be complete and accurate. During an interview on 03/13/18 at 10:52 AM, the current Administrator stated she had been called by corporate staff to come to the facility on 03/09/18. She stated she was just learning about the non-invasive mechanical ventilators the	A BUILDING 345243 ROUDER OR SUPPLIER NTER HEALTH & REHABICH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 32 F 641 F 6	

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345243	B. WING		C 03/13/2018
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	1 33/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 641	Continued From pag	ge 33 settings the resident's MDS	F 64	.1	
F 656 SS=J	should be coded for Develop/Implement	ventilator. Comprehensive Care Plan	F 65	56	
	implement a comprecare plan for each resident rights set for §483.10(c)(3), that in objectives and timefi medical, nursing, an needs that are identificated assessment. The confective the following (i) The services that or maintain the residentification of maintain the residentification of maintain the residentification of maintain the residentification of the following of the services that the services that the services that the services of the services of the service of the servic	acility must develop and shensive person-centered esident, consistent with the arth at §483.10(c)(2) and includes measurable rames to meet a resident's diffied in the comprehensive ingrehensive care plan must ingrehensive services of systems of stable plan in the services of specialized is the nursing facility will in the proposition of plan in the services in the sident indicate its in the resident and the interview in the sident and the interview in the sident in the side			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 656	Continued From pag		F 6	56		
	local contact agencientities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on record redirector and current the facility failed to interventions by not non-invasive mechanthe care plan for 1 or respiratory services. Resident #1 was foot devices he was decounted by the care plan for 1 or respiratory services. Resident #1 was foot devices he was decounted by the facility and the care plan for 1 or respiratory services. Resident #1 was plan to stop passing nig connect Resident #1 non-invasive mechanthe facility alerted Nurse #1. Non the connected Resident alerted Nurse #1. Non to connected Resident alerted Nurse #1. Non to connected Resident alerted the device or room to find out his that Resident #1 had order she re-entered turned off the non-integration and pronounced Rejeopardy was remove when the facility pro acceptable credible	in the comprehensive care, in accordance with the th in paragraph (c) of this T is not met as evidenced view, staff, former Medical Medical Director interviews implement care plan applying oxygen and a nical ventilator as stated in f 3 residents sampled for (Resident #1). When and by staff without the eased. If began on 03/06/18 when niced in bed and Nurse #1 did th time medications and I to his oxygen and his nical ventilator.				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 656	Continued From page	e 35 f D (no actual harm with	F	656		
	potential for more that immediate jeopardy)	n minimal harm that is not to complete educate and stems put into place for				
	The findings included	l:				
	with diagnoses that in	ed to the facility on 12/19/15 ncluded: respiratory failure, nsion, diabetes mellitus, and ulmonary disease.				
	revised on 01/07/18 a tracheostomy related. The goal of the states would have clear and bilaterally through the #1 would have no sign by the review date. A plan read, Resident #1 drainage around his Resident #1 would have normal limits through interventions include were secured at all till observe and docume confusion, and increase.	n initiated 01/05/16 and read in part, Resident #1 had red to a respiratory illness. It care plan was Resident #1 requal breath sounds review date and Resident resor symptoms of infection additional goals of the care reached to a temperature within the review period. The residence of the care resident respiratory in the residence of the care resident respiratory.				
	rate, depth, and qual (initiated 01/05/16), c collar (initiated 01/05 respiratory status to t Resident #1 was to b mechanical ventilator revised on 06/23/17)	ity every shift as ordered exygen via tracheostomy (16), report any changes in the nurse (initiated 07/17/17), re placed on the non-invasive (initiated on 03/24/16 at night as ordered, suction on 01/05/16). No changes				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C		
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	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	1 00/10/2010
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F 656	Continued From page	-	F 65	6	
	were made to the ca 01/07/18.	are plan with the revision on			
	Respiratory Therapi	an order dated 05/13/16 read, ist (RT) to titrate oxygen to se oximeter greater than 91%.			
		an order dated 07/17/17 read, anical ventilator at bedtime.			
	Data Set (MDS) dat Resident #1 was mi required limited to e with activities of dai revealed no behavior noted. Resident #1 suctioning and had	recent quarterly Minimum red 01/02/18 revealed that aldly cognitively impaired and extensive assistance from staff by living. The MDS further for or rejection of care were also required oxygen and a tracheostomy during the face period. Ventilator use was MDS.			
	and Recommendati indicated that on 03 #1 was found withon was assessed for vi present. Advance d Resident #1 was no Resuscitate (DNR).	on, Background, Assessment, on (SBAR) dated 03/09/18 w/06/18 at 10:55 AM Resident ut signs of life. Resident #1 tal signs and none were irectives were reviewed and oted to be a Do Not The Director of Nursing ere notified of Resident #1's			
	Assistant (NA) #1 o stated she routinely with Resident #1. S was caring for him o #1 stated it was a ro	onducted with Nursing n 03/09/18 at 3:43 PM. NA #1 cared for and was familiar he also confirmed that she on 03/06/18 on 2nd shift. NA outine night on the unit for 9:50 PM NA #3 assisted her			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED			
			7 50.25	_		(C
		345243	B. WING			03/	13/2018
	ROVIDER OR SUPPLIER	в/сн	•	59	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD CHARLOTTE, NC 28212		
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F 656	provided Resident #' urinal, and oxygen to Resident #1 was able and she handed him if he placed it on him then left the room an later when the call lig room and noticed Re NA #1 stated she cor oxygen or not she wa breathing. NA #3 sur room and confirmed and was a DNR. NA because she was so An interview was cor 03/08/18 at 3:27 PM. routinely cared for ar #1 and was caring fo shift. NA #3 stated th to 10:00 PM with ass place Resident #1 in she had removed his but could not recall if Approximately 30-45 that Resident #1's ca NA #1 entered his ro She stated that they chest was not rising Nurse #1. Nurse #1 checked his vital sign recall if Resident #1 NA #3 stated she wa been hooked up to h #1 was responsible f	t #1 in the bed. After ced in the bed and care was I was handed his call bell, abing. She stated that e to put his own oxygen on the tubing but was not sure self or not. NA #1 stated they d returned 35-45 minutes that was on and they entered esident #1 was not breathing. The sald not recall if he had on his as so upset that he was not an amount of the was not breathing that he was familiar with Resident or him on 03/06/18 on 2nd that at approximately 9:50 PM sistance from NA #1 they the bed. NA #3 stated that is oxygen to put him to bed if she had replaced it or not. The minutes later NA #3 stated that is oxygen to put him to bed if she had replaced it or not. The minutes later NA #3 stated that is oxygen to put him to bed if she had replaced it or not. The minutes later NA #3 stated that is oxygen to put him to bed if she had replaced it or not. The minutes later NA #3 stated that is oxygen to put him to be and that he needed. The noticed that Resident #1's for falling and they ran to get that the stated she could not that his oxygen on or not. It is not sure if Resident #1 had its ventilator because Nurse	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
A BOLDING	С
345243 B. WING	03/13/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	·
BRIAN CENTER HEALTH & REHAB/CH	
CHARLOTTE, NC 28212	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODE	JLD BE COMPLETION
F 656 Continued From page 38 03/08/18 at 3:06 PM. Nurse #1 confirmed that she was working with Resident #1 on 03/06/18 on 2nd shift. Nurse #1 stated that Resident #1 had been his usual self on 03/06/18, he had been up in the wheelchair and had his oxygen in place at 2-3 liters via tracheostomy collar. She stated that at approximately 10:55 PM on 03/06/18 NA #1 and NA #3 stated "Resident #1 is in bed and his tongue is hanging out." Nurse #1 stated she ran to Resident #1's room and he was unresponsive. Nurse #1 directed the NAs to get the crash cart and she went to make sure he had a DNR order in place. She stated that before she left the room to check if Resident #1 had a DNR order she hooked his oxygen to the ventilator and turned it on and when she returned to the room and was sure he had a DNR order she hooked his oxygen to the ventilator and turned it on and when she returned to the room and was sure he had a DNR order she turned the ventilator off. Nurse #1 stated that when she entered Resident #1's room he did not have his oxygen on and she had not had time to place him on his non-invasive mechanical ventilator because she was passing medications. Nurse #1 stated that she pronounced Resident #1 dead at 11:00 PM. An interview was conducted with the former Medical Director (FMD) on 03/08/18 at 4:41 PM. The FMD stated that she rared for Resident #1 until approximately 02/28/18 and was very familiar with him. The FMD stated that she had never seen Resident #1 without his oxygen and she honestly did not have to see him very often because he was a stable as he could be with a tracheostomy and being ventilator dependent. The FMD stated that if Resident #1 did not have his oxygen or his ventilator on that certainly could have contributed to his death along with his heart	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018
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F 656	An interview was con Medical Director (CM The CMD stated that the facility and he had Resident #1 while he wheelchair before his that he expected the care and place Residhis non-invasive medical by the plan of care. An interview was con 03/09/18 at 12:07 PM Resident #1 required support and that it wa #1 went to bed to ass DON stated that she Resident #1's oxyger mechanical ventilator by the plan of care. Sesident #1 was able tubing and has known periods of time without the control of the control of the care of the control of the care. Sesident #1 was able tubing and has known periods of time without the care of the care o	ygen in place and would be asive mechanical ventilator ected by the plan of care. ducted with the current D) on 03/12/18 at 11:41 AM. this was only his 3rd time in dimet and visited with was sitting in up in his passing. The CMD stated staff to follow the plan of ent #1 on his oxygen and on hanical ventilator as directed ducted with the DON on I. The DON stated that the use of non-invasive life is usually on when Resident ist him with breathing. The expected Nurse #1 to apply and non-invasive as ordered and as directed the further stated that to apply his own oxygen in Resident #1 to go long ut his oxygen and it never	F	356		
	Resident #1 was in the oxygen and non-invalue so maybe the position something to do with Compliance	it. Credible Allegation of F656 Care planning				
	The Resident idealleged deficient practice	entified to be affected by the tice.				

NAME OF PR			ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 656	medication to reside experienced no dist condition. Resident and drink without pr Aide #1 and Nurse // in preparing for bed Aide #3 transferred from the chair to the #1's call light and ur NA #3 exited room. another resident's rocall light was on. Nother the call light was on. Nother hand. NA #1 we the call light. Reside from his mouth. NA was gray. NA #1 we room and yelled for station to get help. Nurse #2 responder #1 placed resident #1 Nurse #2 exited res crash cart. At 10:55 resident #1 was a D and Nurse #2 assess and Vital signs were Director of Nursing with the death. A 24 hour report was Registry, NCDHHS 3/10/18 reporting the notified by the Admi	B Nurse #1 administered ent #1. Resident #1 ress or change in his baseline #1 swallowed his medication oblems. At 9:50pm Nurse Aide #3 assisted resident #1. Nurse Aide #1 and Nurse resident #1 via sit to stand lift bed. NA #1 placed resident inal within reach. NA#1 and At 10:45pm NA#1 exited from and noted resident #1's A #1 noted that resident #1 of the bed and the call bell in an around the bed to address ent #1's tongue was protruding at #1 stated resident's color ent to the door of resident #1's help. NA #3 ran to the nurses' At 10:47pm Nurse #1 and do to resident #1's room. Nurse #1 on the respiratory assistive noted to be unresponsive. Ident #1's room to obtain the pm Nurse #1 checked do directives and noted entering in the was notified of resident #1's seed resident #1's vital signs absent. At 11:00pm Nurse #1 seed resident #1's vital signs absent. At 11:03pm the was notified of resident #1's	F 6	56		
TAG	At 9:30pm on 3/6/18 medication to reside experienced no dist condition. Resident and drink without pr Aide #1 and Nurse // in preparing for bed Aide #3 transferred from the chair to the #1's call light and ur NA #3 exited room. another resident's recall light was on. Nother hand. NA #1 we the call light. Reside from his mouth. NA was gray. NA #1 we room and yelled for station to get help. Nurse #2 responded #1 placed resident #1 Nurse #2 exited res crash cart. At 10:55 resident #3 advanced resident #1 was a Dand Nurse #2 assess and Vital signs were Director of Nursing wideath. A 24 hour report was Registry, NCDHHS 3/10/18 reporting the notified by the Admi	ge 40 3 Nurse #1 administered ent #1. Resident #1 ress or change in his baseline #1 swallowed his medication oblems. At 9:50pm Nurse Aide #3 assisted resident #1. Nurse Aide #1 and Nurse resident #1 via sit to stand lift bed. NA #1 placed resident inal within reach. NA#1 and At 10:45pm NA#1 exited from and noted resident #1 of the bed and the call bell in the around the bed to address ent #1's tongue was protruding at 1 stated resident's color ent to the door of resident #1's help. NA #3 ran to the nurses' At 10:47pm Nurse #1 and at to resident #1's room. Nurse #1 on the respiratory assistive noted to be unresponsive. Ident #1's room to obtain the pm Nurse #1 checked at directives and noted wNR. At 11:00pm Nurse #1 seed resident #1's vital signs absent. At 11:03pm the was notified of resident #1's s sent to the NC Health Care by the Administrator on is event. The police were nistrator on 3/10/18. The NC as notified via email on	TAG	CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	\ , ,	(X3) DATE SURVEY COMPLETED	
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F 656	the Interdisciplina was determined the oxygen via trach on the initiated for Render Respiratory Thera Nurse #1 with contasks which led to physician orders the system. The IDT result of a lack of Further Root Cauregarding the admitracheostomies readucation was concluded by the contact of the initiation of the initiati	Cause Analysis was conducted by ry Team (IDT) on 3/9/18 and it nat the Nurse #1 did not apply collar and Astral ventilation was esident #1 immediately after the desident to bed. There was no apist (RT) on duty to assist impletion of respiratory related in Nurse #1 failing to follow the orapply the Astral ventilation of determined this event was the RT staffing on 2nd shift. See Analysis was conducted in assistance inducted with the Administrator, go, Respiratory therapist and resentative by the Division Team from requirements for residents es on 6/16/17. This education residents with tracheostomies on would be admitted to the Since 6/16/17, 4 residents teria, have been admitted in ant received physician's order to sistance due to a decline in ining in the facility	F 6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		36. 10.20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	updated to reflect inte tracheostomy care, o donning and doffing t . On 3/9/18 R were identified with tr respiratory equipmen assistance was trans 3. Systemic Measu . On 3/9/18 th Nurse Managers re-e regarding following the tracheostomies requi ensure care planned oxygen administration devices providing ver place.	e to ensure care plans were erventions including xygen administration and he Astral/Trilogy device. Lesidents #8, #9, #10 and #11 racheostomies utilizing that requiring ventilation ferred to hospital setting. The Director of Nursing and Educated licensed nurses are care plan of residents with ring ventilation assistance to interventions including and donning and doffing intilation assistance are in the District Director of Clinical	F	556			
	resident requiring resident requiring resident requiring resided education includes the Specific types of resident of respiratory support -Admission criteria restraction from trackeostomies, which Director of Clinical Scoffering placement. -No ventilation assists - No ventilation assists - No ventilation assists - No 3/9/18 R Managers re-educate facility's policy for Resident - Resident - No ventilation assists - No 3/9/18 R Managers re-educate facility's policy for Resident - No ventilation assists - No ventilation - No venti	apabilities with a focus on piratory assistance. This e following: piratory referrals and levels trequired garding referrals with hincludes the District ervices approval prior to ance will be provided via redevices respiratory Therapist/Nurse ed licensed nurses using the spiratory/Tracheostomy oning, applying t-collar, and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	В/СН	:	STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	7 33.10.2010
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F 656	re-educated the Nurs observations of resid requiring oxygen admotification of the nur applied as required. No licensed work before receiving. New hires (aides) will be educate the facility's policy fo Care during the orier. All licensed be educated annually continued proficiency care utilizing the facil Respiratory/Tracheos. The Directo Managers will review the clinical meeting to respiratory equipmer according to the phys. The Directo Managers will audit of respiratory equipmer ensure care planned respiratory equipmer. The Director results of these audit meeting and the comrecommendations as The facility with tracheostomies Trilogy, Astral or other ventilation assistance tracheostomies will be Director of Clinical Services.	ne Nurse Managers se Aides on reporting lents with tracheostomies ministration to include ree when oxygen is not I nurses or nurse aides will geducation after 3/9/18. Ilicensed nurses and nurse led by the Nurse Manager on r Respiratory/Tracheostomy mation process. nurses and nurse aides will y, by the Nurse Manager, for y in respiratory/tracheostomy lity's policy for stomy Care. r of Nursing or Nurse y new admissions daily during to validate physician ordered at is available and applied sician's orders. r of Nursing or Nurse lo residents requiring at weekly for 12 weeks to interventions related to at are in place r of Nursing will report the se during the weekly QAPI mittee will make se needed. will no longer admit residents that require the use of the ler systems that provide le. All referrals with ler reviewed by the District	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345243	B. WING			l	C 13/2018
	ROVIDER OR SUPPLIER	В/СН		5	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD CHARLOTTE, NC 28212		10,2010
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 4. The Administrator implementing this acc		F	656			
F 677 SS=D	2:20 PM when nursin that they had received implementation of car specially related to re	re plan interventions	F	677			
	out activities of daily I services to maintain gersonal and oral hygothis REQUIREMENT by: Based on observation interviews the facility care for a dependent	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced ns, record review, and staff failed to perform incontinent resident for 1 of 3 residents of daily living (Resident #6).					
	with diagnoses that in reflux disease, history obstructive pulmonary. Review of the most re Minimum Data Set (Morevealed that Resider impaired and required staff member with toil revealed that Resider	ed to the facility on 04/08/16 included gastro esophageal of of ileus, and chronic y disease. ecent comprehensive IDS) dated 01/08/18 int #6 was cognitively dextensive assistance of 1 eting. The MDS further					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345243	B. WING			03/	13/2018
	ROVIDER OR SUPPLIER	AB/CH	1	59	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD HARLOTTE, NC 28212	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	A continuous observation Resident #6 was obwith a gown on that lower abdomen and noted immediately croom. There was a colored soft non for Resident #6's legs the mid-thigh region. The colored soft non for #6's abdomen just a of Resident #6's beliquid on the floor. Find defecated and wanted a cup of coff were noted to pass the observation. Du observation the facility knocked on Resident room and was observation. Nursing Assistenter Resident #6's exit the room. She rewith a bag of linent with a bag of linent she's room delivered the room. Resident room and noted the and asked the house An interview was considerated.	vation was made of Resident in 10:09 AM to 10:31 AM. It is served to be resting in bed was pulled up exposing his it legs. There was fecal odor upon entering Resident #6's large pile of light brown med stool laying between hat extended from the brief to here was also light brown med stool laying on Resident above the brief. To the left side d was a large pool of yellow desident #6 indicated that he urinated on himself and fee. Numerous staff members by Resident #6's room during	F	677			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345243	B. WING			C
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	<u> </u>	3/13/2018
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	in approximately 20 to An observation of Re 03/08/18 at 10:53 AM bed with a blanket the extremities. There was detected out in the has Resident #6's room. Inon-formed stool was lower abdomen just a of light brown colored to ooze down between his knee that was explanket. An observation was resident #6's room oprovide incontinent of heavily prevalent in the #2 stated "he had a lobserved to provide i #6 and to remove the heavily soiled with light matter. No skin break Resident #6's buttook red but the skin was in mattress had a large indicating the blue mas Resident #6 indicated urinated all over hims dress Resident #6 and wheelchair. A follow up interview	ork her way towards lid be providing care to him to 30 minutes. sident #6 was made on 1. Resident #6 was resting in at covered his lower as a strong fecal odor now all directly in front of Light brown colored soft is observed to be lying on his above the brief and the pile if non-formed stool continued in his legs nearly reaching bosed from under the commander of NA #2 entering in 03/08/18 at 11:19 AM to hare. The fecal odor was now the hallway and in Resident in the ring Resident #6's room NA hauge blow out." NA #2 was incontinent care to Resident in the linen from his bed that was hit brown colored fecal adown was noted to a areas, they were slightly intact. Under the sheet the ring that was darker in color attress was wet. Again in that he had defecated and self. NA #2 was observed to ad place him in his	F 6'	77		
		AM. NA #2 explained that whole hall by herself and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		· /	(X3) DATE SURVEY COMPLETED			
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		33,13/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Resident #6 was up arrived to work but to stated that she had phim at around 8:00 A arriving and she was NA #2 stated that who supplies to his room fecal odor and only work care to Resident #6 of An interview was confund to Manager (UM) on 03 stated she had been December 2017. The she had 4 to 5 NAs of yesterday was the saturit was fully staffed did not have the entitiex plained that the 2 in herself made rounds day looking for things incontinent care. She were able to alert the incontinent and need residents including Rechecked and change unacceptable that Residents incontinent and need residents including Rechecked and change unacceptable that Residents incontinent Residents including Rechecked and change unacceptable that Residents including Residents including Rechecked and change unacceptable that Residents including Rechecked and change unacceptabl	She stated that generally and dressed when she day he was not. NA #2 provided incontinent care to M prior to his breakfast tray just now getting back to him. en she delivered linen earlier she had not noted the when she arrived to provide did she detect the fecal odor. Inducted with the Unit 1/09/18 at 10:23 AM. The UM in her current role since at UM explained that generally on her unit each day and arme. She indicated that the on 03/08/18 and that NA #2 are hall by herself. The UM nurses on the unit and apporadically throughout the state that needed to be done like added that some residents at staff that they were led to be clean up but some desident #6 were routinely d. The UM stated that it was esident #6 laid in bed that and that care should have	F	577		
	An interview was cor 03/12/18 at 12:55 PM Resident #6's room of legs with a blanket. I see that he was soile odor. She stated if she smelled she would he	nducted with the SW on M. The SW recalled entering on 03/08/18 and covering his The SW stated she did not and did not smell the fecal ne would have seen it or ave immediately went and him up. She stated "I just				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345243	B. WING				C 13/2018
NAME OF PROVIDER OR SUPPLIE BRIAN CENTER HEALTH & I		B/CH			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	1 03/	13/2010
PREFIX (EACH DEF	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
An interview wa Nursing (DON) of DON stated that care as soon as resident heavily was left soiled. Sunacceptable for over an hour. F 695 SS=J § 483.25(i) Resistracheostomy of The facility must needs respiratory care and trached care, consistent practice, the cordinate plan, the reand 483.65 of the This REQUIREM by: Based on record the facility failed non-invasive means the physician for respiratory serving Resident #1 was physician ordered. Immediate Jeop Resident #1 was persident #1 was pe	uncovered and extended and exte	wered and I threw the blanket ited his room. Iducted with the Director of 1/13/18 at 10:52 AM. The expected NA #2 to provide sible and to never leave any d for as long as Resident #6 indicated that was sident #6 to lay soiled for stomy Care and Suctioning The care, including indicated that a resident who re, including tracheostomy ctioning, is provided such professional standards of inensive person-centered ints' goals and preferences,		695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NO _		, ا	3
		345243	B. WING				13/2018
	ROVIDER OR SUPPLIER	AB/CH	1	59	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	mechanical ventilatoremoved by NA #3 b #1 to the bed and war and NA #3 exiting Rowas passing her night not stop passing her Resident #1 to his noventilator. Approximate staff discovered Resand alerted Nurse #1 had not connected From-invasive mechanis room and turned Resident #1's room After confirming that Resuscitate (DNR) of #1's room and turned mechanical ventilator #1 dead. Immediate 03/13/18 at 2:20 PM and implemented an allegation of compliance at a low (no actual harm with minimal harm that is complete staff educates systems put into place respiratory devices at The findings included Review of the manufactor o	connected to his non-invasive or. Resident #1's oxygen was before transferring Resident as not replaced prior to NA #1 esident #1's room. Nurse #1 ht time medications and did medications to connect con-invasive mechanical ately 45 minutes later the sident #1 was not breathing 1. Nurse #1 realized that she resident #1 to his nical ventilator and entered the device on. She exited to find out his code status. Resident #1 had a Do Not order she re-entered Resident doff the non-invasive or and pronounced Resident experience. The facility provided acceptable credible ance. The facility remains out over scope and severity of Dopotential for more than not immediate jeopardy) to ation and ensure monitoring as ordered. d: facturer's instructions for the mechanical ventilation) 'The Astral device provides	F	695			

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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	ROVIDER OR SUPPLIER	в/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	Ē	337	.0.2010
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 695	who require mechanic device is intended to institution/hospital and both invasive and nor Resident #1 was read 12/19/15 with diagnos failure, heart failure, heart failure, healtitus, and chronic disease. Resident #1 03/06/18. Review of a care plan revised on 01/07/18 ra tracheostomy (Tracillness. The goals of t Resident #1 would hasounds bilaterally through Resident #1 would hasinfection by the review included: oxygen via 01/05/16), Resident #1 won-invasive mechan 03/24/16) at night as (initiated on 01/05/16). Review of the most reduced the mo	reighing more the 11 pounds cal ventilation. The Astral be used in home, do portable applications for nativasive ventilation." Imitted to the facility on sees that included: respiratory hypertension, diabetes obstructive pulmonary expired at the facility on a initiated 01/05/16 and ead in part, Resident #1 had h) related to a respiratory he stated care plan were live clear and equal breath ough the review date. In the interventions trach collar (initiated on ordered, suction as needed b). Recent quarterly Minimum do 01/02/18 revealed that ly cognitively impaired for and required limited to from staff with activities of further revealed no	F6	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		345243	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 5939 REDDMAN ROAD CHARLOTTE, NC 28212	<u>l</u>	03/13/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From page	e 51	F	695		
	Review of a physiciar read, Respiratory The	order sheet dated 03/01/18 erapist (RT) to titrate oxygen se oximeter greater than				
		order sheet dated 03/01/18 echanical ventilator at				
	(TAR) dated 03/01/18 RT/Nursing to place of	e removed from the				
	read, Nurse #1 inform had passed away in thappened Nurse #1 s Assistants (NAs) put 10:15 PM and they reroom again at 10:55 Fedeceased. RT #1 ask was placed on trache bled in or was he place non-invasive mechan Nurse #1 stated she fet to her medication pass was on his tracheosted non-invasive mechan event. RT #1 checked mechanical ventilator it was powered on at	ical ventilator as ordered. had not gotten there yet due is so she was unsure if he had not gotten there yet due is so she was unsure if he had really collar or his ical ventilator at the time of it the non-invasive event log and it stated that 10:51 PM and stopped at no as needed (PRN) RT on				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345243	B. WING				13/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
				5	939 REDDMAN ROAD		
BRIAN CE	NTER HEALTH & REI	HAB/CH		С	CHARLOTTE, NC 28212		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 695			F	395			
	An interview was o	conducted with NA #1 on					
	03/09/18 at 3:43 P	M. NA #1 stated she routinely					
	cared for and was	familiar with Resident #1. She					
	also confirmed tha	t she was caring for him on					
	03/06/18 on 2nd sl	hift. NA #1 stated it was a					
	_	e unit for Resident #1 and at					
		sisted her with placing Resident					
		r Resident #1 was placed in the					
		provided, Resident #1 was					
		II, urinal, and oxygen tubing. esident #1 was able to put his					
		d she handed him the tubing					
		he placed it on himself or not.					
		then left the room and returned					
	-	r when the call light was on.					
		dent #1's room and noticed he					
	was not breathing.	NA #1 stated she could not					
	recall if he had on	his oxygen or not, she was so					
		not breathing. NA #3					
		#1 to the room and confirmed					
		eathing and had a Do Not					
		order. NA #1 stated she left					
	the room because	she was so upset.					
	An interview was o	conducted with NA #3 on					
	03/08/18 at 3:27 P	M. NA #3 confirmed that she					
		and was familiar with Resident					
	_	for him on 03/06/18 on 2nd					
		that Resident #1 had been his					
		He was up in his wheelchair on					
		s oxygen in place via his					
		had been to the dining room					
		stated that at approximately					
		PM with assistance from NA #1					
		ent #1 in the bed. NA #3 stated					
		ved his oxygen to put him to recall if she had replaced it or					
		30-45 minutes later NA #3					
		nt #1's call light was on and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			Ι,	С
		345243	B. WING	B. WING		1	13/2018
NAME OF P	ROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2010
TO THE OT THE	NOVIDER OR GOLF ELER				5939 REDDMAN ROAD		
BRIAN CE	NTER HEALTH & REHA	B/CH			CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 695	Continued From page	e 53	F	695	5		
		ed his room to see what he	'	030			
		entered his room Resident					
	-	nand rail and turned himself					
		ming out of the bed. She					
	_	his legs back in the bed and					
		ve the room they noticed that					
	,	ng or falling and they ran to					
		#1 came into the room and					
	•	ital signs and Resident #1					
		eep breath at one point					
	when Nurse #1 was i	n the room. NA #3 stated					
	she was not sure if R	esident #1 had been hooked					
	up to his ventilator be						
		NA #3 stated that after she					
	had put Resident #1						
		rse #1 that he was in the bed					
	and ready for her to h	nook him up to his machine.					
		ducted with Nurse #1 on					
		Nurse #1 confirmed that					
		Resident #1 on 03/06/18 on					
		stated that Resident #1 had					
		n 03/06/18, he had been up					
		I had his oxygen in place at stomy collar. She stated that					
		55 PM on 03/06/18 NA #1 esident #1 is in bed and his					
		t." Nurse #1 stated she ran					
		n and he was unresponsive.					
		e NAs to get the crash cart					
		e sure he had a DNR order					
		that before she left the room					
	· ·	#1 had a DNR order she					
		vasive mechanical ventilator					
	•	when she returned to the					
	room and was sure h	e had a DNR order in place					
	she turned the ventila	ator off. Nurse #1 stated that					
	when she entered Re	esident #1's room he did not					
	have his oxygen on a	and could not recall if it was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018	
	ROVIDER OR SUPPLIER	\B/CH		STREET ADDRESS, CITY, STATE, ZIP COD 5939 REDDMAN ROAD CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 695	had time to place him mechanical ventilator medications. Nurse a had time to start her was generally when non-invasive mechanthat Resident #1 had because she had nowere not on. Nurse #2 pronounced Resident #2 pronounced Resident #3 to Resident #4 was produced Resident #4 was produ	the further stated she had not in on his non-invasive in because she was passing if 1 stated that she had not yet tracheostomy care and that she would put him on the nical ventilator. She stated it alarms to his ventilator but it hooked him up yet they if 1 stated that she and Nurse it dent if 1 dead at 11:00 PM. Inducted with Nurse if 2 on it is nown. Nurse if 2 confirmed that the unit where Resident if 1 on 2nd shift. She stated that the of the NAs called Nurse if 1 to Resident if 1 on 2nd shift. She stated she if 1 to Resident in bed and seemed to indical ventilator. Nurse if 2 if 1 had on the non-invasive if 2 if 1 had on the non-invasive if 2 if 1 had on the non-invasive if 1 had a nurse if 1 turned the yeboth auscultated lung if 1 the was none and	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			l c	
		345243	B. WING	B. WING			13/2018
NAME OF P	ROVIDER OR SUPPLIER			ε	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	AB/CH		5	939 REDDMAN ROAD		
				CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	take himself off the value to put himself on it. It usually required betwhis tracheotomy collists aracheotomy collists aracheotomy collists aracheotomy collists aracheotomy collists. It condition of the resident arrived to work on 03 generally Resident # wheelchair waiting for tank of oxygen and off questioned Nurse #* RT #1 stated she repeture with the state of the properties of the pro	alert and would sporadically ventilator but he was not able He added that Resident #1 ween 2-3 liters of oxygen via ar during the day but the RT hat depending on the dent. RT #1 stated that he 3/07/18 at 5:20 AM and #1 would be up in his or the RT to get him a new on this day he was not. RT #1 1 where Resident #1 was at. plied, "He was deceased." RT and Nurse #1 what deceased and he hook him up yet. He further	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C 03/13/2018	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH			STREET ADDRESS, CITY, STATE, ZIP COD 5939 REDDMAN ROAD CHARLOTTE, NC 28212		J3/13/2016	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	Medical Director (FM The FMD stated that until approximately 0 familiar with him. The never seen Resident she honestly did not because he was as stracheostomy and be The FMD stated that his oxygen or his ver have contributed to his non-intervent of the first oxygen of the first oxygen or his ver have contributed to his non-intervent oxygen of the first oxygen oxyg	aducted with the former ID) on 03/08/18 at 4:41 PM. she cared for Resident #1 2/28/18 and was very at FMD stated that she had #1 without his oxygen and have to see him very often stable as he could be with a sing ventilator dependent. If Resident #1 did not have notilator on that certainly could his death along with his heart are, and hypertension. The would expect that Resident expension in place and would be exasive mechanical ventilator atted that Resident #1 did very with his oxygen hooked via but at night he required the non-invasive mechanical er knowledge was a should death at 2:51 PM. The that Resident #1 was very a have to visit him on routine Resident #1 was very chronic respiratory failure neostomy and was	F 6	95			
	mechanical ventilato He added the non-in	at required the non-invasive r was ventilator dependent. vasive mechanical ventilator s positive airway pressure					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345243	B. WING		03/13/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH				STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 695	pressure (Bipap). The superior form of vental Resident #1's setting or Bipap and confirm non-invasively mechanon-invasive ventilate pulmonologist stated could not confirm that non-invasive mechanon-invasive had be a set of the facility and he had resident #1 while he wheelchair before his he was not familiar volumed in the facility on a weel that he expected the orders and place Remechanical ventilato communicate any issue the pulmonologist. An interview was con Nursing (DON) on 000 DON stated that Resident #1 with breathing. The Invalidation of the facility on the facility on the pulmonologist.	a bi-level positive airway the pulmonologist stated "it is tilation." He added that g were not available via Cpap the that Resident #1 was anically ventilated via the tor at night. The if that without an autopsy he at the lack of oxygen or inical ventilator contributed to inducted with the current inducted with the current inducted with the sat 11:41 AM. It this was only his 3rd time in at met and visited with the was sitting up in his is passing. The CMD stated with the equipment that was the the non-invasive the pulmonologist who visited thy basis. The CMD stated the staff to follow the physician sident #1 on his non-invasive	F 695			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE S	
		345243	B. WING		C	
	ROVIDER OR SUPPLIER		B. Willo	STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	03/1	3/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	death. The DON stat #1 to apply Resident mechanical ventilato stated that Resident oxygen tubing and h long periods of time never bothered him is when Resident #1 w his oxygen and non- ventilator on so may had something to do Review of Resident a dated 03/12/18 revea death was respirator Compliance 1. The Resident id alleged deficient prace At 9:30pm on 3/6/18 medication to reside experienced no distr condition. Resident #1 and drink without pro Aide #1 and Nurse A in preparing for bed. Aide #3 transferred r from the chair to the #1's call light and uri NA #3 exited room. another resident's ro call light was on. NA had his right leg off of his hand. NA #1 were	regards to Resident #1's red that she expected Nurse #1's non-invasive r as ordered. She further #1 was able to apply his own as known Resident #1 to go without his oxygen and it before. The DON stated that as in the bed he usually had invasive mechanical be the position of lying down with it. #1's Certificate of Death aled the immediate cause of y failure. Credible Allegation of F695 entified to be affected by the ctice. Nurse #1 administered	F 6	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018	
	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	·	00/10/2010	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 695	was gray. NA #1 wer room and yelled for h station to get help. A Nurse #2 responded #1 placed resident #1 device. Resident #1 Nurse #2 exited resident's advanced #1 was a DNR. At Nurse #2 assessed r Vital signs were absorbed for Nursing was notified A 24 hour report was Registry, NCDHHS b 3/10/18 reporting this notified by the Admin Board of Nursing was 3/10/18 by the Direct A Root Cau the Interdisciplinary was determined that oxygen via trach collenot initiated for Resid NA # 1 assisted Residensial Respiratory Therapis Nurse #1 with completasks which led to Nuphysician orders to a	#1 stated resident's color at to the door of resident #1's nelp. NA #3 ran to the nurses' at 10:47pm Nurse #1 and to resident #1's room. Nurse 1 on the respiratory assistive noted to be unresponsive. Ident #1's room to obtain the m Nurse #1 checked directives and noted resident 11:00pm Nurse #1 and esident #1's vital signs and ent. At 11:03pm the Director ed of resident #1's death sent to the NC Health Care by the Administrator on sevent. The police were istrator on 3/10/18. The NC is notified via email on or of Nursing. see Analysis was conducted by Team (IDT) on 3/9/18 and it Nurse #1 did not apply ar and Astral ventilation was dent #1 immediately after the dent to bed. There was no to t (RT) on duty to assist etion of respiratory related urse #1 failing to follow the pply the Astral ventilation itermined this event was the	F 6	95			
	regarding the admiss tracheostomies requi	Analysis was conducted sion of residents with ring ventilation assistance. ucted with the Administrator,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345243	B. WING			C 03/13/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		03/13/2016	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 695	facility Sales Repreregarding admission with tracheostomies required that no respective required that no respective required that no respective requiring ventilation facility thereafter. So exceeding this critic error and 1 resident add ventilation assistatus while remains a status while remains while remains a status with the alleged deficient on 3/9/18. Director of Nursing residents with trach ventilation assistant Astral/Trilogy deviction and the physician's order on 3/9/18 were identified with respiratory equipments assistance were traced as a systemic Measure of the status of	Respiratory therapist and sentative by the Division Team in requirements for residents is on 6/16/17. This education sidents with tracheostomies in would be admitted to the Bince 6/16/17, 4 residents with a received physician's order to stance due to a decline in ing in the facility. The potential to be affected by it practice. with tracheostomies requiring the potential to be ged deficient practice. an audit was completed by the and Nurse Managers, of the electromies requiring the end of the end o	F 69	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345243	B. WING			C 03/13/2018	
	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, ZIP COI 5939 REDDMAN ROAD CHARLOTTE, NC 28212		10,10,10	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	tracheostomies whice Director of Clinical Soffering placement. -No ventilation assist Astral/Trilogy or other. On 3/9/18 F. Managers re-educate facility's policy for Recare to include suctice completing a respiration. On 3/9/18 the re-educated the Nurse observations of reside requiring oxygen administration of the nurse observation of the nu	egarding referrals with in includes the District dervices approval prior to ance will be provided via redevices. Respiratory Therapist/Nurse ed licensed nurses using the espiratory/Tracheostomy oning, applying t-collar, and ory assessment. The Nurse Managers are Aides on reporting ents with tracheostomies ininistration to include see when oxygen is not nurses or nurse aides will geducation after 3/9/18. The incensed nurses and nurse ed by the Nurse Manager on respiratory/Tracheostomy station process. The nurses and nurse aides will the incensed nurse aides will the incensed nurse aides will the incense and nurse aides w	F 69	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			1	C 13/2018	
	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212			13/2010	
(X4) ID PREFIX TAG			ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 695 F 835 SS=K	results of the audits of meeting and the com recommendations as The facility with tracheostomies to Trilogy, Astral or othe ventilation assistance tracheostomies will be Director of Clinical Seplacement will be offer by the DDCS. The Administrator implementing this accomplementing this accomplement will be offer by the DDCS. The Administrator implementing this accomplementing this accomplement of respirate care for tracheostomic required non-invasive been discharged from Administration CFR(s): 483.70	uring the weekly QAPI mittee will make needed. will no longer admit residents hat require the use of the r systems that provide All referrals with e reviewed by the District ervices (DDCS) and ered for only those approved is responsible for exptable plan of correction. was removed on 03/13/18 at g staff interviews revealed d education on the ory devices, how to properly es, and that residents that a mechanical ventilation had in the facility.		35	JEI IGENOTY			
	A facility must be admenables it to use its reefficiently to attain or practicable physical, well-being of each restrict REQUIREMENT by: Based on observation Respiratory Therapist current Medical Directions	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial						

* *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, Z 5939 REDDMAN ROAD CHARLOTTE, NC 28212	IP CODE	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIA	DATE
F 835	provide leadership ar staff to ensure that a non-invasive mechan (Resident #1). The fa failed to provide lead facility staff to ensure of (Resident #9, #10, capabilities that the fa handle. This affected (Resident #1, #9, #10 Immediate Jeopardy facility Administration and management to ordered respiratory d facility continued to p mechanical ventilatio #11 until they were di 03/09/18. The facility that the non-invasive being used in manne was not equipped to Immediate jeopardy v2:20 PM when the facility that the non-invasive being used in manne was not equipped to Immediate jeopardy v2:20 PM when the facility that is not immediate at a lowe actual harm with pote harm that is not immediate in not immediate in the facility of the findings included 1. This tag is cross results as a sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet the sased on record reviet therapist, former Mediate in the sased on record reviet therapist, former Mediate in the sased on record reviet the sased on record revie	ind oversight to the facility physician ordered ical ventilator was applied cility's Administration also ership and oversight to the that the respiratory needs and #11) did not exceed the acility was equipped to 4 of 5 sampled residents 0, and #11). began on 03/06/18 when the failed to provide oversight ensure that physician evices were applied. The rovide non-invasive in to Resident #9, #10 and scharged from the facility on management was not aware mechanical ventilators were in which the facility staff handle effectively. Was removed on 03/13/18 at cility provided and eptable credible allegation of ity remains out of ity remains	F8	335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345243	B. WING		03/13/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH			5	TREET ADDRESS, CITY, STATE, ZIP CODE 939 REDDMAN ROAD CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 835	the physician for 1 of respiratory services (Resident #1 was four physician ordered de An interview was cor Clinical Services (DC The DCS stated that facility since August one had shared with where Resident #1 re was being used on the An interview was cor President of Operation 12:16 PM. The VPO reassigned to the fact She stated that the Agiven her a tour of the	inical ventilator as ordered by 3 residents sampled for (Resident #1). When and by staff without the evices he was deceased. Inducted with the Director of (SS) on 03/13/18 at 12:47 PM. she has worked with this of 2017 and stated that no her the specifics of the unit esided or the equipment that and unit.	F 835			
	12/05/17 with diagnorespiratory failure wit carbon dioxide in the Review of a physicia place on non-invasivinght or if in respirators.	n order dated 12/05/17 read, e mechanical ventilator at ory distress. ecent quarterly Minimum				
	Resident #9 was mild required extensive as with activities of daily	d 12/21/17 revealed that dly cognitively impaired and ssistance of 2 staff members v living. The MDS further 9 had no behaviors or				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345243	B. WING		C	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		03/13/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 835	Resident #9 require a tracheostomy. No on the MDS. Review of Medicati (MAR) dated 03/01/1 the following: Place ventilator at night of time indicated was initialed it indicating. There was no time device was remove. An interview was conthered the was a specialty unity had a tracheostomy hours or less at night to failure and had been year or so. RT #1 sfacility had put a terresidents with trach use of the non-invanthen around Nover they stated that the those resident that long as they were conformed a day then the facility or would	on Administration Record (18 through 03/31/18 revealed on non-invasive mechanical rif in respiratory distress. The 9:00 PM and the staff had the device had been applied. indicating what time the d. onducted with Respiratory in 03/08/18 at 12:52 PM. RT nit where Resident #9 resided that accepted residents that rand required a ventilator 8 int. RT #1 stated that Resident -invasive mechanical manage her respiratory in at the facility for well over a tated that in June of 2017 the imporary hold on admitting eostomy's that required the sive mechanical ventilator. inber or December of 2017 y could resume admissions of required the ventilators but as inly required for 8 hours a day d that if they required the anical ventilator more than 8 is resident could not admit to have to be discharged to	F 83			
	there was no RT on nurse on the unit we	tunit. He explained that if the unit at bedtime than the buld place Resident #9 on the anical ventilator and then the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		345243	B. WING		C 03/13/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 835	generally take her of that there was no ware Resident #9 was act mechanical ventilator would go on at bedtimmorning. Review of Resident at the RT verified the for had been on the non ventilator greater that ventilator was turned 9:13 AM (8 hours and 2/25/18: the ventilator was turned at 7:20 AM (9 hours of 3/02/18: the ventilator was turned at 9:42 AM (11 hours of 3/03/18: the ventilator was turned at 8:32 AM (8 hours of 3/06/18: the ventilator was turned at 8:32 AM (10 hours of 3/09/18: the ventilator was turned at 9:35 AM (10 hours of 3/09/18. An interview was con Medical Director (CMHe stated he was neonly his 3rd at the far was not familiar with in the facility like the	in the morning would f. The RT further explained by to track the exact time that ually on the non-invasive r. The rule was she usually me and come off in the #9's ventilator log along with ollowing days Resident #9 -invasive mechanical n 8 hours. The non-invasive mechanical on 12:15 AM and turned off d 58 minutes) The non-invasive mechanical on 10:17 PM and turned off and 3 minutes) The non-invasive mechanical on 10:07 PM and turned off and 35 minutes) The non-invasive mechanical on 12:07 AM and turned off and 25 minutes) The non-invasive mechanical on 12:07 AM and turned off and 25 minutes) The non-invasive mechanical on 11:26 PM and turned off and 11:26 PM and turned off	F 83	5	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345243	B. WING_			C 03/13/2018	
	ROVIDER OR SUPPLIER	В/СН	STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212			1 33.13.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 835	devices up to the pul facility on a weekly b was not aware that the to handle residents the hours of ventilator suguestioned it before facility. An interview was compulmonologist on 03/Pulmonologist stated tracheostomy and contracheostomy and described form of ventilation." In that required the nonventilator was ventilated as the settings that Resider available on the tradial airway pressure (Cpa airway pressure (Bi-pulmonologist stated or procedural change to the facility and that	monologist who visited the asis. The CMD stated that he he facility was not equipped hat required greater than 8 apport or he would have he came to work at the device as a "superior he added that any resident he he had a sive mechanical tor dependent and the he had a required were not tional continuous positive ap) or the Bi-level positive	F8	35			
	An interview was cor Clinical Services (DC The DCS stated that facility since August one had shared with where Resident #1 re was being used on the An interview was cor President of Operation						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	,	90.10.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 835	Continued From pag	e 68	F8	35		
	She stated that the A given her a tour of the	cility in November of 2017. Administrator at the time had be facility but she had no vices that were being used				
	Nursing (DON) on 03 DON stated that Res non-invasive life sup on when Resident #8 with breathing. The I time the RT would appremove then in the nathere was no RT on to place Resident #9	nducted with the Director of 3/09/18 at 12:07 PM. The sident #9 required the use of port and that it was usually 9 went to bed to assist her DON stated that most of the oply them at bedtime and norning. She added that if duty the nurses were trained on her the non-invasive r and if necessary to remove as well.				
	DON on 03/13/18 at that when she came August 2017 she wa where Resident #9 rhad tracheostomies non-invasive mechan were transitioning he portrayed to her as a residents came to be the tracheostomy) at The DON stated that non-invasive mechan machines that had the Cpap and Bi-pap may when she began wor told that Resident #9 but opted to stay her had no help in the come.	was conducted with the 10:52 AM. The DON stated to work at the facility in s told the specialty unit esided accepted patients that and required the nical ventilators when they ome. She stated it was a short term unit where decannulated (removal of nd then discharged home. It to her knowledge the nical ventilator were ventilator ne capability to function as a achine. The DON stated that rking at the facility she was o could not be decannulated the at the facility because she ommunity. She added that as se were on the non-invasive				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AB/CH	STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 835	facility did not requi operate and Reside facility because she mechanical ventilat 3. Resident #10 wa 02/23/18 with diagrarkinson's disease tracheostomy and of the Areview of the adm (MDS) dated 03/02 was cognitively inta The MDS further intextensive assistant toileting and hygien rejection of care. The Resident #10 requilinated a tracheostomy identified on the MDA review of a physicidated 02/26/18 indiventilator dependenciosely by pulmono regard to his chronifor mechanical ventilated to place of the color of the physicindicated to place of the physicin	ses than 8 hours then the re any special license to ent #9 was fine to stay in the was only on the non-invasive or at night. Is admitted to the facility on loses which included as, chronic respiratory failure, dependence on a ventilator. Inission Minimum Data Set (18 indicated Resident #10 oct for daily decision making. dicated Resident #10 required the with bed mobility, transfers, and had no behaviors or the MDS also indicated red oxygen, suctioning, and one was obs. Islan's history and physical cated Resident #10 remained and and would be followed logy and respiratory therapy in c respiratory failure and need	F 83	5		
	(MAR) dated 03/01a to place on non-invibedtime. The time i	cation Administration Record /18 through 03/31/18 indicated asive mechanical ventilator at ndicated was 9:00 PM and the indicating the device had been				

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		345243	B. WING _		C 03/13/2018	
	ROVIDER OR SUPPLIER	B/CH		STREET ADDRESS, CITY, STATE, ZIP CO 5939 REDDMAN ROAD CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION IE APPROPRIATE DATE	
F 835	During an interview of Respiratory Therapis where Resident #10 accepted residents the required a ventilator #1 stated that Reside admitted to the facilitinon-invasive mechanianage his respirate in June of 2017 the facility non-invasive mechanical ventilator around November or told by the former Adresume admissions or required the ventilator required the mechanian day or less. RT #1 state the non-invasive med 8 hours a day then the admitted to the facility discharged to a tradification and then the resident #10 on the ventilator and then the morning would generate further explained the #10 usually went on came off in the morning morning would generate for the morning would g	on 03/08/18 at 12:52 PM of (RT) #1 explained the unit lived was a specialty unit that hat had a tracheostomy and 8 hours or less at night. RT ent #10 had recently been by and required the hical ventilator at night to acility had put a temporary sidents with tracheostomy's of the non-invasive of the non-invasive of the non-invasive of those residents that for as long as they only ical ventilator for 8 hours a lated if a resident required chanical ventilator more than the resident could not be by or they would have to be so the non-invasive mechanical lies of the unit would place non-invasive mechanical lies RT that was on duty in the really take him off. The RT general rule was Resident the ventilator at bedtime and ing.	F	335		
	3:45 PM of Resident contained inside the	n with RT #1 on 03/09/18 at #10's ventilator log monitor for the ventilator RT ing days Resident #10 had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	,	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	greater than 8 hours. " 02/24/18: the noventilator was turned turned off at 8:28 AM " 03/02/18: the noventilator was turned turned off at 9:42 AM Resident #9 was disconsidered and the series of the	n-invasive mechanical on at 11:57 PM and was (8 hours and 31 minutes) in-invasive mechanical on at 10:07 PM and was (11 hours and 35 minutes) charged from the facility on the required the non-invasive of at night and described the form of ventilation." He cent who required the nical ventilator was ventilator ettings that Resident #10 ailable on the traditional charges that Resident #10 ailable on the traditional charges since he the facility and when he here were already patients on 03/12/18 at 11:41 AM, the corr (CMD) stated he was	F8	35		
	visit at the facility. The familiar with the non-	d today was only his third e CMD explained he was not invasive mechanical it the management of those				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER	в/сн	•	STREET ADDRESS, CITY, STATE, ZIP COE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 835	facility on a weekly be was not aware the fall handle residents that hours of ventilator surplements of ventilators are questioned it before I facility. During an interview of District Director of CI stated she had worke August of 2017 and swith her the specifics #10 lived or the ventil being used on that upon the properties of the properties of the facility but she had non-invasive mechanisms and interview of Director of Nursing (I required the use of nothat it was usually put to bed to assist him of further stated most of apply the non-invasive bedtime and remove explained if there was were trained to place non-invasive mechanisms.	monologist who visited the asis. The CMD stated he cility was not equipped to required greater than 8 pport or he would have he came to work at the an 03/13/18 at 12:47 PM, the cinical Services (DDCS) and with the facility since stated no one had shared of the unit where Resident lator equipment that was hit. In 03/13/18 at 12:16 PM, the crations (VPO) stated she cassigned to the facility in the further stated the sime had given her a tour of and no knowledge of the cinical ventilators that were it. In 03/09/18 at 12:07 PM, the DON) stated Resident #10 con-invasive life support and to no when Resident #10 went with breathing. The DON of the time the RT would be mechanical ventilators at then in the morning. She is no RT on duty the nurses	F8	35		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C 3/13/2018	
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CO 5939 REDDMAN ROAD CHARLOTTE, NC 28212		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	AM the DON explair at the facility in Augus specialty unit where residents who had to the non-invasive methey were transitioni was portrayed to her residents came to be the tracheostomy) a The DON further stanon-invasive mechacapability to function machine. The DON residents were on the devices less than 8 require any special I stated she did not more residents who require mechanical ventilator. Pulmonologist and the residents who require ventilation.	terview on 03/13/18 at 10:52 ted when she came to work list 2017 she was told the Resident #10 lived accepted racheostomies and required chanical ventilators when ling to go home. She stated it r as a short term unit where re decannulated (removal of lind then discharged home. Ited to her knowledge the linical ventilators had the line as a C-pap and Bi-pap explained as long as re non-invasive ventilator mours then the facility did not license to operate. She lake the decision to accept	F8	35			
	A review of the admindicated Resident # daily decision makin Resident #11 require transfers but extensimobility, dressing, to no behaviors or rejeindicated Resident # suctioning, and had	ssion MDS dated 02/16/18 211 was cognitively intact for g. The MDS also indicated ed minimal assistance with ve assistance with bed bileting and hygiene and had ction of care. The MDS also					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345243	B. WING		C	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		03/13/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 835	Continued From pa	ge 74	F 83	5		
	02/16/18 indicated l	onologist progress note dated Resident #11 needed the anical ventilator to live.				
	indicated to place o	cian's order dated 03/01/18 n non-invasive mechanical nd as needed for respiratory				
	(MAR) dated 03/01/ to place on non-inva- bedtime. The time in staff had initialed it	ration Administration Record (18 through 03/31/18 indicated asive mechanical ventilator at indicated was 9:00 PM and the indicating the device had been no time indicating what time oved.				
	Respiratory Therap where Resident #11 accepted residents required a ventilator #1 stated that Resident #1 stated that Resident admitted to the facilinon-invasive mechanism of 2017 the hold on admitting rethat required the us mechanical ventilate around November of told by the former Aresume admissions required the ventilate required the mechanism of the mechanism of the state of the ventilate required the mechanism of the state of	anical ventilator at night to tory failure. RT #1 explained facility had put a temporary esidents with tracheostomy's e of the non-invasive or. He further explained or December of 2017 he was dministrator they could of those residents that tors as long as they only nical ventilator for 8 hours a stated if a resident required				
	the non-invasive me	echanical ventilator more than the resident could not be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 835	discharged to a traditi explained if there was bedtime the nurse on Resident #11 on the rountilator and then the morning would general further explained the #11 usually went on the came off in the morning. During an observation 3:45 PM of Resident acontained inside the rountilator greater than wentilator greater than Resident #9 was disconsident #9 was disconside	or they would have to be conal ventilator unit. He is no RT on the unit at the unit would place non-invasive mechanical in RT that was on duty in the fally take him off. The RT general rule was Resident the ventilator at bedtime and ing. In with RT #1 on 03/09/18 at #10's ventilator log monitor for the ventilator RT is no dates when Resident in non-invasive mechanical in 8 hours. The no dates when Resident in non-invasive mechanical in 8 hours. The no 03/09/18 at 2:52 PM, the interest in the required in and he required in and he required in and he required in a sive mechanical ventilators is ventilation." He explained united the non-invasive was ventilator dependent Resident #11 required were readitional continuous positive ap) or the Bi-level positive ap) machines. The he had made no policy or ince he had been coming to the walked into the unit there	F	335			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 835	current Medical Direnew to the facility a visit at the facility. The facility of the facility of the period of the	on 03/12/18 at 11:41 AM, the ector (CMD) stated he was and today was only his third the CMD explained he was not an invasive mechanical eff the management of those almonologist who visited the basis. The CMD stated he facility was not equipped to at required greater than 8 support or he would have the came to work at the clinical Services (DDCS) and with the facility since a stated no one had shared as of the unit where Resident attilator equipment that was unit. on 03/13/18 at 12:16 PM, the perations (VPO) stated she eassigned to the facility in She further stated the time had given her a tour of the enical ventilators that were	F 835			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
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F 835	were trained to pla non-invasive mech remove him from to ventilator. During a follow up AM the DON expla at the facility in Au specialty unit when residents who had the non-invasive in they were transition was portrayed to here in the tracheostomy. The DON further is non-invasive mech capability to function machine. The DON residents were on devices less than require any special stated she did not residents who required in the pulmonologist and residents who required in the pulmonologist and residents who required in the pulmonologist and residents wh	was no RT on duty the nurses are Resident #10 on his nanical ventilator and could he non-invasive mechanical interview on 03/13/18 at 10:52 ained when she came to work gust 2017 she was told the re Resident #10 lived accepted tracheostomies and required nechanical ventilators when ning to go home. She stated it her as a short term unit where be decannulated (removal of and then discharged home. Intated to her knowledge the nanical ventilators had the on as a C-pap and Bi-pap on explained as long as the non-invasive ventilator 8 hours then the facility did not all license to operate. She make the decision to accept uired a non-invasive with the 1 they made decisions to accept uired non-invasive mechanical Credible Allegation of	F	335		
	Compliance 1. The Resident alleged deficient p	F835 Administration identified to be affected by the ractice.				
	At 9:30pm on 3/6/	18 Nurse #1 administered				

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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	ROVIDER OR SUPPLIER	НАВ/СН	1	STREET ADDRESS, CITY, STATE, ZIP C 5939 REDDMAN ROAD CHARLOTTE, NC 28212	CODE			
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F 835	experienced no discondition. Resider and drink without paide #1 and Nurse in preparing for be Aide #3 transferrer from the chair to the #1's call light and the NA #3 exited room another resident's call light was on. In had his right leg of his hand. NA #1 we the call light. Reside from his mouth. Nowas gray. NA #1 we room and yelled for station to get help. Nurse #2 responde #1 placed resident #1 placed resident #2 exited recrash cart. At 10:5 resident's advance #1 was a DNR. Nurse #2 assesse Vital signs were at of Nursing was now A 24 hour report we Registry, NCDHHS 3/10/18 reporting to notified by the Adm Board of Nursing was 3/10/18 by the Direct was a Root Cause #1.	dent #1. Resident #1 stress or change in his baseline at #1 swallowed his medication broblems. At 9:50pm Nurse e Aide #3 assisted resident #1 d. Nurse Aide #1 and Nurse d resident #1 via sit to stand lift he bed. NA #1 placed resident furinal within reach. NA#1 and h. At 10:45pm NA#1 exited hroom and noted resident #1's has and the call bell in hent around the bed to address hent #1's tongue was protruding has and the call bell in hent around the bed to address hent #1's tongue was protruding has and has a ran to the nurses has a ran to the sident has a ran to the sident has a ran to the nurses has a ran to the sident has	F8	335				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5939 REDDMAN ROAD CHARLOTTE, NC 28212		3/13/2016
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F 835	oxygen via trach colla not initiated for Resic NA # 1 assisted Resi Respiratory Therapis Nurse #1 with completasks which led to Nuphysician orders to a system. The IDT deresult of a lack of RT Further Root Cause A regarding the admission tracheostomies requied the admission with tracheostomies regarding admission with tracheostomies required that no residence and 1 resident and ventilation assist status while remaining the alleged deficient. "Residents with the ventilation assistance affected by the alleged residents with tracheostomics are sidents with the ventilation assistance affected by the alleged residents with tracheostomics are sidents with the ventilation assistance affected by the alleged residents with tracheostomic affected by the alleged residents with the alleged residents with tracheostomic affected by the alleged residents with the alleged residents and	Nurse #1 did not apply ar and Astral ventilation was lent #1 immediately after the dent to bed. There was no it (RT) on duty to assist etion of respiratory related urse #1 failing to follow the pply the Astral ventilation itermined this event was the staffing on 2nd shift. Analysis was conducted sion of residents with iring ventilation assistance. Ucted with the Administrator, Respiratory therapist and entative by the Division Team requirements for residents on 6/16/17. This education dents with tracheostomies would be admitted to the nice 6/16/17, 4 residents as, have been admitted in received physician's order to cance due to a decline in ag in the facility the potential to be affected by practice. Tracheostomies requiring the have the potential to be end deficient practice. dit was completed by the nice of the nice of the nice of the potential to be end deficient practice. The potential to be end deficient practice. The potential to be end deficient practice. The potential to be end of the potential to be end of the potential to be end deficient practice. The potential to be end deficient practice. The potential to be end of the potential to th	F8	35		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	В/СН		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212		03/13/2010
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F 835	Director of Nursing ar residents with trached ventilation assistance updated to reflect interacheostomy care, or donning and doffing to a more identified with the respiratory equipment assistance was transal. Systemic Measual On 3/9/18 the fact suspended by the Resolution (RVPO). Was established with by the RVPO at least adherence to the plar of administrator form on 3/10/18 by the RVD District Director of Clieducation to the Interall aspects of the plarall on 3/10/18 the Eservices provided ed Interdisciplinary Team facility's admission caresident requiring reseducation includes the Specific types of levels of respiratory synamics.	dit was completed by the and Nurse Managers, of ostomies requiring to ensure care plans were exventions including axygen administration and the Astral/Trilogy device. The ensure that requiring ventilation ferred to hospital setting. The ensure care plans were exventions including axygen administration and the Astral/Trilogy device. The ensure that requiring ventilation ferred to hospital setting. The ensure that requiring ventilation ferred to hospital setting. The ensure that requiring ventilation ferred to hospital setting. The ensure that requiring the that required the ensure that the ensure	F8	335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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BRIAN CE	NTER HEALTH & RE	HAB/CH		c	CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 835	Continued From n	ogo 94		005				
F 033	Continued From pa		F	835				
		of Nursing and Nurse Managers						
		ed nurses and nurse aides on						
		et Prevention beginning on						
		g 3/10/18 No staff will be						
		ntil the training is complete. o included ensuring staff						
		lure to provide respiratory						
		rvices such as tracheostomy						
		administration as ordered by the						
		stitute resident neglect. The						
	' •	have a no tolerance approach						
	to any deviation fro							
	" On 3/9/18 Res	spiratory Therapist/Nurse						
		ated licensed nurses using the						
	facility's policy for	Respiratory/Tracheostomy						
	Care to include su	ctioning, applying t-collar, and						
		ratory assessment.						
		Director of Nursing and Nurse						
	_	ated licensed nurses regarding						
		plan of residents with						
		quiring ventilation assistance to						
	•	ed interventions including						
		tion and donning and doffing						
		ventilation assistance are in						
	place.	Nurse Managers re-educated						
		n reporting observations of						
		heostomies requiring oxygen						
		nclude notification of the nurse						
		ot applied as required.						
		urses or nurse aides will work						
		ducation after 3/9/18.						
	" New hires (lice	ensed nurses and nurse aides)						
		y the Nurse Manager on the						
		Respiratory/Tracheostomy						
	Care during the or							
		urses and nurse aides will be						
	educated annually	, by the Nurse Manager, for						
	continued proficier	ncy in respiratory/tracheostomy						

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345243	B. WING _			C 03/13/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5939 REDDMAN ROAD CHARLOTTE, NC 28212		3/13/2016
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F 835	will review new admis clinical meeting to va respiratory equipment according to the phys." The Director of N will audit 10 residents equipment weekly for respiratory equipment physician's orders. The Director of N will audit 10 residents equipment weekly for planned interventions equipment are in place. The Director of N of this morning during and the committee w as needed. The facility will n tracheostomies that in Astral or other system assistance. All refer be reviewed by the D Services (DDCS) and for only those approved. The facility Admin implementing this according to the planned interventions are reviewed by the D Services (DDCS) and for only those approved. The facility Admin implementing this according to the planned interventions are reviewed educated to the planned interventions.	ity's policy for stomy Care. Nursing or Nurse Managers sisions daily during the lidate physician ordered at is available and applied sician's orders. Nursing or Nurse Managers is requiring respiratory in 12 weeks to ensure at applied according to the inversion of Nurse Managers is requiring respiratory in 12 weeks to ensure care in applied according to the inversion of Nurse Managers is requiring respiratory in 12 weeks to ensure care is related to respiratory in 12 weeks to ensure care in a related to respiratory in 12 weeks to ensure care in a related to respiratory in 12 weeks to ensure care in a related to respiratory in 12 weeks to ensure care in a related to respiratory in 12 weeks to ensure care in a related to respiratory in the weekly QAPI meeting ill make recommendations in a longer admit residents with require the use of the Trilogy, in that provide ventilation in that pro	F 8	35		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 835	how to properly care provide care according staff interviews also required use of non-information for the staff interviews also required use of non-information for the staff interviews also required use of non-information for the staff interviews also required use of non-information for the staff interviews also required to the staff interview also required to the staff interviews also required to the staff interview also required to the staff interviews also required to the staff interview.	eceived training regarding for tracheostomies and to ig to physician's orders. The evealed that residents who	F 83	5		
	resources are necess competently during be and emergencies. The update that assessme least annually. The faupdate this assessme facility plans for, any substantial modification assessment. The facinaddress or include: §483.70(e)(1) The facinaddress or include: §483.70(e)(1) The facinaddress or include: §483.70(e)(1) The facinaddress or include: §10 The care required considering the types physical and cognitive and other pertinent fathat population; (iii) The staff competer provide the level and resident population; (iv) The physical enviservices, and other pertinent population;	esessment. Iduct and document a ent to determine what eary to care for its residents oth day-to-day operations e facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a on to any part of this lity assessment must cility's resident population, ted to, f residents and the facility's by the resident population of diseases, conditions, e disabilities, overall acuity, acts that are present within encies that are necessary to types of care needed for the	F 83	8		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED	
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F 838	Continued From page	e 84	F 8	338			
	may potentially affect facility, including, but food and nutrition ser						
	but not limited to,	cility's resources, including					
	(iii) Services provided pharmacy, and specif (iv) All personnel, inc employees and those	al and non- medical); I, such as physical therapy, fic rehabilitation therapies; luding managers, staff (both who provide services under					
	related to resident ca	ning and any competencies					
	or other agreements	with third parties to provide t to the facility during both					
	(vi) Health information	n technology resources, electronically managing lectronically sharing					
	all-hazards approach	c assessment, utilizing an					
	facility failed to comp to include the residen	iew and staff interviews the lete the facility assessment it population of residents					
	required use of non-inventilators. The faciling Respiratory Therapis	espiratory services and who nvasive mechanical ty also failed to include to staffing in the facility vided respiratory services.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF B		345243	B. WING _	OTDEET ADDDE		03/	13/2018
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B ISS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 838	Continued From page	85	F 8	38			
	sections labeled Card and Special Treatmer Needs included ventil number of residents p zero. A section labele of staff positions reve Respiratory Therapist During an interview of Respiratory Therapist facility had accepted in	ated 11/27/17 revealed liac/Respiratory Treatments and Resident Care ators but the average per month was listed as ed staffing plan with a listing aled it was blank for 103/08/18 at 12:52 PM (RT) #1 explained the residents who had a					
	less at night. He furth 2017 the facility had padmitting residents we required the use of the ventilator but around 2017 he was told by the could resume admission required the ventilator.	puired a ventilator 8 hours or her explained in June of but a temporary hold on th tracheostomy's that e non-invasive mechanical November or December of he former Administrator they ions of those residents that as as long as they only sive mechanical ventilator					
	Pulmonologist stated facility for approximat provided a non-invasi night for residents wh and required supplem were sleeping. He ful policy or procedural coming to the facility a	n 03/09/18 at 2:51 PM, the he had been coming to the ely 2 years and the facility we mechanical ventilator at o were ventilator dependent tental ventilation when they of the stated he had made no hanges since he had been and when he walked into the ly patients established there.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345243	B. WING			1	C 1 13/2018	
	ROVIDER OR SUPPLIER			5939 REDDM	RESS, CITY, STATE, ZIP CODE IAN ROAD TE, NC 28212	1 03/	13/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 838	During a follow up int AM RT #1 stated he or RTs and he sent a text RTs and they signed explained they usuall coverage on most da from 10:00 AM to bet to see the new admiss know why the non-invor RT staffing was no assessment. During an interview or current Medical Direct facility and today was facility. He further state the non-invasive medite management of the Pulmonologist who vibasis. During an interview or Director of Nursing (Exame to work at the fives told the facility and tracheostomies and rechanical ventilator department management of the facility and tracheostomies and rechanical ventilator department management of the facility and tracheostomies and rechanical ventilator department management of the facility and tracheostomies and rechanical ventilator department management of the facility and tracheostomies and rechanical ventilator department management of the facility and tracheostomies and rechanical ventilator department management of the facility and today was facility. He further state the facility and today was facility and today was facility and today was facility.	did the staffing schedule for at message by phone to the up for shifts to work. He y had 14-16 hours of RT ys and they typically worked ween 3:00 PM and 5:00 PM asions. He stated he did not vasive mechanical ventilators t included on the facility In 03/12/18 at 11:41 AM, the stor stated he was new to the actor stated he was new to the stated he was not familiar with chanical ventilators but left mose devices up to the sited the facility on a weekly In 03/13/18 at 10:52 AM the DON) explained when she acility in August 2017 she accepted residents who had equired the non-invasive so She explained so participated with allity assessment and ed a section. She stated for the sections that and the former Administrator istrative sections. She	F	338				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345243	B. WING		C 03/13/2018
	ROVIDER OR SUPPLIER	AB/CH		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 865 SS=D	non-invasive mecha was a service the far further stated the por Respiratory Therapis included in the facility. During an interview of Vice President of Ophad been reassigned of 2017. She confirm with completion of the During an interview District Director of Costated she had work August of 2017 and with her the specificate required use of their ventilators. She state the former Administrassessment and sor helped him with it. QAPI Prgm/Plan, Dic CFR(s): 483.75(a) Quality a improvement (QAPI) §483.75(a) Quality a improvement (QAPI) §483.75(h) Disclosure of the received is closure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the received in so far as significant in the state of the secret disclosure of the secret disclos	ent should have included nical ventilators since that cility had provided. She pulation of residents and st staffing should have been by assessment. On 03/13/18 at 12:16 PM, the perations (VPO) stated she do to the facility in November med she had not participated the facility assessment. On 03/13/18 at 12:50 PM, the perations (VPO) stated she do not participated the facility assessment. On 03/13/18 at 12:50 PM, the linical Services (DDCS) ed with the facility since stated no one had shared as of the unit where residents the inon-invasive mechanical the dit was her understanding the facility me of his team had probably sclosure/Good Faith Attmpt (h)(h)(i) Description: The state of information in the state of information.	F 83		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		PLETED
		345243	B. WING		ı	C / 13/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 865	and correct quality da basis for sanctions. This REQUIREMEN' by: Based on record reversely facility's Quality Asset Committee failed to procedures and monthe committee put in 2018 following a consubsequently recited current complaint survey. The facility during two feet a pattern of the facility during two feet a pattern of the facility effective Quality Asset The findings included. This tag is cross reference to a non-inventilator or provided physician and was for residents sampled for (Resident #1).	by the committee to identify eficiencies will not be used as . T is not met as evidenced views and staff interviews the essment and Assurance maintain implemented itor these interventions that to place on February 09, applaint survey and in March 13, 2018 on the arvey. The repeat deficiency offication (F580). The adduring the facility's current the continued failure of the deral surveys of record show the deral surveys and staff of failed to notify the resident's the resident was not an average of the deral surveys or record by the sund deceased for 1 of 3 or respiratory services	F 80	35		
	regulation was cited	survey 02/09/17, this for failure to notify the an elevated Sodium (NA)				

) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345243	B. WING _			C 03/13/2018	
	1	STREET ADDRESS, CITY, STATE, ZIP COD	<u>I</u> E	03/13/2010	
н		5939 REDDMAN ROAD CHARLOTTE, NC 28212			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
)	F8	865			
nts sampled for					
Administrator on 03/13/18 ated that the Quality see met on a monthly dministrator, DON, all num Data Set (MDS) MD), and the Pharmacist explained that they talked by that had come up and curred and what the plan ON stated that they felt comfortable with the they would resolve the enext one. The DON be a facility and had a cent Plan (PIP) in place to the indicated the audits of were still in progress with no further issues at this time she planned on with the staff a little. She stated that she are staff during their shift ent and able to retain the one. She indicated that in the dath of the 3rd shift staff to for education when they places to be which aining the information.					
	A 345243 H MENT OF DEFICIENCIES JET BE PRECEDED BY FULL IDENTIFYING INFORMATION) A that was not obtained as nts sampled for ident #2). A teed with the Director of Administrator on 03/13/18 ated that the Quality dee met on a monthly diministrator, DON, all num Data Set (MDS) MD), and the Pharmacist explained that they talked by that had come up and curred and what the plan ON stated that they if from month to month the felt comfortable with the they would resolve the enext one. The DON tified issues with the enext one. The DON tified issues with the enext one. The DON tified issues with the enext one and that she indicated the audits of were still in progress with no further issues at this time she planned on with the staff a little. She stated that she are staff during their shift ent and able to retain the one She indicated that in the staff a little of the indicated that in the staff at the staff during their shift ent and able to retain the one She indicated that in the staff at the staff during their shift ent and able to retain the one of the indicated that in the staff at the staff during their shift the staff to for education when they a places to be which and any staff to for education was definitely change and it was	A. BUILDIN 345243 B. WING_ MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) About the Director of Administrator on 03/13/18 ated that the Quality deemet on a monthly diministrator, DON, all num Data Set (MDS) MD), and the Pharmacist explained that they talked by that had come up and curred and what the plan ON stated that they is from month to month the felt comfortable with the enext one. The DON biffied issues with the enext one indicated the audits of were still in progress with no further issues at this time she planned on with the staff a little. She stated that she are staff during their shift ent and able to retain the on. She indicated that in each that and the staff to for education when they replaces to be which aning the information. In building was definitely change and it was	A BUILDING 345243 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 5939 REDDMAN ROAD CHARLOTTE, NC 28212 MENT OF DEFICIENCIES JIST BE PRECEDED BY FULL LIDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION TAG PREFIX (EACH CORRECTIVE ACTION DEFICIENCY) F 865 hat was not obtained as not sampled for ident #2). cited with the Director of Administrator on 03/13/18 ataed that the Quality dee met on a monthly diministrator, DON, all num Data Set (MDS) MD), and the Pharmacist explained that they talked by that had come up and curred and what the plan ON stated that they are from month to month is felt comfortable with the they would resolve the enext one. The DON tiffed issues with the facility and had a mith Plan (PIP) in place to 6the indicated the audits ywere still in progress with no further issues at this time she planned on with the staff a little She stated that she got shift staff in the same estaff during their shift and able to retain the on. She indicated that in add the 3rd shift staff to for education when they places to be which aning the information. building was definitely	A BUILDING 345243 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DESTRUCTION OF THE APPROPRIA DESTRUCTION	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		345243	B. WING _			C	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH				STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 865	. •	e 90 le to achieve success.	F8	65			