STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to promptly provide medical care for 1 of 1 sampled residents with a fracture. (Resident #1) The findings included: Resident #1 was admitted to the facility 07/31/12 with diagnoses which included cerebral palsy, diabetes, dysphagia, dysarthria, hypertension, gastrostomy and osteoarthritis. The current care plan dated 02/03/16 for Resident #1 included the following problem areas: -Resident is dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. -Has an activity of daily living (ADL) self-care performance deficit related to musculoskeletal impairment, activity intolerance, diagnoses of cerebral palsy, left hand contracture, right shoulder subluxation. -Has impaired cognitive function/dementia or impaired thought processes related to short term memory loss, developmentally delayed.	F 309	Brian Center Shamrock acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of Quality of Care of residents. This plan of correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 from the survey conducted on March 22-23, 2016 Brian Center Shamrock□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the statement nor does it constitute an admission that any deficiency is accurate. Further, Brian Center Shamrock reserves the right to refute any deficiency on this Statement through Informal Dispute Resolution, formal appeal, and/or other administrative or legal procedures.	4/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 1 Approaches to this problem area included, ask yes/no questions in order to determine the resident's needs. -Has a communication problem related to inarticulate speech. Approaches to this problem area included, anticipate and meet needs. -Has chronic pain related to right shoulder subluxation. Approaches to this problem area included, Administer pain medication prior to treatments and therapy, if indicated or as ordered; anticipate the resident's need for pain relief and respond immediately to any complaint of pain; notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Review of nurses notes in the medical record of Resident #1 included the following: 03/06/16 9:50 PM Resident observed on bedroom floor, next to her bed on her buttocks. Full body check. Bruise noted on her right upper arm 3 centimeters X 2 centimeters. No swelling noted. Resting comfortable with call bell in reach. 03/10/16 2:02 PM Resident was transported to hospital today at 1:30 PM. Resident has a transverse fracture to right humeral, resident will receive further treatment there. 03/10/16 2:25 PM Late entry for 03/09/16 Resident had scheduled skin assessment of shift and upon inspection writer noted right arm/hand to be bruised and swollen. Resident has history of dislocated right shoulder but is able to use right arm/hand in limitation. At the time of assessment, resident was unable to move arm and reported pain when said arm was maneuvered. Order received for nurse practitioner to get X-ray.	F 309	F309 Provide Care/Services for the Highest Well Being Criteria 1. Resident #1 was transferred to the Emergency Department on 3/10/16 by the Charge Nurse for evaluation and treatment of a change of condition following a fall. Resident #1 returned to the facility on 3/10/16. Criteria 2. Current residents with a change of condition have the potential to be affected by this alleged deficient practice. The DON, ADON and Unit Manager will review all residents with a change of condition during the last 30 days to validate communication and notification, implementation of interventions and documentation of assessments. This audit will be completed by 4/15/16. Criteria 3. The DON, ADON and Unit Manager will re-educate Licensed Nursing Staff regarding the identification of change of condition, shift to shift communication and notification regarding change of condition, implementation of interventions and documentation of assessments of residents with changes of condition. This education will be completed by 4/15/16. The DON, ADON and Unit Manager will randomly review 10 residents with change of condition weekly for 12 weeks to validate the identification, communication and notification, implementation of	

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F 309	Continued From page 2 Review of physician/nurse practitioner progress notes in the medical record of Resident #1 included: 03/09/16-Seen per nursing request to follow-up edema. Noted with increased swelling right arm after fall. Complaint of pain right arm. History of cerebral palsy noted with anxiety, agitation. Right forearm with 2+ swelling noted up to elbow. Right shoulder protruding forward but history chronic dislocation. Right arm swelling, right arm pain, status post fall. X-ray right forearm, right elbow, right humerus, right shoulder. Has PRN pain medications available. A physician's order was written on 03/09/16 at 3:30 PM to X-ray right shoulder, right humerus, right elbow, right forearm, right wrist due to pain and swelling. Review of the medical record of Resident #1 noted the X-ray results were sent via Fax transmission to the facility on 03/09/16 at 11:11 PM. These results noted a transverse fracture of the right humerus with moderate displacement. Review of physician orders and the March 2016 Medication Administration Record (MAR) for Resident #1 prior to 03/10/16 noted daily dosing of 7.5 milligrams of Mobic (an anti-inflammatory medication) every day and 650 milligrams of acetaminophen as needed (PRN) every 4 hours for pain. Documentation in the March 2016 MAR for Resident #1 noted one dose of 650 milligrams of acetaminophen had been given 03/06/16 and 03/07/16. Hospital records from 03/10/16 noted Resident #1 was seen in the emergency room on 03/10/16. Hospital records noted the orthopedic physician did not feel Resident #1 was a surgical candidate so they attempted to stabilize the fractured arm in	F 309	interventions and documentation of assessment of residents with a change of condition. Opportunities will be corrected by the DON, ADON and Unit Manager as identified during these reviews. Criteria 4. The DON will review the details of these audits and trends identified during the monthly Quality Assurance and Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will make recommendations as required.	

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F 309	Continued From page 3	F 309		

a sling. Hospital records indicated there were issues with keeping the sling in place as well as pain management so Resident #1 was admitted for pain management. Hospital records indicated Dilaudid was administered for pain with concerns of further pain management due to Resident #1 not being able to ask for pain medication. Discharge orders for pain managment included acetaminophen 650 milligrams every 4 hours PRN pain and Percocet 10/325 every 4 hours PRN pain.

On 03/22/16 at 12:00 PM Nurse Aide #1 stated she had worked with Resident #1 on 03/07/16, 03/08/16 and 03/09/16. Nurse Aide #1 stated she noticed the right arm of Resident #1 was red and bruised on 03/07/16. Nurse Aide #1 stated Resident #1 complained of the right arm hurting during ADL care. Nurse Aide #1 stated as the week progressed she could tell a change in Resident #1 because she didn't propel in her chair as well as usual and that the arm appeared to progressively become more swollen. Nurse Aide #1 stated she reported the concern to nursing staff.

On 03/22/16 at 12:46 PM Nurse #1 stated he regularly worked with Resident #1 and was not aware of any new issues with the arm of Resident #1 until 03/10/16. Nurse #1 stated when he came to work on 03/10/16 at 7:00 AM no concerns were reported from the night shift nurse related to Resident #1. Nurse #1 stated as he was making rounds at the beginning of his shift he noted Resident #1 was in bed but noted something did not appear normal with her posture so he entered the room. Nurse #1 stated when he looked at the right arm of Resident #1 he noticed it was red and swollen and knew

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	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

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F 309	Continued From page 4	F 309		

something was wrong. Nurse #1 stated he was surprised that nothing that had been reported to him about Resident #1 and returned to the nursing station to try and determine what had happened. Nurse #1 stated he noticed papers on the Fax machine related to Resident #1. Nurse #1 stated the paperwork was X-ray results for Resident #1 which had been sent on 03/09/16 at 11:11 PM and were "positive" for a transverse fracture of the right humerus with moderate displacement. Nurse #1 stated he called and reported the results to the physician, family and Director of Nursing (DON) of Resident #1 that morning. Nurse #1 stated he could tell Resident #1 was in pain and gave her PRN acetaminophen. Nurse #1 reviewed the March 2016 MAR for Resident #1 and stated he must have forgotten to document administration of the acetaminophen on 03/10/16. Nurse #1 stated the nurse practitioner typically came in the building on Thursdays (03/10/16) but he did not see the nurse practitioner the morning of 03/10/16. Nurse #1 stated he never spoke to the physician of Resident #1 and eventually sent Resident #1 to the hospital for assessment because of his concern for her comfort.

On 03/22/16 at 1:53 PM Nurse #2 (that wrote the late entry nurses note on 03/10/16) stated she was on duty and responsible for the skin assessment for Resident #1 on 03/09/16. Nurse #2 stated she noticed the right arm of Resident #1 appeared to be blue/discolored and swollen and that Resident #1 was in pain when the right arm was touched. Nurse #2 stated she reported the concern to the nurse practitioner of Resident #1 on 03/09/16 and knew Resident #1 was assessed by the nurse practitioner with an X-ray ordered.

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F 309	Continued From page 5	F 309		

On 03/22/16 at 3:00 PM Nurse #3 stated she worked with Resident #1 on 03/09/16 between 3:00 PM-11:00 PM. Nurse #3 stated she assisted with the X-ray of Resident #1 on 03/09/16 and noted Resident #1 was in pain. Nurse #3 stated the X-ray results did not come back during her shift and the concern was reported during shift change to Nurse #4.

On 03/22/16 at 3:11 PM Nurse #4 stated she worked on 03/09/16 from 11:00 PM-03/10/16 at 7:00 AM but did not recall working with Resident #1 and did not recall receiving report of any concerns about Resident #1 related to pain, swelling, an X-ray or right arm pain.

On 03/22/16 at 3:51 PM the physician of Resident #1 stated he did not recall if he had been notified of the X-ray results of Resident #1 between 03/09/16-03/10/16. The physician stated if the results had been called during the night on 03/09/16 it would have gone to the on call service. The physician stated the nurse practitioner typically came in on Thursday (03/10/16) and, if Resident #1 was not in pain, it would have been appropriate for staff to wait for the nurse practitioner to assess Resident #1 the AM of 03/10/16 though ultimately, Resident #1 should have been sent to the hospital for assessment and treatment.

On 03/22/16 at 3:56 PM the nurse practitioner of Resident #1 stated when she saw Resident #1 on 03/09/16 she noted the right arm was grossly swollen and X-rays were ordered. The nurse practitioner stated she normally would be in the facility on Thursday, 03/10/16 but had taken the day off. The nurse practioner stated though she

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	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

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F 309	Continued From page 6	F 309		

had taken the day off she was available by phone and did not receive any calls about Resident #1. The nurse practitioner stated she found out about the fractured humerus of Resident #1 on 03/11/16 when she came to the facility and found the results in "her box". The nurse practitioner stated it was at that time that staff told her that Resident #1 had gone to the hospital the day before.

On 03/22/16 at 4:30 PM Nurse #5 stated she worked on 03/09/16 from 11:00 PM-03/10/16 at 7:00 AM. Nurse #5 stated the hall that Resident #1 resided was divided between herself and Nurse #4 during their shift. Nurse #5 stated she did not recall working with Resident #1 during her shift from 03/09/16-03/10/16. Nurse #5 stated she did not recall any issues with a fall or X-ray and had not been in touch with the physician of Resident #1 during her shift on 03/09/16 from 11:00 PM-03/10/16 at 7:00 AM.

On 03/22/16 at 4:45 PM the Director of Nursing (DON) stated she was aware Resident #1 had been seen by the nurse practitioner on 03/09/16 with X-rays ordered due to right arm pain/swelling and bruising. The DON acknowledged X-ray results came back late on 03/09/16 and did not understand why the nurse that worked with Resident #1 on 03/09/16 from 11:00 PM-03/10/16 at 7:00 AM was not aware of the pain/swelling of the resident's right arm or that X-rays had been ordered. The DON stated though X-ray results confirmed a fracture of the right humerus she felt it was non-emergent and could await evaluation by the nurse practitioner who typically would have been in the facility the morning of 03/10/16. The DON stated staff realized the nurse practitioner was not going to be in the facility later in the morning on 03/10/16 and contact was made with

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	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

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BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

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F 309	Continued From page 7 the physician. The DON stated the physician had been notified between 11:00 AM and 12:00 PM on 03/10/16 and instructed staff to transport Resident #1 to the hospital. The DON could not explain why Resident #1 was not sent to the hospital until 1:30 PM. The DON stated she expected nursing staff to communicate any concerns involving residents and did not understand why the nurse that worked with Resident #1 on 03/09/16 from 11:00 PM-03/10/16 at 7:00 AM was not aware of the brusing/swelling and X-ray ordered and did not report this to the oncoming nurse on 03/10/16 at 7:00 AM.	F 309		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure medications were administered as ordered for 2 of 2 sampled residents with medications reviewed. (Residents #6 and #7) The findings included: 1. Resident #7 was admitted to the facility 02/04/16 with diagnoses which included malignant neoplasm of brain, hypopituitarism, hypertension, thrombocytopenia, depression, diabetes, hyperlipidemia and dermatitis. Admission paperwork included an FL2 (a medical form completed by a physician prior to admission	F 333	F333 Residents Free of Significant Med Errors Criteria 1. The ADON completed a Medication Variance for Residents #6 and #7 on 3/23/16. Resident #7 discharged from the facility on 2/06/16. The DON contacted the Physician for Resident #6 on 3/23/16, notified him regarding the Medication Variance and received an order to clarify the frequency of Oxycodone. Criteria 2. Newly admitted and readmitted residents have the potential to be affected by this	4/15/16

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	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

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F 333	Continued From page 8 which includes diagnoses and medications) dated 02/02/16 and included the following medications: Amlodipine 10 milligrams (mg) every day Atorvastatin 20 mg every day Baclofen 10 mg three times a day Carvedilol 12.5 mg twice a day Flonase twice a day Gabapentin 300 mg three times a day Levothyroxine 50 micrograms every day Metformin 500 mg every day Pantoprazole 40 mg every day The FL2 was dated and signed on admission on 02/04/16 by the nurse practitioner of Resident #7. There were no additional physician orders in the medical record of Resident #7. Resident #7 resided in the facility from 02/04/16-02/06/16. Review of the February 2016 Medication Administration Record (MAR) for Resident #7 noted the following medications were included and administered: Amlodipine 10 mg every day Atorvastatin 20 mg every day Lasix 40 mg every day (This medication was not part of the admission orders and was administered 02/05/16 and 02/06/16). Metformin 500 mg every day Pantoprazole 40 mg every day Prednisone 20 mg every day (This medication was not part of the admission orders and was administered 02/05/16 and 02/06/16). Seroquel 50 mg every day (This medication was not part of the admission orders and was administered 02/04/16 and 02/05/16). Carvedilol 12.5 mg; two tablets, twice a day (This medication was ordered 12.5 mg, twice a day on admission) Baclofen 10 mg every 8 hours as needed (This medication was ordered to be given three times a	F 333	alleged deficient practice. The DON, ADON and Unit Manager completed and audit of current residents admitted or readmitted to the facility during the last 30 days to validate accurate transcription of physician orders. This audit was completed on 4/15/16. Criteria 3. The DON, ADON and Unit Manager re-educated Licensed Nurses on the facility policy for transcription of physician's order to include new admission and readmission orders. This education was completed on 4/15/16. The DON, ADON and Unit Manager will randomly audit 10 newly admitted or readmitted residents weekly for 12 weeks to validate accurate transcription of physician's orders. Opportunities identified as a result of these audits will be corrected daily as identified. Criteria 4. The DON will review the details of these audits and trends identified during the monthly Quality Assurance and Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will make recommendations as required.	

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F 333	Continued From page 9	F 333		

day, not as needed. Resident #7 did not receive the medication while admitted to the facility from 02/04/16-02/06/16).
The Flonase, Gabapentin and Levothyroxine included on the signed FL2 for Resident #7 were not included on the February 2016 MAR.

On 03/23/16 at 10:54 AM the Director of Nursing (DON) stated the FL2 would have been the source for admission medications for Resident #7 when admitted to the facility on 02/04/16. The DON stated the nurse that put the admission medications for Resident #7 in the electronic MAR on admission no longer worked at the facility and contact information was not available. In a follow-up interview on 03/23/16 at 12:15 PM the DON stated she had been in touch with Hospice services (Resident #7 had been under their care at the time of admission) to see if there were any medication orders that had not been included in the medical record of Resident #7. The DON stated she could not explain the inconsistencies with the admission FL2 and February 2016 MAR for Resident #7.

2. Resident #6 was admitted to the facility 12/13/15 with diagnoses which included paraplegia, restless leg syndrome and cramp and spasm.

The care plan dated 03/22/16 for Resident #6 included the problem area, Has an activity of daily living (ADL) self care performance deficit related to activity intolerance, trauma, paraplegia and bilateral foot drop. One of the approaches to the problem area was, Ensure effective pain management prior to ADL activities.

Physician progress notes in the medical record of

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	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

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F 333	Continued From page 10	F 333		

Resident #6 included:
01/18/16-Seen per nursing request to evaluate chonic pain. On Oxycodone 15 milligrams (mg) every 6 hours as needed (PRN) and Duragesic Patch. He reports increased pain to joints due to cold weather. Increase Oxycodone to 15 mg every 4 hours PRN pain.

Resident #6 was admitted to the hospital 02/25/16 and discharged back to the facility 03/01/16 with diagnoses which included urinary tract infection with sepsis, transient hypotension, diabetes and chronic pain/stable. Discharge orders from the hospital included, Oxycodone 15 mg every 4 hours as needed for pain.

Review of the March 2016 electronic Medication Administration Record (MAR) for Resident #6 noted the 15 mg of Oxycodone was entered twice on the MAR and included:
Oxycodone 15 mg, 1 tablet every 4 hours PRN pain. This was documented as given the following dates and times:
03/04/16 at 3:47 PM
03/06/16 at 8:05 PM
03/07/16 at 8:11 PM
03/08/16 at 9:05 AM, 1:12 PM, 10:56 PM
03/10/16 at 5:35 PM
03/11/16 at 8:17 AM, 6:04 PM
03/12/16 at 10:32 AM, 2:10 PM
03/13/16 at 12:41 PM, 10:48 PM
03/14/16 at 12:41 PM
03/15/16 at 9:57 AM, 3:53 PM
03/17/16 at 11:45 AM
03/19/16 at 2:48 PM, 4:42 PM
03/20/16 at 11:26 AM, 4:16 PM, 9:52 PM
03/21/16 at 3:57 PM
03/22/16 at 6:51 PM
03/23/16 at 10:12 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

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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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 11	F 333		

Oxycodone 15 mg, 1 tablet every 6 hours PRN pain. This was documented as given the following dates and times:
03/03/16 at 8:01 PM
03/04/16 at 10:40 AM
03/05/16 at 1:13 PM
03/06/16 at 10:29 AM, 4:27 PM
03/08/16 at 6:09 PM
03/11/16 at 1:21 PM
03/16/16 at 4:58 PM
03/17/16 at 5:46 PM
03/18/16 at 1:21 PM
03/19/16 at 8:26 PM

On 03/22/16 at 6:30 PM the Assistant Director of Nursing (ADON) stated nursing staff utilize the hospital discharge orders when residents were readmitted to the facility. The ADON reviewed the March 2016 electronic MAR for Resident #6 and stated the Oxycodone 15 mg every 6 hours PRN should not have been included on the MAR when Resident #6 was readmitted to the facility on 03/01/16.

On 03/23/16 at 1:25 PM Nurse #1 stated he entered the medication orders into the electronic MAR for Resident #6 when the resident was readmitted to the facility on 03/01/16. Nurse #1 stated when readmission orders were entered into the electronic MAR for Resident #6 he combined the readmission hospital discharge orders with the last physician orders available on the resident's paper medical record. Nurse #1 reviewed the electronic MAR and paper medical record of Resident #6 and stated he must have entered the Ocycodone 15 mg every 4 hours as needed from the 03/01/16 hospital discharge records and the Oxycodone 15 mg every 6 hours as needed from the December 2015 or January

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 03/23/2016

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BRIAN CENTER NURSING CARE/SHAM	**2727 SHAMROCK DRIVE CHARLOTTE, NC 28205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 12 2016 monthly physician orders (prior to when it was changed on 01/18/16) from the paper medical record of Resident #6. Nurse #1 stated the Oxycodone 15 mg every 6 hours PRN should not have been included on readmission 03/01/16 for Resident #6. On 03/23/16 at 2:30 PM the physician of Resident #6 was interviewed and stated the Oxycodone should only have been written on the March 2016 MAR as 15 mg and administered every 4 hours PRN on readmission to the facility on 03/01/16.	F 333		