STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 12/14/17. Event ID# F54X11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe orders for lab work for 2 of 6 residents reviewed for unnecessary medications (Residents #22 and 18). Findings included: 1. Resident #22 was admitted to the facility 11/18/2016 and readmitted 9/12/2017 with diagnoses including aspiration pneumonitis, chronic obstructive pulmonary disease and unspecified atrial fibrillation. The admission Minimum Data Set (MDS) assessment dated 9/19/2017 assessed the resident to be cognitively intact. A physician order for Levaquin 500 milligrams (mg) by mouth for ten days was noted to start on 12/6/2017. A physician order dated 12/6/2017 revealed Complete Metabolic Profile lab was to be drawn on 12/11/2017. A review of the chart revealed no lab work dated 12/11/2017 was in the chart. Staff were unable to	F 658	Brian Center Monroe 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 the CMS Rules of Participation. 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 December 11-14-2017. Brian Center Monroe□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.	1/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/2018

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F 658	Continued From page 1 locate the lab results. The nurse who transcribed the orders was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 12/14/2017 at 11:00 AM. She reported that the order for the lab work was not transcribed and the lab work was not obtained. She further reported she would have found the error this week when she reviewed charts of residents taking antibiotics. She concluded by reporting the lab work would be obtained on 12/15/2017 and the facility physician had been notified of the missed lab work on 12/14/2017. The facility physician was interviewed on 12/14/2017 at 12:37 PM. She reported that the labs had been ordered to be drawn on 12/18/2017 and that the resident was not harmed by missing the lab work. 2. Resident #18 was admitted to the facility on 1/20/2017 with diagnoses to include pneumonia, atrial fibrillation and end stage renal disease. The most recent quarterly MDS dated 10/11/2017 assessed the resident to be cognitively intact. A review of the physician orders dated 11/15/2017 revealed an order for lab work Complete Blood Count with differential to be drawn on 11/20/2017. A review of the chart revealed no lab work dated 11/20/2017 was in the chart. Staff were unable to locate the lab results. The nurse who transcribed the orders was not	F 658	F658 1. Resident #22 had a physician order dated 12/6/17 to obtain a Complete Metabolic Profile lab on 12/11/17. The nurse failed to transcribe the order and the lab work was not obtained. The facility MD was notified of missed lab and new order was received on 12/14/17 to obtain lab work. Resident #18 had a physician order dated 11/20/17 to obtain a Complete Blood Count with differential to be drawn on 11/20/17. The nurse failed to transcribe the order and the lab work was not obtained. The facility MD was notified of missed lab and new order was received on 12/14/17 to obtain lab work. 2. Current residents have the potential to be affected by this finding. Nurse Management audited current residents charts back 30 days to ensure that all labs that had been ordered had been obtained and results filed in the medical record. The audit was completed on 1/3/18 3. Area SDC/or designee will re-educate Licensed Nurses on the Diagnostic Services Management System. The Facility's process for Diagnostic Service Management will be as follows: The nurse will transcribe order in PCC, enter lab into E-Lab, and log into Lab Tracking System. The nurses will review Lab Tracking binder to ensure labs have been obtained and follow up initiated as necessary. Nurse Management will bring lab tracking binder to daily clinical morning meeting for review. Nurse Management/or designee will randomly audit 5 residents chart weekly x 12 weeks to ensure that all labs ordered	

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F 658	Continued From page 2 available for interview. An interview was conducted with the ADON on 12/14/2017 at 11:00 AM. She reported that the order for the lab work was not transcribed and the lab work was not obtained by the facility. The ADON further reported a hemoglobin level was drawn at the dialysis center the week of 11/20/2017, but the facility needed to look at the process for transcribing orders. The ADON concluded by stating the facility physician had been notified on 12/14/2017 of the missed lab work for 11/20/2017. The facility physician was interviewed on 12/14/2017 at 12:37 PM. She reported that the labs had been drawn at the dialysis center for the resident and the missed lab work did not harm the resident, but future labs would be referred to the dialysis center.	F 658	has been obtained, addressed, and results filed in the medical record. 4. The Director of Nursing/or designee will report findings of the audits to the QAPI committee monthly x 3 to determine the need for additional monitoring and/or education. Date of Compliance: 1/10/18	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 865		1/10/18

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F 865	Continued From page 3 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan for the annual survey dated 12/5/16 to 12/9/16, in order to achieve and maintain compliance. The facility had a repeat deficiency for 483.20 Services Meet Professional Standards. This deficiency was cited again on the current recertification survey dated 12/11/17 to 12/14/17. The repeat deficiency for failure to provide Services to Meet Professional Standards (483.20) showed a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 483.20- Based on record review, observation and staff interview the facility failed to administer orally as ordered, instead of crushed and mixed together, and administered per gastrostomy tube medications for 1 of 1 residents (Resident #2). The facility also failed to read the physician ' s orders as documented on the Medication Administration Record to verify prescribed rate when administering a continuous tube feeding and bolus water flushes for 1 of 3 residents with a gastrostomy tube (Resident # 78) during the recertification survey dated 12/5/16 to 12/9/16. Based on record review and staff interviews during the recertification survey dated 12/11/17 to 12/14/17 the facility failed to transcribe orders for lab work for 2of 6 residents for unnecessary	F 865	F865 1. The Facility Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan for the annual survey dated 12/5/16 to 12/9/16, in order to achieve and maintain compliance. The facility had a repeat deficiency for 483.20 Services Meet Professional Standards. The facility was cited again on the current recertification survey dated 12/11/17 to 12/14/17. Facility Administrator and District Director of Clinical Services conducted a Quality Assurance and Improvement Committee meeting on 1/05/18 to discuss the current survey citations from survey exit on 12/14/17. 2. All residents residing in the facility have the potential to be affected. 3. The District Director of Clinical Services reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee on 1/5/18 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. The Quality Improvement Organization has been contacted and will provide additional education for facility staff related to the Quality Assurance process. 4. The Interdisciplinary Team including the facility Medical Director will meet at	

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F 865	Continued From page 4 medications (Residents #18 and 22). A review of the medical record for Resident #18 revealed a physician ' s order for Complete Metabolic Profile to be drawn on 12/11/17. Review of Resident #18 ' s laboratory results revealed a Complete Metabolic Profile was not found for 12/11/17 and the staff were unable to locate the laboratory results. A review of Resident #22 ' s physician ' s orders revealed a Complete Blood Count with Differential ordered for 11/20/17. Review of Resident #22 ' s chart revealed no laboratory work dated 11/20/17 and staff were unable to locate the laboratory results. An interview with the Director of Nursing revealed the facility had a Quality Assurance (QA) Committee. She stated the committee consisted of the Administrator, Medical Director, Assistant Director of Nursing, Social Worker, Activities Manager, Dietary Manager, Housekeeping Manager, Maintenance Manager, Therapy Manager, Business Office Manager, Nurses Assistant Representative, the Director of Nursing, and the Pharmacy Consultant that joins the group every other month. The Director of Nursing stated the Quality Assurance Committee met at least quarterly but tries to meet monthly. The Director of Nursing stated her expectation would be that the facility would not have repeated a deficiency. She stated the plan the facility had in place for the repeat deficiency was not working and would be corrected.	F 865	least monthly to conduct the facility□s Quality Assurance and Performance Improvement meeting. Should any interdisciplinary team member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee. The District Director of Operations or designee will review the facility QAPI meeting minutes at least monthly x 3 months. Date of Compliance 1/10/18	