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 04/12/2017

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 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum	F 278	Brian Center Shamrock acknowledges receipt of the Statement of Deficiencies	5/5/17

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

Electronically Signed | 05/05/2017

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F 278	Continued From page 1 Data Set (MDS) assessment regarding skin problems for 1 of 4 sampled residents (Resident #1). The findings included: Review of Resident #1's wound care specialist note dated 03/13/2017 revealed Resident #1 had a diabetic wound on his left heel. Review of Resident #1's MDS dated 02/20/2017 revealed Section M1040 was incorrectly coded as none of the above. An interview on 04/11/2017 at 6:24 PM with the MDS Coordinator revealed Section M1040 on Resident #1 ' s MDS dated 02/20/2017 should have been coded as yes for a diabetic ulcer. She stated it was "an oversight" and the MDS for Resident #1 needed to be coded accurately. An interview on 04/11/2017 at 6:40 PM with the Regional Director of Clinical Services and revealed the quarterly MDS dated 02/20/2017 for Resident #1 was not coded accurately on Section M1040. It was not coded yes for a diabetic ulcer. She stated she expected the MDS to be coded accurately. An interview on 04/11/2017 at 6:40 PM with the Administrator revealed it was her expectation that the MDS was coded correctly and was accurate.	F 278	and proposes this Plan of Correction to the extent that the summary of finding 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 CMS 2567 from the survey conducted on 4/11/17-4/12/17. Brian Center Shamrock's response to the cited deficiencies 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. F 278 Assessment Accuracy/Coordination/Certified Criteria 1. The Resident with MR # 1 who's Quarterly Assessment ARD dated 2/20/17 identified was modified with the correct coding and submitted on 4/11/17. Criteria 2. All residents have the potential to be affected by the alleged deficient practice. The RCMD or designee will complete an audit of all current residents receiving a Quarterly and/or Comprehensive assessment during the last 14 days to verify accurate assessments of those	

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F 278	Continued From page 2	F 278	residents skin status per the RAI manual guidelines. The Resident with MR # 1 who's Quarterly Assessment ARD dated 2/20/17 identified was modified with the correct coding and submitted on 4/11/17. Criteria 3. The District Director Care Management will re-educate the Interdisciplinary Team and MDS Staff on accurate coding related to skin status on 5/5/17. The RCMD will review all completed MDSs weekly for 12 weeks to verify accurate coding of skin. The Administrator/DON will randomly review completed MDSs weekly for 12 weeks to verify accurate coding. Opportunities will be corrected as identified as a result of these audits. Criteria 4. The results of these audits will be presented by the Resident Care Management Director Weekly for 6 months at Facility QAPI meeting, and make changes or recommendations as indicated.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		5/5/17

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F 520	Continued From page 3 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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. (i) Sanctions. 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 observation record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2016. This was for a recited deficiency which was originally cited in September of 2016 and recited in April 2017 on the current complaint investigation survey. The continued failure of the	F 520	F520 QAA Committee-Member/Meet Quarterly/Plans Criteria 1. A QAPI (Quality Assurance Performance Improvement) meeting was be held on 5/3/17 to discuss F278 (MDS Accuracy/Coordination/Certified) and develop an immediate plan for improvement and to ensure practices are	

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F 520	Continued From page 4 facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1a. F278 Accurate Assessment: Based on record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment regarding skin problems for 1 of 4 sampled resident (Resident#1). On the federal recertification survey in September of 2016 the facility failed to accurately code the MDS regarding vision and provide documentation of verbal behaviors. On the current survey the facility failed to accurately code the MDS for skin problems. During an interview on 04/12/2017 at 12:41 PM with the Administrator, she stated the MDS staff person had not crossed out information once she entered it into the MDS or have a cross referencing system to be sure everything had been entered in the resident's MDS. The Quality Assurance committee meets monthly and more often if needed. She stated they had been meeting weekly about the F 278 accuracy of the MDS. The Director of Nursing had been doing audits. She stated it was her expectation that the MDS was accurate and that they would remain in compliance.	F 520	being maintained. Criteria 2. The District Director of Clinical Services provided education to the QAPI members. Education completed on 5/3/17. The District Director of Clinical Services will randomly review QAPI minutes and attend meetings when possible. Criteria 3. The QAPI committee will meet more frequently than the required quarterly meeting, meeting at least weekly for 3 months. The weekly meeting will focus on the requirements of the tag F278 (MDS Accuracy/Coordination/Certified) and the committee will develop an action plan for process improvements and deficiency correction. Criteria 4. The results of the weekly monitoring will be brought to the Monthly QAPI committee meeting to ensure quality improvement and to tract progress. The Medical Director will attend the monthly meeting as required and collaborate with the team for improvements and the QAPI plan will be adjusted according to results and success of the plan implanted.	