STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345345	A. BUILDING: _____ B. WING _____	10/4/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(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

(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;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to document treatments provided for 1 of 3 sampled residents (Resident #3) reviewed for wound care.
Resident #3 was most recently admitted on 3/24/16 and was originally admitted on 4/4/08. Admission diagnoses included: Anemia, diabetes, and seizures.

A review of the Resident #3's most recent Minimum Date Set (MDS) revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 7/21/17. The resident unable to complete the Brief Interview for Mental Status (BIMS) assessment due to the resident having been coded as rarely/never understood. The resident was coded as requiring total dependence with the assistance of two people or more bed mobility and toileting. The resident was coded as having only been out of bed once or twice during the seven day assessment period with the assistance of two people. The resident was coded as having been totally dependent for eating with the assistance of one person. The resident was coded as having had one stage 4 pressure ulcer and one unstageable, deep tissue or suspected deep tissue injury in evolution.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345345	A. BUILDING: _____ B. WING _____	10/4/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 1

A review of Resident #3's medical record revealed an order dated 9/11/17which read, Right distal (near the toes) plantar (bottom) medial (toward the inside) foot-cleanse with wound cleanser, cover with calcium alginate (a medicated dressing or bandage) and cover with dry dressing (bandage) daily and as needed. The order was documented as having been noted and Nurse #1's initials were under the word noted.

Review of Resident #3's Treatment Administration Records (TAR's) from 9/1/17 to 10/4/17 did not reveal documentation of the prescribed wound care to the right foot having been provided. Further review revealed the prescribed treatment for the right foot did not appear on the TAR from 9/1/17 to 10/4/17.

Review of Resident #3's care plan with a most recent review date of 7/19/17 revealed a focus area for pressure ulcers. The goal listed was the pressure ulcers would show signs of healing. The approaches listed included: Administer treatments as orders and observe for effectiveness.

An observation was conducted on 10/4/17 at 1:19 PM of Nurse #2 conducting a dressing change on Resident #3. Nurse #2 removed the dressing that was present on the bottom of the resident's foot. A wound was revealed under the dressing. Nurse #2 cleansed the wound with wound cleanser, patted the wound dry, applied the calcium alginate, and covered the calcium alginate and wound with an adhesive dressing.

An interview conducted with Nurse #2 on 10/4/17 at 7:05 PM revealed she was unable to locate in the electronic medical record (EMR) the order for the treatment to Resident #3's right foot. The interview continued and Nurse #2 was unable to identify where in the TAR she had signed off for the treatment having been completed for Resident #3. Nurse #3 stated she was unable to find in the TAR where the treatment for Resident #3 had been transcribed. Nurse #3 then stated the treatment for Resident #3's foot was a newer order and she did not know where the order was.

An interview conducted with the Assistant Director of Nursing (ADON) on 10/4/17 at 7:27 PM revealed the treatment for Resident #3's foot was not being signed off in the TAR because the order had not been transcribed into the TAR. The ADON stated the treatment was being provided for Resident #3 but it was not being signed off in the TAR. The ADON discovered a physician's order dated 9/11/17 which was signed off by Nurse #1 for the prescribed treatment to Resident #3's foot. The ADON further added Nurse #1 had not transcribed the order into the EMR and because it was not in the EMR it did not become a treatment to be signed off on the TAR.

An interview conducted with the Director of Nursing on 10/4/17 at 7:32 PM revealed Nurse #1 had rounded with the wound doctor on 9/11/17 when the order was written. The DON stated Nurse #1 wrote the order for the treatment to Resident #3's right foot but failed to transcribe it into the EMR and into the TAR. The DON further added it was her expectation that when an order is received from a resident's physician that it is transcribed into the EMR and the TAR. The DON further added it was her expectation that when a treatment was provided by a nurse that it would be documented in the TAR.