STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SPRUC	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews the facility failed to use proper technique when providing incontinence care for one (1) of four (4) sampled residents. (Resident #6) The findings are: Resident #6 was admitted to the facility with the diagnoses muscle weakness, spinal stenosis, and fracture of lumbar vertebrae. Review of the latest Minimum Data Set (MDS) dated 07/12/2011 revealed Resident #6 needed extensive assistance with activities of toileting and hygiene. The MDS also revealed that Resident #6 was occasionally incontinent, on a toileting program and had a urinary tract infection with in 30 days. Review of Resident #6's care plan for incontinence dated 07/13/2011 addressed urinary incontinence with a goal of of managing incontinence without signs and symptoms of urinary tract infection. Review of	F 315	F315 Incontinent Care 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #6 regarding inappropriate incontinent care by providing one to one return demonstration training with the identified caregiver by the Staff Development nurse on 10/4/11 and 10/10/11 . 2. Incontinent residents receiving incontinent care have the potential to be affected by the same deficient practice. Incontinent residents have been identified using the most recent MDS assessment. Resident care specialist and licensed nurses have been re-educated on proper incontinent care techniques by the Staff Development Coordinator on 10/21/11. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur. This will include peri-care audits which will be completed by 11/1/11. The Administrative Nursing Staff will validate proper incontinent care techniques. *"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."*	

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

Administrator 10/25/11

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 p[illegible]m participation.

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F 315	Continued From page 1 Resident #6's laboratory results revealed on 06/10/11 a urinalysis was collected which indicated a urinary tract infection. On 06/12/2011 the results of a urine culture revealed Resident #6 was positive for Escherichia coli. Resident #6 was treated with Nitrofurantoin (antibiotic medication). An observation was made on 10/04/2011 at 11:50 AM of Nursing Assistant (NA) #1 performing incontinence care for resident #6. Resident #6 was placed on the bedpan by NA #1. Resident #6 rang the call bell indicating she was finished. NA#1 went back into the room with a clean wash cloth and donned her gloves. NA #1 rolled the resident to her right side, removed the bedpan and cleaned her buttocks and anal area. NA #1 then went into the bathroom, emptied the bedpan into the commode and rinsed it. She then returned the bedpan to the resident's wardrobe while continuing to hold the soiled washcloth in her hand. NA #1 then rolled Resident #6 onto her back to clean the peri-area. NA #1 used the same wash cloth that was used for the anal area to clean her peri-area. On 10/04/2011 at 12:20 AM an interview was conducted with NA #1. NA #1 reported that she should have used a clean wash cloth to clean Resident #6's peri-area after the cleaning anal area. She reported she did this because had to stop to allow Resident #6 to use the bedpan and did not get all of the supplies that she needed. On 10/04/2011 at 1:25 PM an interview with the Staff Development Coordinator was conducted. She reported that the NA should have washed the peri-area prior to washing the buttocks and anal area. She further reported a clean wash cloth	F 315	10 random incontinent care audits will be conducted weekly for a period of 4 weeks, then monthly. Incontinent care education has been included in the orientation of new nursing staff. 4. The Director of Nursing and Assistant Director of Nursing will review data obtained during incontinent care observations, analyzing to identify patterns and trends, and reporting in monthly Quality Assessment and Assurance Committee weekly for a period of 4 weeks, then monthly for a period of 3 months and then randomly thereafter. The QA&A committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance Date of compliance: Nov. 1,2011 *"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."*	11/2/11

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F 315	Continued From page 2 should have been used to clean the peri-area not the same one that had been used to clean the anal area. On 10/05/2011 at 1:55 PM staff an interview was conducted with the Director of Nursing (DON). The DON reported that NA #1 should have used a clean wash cloth to wash the perineal area after washing the anal area.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F441 Infection Control 1.Corrective action has been accomplished for the alleged deficient practice for resident #6, by monitoring for infectious processes. Corrective action for Resident #6 has been accomplished through one to one training including return demonstration of hand washing for identified staff members. Completed on 10/4/11 and 10/10/11. 2. Infection Control rounds completed by the Nursing Home Administrator, Housekeeping Director, DON and RVPO on 10/11/11. Areas which have potential to be affected by the same alleged deficient infection control practices were observed. *"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."*	

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F 441	Continued From page 3 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to use proper infection control procedures while performing incontinence care for one (1) of four (4) sampled residents. (Resident #6) The findings are: An Observation was made on 10/04/2011 at 11:50 AM of Nursing Assistant #1 performing incontinence care for Resident #6. After Resident #6 finished using the bedpan NA #1 washed her buttocks and anal area. NA #1 then took the bedpan into the bathroom to empty it, NA #1 opened the bathroom door, touching the door handle with her contaminated glove. She then turned on the faucet using her contaminated glove as well as holding the dirty wash cloth in the same hand and rinsed the bedpan. NA #1 then left the bathroom and opened the resident's wardrobe using the contaminated gloved hand. NA #1 came back and cleaned Resident #6's peri-area using the same washcloth used to clean the the anal area. NA #1 then removed her gloves, left the resident's room without washing	F 441	This includes isolation practices, hand washing, cross contamination of laundry, improper storage of ice scoop, and excessive dust. No further deficient infection control practices were noted upon rounds. 3. Measures put into place to ensure alleged deficient practice does not reoccur includes re-education for facility staff, as well as contract staff. These infection control standards will include, but not be limited to policies regarding hand washing. Administrative nursing will validate handwashing practices by completing skills validation with all staff. Ten (10) random handwashing audits will then be conducted weekly for a period of 4 weeks to include all shifts and weekends. The Interdisciplinary team will conduct infection control rounds daily, The Director of Nursing/Administrator will review the data obtained from audits and observations, analyzing for patterns/trends and reporting monthly in Quality Assessment and Assurance Committee meetings. *"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."*	

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F 441	Continued From page 4 her hands and retrieved a clean washcloth from the linen cart. NA #1 came back into the room, wet the clean washcloth and washed Resident #6's face. Resident #6's food was delivered to her room during this time. NA#1 opened the resident's silverware, milk carton and straw. NA #1 then placed the straw into the milk carton touching the mouth piece. NA #1 did not wash her hands until after leaving the resident's room and walking down the hall to the shower room. NA #1 was observed to open the shower room door and then wash her hands. An interview was conducted with NA #1 on 10/04/2011 at 12:20 PM. NA #1 reported she should have washed her hands after removing her gloves, prior to fixing Resident #6's food and touching her silverware and straw. NA #1 offered no explanation as to why she did not wash her hands after removing her gloves. An interview was conducted on 10/05/2011 at 1:25 PM with the Staff Development Coordinator. She reported that staff is trained to wash their hands after removing gloves and prior to touching other objects in the room. She further reported anytime gloves are removed hands should be washed or sanitized. She reports when staff is hired they watch a series of videos which include infection control and hand washing. An interview was conducted on 10/05/2011 at 1:55 PM with the Director of Nursing (DON). The DON reported that staff should never touch any other surface with a contaminated glove. She further reported that after gloves are removed hands are to be washed prior to touching anything else.	F 441	The QA&A Committee members will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance. Date of Compliance: Nov.1,2011. *"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."*	11/2/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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