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	345128	A. BUILDING _____ B. WING _____	C 12/16/2011

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BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	620 VALLEY STREET STATESVILLE, NC 28677

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F 000	INITIAL COMMENTS No deficiencies cited as a result of complaint investigation #NC00076801. Event ID #1W9K11.	F 000		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to assist one (1) of one (1) sampled residents with making dental appointments to obtain dentures. (Resident #22) The findings are: Resident #22 was admitted to the facility on 12/14/04. Review of the resident's Annual Minimum Data Set (MDS) of 07/22/11 revealed she was assessed as not having any dental issues and being cognitively intact. Resident #22 was included on the facility's 12/12/11 listing of interviewable residents. Review of Resident #22's current plan of care, developed on 07/26/11, revealed a "problem/need" which specified that she required	F 412	1. Corrective action for the alleged deficient practice toward resident #22 was accomplished by obtaining an appointment on January 12, 2012 with a dentist who will make her dentures. 2. Residents who require dental services have the potential to be affected by the same alleged deficient practice. Therefore, the Director of Nurses and/or the Unit Managers will review all charts for consults for follow-up items that are not completed. This audit began on 12/29/11 and will be completed by 1/4/12.	1/13/12

RECEIVED
JAN 09 2012
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce McGuire | TITLE: NHA | (X6) DATE: 1-6-12

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 program participation.

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F 412	Continued From page 1 extensive assistance with Activities of Daily Living (ADL). One of the care plan's goals specified that the resident's teeth would be brushed daily. Review of Resident #22's medical record revealed a dental consult dated 10/10/11 which specified that she had eight (8) front bottom teeth and did not have dentures. This dental consult specified that prior approval had been requested for dentures. During an Interview with Resident #22 on 12/14/11 at 11:34 a.m. she voiced a concern that she wanted dentures due to only having a few remaining teeth, but was not being assisted by staff to see a dentist. The resident stated that she was examined by a dentist about three (3) months ago and staff were aware that she wanted dentures, but had not assisted her in making any follow up dental appointments to obtain dentures. Observations of the resident's teeth, at this time, revealed that she had no upper teeth and only seven (7) remaining front lower teeth. On 12/15/11 at 12:15 p.m. an interview was conducted with a Nursing Assistant (NA) #4 who regularly cared for Resident #22. The NA stated that Resident #22 only had a few remaining teeth and required assistance with oral hygiene. NA #4 further stated that Resident #22 wanted dentures, but did not recall the resident having a recent dental appointment. On 12/16/11 at 9:00 a.m. an interview was conducted with the facility's Administrator. The Administrator stated that she was aware that Resident #22, who received Medicaid benefits,	F 412	3. Measures put into place or system changes to ensure that the alleged deficient practice does not recur include: Review of consult reports by Director of Nurses and/or Unit Managers or Social Worker and the notation of needed follow –up in a tickler file to be reviewed daily in morning meeting until follow-up is complete. This tickler file was put into practice on 1/2/12. On 12/15/12 the administrator and DON began education for nurses and social worker re: providing dental services to meet our residents' needs. The IDT will report needs uncovered during the assessment process on admission, quarterly and annually. Needs will be addressed during Resident Care Management Reviews weekly. Staff nurses were inserviced on 12/22/11 to note any dental needs on 24 hour communication board which is reviewed daily by the IDT in morning meeting.	

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F 412	Continued From page 2 wanted to obtain dentures. The Administrator stated that she recalled Resident #22 going to the dentist and thought staff had arranged a follow up dental appointment for Resident #22 to have impressions made for dentures. However, the administrator further explained that she was unable to find any documentation in the resident's medical record to reflect that she had been seen by a dentist since 10/10/11 and that there was any follow-up dental appointments made since 10/10/11 to assist Resident #22 in obtaining dentures. On 12/16/11 at 9:20 a.m. the facility's Social Worker (SW) was interviewed. The SW stated that she was aware that Resident #22 wanted dentures and thought that she had a follow up dental appointment, since 10/10/11, to have impressions made for her dentures. The SW was unable to find documentation regarding the resident having a follow up dental appointment since 10/10/11.	F 412	Nursing staff will be inserviced by 01/07/12. New employee will receive training in orientation and inservices will be offered annually. 4. These measures are to ensure corrections are achieved and sustained: The Interdisciplinary Team which includes administrative nurses, Social Worker, Dietary Manager, Administrator will monitor the tickler file Monday through Friday and will report to the QA&A committee monthly for the next 12 months how many residents received outside resources. The QA&A committee will evaluate the effectiveness of the plan monthly and amend it as needed to correct problems and ensure continued compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		

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F 431	Continued From page 3 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of manufacturer's product recommendations, the facility failed to remove expired insulin vials from use in two (2) of six (6) medication carts. The findings are: The manufacturer's recommendation for open multi-dose vials of Novolin R and Novolog insulin revealed vials must be discarded 28 days after opening. 1. On 12/15/11 at 3:43 p.m. during an observation of medication storage, the Station 1	F 431	1. Corrective action was accomplished for the alleged deficient practice by discarding the insulin that had been opened longer than 28 days. 2. Residents who require insulin have the potential to be affected by the same alleged deficient practice. Therefore all medication carts were inspected on 12/15/11 for out-of-date medications. 3. Measures put into place or system changes to ensure that the alleged deficient practice does not recur include: Nurses check carts daily and sign off that it contains no out-of-date meds. When insulin is opened a "date opened" is written on the vial. A drop-down box has been added to the MAR for the administering nurse to verify the 28 day expiration date. This is to be performed each time insulin is scheduled before administering. The DON, SDC, and/or Unit managers began inservice education on these changes for staff nurses on 12/15/11. All nurses will be inserviced by 1/7/12. Training will be offered during orientation and annually.	1/13/12

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F 431	Continued From page 4 Cart 1 medication cart was observed to contain a 10 ml (milliliter) multi-dose vial of Novolin insulin 100 u/ml (units per milliliter). The vial was opened and in the active stock of insulin ready for resident use. The vial had been labeled with an open date of 11/15/11. A second observation revealed a 10 ml multi-dose vial of Novolin R insulin 100 u/ml. The vial was opened and in the active stock of insulin ready for resident use. The vial had been labeled with an open date of 12/14/11. On 12/15/11 at 3:45 p.m. Licensed Nurse (LN) #1 was interviewed. She stated once the vials are opened they should be discarded after 28 days. LN #1 revealed both vials of insulin were past the expiration dates and should be discarded. An interview with the Director of Nursing (DON) on 12/15/11 at 4:45 p.m. revealed based on facility policy once a multi-dose vial of insulin is opened it will expire in 28 days. The interview further revealed it is the responsibility of the third shift nurse to check the medication carts for expired medications and order back up medications if needed. The DON also indicated medication nurses are responsible for checking expiration dates on multi-dose vials prior to drawing up and administering insulin. 2. On 12/15/11 at 4:25 p.m. during an observation of medication storage, the Station 1 Cart 2 medication cart was observed to contain a 10 ml multi-use vial of Novolog insulin 100 u/ml. The vial was opened and in the active stock of insulin ready for resident use. The vial had been labeled with an open date of 11/09/11.	F 431	4. Measures to insure that corrections are achieved and sustained include: DON, SDC, and/or Unit Managers will perform evaluation of compliance with the new systems and report to QA&A committee monthly. The QA&A committee will evaluate the effectiveness of this POC and amend it if needed to correct problems and to ensure continued compliance.	

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F 431	Continued From page 5 On 12/15/11 at 4:30 p.m. LN #2 was interviewed. LN #2 revealed once a vial of insulin is opened it will expire in 28 days and should be discarded. LN #2 acknowledged the insulin was expired and should be discarded. An interview with the Director of Nursing (DON) on 12/15/11 at 4:45 p.m. revealed based on facility policy once a multi-dose vial of insulin is opened it will expire in 28 days. The interview further revealed it is the responsibility of the third shift nurse to check the medication carts for expired medications and order back up medications if needed. The DON also indicated medication nurses are responsible for checking expiration dates on multi-dose vials prior to drawing up and administering insulin.	F 431		
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	F 441		

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F 441	Continued From page 6 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 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 observations, staff interviews, review of the facility policy and record review the facility failed to follow contact precautions for one (1) of one (1) sampled resident with Clostridium Difficile. (Resident #133) The Findings included: The facility's Infection Prevention Manual (dated 2009) included a Fact Sheet for Clostridium difficile which said, "Clostridium difficile is a spore-forming bacterium that causes diarrhea and more serious intestinal conditions such as colitis, sepsis, and rarely death." The Infection Prevention Manual indicated contact precautions should be used, "while having diarrhea." In addition to gloves and hand hygiene, the Infection	F 441	1. Corrective action was accomplished for the alleged deficient practice on 12/15/11 by placing a cart with Personal Protective Equipment outside resident # 133's door and informing the staff about the need to wear PPE during her care. Resident care assignment sheets were updated to reflect current isolation needs. 2. Other residents who are identified as having illnesses requiring isolation practices have the potential to be affected by the same alleged deficient practice. Therefore, the Director of Nursing and Unit Managers surveyed the building on 12/15/11 for any other resident who needed contact precautions. Three other residents were noted to be affected by the deficient practice. Proper equipment and training with return demonstration were provided for staff beginning on 12/ 15/11.	1/13/12

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F 441	Continued From page 7 Prevention Manual, Contact Precautions included, "A. A gown should be donned prior to entering the room or resident's cubicle. B. The gown should be removed before leaving the resident's room. C. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces." Resident #133 was originally admitted to the facility on 11/11/2010 with a diagnosis of dementia. The Minimum Data Set (MDS) dated 09/20/2011 indicated the resident was incontinent of bowel and bladder and totally dependent on staff for personal hygiene. Resident #133 was readmitted from the hospital on 12/08/2011 with a diagnosis of Clostridium difficile (C-diff). Admission orders included Vancocin Hydrochloride 250 mg (antibiotic) every 6 hours for the diagnosis of C-diff. Resident #133 was placed on contact precautions. On 12/12/11 at 1:02 p.m. a sign was observed on Resident #133's door which indicated Contact Precautions. During an interview on 12/15/2011 at 10:56 a.m., the 100/200 Hall Unit Manager provided the hospital report to show the resident had tested positive for Clostridium difficile and indicated Resident #133 was on contact precautions. During an interview on 12/15/11 at 4:54 p.m., Nursing Assistant (NA) #4 was asked about any special precautions taken for Resident #133 based on the contact precautions sign on the door. NA #4 indicated she used gloves when caring for all residents but was unable to identify any additional precautions that were to be taken for Resident #133.	F 441	3. Measures put into place or system changes to ensure that the alleged deficient practice does not recur include: initial inservices 12/ 15/11-1/7/11 and with ongoing annual inservices and new hire orientation re: contact precautions; Mon–Fri. review by the DON, ADON, Unit Managers in morning meeting of each resident on contact precautions presented by Infection Control nurse. 4. Measures to insure that corrections are achieved and sustained include: DON, SDC and/or Unit Managers will analyze the information brought to morning meetings for compliance and completing Infection Control rounds weekly, noting contact precations, and will report to QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the POC and amend if needed to correct problems and to ensure continued compliance.	

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F 441	Continued From page 8 On 12/15/2011 at 4:55 p.m. Nurse # 3 was interviewed about any special precautions that were to be taken for Resident #133. Nurse # 3 shrugged his shoulders and said, "Just the gloves." On 12/16/2011 at 7:43 a.m., NA #2 and NA #3 were observed as they bathed and provided incontinent care to Resident #133. NAs #2 and 3 were wearing gloves but no gowns. During the bath NA #2 indicated the resident had been incontinent of diarrhea. NA #2 washed the stool from the resident while NA #3 held the resident onto her right side. NA #3 held the resident's contracted legs against her uniform with one hand while she reached over and wiped the resident's buttocks and rectal are with a dry towel. The NAs applied a fresh brief and completed the bath care. During an interview on 12/16/2011 at 8:08 a.m., NA #2 and #3 were interviewed about contact precautions for Resident #133. Neither NA #2 nor NA #3 was able to identify when it would be appropriate to wear a gown when caring for this resident. NA #2 said, "A gown is an extra precaution. As long as we wear gloves we don't have to wear gowns." NA #3 said, "We just wear gloves." The facility's Infection Control Nurse was unavailable for interview. During an interview on 12/16/2011 at 9:04 a.m. about contact precautions for Resident #133, the DON said, "It is our expectations for staff to follow our Infection Control Policy and Procedures with	F 441		

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F 441	Continued From page 9 contact precautions." The DON indicated there should be a cart by the door with the equipment necessary for contact precautions. On 12/16/2011 at 10:11 a.m. the 100/200 Hall Unit Manager said, "According to the Infection Control Manual we only need to wear the gown and gloves when she is actively having diarrhea. She did start back with the diarrhea yesterday, so this morning they probably should have gowned up."	F 441		

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