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

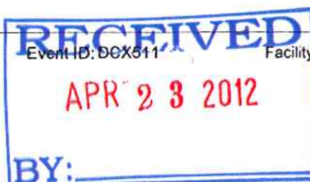
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING ______ B. WING ______	C 03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interviews and record review the facility failed to make fluids accessible to one (1) of three (3) sampled residents. (Resident #2) The findings are: Resident #2 was diagnosed with dementia and aphasia. Review of the resident's Minimum Data Set (MDS) of 02/04/12 revealed she had cognitive deficits, did not walk in room, required extensive assistance with transfers, required extensive assistance with locomotion when in a wheelchair and required only supervision with eating and drinking. The resident's current plan of care addressed the area of "Fluid Deficit" and the need to be provided with thickened liquids. Review of Resident #2's March 2012 physician's orders revealed an order for nectar thickened liquids. Observations of Resident #2 on 03/27/12 at 10:23 a.m., 11:15 a.m., 11:45 a.m. and 12:30 p.m. revealed she was seated in a wheel chair in her room and did not have fluids within her reach. A	F 246	F 246 1)Residents affected by the alleged deficient practice: Fluids were provided within reach for Resident #2 on 3/28/12. Director of Nursing (DON) began in service education for nursing staff on 4/13/12 regarding "Accommodation of needs; providing fluids accessible to residents." 2)Current facility residents have the potential to be affected by the alleged deficient practice. Director of Nursing (DON) and Unit Managers conducted rounds in facility to identify residents that were not able to access fluids in their room. Concerns identified were corrected during the rounds. Staff Development Coordinator (SDC) and DON began in service education for nursing staff on 4/13/12, regarding "Accommodation of needs; providing fluids accessible to residents." DON, Unit Managers, Charge nurses and RN supervisors will conduct rounds **" 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	4/25/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Licensed Administrator	4-20-2012

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 246	Continued From page 1 cooler in the resident's room was observed to contain nectar thickened beverages, but the cooler was not accessible to the resident. On 03/27/12 at 1:10 p.m. Resident #2 was observed in her room eating her lunch. Family members were present in the room and encouraged the resident to eat her lunch meal. The resident was observed to be able to independently consume thickened fluids that were served on her meal tray. The resident's family members stated that Resident #2 could consume fluids independently, but they needed to be within the resident's reach. The family confirmed that thickened beverages were kept in the cooler in the resident's room, but they were not accessible to the resident due to her cognitive and physical limitations. Further observations of Resident #2 on 03/27/12 at 4:35 p.m. and on 03/28/12 at 10:30 a.m. revealed she was seated in her room and did not have fluids within her reach. Observations on 3/28/12 at 10:40 a.m. revealed Resident #2 was provided medications by Licensed Nurse (LN) #1. During this observation LN #1 provided Resident #2 with fluids and the resident was observed to consume the fluids independently without difficulty. On 03/28/12 at 11:35 a.m. an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated that she provided care for Resident #2 and confirmed that the resident was able to independently consume fluids. NA #1 explained that thickened beverages were kept in cooler in Resident #2's room and staff were to offer the	F 246	daily to assure fluids are accessible to residents. 3)Systemic Changes: Staff Development Coordinator (SDC) and DON began in service education for nursing staff on 4/13/12, regarding "Accommodation of needs; providing fluids accessible to residents." DON, Unit Managers, Charge nurses, RN supervisors and Department managers will make rounds daily beginning 4/13/12, to assure fluids are accessible to residents. 4) QAA: The DON will review data obtained during compliance rounds to determine continued compliance. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan **" 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 246	Continued From page 2 fluids to the resident during the provision of care. On 03/28/12 at 1:20 p.m. Resident #2 was observed in her room eating her lunch meal independently without staff in the room. During this observation the facility's Director of Nursing (DON) was present. The DON confirmed that Resident #2 could consume fluids independently and should have thickened beverages within her reach when she was in her room.	F 246	F 315 1)Residents affected by the alleged deficient practice: Resident #3 was transferred to hospital on 11/19/11 and did not return to the facility. Director of Nursing (DON) began in service education on 4/13/12 for licensed nurses and nursing assistants regarding Policy and Procedure for monitoring urine output and characteristics of urine and documentation for residents with a catheter.	4-25-2012
F 315 SS=G	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 record review and staff interviews the facility failed to monitor the urinary output and urine characteristics to prevent urinary tract infections for one (1) of three (3) sampled residents with urinary catheters. (Resident #3) The findings are: Resident #3 was admitted to the facility on 10/17/11 with diagnoses which included wound infection and benign prostatic hypertrophy (BPH).	F 315	2)Current facility residents have the potential to be affected by the alleged deficient practice. On 4/13/12, Director of Nursing (DON) and Unit Managers identified residents with a urinary catheter and performed an audit of the chart to review documentation related to the catheter use and monitoring of urine as ordered by physician **" 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 315	Continued From page 3 The resident had an admission order for staff to provide him with suprapubic catheter care every shift and as needed. Review of Resident #3's Minimum Data Set (MDS) of 10/24/11 revealed he had no cognitive deficits, had an indwelling catheter in place and required extensive assistance with toilet use and personal hygiene. The resident's Care Area Assessment (CAA) of 10/28/11 specified that he required catheter care due to having a suprapubic urinary catheter and was bedridden. Review of Resident #3's care plan of 10/28/11 revealed the resident had a history of urinary tract infections (UTI) and had a suprapubic catheter. A care plan goal specified the resident's risk for complications of infection would be minimized with interventions during the next ninety (90) days. Care plan approaches directed nursing staff to monitor the odor, color, clarity and amount of Resident #3's urine and to notify physician as needed. Review of Resident #3's "Nursing Daily Skilled Summary" revealed there was a designated area on this sheet for nursing staff to document their assessment of the resident's urine. Further review of this documentation revealed that nursing staff had not documented any assessment of Resident #3's urine on 11/14/11, 11/15/11, 11/16/11 and 11/18/11. On 11/17/11 a physician's order was received to initiate intravenous fluids on Resident #3. Further review of Resident #3's medical record revealed the following nursing notes: Nursing note of 11/18/11 at 10:30 p.m.:	F 315	and/or policy and procedure. Staff Development Coordinator (SDC) began in service education for current licensed nurses and nursing assistants on 4/13/12, regarding Policy and Procedure for monitoring of urine output and characteristics and documentation guidelines for residents with a catheter. In service education will be provided during orientation for newly hired licensed nurses and nursing assistants. . 3)Systemic Changes: Staff Development Coordinator (SDC) began in service education for current licensed nurses and nursing assistants on 4/13/12, regarding Policy and Procedure for monitoring urine output and characteristics and documentation guidelines for residents with a catheter. In service education will be provided during **" 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 315	Continued From page 4 Intravenous (IV) site showing signs of infiltration. Infusion stopped and physician notified. Will continue to monitor. Nursing note of 11/19/11 at 6:00 a.m.: IV attempted twice without success, fluids encouraged and no complaints voiced. Nursing note of 11/19/11 (note not timed): Resident #3 reported lower abdominal pain and had no urine output in his urinary catheter bag. The note specified that Resident #3's suprapubic urinary catheter was changed and 900 cubic centimeters (cc's) of yellow, cloudy urine was drained from the resident. The note further specified that Resident #3 was sent to the hospital for an unstable heart rate. This nursing note was signed by Licensed Nurse (LN) #2. Review of Resident #3's Hospital History and Physical of 11/19/11 revealed a diagnosis of possible sepsis secondary to urinary tract infection. Review of Resident #3's Hospital Discharge Summary of 11/29/11 revealed the following discharge diagnosis; "Sepsis from urinary source with Proteus and blood cultures and E. coli and Proteus in urine culture." On 03/28/12 at 11:15 a.m. an interview was conducted with LN #2. During this interview the nurse stated that she had cared for Resident #3 on 11/19/11 during the 7:00 a.m. to 3:00 p.m. shift. LN #2 explained that when she came on duty on 11/19/11 the nursing staff who worked the prior shift (11:00 p.m. to 7:00 a.m.) did not report to her that Resident #3 had experienced	F 315	orientation for newly hired licensed nurses and nursing assistants. DON, Unit Managers and RN supervisor will review physician orders daily beginning 4/13/12 to identify residents with new orders for catheters. Residents with catheters chart will be reviewed three times a week for four weeks then weekly for three months for monitoring of urine output and characteristics and documentation according to Policy and Procedure. 4) QAA: The DON will review data obtained during chart audits and reviews. Patterns/trends will be identified and analyzed and reported in QA&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to assure continued compliance. **" 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 315	Continued From page 5	F 315		

any problems with his suprapubic catheter (including blockages) or that he was not urinating. LN #2 stated that on 11/19/11 at approximately 8:30 a.m. Resident #3 complained of abdominal pain and she administered a medication to relief the pain. The nurse stated that while caring for Resident #3 she observed there was no urine in his suprapubic catheter's collection bag, so she obtained a physician's order to change the catheter. LN #2 explained that when she changed the resident's catheter she drained approximately nine hundred (900) cc's of cloudy urine from his bladder. LN #2 stated that Resident #3's heart rate became unstable, so she then obtained orders for him to be sent to the hospital for evaluation.

Interview on 03/28/12 at 1:10 p.m. with the facility's Director of Nursing (DON) revealed that if a resident had a urinary catheter nursing staff was expected to monitor the resident's urine output during the provision of care. The DON explained that nursing staff should report any concerns observed regarding the resident's urine including color, odor and if the resident had little or no output. The DON stated that Resident #3 was not on strict fluid intake and output monitoring, but nursing staff would have been expected to provide catheter care at least every shift as ordered. The DON also stated that nursing staff were to monitor the resident's urine each shift and the nurses were expected to document an assessment of the resident's urine on the "Nursing Daily Skilled Summary" sheet. The DON confirmed that nursing staff did not document any assessment of the resident's urine on 11/14/11, 11/15/11, 11/16/11 and on 11/18/11. The DON stated that if Resident #3 had little or

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F 315	Continued From page 6 no urine output on 11/19/11, during the 11:00 p.m. to 7:00 a.m. shift, the nurse on duty should have assessed the resident and reported this concern to the oncoming shift nurse (LN #2) and to the resident's physician for possible treatment. On 03/30/12 at 10:05 a.m. an interview was conducted with Resident #3's physician. The physician stated that when Resident #3 was admitted to the facility on 10/17/11 he had diagnoses of failure to thrive, wound sepsis and other clinical conditions that made it a challenge to keep him properly hydrated. The physician explained that he did not believe Resident #3's condition warranted staff to perform strict monitoring of the resident's fluid intake and output, but staff were expected to monitor the resident's urine output for signs of dehydration and infection. The physician stated that he did not recall being informed that Resident #3 experienced any issues regarding decreased urine output or urine retention until the morning of 11/19/11. The physician confirmed that Resident #3 was diagnosed with a UTI when he was admitted to the hospital on 11/19/11, but the physician did not believe the resident's sepsis was caused from the UTI.	F 315		