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

APR 25 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/DURHAM	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to do weekly skin assessments for 2 of 4 sampled residents (Resident #2 and Resident #4) identified to be at risk for pressure ulcers. Findings include: 1. Resident # 2 was admitted to the facility on 12/16/11 diagnoses include Transverse mylelitis and Diabetes. A record review of the most recent Minimum Data	F 280	**483.20 (d) (3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE- REVISE CP** Resident #2 re- assessed by facility Director of Nursing using weekly skin check assessment form to ensure that any skin abnormalities had appropriate interventions in place. DON also reviewed the resident care plan on 4/4/12 Resident # 4 re- assessed by facility Director of Nursing using weekly skin check assessment form to ensure that any skin abnormalities had appropriate interventions in place. DON also reviewed the resident care plan on 4/4/12 Facility resident were re-assessed using weekly skin check form by facility Director of Nursing and Assisted Director of Nursing. Intervention for each resident at risk for skin breakdown was reviewed to ensure that inappropriate intervention and care plan had been initiated on 4/4/12.	4/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donald B. Joseph	Administrator	4-25-12

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.

J.F. ✓

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F 280	Continued From page 1 Set (MDS) dated 3/1/2012 indicated that the resident was cognitively intact and able to make her needs known. Resident # 2 needed extensive assistance for transfers, dressing and was totally dependent for bathing and hygiene. A review of the Care Plan dated 12/16/11 indicated that resident #2 had an actual problem identified as pressure ulcer. The pressure ulcer assessment used by the facility indicated this resident was at moderate risk for development of further pressure ulcers. The care plan also indicated the resident was at risk for skin breakdown due to incontinence and impaired mobility. The approaches for resident #2 included turning and positioning , completion and documentation of a full body assessment weekly and use of a pressure reduction mattress and chair cushion . The goal of this plan was the resident would be free of further breakdown through the next review. On 1/6/12 and 2/24/12 the care plan was reviewed and the current plan of care was to be continued. A review of the record revealed five head to toe weekly skin checks forms completed for resident #2 during January, February and March 2012. Documentation was lacking for the weeks of 1/5/2012, 1/12/2012, and 1/26/2012. In February, documentation on the Head to Toe assessment form was lacking for the weeks of 2/2/2012, 2/6/2012, and 2/13/ 2012. In March 2012, documentation on the Head to Toe assessment form was lacking for the weeks 3/19/2012, 3/26/2012, and 3/30/2012. A review of the Treatment records for resident #2 revealed that head to toe skin assessments were	F 280	Facility licensed staff was provided re- education regarding skin care management to include: skin assessments, Braden scales, weekly measurements and documentation by Staff Development coordinator completed on 4/4/12. Any staff that had not received the inservice will receive prior to work. All new nursing staff will receive this in-service upon hire during orientation beginning 4/27/12. The facility Director of Nursing or designee will complete an audit of each treatment records M-F for two weeks, then weekly x 4, monthly thereafter to ensure that all documentation is completed per physician orders. The DON will implement correction plan for trends identified. The QA&A committee will review the findings of the audit to determine effectiveness, duration, and frequency of audits going forward weekly times four, then monthly thereafter if indicated.	

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F 280	Continued From page 2 to be done weekly. The Treatment record for February and March 2012 revealed documentation was lacking for the weeks of 2/16/2012 and 2/23/2012 and 3/8/2012, 3/22/2012, 3/29/2012 for resident #2. During an observation on 4/3/12 at 3:30PM about wound care for resident #2, no concerns were observed in technique or infection control. An interview with Nurse #1 was conducted on 4/3/12 at 4:00PM and it was revealed Nurse #2 was responsible for treatments for all residents in the facility. During an interview on 4/3/12 at 4:00PM Nurse #2 indicated it was the staff nurses who completed the weekly head to toe assessments form. In addition, the staff nurses were responsible for the completion of the weekly skin assessments on the Treatment Record. Nurse #2 stated she only was responsible for wound assessments and treatments for existing wounds. During an interview on 4/4/12 at 3:30PM the Director of Nursing verified the lack of documentation for resident #2 and indicated that her expectation was that the care plan would be followed by nurses for all residents at risk for pressure ulcers and the documentation should be done by the staff nurses on the head to toe assessment form and the Treatment Administration Record. 2. Resident #4 was admitted to the facility on 1/22/2010 with diagnosis which included Cerebral Vascular Accident (C.V.A.) with right sided hemiplegia, and Diabetes. The most recent MDS dated 2/7/2012 indicated	F 280		

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F 280	Continued From page 3 the resident was totally dependent on staff for all activities of daily living including dressing, hygiene and bathing, and transfers. Extensive assistance is needed for bed mobility and the resident was incontinent of bowel and bladder. A review of the Care Plan dated 10/18/11 indicated resident #4 had an actual problem identified as pressure ulcer. The approaches for resident #4 included turning and positioning, completion and documentation of a full body assessment weekly. The goal of this plan included that the resident would be free of further breakdown through the next review. On 2/7/12 and 3/20/12 the care plan was reviewed and the current plan of care was to be continued. A review of the Head to Toe Skin Checks form for the month of March 2012 revealed that documentation was lacking 3/9/12, 3/23/12, and 3/30/12. The Treatment Administration Record was also reviewed for resident #4 for the month of March 2012 and it revealed that documentation was lacking 3/23/12 and 3/30/12. During an interview on 4/4/12 at 3:30PM the Director of Nursing verified the lack of documentation for resident #4 and indicated that her expectation was that the care plan would be followed by nurses for all residents at risk for pressure ulcers and the documentation should be done by the staff nurses on the head to toe assessment form and the Treatment Administration Record.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	**483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER**	4/27/12

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F 315	Continued From page 4 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 staff interviews and record reviews the facility failed secure a catheter tubing to prevent pulling and /or trauma for 1 of 1 (resident #2) sampled resident with an indwelling catheter. The findings include: The facility policy for Urinary Catheters revised in 2009, read in part; " secure catheter properly to prevent movement. A leg strap or tape may be used. " Resident # 2 was admitted to the facility on 12/16/11 diagnoses which included Transverse Mylelitis, Congestive Heart Failure, and Diabetes. A record review of the most recent Minimum Data Set (MDS) dated 3/1/2012 indicated the resident was cognitively intact and able to make her needs known. Resident # 2 needed extensive assistance for transfers, dressing and was totally dependent for bathing and hygiene. The MDS also indicated the resident had an indwelling catheter due to a Stage 4 sacral ulcer. A review of the Care Plan dated 12/16/11	F 315	Resident #2 has been provided a leg strap to secure the indwelling catheter properly to the resident. This was completed on 4/4/12. Each facility resident that utilize an indwelling catheter was re- assessed to assure that anchoring strap has been provided and is in place on 4/4/12. The facility will provide re-education to facility direct care staff regarding the importance of anchoring strap for each resident identified with indwelling Foley catheter to prevent excessive tension. The inservice was initiated on 4/4/12. All new nursing staff that will be hired will receive this in-service upon hire during orientation beginning 4/27/12. Any staff that has not received the inservice will receive prior to work. The Director of Nursing, Assistant Director of Nursing, and the Unit Managers will complete 1-2 sampled residents that have been identified with indwelling catheters to ensure that anchoring strap has been	

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F 315	Continued From page 5 revealed resident #2 had an indwelling catheter due to urinary retention and contamination of a pressure ulcer. The approaches included anchoring the catheter to prevent excessive tension. The goals for the care of the indwelling catheter were that resident # 2 would be free from complications related to catheter with no signs and symptoms of Urinary Tract Infections, discomfort or trauma through next review. The Care Plan was reviewed and updated 2/23/12. During an observation on 4/3/12 at 3:30PM, when NA#1 was turning resident #2, it was observed the catheter was not secured to the resident #2 ' s leg. On 4/4/12 at 10:30 AM an observation, when NA#2 entered resident #2 ' s room with the surveyor, the resident was in her bed and the observation revealed that the catheter was not anchored resident #2 ' s leg. An interview was conducted with NA #2 on 4/4/12 at 10:35AM who stated " I am not caring for this resident today and I know the catheter should be secured to the patient ' s leg to prevent pulling during care. I don ' t know why it is not secured. " On 4/4/12 at 2:30PM an interview was conducted with NA#1 and it was revealed that she was caring for resident #2 on 4/3/12 and 4/4/12. NA#1 stated that she forgot about anchoring the catheter to the patient ' s leg and knew it was important so it did not get pulled out especially during care.	F 315	provided and inplace. The audit will be documented utilizing the catheter audit tool. The audit will be conducted daily times two weeks, then weekly times four weeks, then monthly thereafter. Audits began on 4/6/12. The QA&A committee will review the findings of the audit to determine effectiveness, duration, and frequency of audits going forward weekly times four, then monthly thereafter if indicated.	