STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	969 COX RD GASTONIA, NC 28054

(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 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation. Event ID# NYVR11.	F 000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 226 SS=B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility documents and staff interviews the facility failed to check references on 2 of 5 new employees whose files were reviewed for reference checks. (Nurse Aide #1 and Nurse #1) The findings included: The facility's policy entitled "Abuse and Neglect" read in part, "The facility will screen for employees with a history of abusive behavior or who may be at risk for being abusive." During a review of new employee files it was found there was no documentation of attempts to obtain reference checks for Nursing Assistant #1 and Nurse #1. On 09/12/13 at 11:20 AM an interview was conducted with the Director of Nursing (DON) who verified it was her job to check references for new employees. The DON stated she thought she had checked the references for Nurse #1 and Nursing Assistant #1 she was unable to explain	F226	Reference checks for Nurse #1 and Nursing Assistant #1 were completed 9/13/13. Current residents have the potential to be affected All hiring Department Managers have been in-serviced by the Administrator regarding completion of reference checks prior to hire. Completed on 10/2/13. Administrator/Designee will audit with monitoring tool, all potential hire reference checks for completion weekly for three (3) months	10/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly K. Boone — TITLE: NHA — (X6) DATE: 10/3/13

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.

DHSR Mecklenburg Received OCT - 4 2013 by: PRM

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F 226	Continued From page 1 why the reference checks where not documented in their employee files. On 09/12/13 at 5:50 PM an interview was conducted with the Administrator. The Administrator stated it was his expectation for references to be checked prior to Nurse #1 and Nurse Aide #2 being hired.	F 226	Administrator/Designee will report results of audit to Quality Assurance Performance committee for a period of Three (3) months or until substantial compliance has been achieved and maintained as determined by the QAPI Committee.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility medication rate was greater than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.90% for 2 of 4 residents observed during medication pass. (Residents #9 and #79.) The findings included: 1. Resident #9 was admitted to the facility 08/24/12 with diagnoses which included diabetes mellitus and depression. A review of Resident #9's medical record revealed a physician's order dated 08/19/13 for artificial tears 2 drops to each eye twice a day for dry eyes. On 09/10/13 an observation at 5:49 PM revealed Certified Medication Aide (CMA) #1 administering	F 332	1:1 education provided to CMA #1 on Medication Administration and Five Rights of Medication Administration regarding resident #9. This education was completed on 9/11/13. No negative outcome resulted from missed Artificial Tears eye drop. Old Scopolamine patch was removed by CMA #2 from Resident #79. CMA #2 was educated on removal of old patch before placing new patch. This education was completed on 9/10/13. No negative outcome resulted from failure to remove old patch. Current residents have the potential to be affected Medication Aides have been been in-serviced by the DON/Designee regarding medication administration. Completed on 10/3/13	10/8/13

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F 332	Continued From page 2 medications to Resident #9. One drop of artificial tears was observed instilled into each eye. An interview with CMA #1 was conducted on 09/11/13 at 4:00 PM. She verified 1 drop of artificial tears was administered to Resident #9 on the afternoon of 09/10/13. CMA #1 reviewed the order on the Medication Administration Record at that time. She acknowledged the physician's order was for 2 drops of artificial tears twice a day. CMA #1 stated she thought the order was for 1 drop to be administered. An interview with the Director of Nursing (DON) was conducted on 09/12/13 at 8:10 AM. The DON stated it was her expectation that certified medication aides followed physician's orders when administering medications. 2. Resident # 79 was admitted to the facility 06/27/13 with diagnoses which included a recent stroke and diabetes mellitus. A review of Resident #79's medical record revealed a physician's order for Transdermal-Scopolamine 1.5 milligrams per 72 hours topical patch to be applied every 72 hours for secretions. The order specified to remove the old patch before applying the new one. On 09/10/13 an observation at 8:04 AM revealed Certified Medication Aide (CMA) #2 placing a Scopolamine patch behind Resident #79's right ear. The old patch was observed behind the resident's left ear. CMA #2 was observed administering the remaining medications and returning to the medication cart at 8:25 AM. She signed off the medications she just administered	F 332	DON/Designee will observe random Medication Observations of Medication Aides five (5) times a week for two (2) weeks, then three (3) times a week for two (2) weeks, then two (2) time a month for two (2) months. DON/Designee will report Results of Audit to Quality Assurance Performance Committee for a period of three (3) months or until substantial compliance has been achieved and maintained as determined by the QAPI Committee	

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F 332	Continued From page 3 on the Medication Administration Sheet and proceeded to prepare medications for the next resident. When asked about the old Scopolamine patch, she answered the resident did not have an old patch behind his right ear. CMA #2 stated she forgot to look behind the resident's left ear. She stated the old patch should have been removed before applying the new patch. An interview with the Director of Nursing (DON) was conducted on 09/12/13 at 8:10 AM. The DON stated it was her expectation that certified medication aides followed physician's orders when administering medications.	F 332		10/8/13
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	F 441	Contact Precautions discontinued for Resident #110, as results of testing were negative. Assessment completed for Resident #135 to ensure no transmission of infection. Audit completed by the Infection Control Nurse to determine any resident currently on contact precautions and to determine appropriate action needed in regards to infection control. Current resident have the potential to be affected	

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F 441	Continued From page 4 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 facility policy, record review, and resident and staff interviews the facility failed to follow contact precautions for a resident who had Extended-Spectrum Beta-lactamase (ESBL) in her urine and continued to share commode with her roommate. (Resident #110 and #135) The findings included: Facility policy entitled " Infection Prevention and Control Program " dated March 2012 read in part: "Precautions/accommodations are in place and followed as recommended for residents with transmissible infections; Equipment in transmission based precaution rooms is either dedicated to that resident and appropriately cleaned or is thoroughly cleaned and disinfected between residents using appropriate agents and procedures; Multiple use items (e.g. ....commodes ...) are	F 441	In-service conducted by the Staff Development Coordinator for direct patient care staff on the Policy and Procedure regarding Contact Precautions. Contact Precautions Monitoring Tool implemented to ensure Compliance. Contact Precautions Monitoring Tool to be completed by the Staff Development Coordinator/Designee daily for two (2) weeks; then three (3) times weekly for two (2) weeks; then once weekly for two (2) weeks; then once monthly for two (2) months. Staff Development Coordinator will report results of Contact Precautions Monitoring Tool to Quality Assurance Performance Committee for a period Of three (3) months or until Substantial compliance has been Achieved and maintained as Determined by the QAPI Committee	

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F 441	Continued From page 5 properly cleaned /disinfected between each resident use." Resident #135 was admitted to the facility on 04/19/11. Review of Resident #135's most recent Quarterly Minimum Data Set (MDS) dated 06/10/13 revealed she was cognitively intact and needed supervision to ambulate in her room and for toilet use. Resident #110 was most recently admitted to the facility 04/16/13. Review of Resident #110's most recent Annual Minimum Data Set (MDS) revealed she had moderate cognitive impairment. The MDS further assessed Resident #110 as being independent with ambulation in her room and needing the supervision of one person with toilet use. A urine culture report dated 08/22/13 revealed Resident #110 was positive for ESBL in her urine. Written on this report was, "Heplock IV (intravenous) Merepecin (sic) 1 Gram twice daily for 5 days." A physician's order dated 09/06/13 written in Resident #110's medical record read, "Clarification order: Contact precautions related to ESBL in urine." A physician's order dated 09/07/13 for Resident #110 read, "Obtain UA (urinalysis) with C&S (culture and sensitivity) post antibiotic therapy of negative may discontinue contact precautions." The results of the UA and C&S were not posted in Resident #110's record as of 09/12/13. An observation was made 09/10/13 at 9:55 AM of	F 441		

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F 441	Continued From page 6 a contact precaution sign on the door to Resident #110 and Resident #135's room. On 09/12/13 at 5:20 PM the Unit Manager (UM) was interviewed. The UM stated Resident #135 was continent of urine and she confirmed Resident #135 shared the toilet with Resident #110 during the time Resident #110 was on contact precautions for ESBL in her urine. On 09/12/13 at 5:25 PM an interview was conducted with the Infection Control Nurse (ICN). The ICN stated Resident #110 was on contact precautions because of ESBL in her urine. She stated she was not sure if the roommate, Resident #135 used the toilet as well. The ICN stated if both residents were continent of urine they should not have been sharing the same toilet. The ICN then stated Resident #110 should have had a bedside commode for her individual use. On 09/12/13 at 5:41 PM an interview was conducted with Resident #110 and her roommate Resident #135. They stated they had been roommates for a long time and they had always shared the bathroom.	F 441		