

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

10/23/13
Accepted

PRINTED: 10/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/04/2013
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HLTH & RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY RD CLAYTON, NC 27520
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F 280 SS=B	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update the Care Plan for one of one resident (Resident #1) in the selected sample, who was at high risk for fractures and sustained a fracture. Findings include:</p> <p>1. Record review indicated Resident #1 resident was admitted to the facility on 4/27/13 with cumulative diagnoses of Advanced Alzheimer's Disease, Intestinal Obstruction, Hypertension, Joint Contractures, Unspecified Arthropathy, Vitamin D Deficiency, Dysphasia, Oropharyngeal, Hyperosmolality, Hypopotassemia, and a History</p>	F 280	<p>F 280</p> <p>Resident #1's plan of care was updated on October 15, 2013 by the Resident Care Management Director (RCMD) to address the care related to left forearm edema, bruising and subsequent left humerus fracture.</p> <p>The Interdisciplinary Team will assess and update the plan of care for all Residents who sustained a bruise or fracture in the last 30 days as appropriate.</p> <p>Effective immediately and going forward on an ongoing basis, bruises or fractures sustained by a resident, will be thoroughly investigated with an emphasis on opportunities to improve quality of care and prevent such injuries. This process includes discussion by the interdisciplinary team during morning meeting with documentation of that discussion. As appropriate, the plan of care will be updated to reflect changes in status and interventional strategies.</p> <p>"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."</p>	10-28-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kathy B. Baithes INTERIM ADMINISTRATOR
TITLE
10-18-13
(X6) DATE

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 280	<p>Continued From page 1 of Osteoarthritis.</p> <p>Review of the Radiology Report from the local Medical Emergency Services completed 09/26/13 indicated a diagnosis of Osteopenia, which is a condition where bone mineral density is lower than normal. It is considered by many doctors to be a precursor to Osteoporosis.</p> <p>Interviews with staff and the attending Physician on 10/04/13 at 4:15 PM indicated Resident #1 also had diagnoses of a recent Infection/Sepsis.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment with Assessment Reference Date of 7/15/2013 indicated Resident #1 had Cognitive Patterns which included short and long term memory problems and severe impairment with Cognitive Skills for Daily Decision Making. The MDS also indicated Resident #1 was Totally Dependent on staff for most Activities of Daily Living, was Non-Ambulatory with Multiple Joint Contractures, including hands. Active Diagnoses included Hypertension and Alzheimer's Disease.</p> <p>The Nursing notes of 8/26/13 at 10:30 PM indicated, "Areas on the left elbow joint (above and below) swollen, reddish pink in color. Has mild dependent edema under left lower forearm at elbow joint. Temp. (temperature) 97.8. Has brace on left forearm and hand. The brace was removed when swelling noted. Will continue to monitor."</p> <p>No monitoring was documented in the record as mentioned on 8/26/13 after 10:30 PM when the swelling was discovered.</p> <p>The Nursing note of 8/27/13 at 6:30 AM read:</p>	F 280	<p>Residents with bruises or fractures will be reviewed at weekly comprehensive meetings and Care Plans will be updated as needed ongoing. In addition, residents with contractures will be discussed during the weekly "at risk" meeting and evaluated for care strategies which minimize potential for injury, maximize care and comfort.</p> <p>A complete audit of 5 charts (based on residents known to have sustained bruises or fractures) will be completed each month x 3 months to ensure the plan of care correctly reflects the resident's condition related to bruises or fractures. This audit will be discussed in QAPI x 3 months with Interdisciplinary Team. Based on findings, QAPI will make recommendations regarding future monitoring, training and interventions.</p> <p>The Director of Nursing is responsible for ongoing compliance with this corrective action which will be fully implemented by October 28, 2013. During this period, results of monitoring will be provided to the QAPI team for recommendations.</p> <p>"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."</p>		

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F 280	<p>Continued From page 2</p> <p>"Notified Dr. of swollen areas of left on elbow, new orders received to have X-Ray done of left elbow and to elevate the left elbow on pillows.</p> <p>Review of the initial Radiology report by the facility's contracted imaging company indicated an X-Ray of the Left Humerus was completed on 08/27/13 at 4:46 PM. The results read: Impacted fracture involving the humeral neck. The shoulder joint is grossly intact. Conclusion: Acute Left Humerus Fracture as described.</p> <p>Review of the local Emergency Services report dated 08/27/13 indicated, " (Resident #1) was admitted to the Emergency Department at 8:31 PM via stretcher from the Nursing home. Staff (referring to the Nursing Home staff) noticed bruising to the left upper arm, sent patient out for X-Ray. Per the X-Ray report, the patient with Humeral Neck Fracture. Patient transferred here (referring to ER) to be evaluated. Review of the Radiology results dated 08/27/13 completed at 11:02 PM revealed: Humerus Left; Reason: Investigation Pain. History: Left Humerus Findings: There is a minimally displaced fracture through the surgical neck of the Left Humerus, with slight anterior displacement and angulation of the distal fracture fragment. The transthoracic view is significantly compromised by overlying tissue. Diagnosis: Fracture of Humerus, proximal, Left, closed. Personalized Discharge Instructions: Keep arm in a sling until seen in follow-up. Use (name brand pain relievers) as needed for pain control and the prescribed narcotic only as needed for severe pain."</p> <p>Review of the Care Plan of 7/19/13 indicated Resident #1 was, "At risk for decline in skin integrity and circulation impairment due to splint</p>	F 280	<p>"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."</p>		

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F 280	<p>Continued From page 3</p> <p>use on bilateral hands. Also, Has ROM (Range of Motion) deficits in bilateral upper extremities and hands and is at risk for further functional loss due to decreased mobility."</p> <p>The Care Plan was not updated to address the Left Forearm Edema and Bruising, and subsequent Fracture of the Left Shoulder, which occurred on 08/26/13.</p> <p>Observation of Resident #1 on 10/03/13 from 12:45 PM - 1:20 PM and on 10/04/13 at 1:20 PM revealed Resident #1 was in bed with bilateral hand splints in place.</p> <p>Interview on 10/4/13 at 2:30 PM with MDS Nurse #1 revealed the MDS Nurse did not know why the Care Plan did not address the incident of 8/26/13 (Bruise) Left Forearm and the reason the Care Plan was not updated after the Radiology studies showed a Fracture to the Left Shoulder.</p> <p>Interview with MDS Nurse #2 on 10/4/13 at 2:40 PM revealed MDS Nurse #2 did not know why the Care Plan was not updated for incident of 8/26/13 (Bruise) Left Forearm and the reason the Care Plan was not updated after the Radiology studies showed a Fracture to the Left Shoulder.</p> <p>Interview on 10/4/13 at 3:00 PM with the Nurse #3 indicated there was no update to the Care Plan to include the incident of 8/26/13. Nurse #3 could not explain the reason the Care Plan had not been updated. Nurse #3 stated the Care Plans were usually updated after the Interdisciplinary Team (IDT) met and discussed revisions for the residents' Care Plans. There was no specific date mentioned by the Unit Coordinator to indicate when the IDT met to</p>	F 280	<p>"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."</p>		

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F 280	Continued From page 4 discuss the Care Plan for Resident #1. A staff interview with the Director of Nurses (DON) was conducted on 10/04/13 at 5:10 PM. When asked what expectations of the staff were, related to Resident #1's fractured shoulder which occurred on 08/26/13. The DON indicated, " The Care Plan should have been updated during the IDT meeting the next day (08/27/13). The expectation is that the Care Plan reflects what our IDT plan of care is."	F 280		
F 315 SS=E	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 observations, medical record review, policy review, review of the manufacturer ' s instructions, resident interview and staff interviews the facility failed to ensure three (3) of three (3) sampled residents at risk for urinary tract infections were provided appropriate incontinence care. (Residents #1, #2 and #3) Findings included:	F 315	F 315 1. Residents 1,2,3 will have perineal care provided according to facility's policy and procedure and monitored by licensed nursing staff daily for 30 days beginning October 16 th . NA s# 1,2,5,6 were in-serviced on proper perineal care of both male and female residents on October 16, 2013. 2. All direct care nursing staff will receive in-service on how to provide perineal care of the female and male resident according to the facility's P&P which follows Lippincott Manual of Nursing Practice, by October 22, 2013 "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."	10-28-13

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F 315	<p>Continued From page 5</p> <p>The facility has a procedure for " Perineal care of the male patient " and " Perineal care of the female patient " revised October 6, 2012 that read in part:</p> <p>Introduction: Perineal care, which includes care of the external genitalia and the anal area, should be performed during the daily bath and, if necessary, at bedtime and after urination and bowel movements. The procedure promotes cleanliness and prevents infection.</p> <p>A. For the male resident; Hold the shaft of the penis with one hand and wash with the other, beginning at the tip and working in a circular motion from the center to the periphery to avoid introducing microorganisms into the urethra. Use a clean section of washcloth for each stroke to prevent the spread of contaminated secretions or discharge. If using soap and water, wet a clean washcloth and rinse thoroughly, using the same circular motion.</p> <p>B. For the female resident: Implementation: Separate her labia with one hand and wash with the other, using downward strokes from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina.</p> <p>1. Resident#2 has cumulative diagnosis which included urinary retention, resolving urinary tract infection, and severe bilateral contractures of the knees and hips.</p> <p>Review of the admission MDS (Minimum Data Set) assessment dated 9/14/13 revealed the resident was alert and oriented, required extensive assistance of staff for activities of daily living (bathing and toileting) and incontinent of</p>	F 315	<p>Perineal Care for incontinent residents and for current residents who have been diagnosed with UTI in the past 90 days, will be observed by licensed nursing staff to ensure facility's P&P is followed by all staff. A Licensed nurse will conduct 10 random observations weekly X 4 weeks, then 5 observations per week X 4 weeks. Licensed nurse will monitor and assure that care is properly provided at that time, correcting any variation from policy and procedure, ensuring proper infection prevention and offering comments to assist the care provider in resident comfort and hygiene. Staff identified as needing additional in-servicing will receive in-servicing by SDC or designee immediately and it will be documented on an in-service form and kept by the SDC. This monitoring will occur from October 15-December 15, 2013.</p> <p>"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."</p>	
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F 315	<p>Continued From page 6</p> <p>stool. Record review indicated since the removal of the urinary catheter on 9/5/13 the resident had been incontinent of urine.</p> <p>Review of the careplan dated 9/9/13 and revised 9/25/13 addressed the need for incontinence care that included perineal care daily and whenever necessary.</p> <p>Observation on 10/3/13 at 2:10 pm revealed a strong urine odor upon entrance to the resident ' s room. Interview with Resident#2 at the time of the observation revealed he could not recall the last time he had been provided incontinent care that day.</p> <p>Observation of incontinence care on 10/3/13 at 2:15 pm performed by NA#5 and NA #6 was done. The resident had experienced bowel and bladder incontinence. The soiled bottom sheet linens positioned under the resident had 2 progressive pinkish and brown colored rings that had a strong urine smell. There were two 30 inch square cloth under pads that overlapped each other. The resident was lying on the soiled cloth under pads that were positioned from his back to his knees. They were wet and had progressive urine stains and bowel. The top sheet was also wet with urine. NA#6 took a dry towel and wet the ends with water and soap from the wall soap dispenser. NA#5 used this cloth towel to cleanse the resident ' s right side. This area was not rinsed. The resident was repositioned and NA#6 washed the resident ' s body on the left side with another towel that was wet with water and soap from the wall dispenser. The resident ' s skin was then dried using the other end of the towel. The resident was repositioned on his back. NA#6 folded the same wet wash cloth that was folded</p>	F 315	<p>3. All new employees will be trained to provide perineal care of the male and female resident according to facility policy and demonstrate competency in performing perineal care of the male and female resident beginning 10/17/13 and will continue with each orientation going forward.</p> <p>All direct care staff will be in-serviced twice a year on the topic of perineal care and demonstrate their skill to provide perineal care to male and female residents according to facility procedure and policy beginning October 18th, 2013</p> <p>Results of monitoring of this corrective action will be provided to the QAPI team for recommendations for 4 months. New UTIs will be tracked and trended and reported to QAPI on an ongoing basis. Tracking and trending will be used to determine the need for increased monitoring/ training in perineal care.</p> <p>“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.”</p>		

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F 315	<p>Continued From page 7</p> <p>and wiped both sides of his groin and pubis hairs. The resident 's penis was not cleansed. After the incontinence care was done, the director of nurses in the presence of NA#6 and NA#7 was showed the soiled linens removed from Resident #2 ' bed which had progressive stains of urine and a strong urine odor.</p> <p>Observation on 10/3/13 at 2:30 pm with Nurse#3 of the soap dispenser used for perineal care revealed antibacterial hand soap was in the dispenser. Review of the label on the soap container revealed manufactures instructions for hand washing to decrease bacteria on the skin.</p> <p>Interview on 10/3/14 at 2:45 pm with NA#5 revealed she used the wet towel given to her by NA#6 and did not know that it was from the soap dispenser on the wall. NA#5 indicated " We do not use that soap (referring to the soap in the dispenser) I was just assisting her to care for ____ (name of Resident#2). "</p> <p>Interview with NA#6 on 10/3/13 at 3:15 pm revealed soap in the dispenser was used because she did not see the bottle of body soap. When inquiring about incontinence care NA#6 indicated that she should have cleansed the resident 's penis. NA#6 indicated Resident#2 drinks a lot of fluids during the day.</p> <p>2. Resident#1 has cumulative diagnoses which included Alzheimer 's disease, history of sepsis and history of urinary tract infections (UTI). Review of the Quarterly Minimum Data Set (MDS) dated 7/15/2013 revealed severe cognitive impairment, totally dependent on staff for most activities of daily living, always incontinent of bowel and bladder, and multiple joint</p>	F 315	<p>The Director of Nursing is responsible for sustaining this corrective action which will be fully compliant by October 28, 2013.</p> <p>"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."</p>		

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F 315	<p>Continued From page 8 contractures.</p> <p>Review of the careplan dated 4/9/13 revealed a problem related to incontinence related to impaired cognition and contractures. The goal established were incontinence episodes to be managed without signs and symptoms of potential complications that included skin breakdown or UTI. The approaches included staff to provide perineal care daily as needed.</p> <p>Observation of incontinence care for Resident#1 on 10/3/2013 at 4:55 pm performed by (nursing assistant) NA#2 and NA #1 was done. This observation of incontinence care revealed Resident#1 had experienced urine incontinence. The resident was repositioned on her right side and her left buttock was cleansed by NA#2 using disposable wipes. NA#3 then cleansed the resident ' s rectum twice. A new brief was applied. And the resident was repositioned on her back with a pillow placed between her legs. Resident#2 ' s urinary meatus and labia were not accessible while lying on her right side due to the leg contractures. There was no attempt to reposition the resident to expose her labia and urinary meatus for cleansing. The pubis area was not cleansed.</p> <p>Interview on 10/3/13 at 5:05 pm with NA#2 revealed she wiped the resident from front to back when she was washing her rectum. I know she has contracted legs and did not want to hurt her.</p> <p>Interview on 10/3/13 at 5:05 pm with NA#2 revealed she wiped the resident from front to back when she was washing her rectum. I know she has contracted legs and did not want to hurt</p>	F 315	<p>"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."</p>		

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F 315	<p>Continued From page 9</p> <p>her. NA#2 did not provide information about why Resident#1 's pubis area was not cleansed</p> <p>Observation on 10/4/13 at 10:45 am of the incontinence care performed by NA#3 and NA#4 revealed the resident 's legs were extremely contracted at the hips and knees. The resident was repositioned on her left side. Resident#1 's urinary meatus and labia were exposed and were cleansed in a front to back motion. Resident#1 urinary meatus and labia were accessible to be cleansed without undo resistance from her contractures while positioned on her left side.</p> <p>3. Resident#3 had cumulative diagnoses which included dementia and long standing history of urinary tract infections.</p> <p>Review of the September 2013 physician orders revealed medication orders that included Augmentin 875 mg po bid for 10 days starting 9/23/13 to treat a urinary tract infection.</p> <p>Review of the quarterly MDS (Minimum Data Set) assessment dated 9/30/13 revealed the resident was cognitively impaired requiring extensive to total dependence of staff for ADL (activities of daily living).</p> <p>Review of the careplan dated 5/1/12 and revised 9/24/13 revealed a problem with incontinence of bowel and bladder. One of the interventions included the provision of perineal care daily and as needed.</p> <p>Observation on 10/3/13 at 2:50 pm revealed Resident#3 was transferred to the bed using a mechanical lift by NA#5 and NA#6. The resident had an episode of urine incontinence.</p>	F 315	<p>"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."</p>		

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

PRINTED: 10/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/04/2013
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HLTH & RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY RD CLAYTON, NC 27520		
(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 315	<p>Continued From page 10</p> <p>Resident#3 was positioned on her left side and the right buttock was cleansed with disposable skin wipes. The resident was repositioned on her right side and her left buttock was cleansed with the disposable wipes. Resident#3 was then repositioned on her back, and her pubis area was washed. A clean brief was applied. The urinary meatus and labia were not cleansed.</p> <p>Interview with NA#6 on 10/3/13 at 3:15 pm revealed she " should have washed _____ (name of Resident#3) between her legs. "</p> <p>Interview on 10/4/13 at 5:19 pm with the director of nurses and regional clinical director was held. The director of nurses indicated that her expectation was to have good perineal care provided. The expectation for female perineal care was to wash between the labia from front to back. The expectation for male perineal care was to wash the tip of the penis and wash the shaft of the penis.</p>	F 315	<p>"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."</p>		