| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345339 | A. BUILDING _____ B. WING _____ | R-C 10/15/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BRIAN CENTER HLTH & REHAB** | **1306 SOUTH KING STREET WINDSOR, NC 27983** |

| (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 441} SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | {F 441} | | 11/22/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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 441} | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to follow the policy for Bloodborne Pathogen guidelines for performing a fingerstick blood sugar for 1 of 1 residents, Resident #66. The findings included:<br>On 10/14/14, at 5:01 PM, Nurse #1 prepared to perform a fingerstick blood sugar test on Resident #66. Nurse #1 donned gloves and cleaned and pricked resident's index finger. When the glucometer failed to work properly, a second fingerstick was performed on the resident at 5:10 PM. Nurse #1 was observed to get blood on 3 of her gloved fingers, thumb, index and long finger. Nurse #1 could not get the glucometer to function with the test strip in place. She then opened the test strip bottle and took another strip out of the bottle with her bloody gloved index finger. The blood sugar was obtained at that time. Nurse #1 removed her gloves, washed her hands and took all the trash and equipment out of the room. The nurse put the bottle of test strips back in her medicine cart for further use, and wiped the glucometer with the appropriate cloth. During interview with Nurse #1, at this time, she stated she was unaware there had been blood on her fingers when she removed the test strip from the vial. With surveyor intervention, the nurse removed the bottle from the medication cart and disposed of the bottle of strips.<br>On 10/14/14 at 5:50 PM, Nurse #1 stated that she did not think anything would have happened had she used the test strips on another resident, but she didn't know.<br>An interview was conducted on 10/14/14 at 6:10 PM with the Director of Nursing (DON) and the corporate nurse consultant. The DON stated that an in-service had been completed for staff on | {F 441} | On 10-14-14, in-servicing began with licensed staff who allegedly used a bloody glove to remove a glucose test strip for a vial and placed the vial back into cart for re-use . The re- education included were to only take one test strip into the resident's room at a time to prevent cross-contamination. She was also in-serviced on the spread of infectious diseases and the disposal of any materials which may have come into contact with any bodily fluids. The education was provided by Director of Nursing.<br>The facility licensed nurses along with the Resident Care Specialists were provided re- education on prevention of the spread of infections and blood born pathogens and was completed on 10/29/14 by the Assistant Director of Nursing/Staff Development Coordinator. The contents of the re- education included : Proper hand washing techniques, disposal of contaminated vials, and the practice of taking only one test strip in the resident's room at a time.<br><br>On November 4, 2014, the Facility will host an in-service provided by Eastern Area Health Education Center(Pamela Ward, MaED MT ASCP CIC) educator on the Infection Control and Bloodborne Pathogens Update. This in-service will be video taped to using for newly hired direct care staff during orientation.. | |

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| {F 441} | Continued From page 2<br>Bloodborne Pathogens, and verified that Nurse #1 signed the attendance sheet. The DON stated that she would not expect that a nurse would put a bloody finger into the bottle of test strips. She would also expect that the test strips would be discarded since blood, seen or unseen, could cause cross contamination to another resident and /or staff member. | {F 441} | The facility Director of Nursing will observe at least 3 staff members( varies shifts) weekly times four and monthly times 90 days to ensure that all staff are using the appropriate PPE, performing proper hand washing/dis-infection techniques, and disposing all materials contaminated or possibly contaminated. The observation will be documented on the Observation Audit Tool for Infection Control.<br><br>The facility Director of Nursing or Assistant Director of Nursing will observe 2 licensed nurses while performing a finger stick blood sugar per shift weekly times four and monthly times 90 days.The observation will be documented on the Medication Pass Evaluation and the hand hygiene audit form.<br><br>Any observations of possible cross contamination or non-compliance will be corrected immediately by the Director of Nursing or the Assistant Director of Nursing. Additional Education will be provided to staff as needed by the facility Assistant Director of Nursing.<br><br>The facility Director of Nursing will report results of the medication pass observations and audits to the Quality Assurance Committee (QAPI) meeting weekly times four weeks and monthly times ninety days. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness. | |