STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility applied an antibiotic ointment to skin after incontinent care without a physician order rather than a skin protectant to 1 of 1 sampled residents. (Resident #1) Findings included: Resident #1 was admitted on 9/13/14. Diagnoses included hypertension, depression, high cholesterol and seizures. The resident was also a bilateral amputee to his bilateral lower extremities. A record review of the Minimum Data Set of the yearly assessment dated 9/25/15 revealed Resident #1 was moderately cognitively impaired. He required an extensive assist with assist of two with transfers and bed mobility and assist of one with all other ADL ' s. The resident was always incontinent of bowel and bladder. A record review revealed there were no physician orders to apply antibiotic ointment to Resident #1. The NA #8 began to do incontinent care on Resident #1 on 12/9/15 at 6:23 am. When NA #8 was completed with the care, she applied an	F 309	F309: Residents receive & facility must provide necessary care & services to attain or maintain highest practicable physical, mental & psychosocial well-being in accordance with the comprehensive care plan. Corrective Action: Resident #1 skin was assessed on 12/10/15 by the Director of Nursing, the physician was called and no new orders were given. The facility licensed staff were provided re-education by the Director of Nursing regarding the use of skin barrier, to include the physician order that is required for use of antibiotic ointment on 12/11/15. The facilities newly hired licensed nurses will receive the education during orientation. Any licensed nurses that did not receive the re-education will receive it prior to working there next scheduled shift. Identification of Others: All residents in the building requiring	1/5/16

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

Electronically Signed | 01/10/2016

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F 309	Continued From page 1 antibiotic ointment to the resident ' s buttocks and groin area. During an interview with NA #8 at this time, she was asked why she was applying antibiotic ointment and she replied " we are out of the packets of the " orange stuff " so she was told to use the green packets (antibiotic ointment). The NA reported the nurse instructed her to apply it to the resident after incontinent care was done to protect the skin. An interview with NA #8 and Nurse #2 was conducted at 6:45 am on 12/9/15. The NA showed the nurse the packets that were in her pocket that she reported she applied to the resident after incontinent care was done. The packet was green and noted to be an antibiotic ointment. The NA reported she grabbed the green packets because they were all out of the orange packets. The nurse instructed the NA at this time not to apply that to any resident; it is not the appropriate ointment. Nurse #2 further reported she did not instruct NA #8 to apply an antibiotic ointment to any resident. They are to apply two allowed skin ointments, which are both skin protectants. One of those ointments was in an orange packet. An interview with NA # ' s 2, 7, and 9 on 12/9/15 between 9:00 am and 9:15 am revealed they were never instructed to apply antibiotic ointment to any resident post incontinent care. They revealed there were two ointments that were used for skin protectants. An interview with Nurse #4 on 12/9/15 at 9:18 am revealed that he has never instructed any NA to apply an antibiotic ointment post incontinent care.	F 309	incontinent care were seen to be assured that the proper skin protectant was being used by the nursing assistant. Systemic Changes: The director of nursing and Unit manager completed skin assessments on each resident identified for incontinent care to ensure that appropriate skin barrier cream was being applied. The results of assessment will be documented on resident skin check. For newly admitted residents they will be assessed by admitting nurses for need of barrier creams. Monitoring: The director of nursing and/or unit manager will complete the observation assessment on three sampled residents identified with incontinence. The observation will be performed to ensure that appropriate barrier cream is being used, to include use of antibiotic ointments weekly times three and monthly times one. The Director of Nursing will report the results of assessment observation to the Quality Assurance Committee monthly times three. The committee will review and evaluate for further corrective action. This Plan of correction is the facilities allegation of compliance.	

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F 309	Continued From page 2 An interview with the Unit Manager on 12/9/15/ at 9:25 am revealed that no instruction was given to NA ' s to apply an antibiotic ointment to residents as a skin protectant. An interview with the Administrator on 12/10/15 at 3:45 pm revealed her expectation of NA ' s is to use the appropriate ointments for skin protectants and that an antibiotic ointment is not appropriate.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 322	F3221: NG Treatment/services. Restore	1/5/16

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F 322	Continued From page 3 interviews, the facility failed to notify a nurse of a tube-feeding pump not infusing on 1 of 1 sampled residents (Resident #115). Findings included: A record review of Resident #115 revealed the resident was admitted on 6/18/13. Diagnoses for resident included vascular dementia, hypertension, asthma, rhabdomyolosis, (a disease that breaks down the skeletal muscle) stroke, Parkinson ' s disease and failure to thrive with enteral tube feeding (PEG tube) insertion. A record review of the Minimum Data Set quarterly assessment dated 10/23/15 revealed Resident #115 was moderately cognitively impaired, an extensive assist with two assist for transfers and bed mobility and an extensive assist with one assist with other activities of daily living (ADL ' s). The resident was always incontinent of bowel and bladder and the primary source of nutrition was via a tube feed. Resident #115 is currently on palliative care and was started on tube feeding for failure to thrive. The resident ' s weight as of this record was 110 pounds and height was 67 inches. A record review of the care plans for Resident #115 revealed a care plan for weight loss/nutrition updated on 12/9/15. Approaches included monitor monthly weights, PEG tube as ordered, monitor labs, observe skin turgor and monitor for signs and symptoms of dehydration. A record review of a physician ' s order revealed a tube feed order to infuse at 75 milliliters per hour for 18 hours, start feeding at 4:00 pm and stop feeding at 10:00 am with 200 milliliters of water	F 322	Eating skills.. Corrective Action: Resident #115 attending MD was notified on 12/11/15 by the Director of Nursing. The attending MD stated to review all patients receiving tube feeding on 12/11/15 to review MD orders regarding enternal feeding and that they were being carried out and enternal feeding pump was working properly. The facility direct care nursing staff will be re-educated regarding the procedure when enternal feeding pump is alarming, to include contacting the licensed nurse immediately. All newly hired direct care staff will receive the education during orientation. Identification of Others: The attending MD stated to review all patients receiving tube feeding on 12/11/15 to review MD orders regarding enternal feeding and that they were being carried out and enternal feeding pump was working properly. Systemic Changes: All Nursing Assistants, during their orientation and as needed, will receive in-service education on the tube feeding pumps, to make sure they are informed about the proper procedure for contacting a nurse when the pump alarms. This education was completed on 12/11/15. Monitoring: The DON or designee will complete 3 observation assessments of resident	

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F 322	Continued From page 4 flushes every 4 hours. An observation of Resident #115 at 6:15 am on 12/9/15 revealed a sleeping resident. No signs of distress or discomfort. Resident #115 was connected to a tube feed pump. The tube feed machine was alarming at this time. The tube feeding tube was secured to the left side of the resident ' s abdomen. During an observation on 12/9/15 at 6:15 am of NA #8 preparing to perform incontinent care, it was noted that upon entering the resident ' s room, a tube feed pump was alarming on the roommate, Resident #115. The NA pressed a button on the pump. The pump stopped alarming. The NA did not notify the nurse. The NA left the room to " get more supplies. " Upon reentering the room, the tube feed pump for Resident #115 started alarming again. The NA pressed a button on the pump. The pump stopped alarming. The NA did not notify the nurse. The NA filled the water basin and prepared her supplies for the incontinent care. The tube feed pump for Resident #115 began to alarm again. The NA pressed a button on the tube feed pump. The pump stopped alarming. During an interview with NA #8 at 6:21 am, the NA was asked if she had training on tube feeding pumps. The NA reported, " No, we just cut if off and go and get the nurse " . The NA left the room at this time to get the nurse. She returned after a minute and reported, " I can ' t find the nurse, and it will just have to beep. " An interview with Nurse #2 on 12/9/15 at 6:30 am revealed she did not instruct the NA #8 to silence the pump. The nurse further added the NA ' s are too notify the nurse if a tube feed pump was	F 322	identified with enternal feeding weekly times three and monthly times one. The observation will be completed on various shifts to validate that enternal feedings are infusing per physician orders. The Administrator will report to the QAPI monthly for 3 months to be assured that performance & sustainability of this corrective action are maintained. This Plan of Correction is the Facilities allegation of compliance.	

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F 322	Continued From page 5	F 322		

beeping. The nurse reported that the NA did not notify her that it was beeping. The nurse entered the resident ' s room at this time and resumed feeding on the pump. The nurse confirmed that it was on " hold. "

An interview with NA #8 at 7:00 am on 12/9/15 revealed she was told by a nurse to " cut off " a pump if it is beeping and then get the nurse. The NA reported Nurse #2 was not the nurse that instructed her, but she could not remember who the nurse was. The NA revealed she has had no tube feed pump training but was shown how to " cut it off " by pressing the button on the left. The NA did not know what the button was for she only knew which one to " cut off. " The NA indicated on the pump which button that she was pressing. The button said, " Hold. " The NA was asked at this time if she knew what the button did when she pressed it she replied " no " I just " cut it off. "

An interview with NA ' s # 2, #7 and #9 on 12/9/15 between 9:00 am and 9:15 am revealed that they were never instructed by a nurse to silence or " cut off " a tube feed pump if it was beeping. They were instructed to get the nurse if it was beeping.

An interview with Nurse #4 on 12/9/15 at 9:18 am revealed NA ' s should not touch tube-feeding pumps when they are beeping, they are instructed to get the nurse. Nurse #4 reported he has never instructed any NA to silence or " cut off " a tube feed pump.

An interview with the Unit Manager on 12/9/15 at 9:25 am revealed no NA ' s should ever touch the tube feed pumps. They are instructed to get the nurse if the tube feed pump is alarming. The Unit

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F 322	Continued From page 6 Manager reported no instruction was ever given to NA #8 or any other NA to " cut off " or silence a tube-feeding pump. An interview was conducted with the Administrator on 12/10/15 at 3:45 pm. The Administrator reported that her expectation was that the NA should not have stopped the tube-feeding pump when it sounded and she expects the NA ' s to get the nurse when the tube feeding pumps are alarming.	F 322		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain sanitary conditions in 1 of 2 ice machines. The findings included: Observations made on 12/7/15 at 9:45 AM of Ice Machine #1 in the main dining room revealed a pink colored substance and a black colored mold like substance along the inside edge of the machine where the door rests when closed, as well as along the inside edge of the machine where it may touch ice.	F 371	F371 Procure food from sources approved by Federal State or local authorities. Store, prepare distribute and serve food under sanitary conditions. Corrective Action: On 12/11/15 The Ice Machine in the dining room was immediately drained and cleaned by the Maintenance Director. Also on 12/11/15 All of the resident's in	12/11/15

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F 371	Continued From page 7 Interview on 12/7/15 at 9:45 AM with the Dietary Manager, who was present for the observation, revealed she did not know who was responsible for routine cleaning of the ice machines, but that dietary staff might wipe down the machine as needed if the machine was noted to be dirty. She further stated she did not know who was responsible for draining and cleaning the inside of the ice machines, or if this was ever done. Observations made on 12/9/15 at 3:00 PM revealed no change in the presence of a pink colored substance and a black colored mold like substance inside Ice Machine #1. Interview on 12/9/15 at 3:00 PM with the Dietary Manager, who was present for the observation, revealed she had learned the maintenance department was responsible for the cleaning and maintenance of all ice machines in the facility. She stated she had not reported the condition of Ice Machine #1 to the maintenance department at that time. Interview with the Maintenance Director on 12/9/15 at 3:08 PM revealed the ice machines are drained and cleaned on a quarterly schedule by an outside company. The Maintenance Director stated it was the responsibility of the maintenance department to clean and maintain the ice machines between those cleanings. He stated any resident or employee who observed the need for maintenance or cleaning could add this to the facility Maintenance Log at any time and he would address the request. He further stated he was not aware of the current condition of the ice machine, but that he would go address it immediately. Interview on 9/10/15 at 9:30 AM with the facility Administrator revealed she was not aware of the current condition of Ice Machine #1, but that she expected all ice machines to be checked weekly for cleanliness and maintenance.	F 371	the facility had their drinking cups changed out to new ones or sent to dietary for washing & sterilization. Identification of others: Every resident in the facility had their drinking cups in their rooms changed out to new ones and/or sent to dietary for washing & sterilization. Systemic Changes: Maintenance Department will now be responsible for cleaning the ice machines monthly. A weekly check of the ice machines will be completed and documented, if they are found to need cleaning, it will be completed at that time. Monitoring: The Administrator will report the findings of these changes and their performance and sustainability to the QAPI Committee monthly times 3 months to make sure the solutions are sustained. This plan of correction is the facility's allegation of compliance.	

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F 371	Continued From page 8 Review of the facility Maintenance Log on 12/9/15 for the previous 3 months revealed no staff had reported Ice Machine #1 to the maintenance department for cleaning or maintenance.	F 371		