Amended 7-22-11

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

PRINTED: 07/07/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345128 | A. BUILDING _____ B. WING _____ | C 06/22/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE | 520 VALLEY STREET STATESVILLE, NC 28677 |

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| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident and staff interviews the facility staff failed to provide oxygen to a resident who required continuous oxygen while waiting for an eye exam and while sitting in the facility lobby in one (1) of four (4) Residents. (Resident #3)<br><br>The findings are:<br><br>Resident #3 was re-admitted to the facility on 12/06/10 with diagnoses including severe chronic obstructive pulmonary disease and difficulty with walking. A review of the quarterly Minimum Data Set (MDS) dated 04/30/11 revealed the resident had no short term or long term memory problems, and no impairment in cognition.<br><br>A review of the monthly physician order's dated June 2011 stated oxygen one to two liters per minute by nasal cannula.<br><br>A review of Resident #3's plan of care for respiratory risk included an intervention for oxygen delivery related to difficulty breathing, shortness of breath and respiratory infection. | F 309 | F 309<br>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 3 by providing a new oxygen tank at the time of discovery by the surveyor on June 22, 2011. Resident #3 was provided with oxygen according to the physician's order on that day.<br>2. Residents who require the use of oxygen therapy have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and/or Unit Managers made a list of residents with orders for continuous oxygen and began on 6/22/11 to observe these residents daily Monday through Friday for compliance with the physician's order whether they are in their room or using a portable tank.<br>3. Measures put into place or system changes to ensure that the alleged deficient practice does not recur include: The Staff Development Coordinator, Director of Nursing, or Unit Manager(s) began on 6/22/11 to conduct inservice education for Nurses, Resident<br><br>"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." | 7/17/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce McGuire — TITLE: Administrator — (X6) DATE: 7/15/11

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.

Original Signature Date: 7-10-11

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| F 309 | Continued From page 1<br><br>During an observation on 06/22/11 at 11:22 a.m. Resident #3 was sitting in the activity room in her wheelchair. An oxygen tank was attached to the back of her wheelchair but there was no tubing or nasal cannula connected from the tank to the resident. The regulator on the oxygen tank indicated the tank was empty.<br><br>During an observation on 06/22/11 at 12:13 p.m. Resident #3 was sitting in the lobby in her wheelchair with the oxygen tank attached to the back of her wheelchair and there was no oxygen tubing or nasal cannula attached from the tank to the resident.<br><br>During an observation on 06/22/11 at 12:37 p.m. Resident #3 was sitting in her wheelchair next to her bed and the oxygen tubing and nasal cannula were lying on top of her bed.<br><br>During an observation on 06/22/11 at 12:42 p.m. LN #1 entered Resident #3's room, put the nasal cannula on the resident and turned the oxygen concentrator on at two (2) liters per minute.<br><br>During an interview with Resident #3 on 06/22/11 at 12:14 p.m. she stated she has not had her oxygen on for awhile and "they took it off me and I don't know what they've done with it." She further stated she is "breathing alright for now."<br><br>During an interview with Resident #3 on 06/22/11 at 12:38 p.m. she stated "I've not had my oxygen for awhile and I'm feeling short of breath."<br><br>During an interview with LN #1 on 06/22/11 at 12:41 p.m. she stated Resident #3 wears her | F 309 | Care Specialists, Department Heads, Therapists, Housekeepers, Maintenance workers, Dietary workers regarding observing portable oxygen tanks to determine if they are empty and observing portable tanks and concentrators to determine if the cannula is in place. Nurses were charged with providing the tank before the resident leaves the room if the order is for continuous oxygen. Other staff is charged with asking the nurse for assistance if they observe an empty tank or a cannula not in place. The inservices continued until July 9 to insure that all facility staff received the training.<br>4. Measures to ensure corrections are achieved and sustained:<br>QA&A<br>Unit Managers will conduct rounds to observe oxygen administration at least 5 x week for 4 weeks and then at least 2 x week thereafter for the next year to ensure continued compliance. The Director of Nursing or Unit Manager will review data obtained during and rounds, analyze the data and report<br><br>"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." | |

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| F 309 | Continued From page 2<br>oxygen continuously and takes it off long enough to take a shower or bath. She stated she was unaware Resident #3 did not have her oxygen on until she went into her room and put it on her.<br><br>During an interview with Resident #3 on 06/22/11 at 3:00 p.m. she stated she is unable to transport herself in her wheelchair and staff usually connected her oxygen tubing to the oxygen tank on the back of her wheelchair when they transported her out of her room. She explained sometimes the oxygen in her oxygen tank on her wheelchair runs out and she calls the staff to change it. She stated she can tell when she's not getting any oxygen from the oxygen tank and she is supposed to wear the oxygen all of the time.<br><br>During an interview with LN #1 on 06/22/11 at 3:15 p.m. she verified Resident #3's physician orders were for continuous oxygen one to two liters per minute by nasal cannula. She explained Resident #3 had an appointment to see the eye doctor in the activity room this morning but she did not know who transported Resident #3 to her appointment and she she did not know when Resident #3's oxygen tank was last changed.<br><br>During an interview with the Director of Nurses (DON) on 06/22/11 at 3:53 p.m. she stated the activity room does not have oxygen concentrators and residents who need continuous oxygen should be connected to an oxygen tank on their wheelchair. She stated Resident #3 had an appointment to see an optometrist in the activity room this morning and she thought the optometry staff transported the resident to the activity room for her appointment. She stated it was her | F 309 | patterns/trends to the QA&A committee monthly for the next 12 months. The QA&A committee will evaluate the effectiveness of the above plan, and will amend the plan as needed correct problems and to ensure continued compliance. | |

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| F 309 | Continued From page 3<br>expectation the optometry staff should have put the oxygen on Resident #3 before they transported her or they should have gotten a nurse to put the oxygen on the resident.<br><br>During an interview on 06/22/11 at 3:58 p.m. the DON verified the oxygen tank on the back of Resident #3's wheelchair was empty and it should have been changed. She stated she confirmed with LN #1 that Resident #3's oxygen saturation percentage was 96% on room air after Resident #3 was returned to her room. | F 309 | | |
| 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 | F 441 | F 441<br>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1 by removing and discarding the soiled washcloth during the surveyors observation on 6/22/11 and cleaning the overbed table on the same day. s. The identified staff member<br><br>"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." | 7/17/11 |

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| F 441 | Continued From page 4<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident and staff interview the facility staff failed to properly dispose of a soiled washcloth during incontinence care for one (1) of two (2) residents. (Resident #1)<br><br>The findings are:<br><br>Resident #1 was re-admitted to the facility on 11/04/09 with diagnoses of hypertension, left (L) sided paralysis and urinary tract infection. A review of the quarterly Minimum Data Set (MDS) dated 04/02/11 revealed the resident had no short term or long term memory problems, and no impairment in cognition.<br><br>A review of the Plan of Care dated 04/05/11 for activities of daily living indicated Resident #1 was total care and required extensive assistance.<br><br>A review of the Plan of Care dated 04/05/11 for incontinence indicated Resident #1 required | F 441 | received one-on-one education regarding infection prevention practices for clean and dirty linen handling on 6/22/11<br>2. Residents who require assistance with incontinence care have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing made a list of residents who require incontinent care and assistance with bathing on 6/22/11. Residents will be added or subtracted from the list as indicated on caretracker review and Action Team reviews. Nurses and Resident Care Specialists received inservice education on 6/22/11, 6/23/11, 6/29/11, and 7/9/11 on handling Clean and Dirty linen. New Resident Care Specialists will received training on clean and dirty linen handling during orientation and all nursing department staff will receive annual inservice on the topic.<br>3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur include:The DON and the Staff Development Coordinator and the Unit Managers have | |

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| F 441 | Continued From page 5<br>incontinence care daily and as needed by nursing staff.<br><br>During an observation of Resident #1's incontinence care on 06/22/11 at 11:43 a.m. NA #2 gathered clean towels and washcloths and placed them on one side of the overbed table in Resident #1's room. NA #2 washed her hands, put on gloves and unfastened Resident #1's brief saturated with urine. She wet the washcloth, applied soap and cleaned Resident #1 front to back by turning the washcloth from one side to the other. NA #2 then placed the soiled washcloth on the top surface of Resident #1's overbed table next to the clean towels and washcloths. Resident #1 was turned to his side and NA #1 completed the incontinence care, placed her soiled washcloth inside a pad underneath the resident and assisted NA #1 with dressing Resident #1. NA #2 removed her gloves, washed her hands, put on clean gloves and took the soiled washcloth from Resident #1's overbed table with the other soiled linens out of the room to a soiled linen hamper. NA #2 went back into Resident #1's room, washed her hands and immediately went back out of the room to assist with passing meal trays to residents.<br><br>During an interview with NA #2 on 06/22/11 at 12:11 p.m. she stated she should not have put the soiled washcloth on Resident #1's overbed table but "should have put it on a soiled field." She stated she was asked by other staff to help pass meal trays to other residents and she would go back after lunch to finish cleaning Resident #1's room.<br><br>During an interview with Resident #1 on 06/22/11 | F 441 | initiated skills validations for certified nursing assistants related to infection control related to clean and soiled linen handling... The Staff Development Coordinator (SDC), Director of Nursing (DON), or Unit Manager(s) will conduct five (5) skills validations per week regarding clean and dirty linen handling until current staff have been observed. Newly hired nursing staff will have these skills validations during their orientation period and all nursing staff will be observed quarterly for the next year.<br>4. Measures to ensure corrections are achieved and sustained:QA&A<br>The Director of Nursing or Staff Development Coordinator will review data obtained during skills validations, and analyze the data and report patterns/trends to the QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. | |

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| F 441 | Continued From page 6<br>at 2:45 p.m. he stated most of the time the staff put the dirty linens on his overbed table when they bathe him or clean him up.<br><br>During an interview with the Director of Nursing (DON) on 06/22/11 at 4:00 p.m. she stated staff should not put soiled linens on a resident's overbed table. She further stated NA #2 should have immediately notified housekeeping staff to clean the overbed table after she removed the soiled washcloth from the top of it. | F 441 | | |