STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BLVD SALISBURY, NC 28144

(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 SS=D	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 observation, record review, staff and resident interviews, the facility failed to secure urinary catheter tubing for two (2) of three (3) residents with indwelling urinary catheters (Resident #4 and Resident #6). Findings include: A Facility Policy titled "Indwelling Catheter Care" revised December 2009 stated, in part, "Remove your gloves, reapply the leg band, and reattach the catheter to the leg band. If a leg band isn ' t available, tear a piece of adhesive tape from the roll. To prevent skin hypersensitivity or irritation, retape the catheter on the opposite side. Nursing alert: Provide enough slack before securing the catheter to prevent tension on the tubing ...." 1. Resident # 4 was admitted to the facility 10/12/12. Cumulative diagnoses included: anoxic brain injury with persistent vegetative state, and neurogenic (loss of bladder control) bladder which required the use of an indwelling urinary	F 315	F-315D Residents #4 and #6 were immediately assessed on 1/16/13 and anchoring support straps for the urinary catheter tubing were applied. Facility residents identified with urinary catheters were assessed by Unit Managers to ensure that anchoring support straps were in place if appropriate on 1/16/13 immediately. Care plans for current residents with urinary catheters were reviewed by Interdisclipanry team for accuracy regarding personal preference for anchoring support straps for urinary catheter tubing on 1/25/13. Facilities licensed and unlicensed nursing staff was provided re-education by the Director of Nursing/Unit Managers on implementation of anchoring support straps for urinary catheters on 1/16/13 and will be completed by 2/1/13.	2/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy S Oetsinger — TITLE: Administrator — (X6) DATE: 2/14/13

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.

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F 315	Continued From page 1 catheter. An Admission Minimum Data Set (MDS) dated 10/25/12 indicated Resident #4 was in persistent vegetative state. She required total assistance of one to two people for all areas of ADL (activities of daily living) care. The assessment noted that Resident #4 had an indwelling urinary catheter during the observation period. A Care Plan dated 10/15/12 indicated Resident #4 had an indwelling urinary catheter related to intractable pain die to illness. Approaches included: Anchor catheter to prevent excessive tension and secure catheter to facilitate flow of urine. On 1/16/13 at 2:58 PM., urinary catheter care was observed. Resident #4 was in bed and turned slightly on her left side. NA #1 and NA #2 removed the top covers. The urinary catheter tubing was not secured to Resident # 4's leg or secured by a clamp to the sheet or turning sheet. NA #1 performed urinary catheter care. On completion of care, resident was repositioned for comfort. No securement was used for the urinary catheter tubing. Both nursing assistants stated some residents had their tubing secured. NA #2 stated she had never seen Resident # 4 with her urinary catheter tubing secured with a leg strap. On 1/16/13 at 3:20 PM., NA #1 stated some residents requested leg straps and she applied them if the resident requested a leg strap or if she was instructed to apply a leg strap by the nurse. On 1/16/13 at 3:30 PM., Nurse #1 stated indwelling urinary catheters should be secured	F 315	Facilities newly hired employees will be provided education during new hire orientation regarding use and application of anchoring straps for residents identified with urinary catheters, to include action to be taken if resident does not wish to have anchoring support strap. The resident assigned nurse will check each shift to assure that anchoring leg support strap is in place for resident identified by documenting on medication record each shift. The Director of Nursing/Unit Managers will check the Medication Record and placement of anchoring catheter straps weekly times four weeks and then monthly times three. Nurses and/or Unit Managers will correct opportunities identified as a result of these observations and reviews immediately.	2/1/13

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F 315	Continued From page 2 with a leg strap. She stated Resident #4 had a shower that morning and the nursing assistant probably removed it prior to the shower and did not reapply after the bath. Nurse #1 stated Velcro securement straps that are used for the urinary tubing were readily available for staff use. On 1/16/13 at 4:15 PM., Administrative staff #1 stated suprapubic catheters (a tube that is inserted into your bladder through a small hole in your belly) would not necessarily be secured with a leg strap but indwelling urinary catheters should be secured with a leg strap. 2. Resident #6 was admitted to the facility 8/17/09. Cumulative diagnoses included: urinary retention. A Quarterly Minimum Data Set dated 10/5/12 stated that resident was cognitively intact. He required total assistance of two people for toileting. It was noted that Resident #6 had an indwelling urinary catheter during the assessment period. A Care plan dated 7/31/12 and last reviewed 10/8/12 stated Resident #6 had an indwelling urinary catheter. Approaches included: anchor catheter to prevent excess tension and secure catheter to facilitate flow of urine maintaining urinary drainage bag below level of bladder. On 1/16/13 at 3:40 PM., Resident #6 was observed in the dining room. A urinary catheter drainage bag was secured under his wheelchair. Resident #6 stated that his urinary catheter tubing was not secured with a leg strap. He stated that he used to have a leg strap and wanted one so	F 315	The results of these observations and reviews will be reported by the facility Director of Nursing during the monthly Quality Assurance committee meeting monthly times three. The committee will evaluate and make recommendations as indicated.	

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F 315	Continued From page 3 the tubing would not pull. Nurse #2 was present, palpated resident's right leg where the catheter tubing would be secured, and stated the urinary catheter tubing was not secured to Resident #6's leg. On 1/16/13 at 4:15 PM., Administrative staff #1 stated suprapubic catheters (a tube that is inserted into your bladder through a small hole in your belly) would not necessarily be secured with a leg strap but indwelling urinary catheters should be secured with a leg strap.	F 315		