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	345332	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB	2501 DOWNING STREET SW WILSON, NC 27895

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, pharmacist, and MD interviews, the facility did not accurately transfer a medication order for eye drops onto the resident ' s medication administration record, and did not follow up with the pharmacy to clarify an order for eye drops for one of one resident reviewed for new admission medication orders, Resident #224. Findings included: A review of the Nursing Admission Data Collection assessment dated 12/01/2015 revealed Resident #224 was admitted from a local hospital on 12/01/2015, that he was cognitively intact, and that he required limited assistance with bed mobility and transfers. A review of the discharge summary and medication orders dated 12/01/2015 from the hospital revealed an order for Tobradex eye drops (tobramycin-dexamethasone, an antibiotic/anti-inflammatory eye medication), 0.3-0.1 % drops, 1 drop in both eyes, four times per day. In an observation of medication administration for the resident on 12/03/2015 at 10:00 AM, Nurse #3 checked the medication administration record (MAR) as she removed each of Resident #224 ' s oral medications from the drawers of the medication cart and placed them in a cup. Nurse #3 noted that there were no	F 281	Resident #224 eye drop medication order was clarified on 12-3-15 and the Medication Administration Record (MAR) was updated to reflect the new order All residents have the potential to be affected by the alleged deficient practice. All residents medication will be reviewed for potential errors and corrections made if necessary with the physician being notified. All new admission orders will be entered by a licensed nurse and a second check performed by another licensed nurse for accuracy. The DON or designee will do a third review of the orders for accuracy. All other orders written for existing residents will be reviewed in our daily morning meeting for accuracy by the DON of designee. All licensed nurses will be in-serviced on ordering and receiving medication and obtaining timely clarification of orders with utilization of Point Click Care. The DON or designee will audit all new admission orders and randomly select 5 existing residents orders for review weekly X 4 weeks. Results of the audits will be brought to the QAPI Committee meeting	12/31/15

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

Electronically Signed | 12/28/2015

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F 281	Continued From page 1 tobramycin-dexamethasone eye drops or ointment in the cart. Nurse #3 also noted that the Tobradex eye drop medication order on the administration record was as follows: " Tobradex Ointment 0.3-0.1%, instill 0.3 drop in both eyes four times a day for dry eyes. " Nurse #3 stated she would need to clarify the number of drops to administer before administration and also would need to check the availability of the eye drops. Nurse #3 left the medication cart at 10:10 AM and then returned to the cart at 10:20 AM, stating that the order was clarified to be Tobradex, 0.3-0.1%, one drop in both eyes four times per day, and that the eye drops were on order. Nurse #3 then entered the Resident #224 ' s room and administered his oral medications. While Nurse #3 was in the resident ' s room, she noted a bottle of eye drops on the bedside table. Nurse #3 collected the eye drops and placed the eye drop bottle in a clean plastic glove, then asked the resident why these eye drops were in his room. Resident #224 replied that he had been taking them because his eyes felt " gritty, " and that he had taken them about 6:00 AM that day, 12/03/2015. An observation of eye drop medication bottle which had been on Resident #224 ' s bedside table revealed it was a non-antibiotic eye drop. It was not Tobradex (tobramycin-dexamethasone), the ordered eye medication. Nurse #3 stated in an interview on 12/03/2015 at 10:35 AM that she checked the availability of the Tobradex eye drops and learned that they were on order but had evidently not arrived yet. Nurse #3 explained that day (12/03/2015) was the first day she had administered medications to Resident #224 since his admission on	F 281	for further recommendations needed.	

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12/01/2015. Nurse #3 further explained that the medication administration record was created upon admission by Nurse #4, and that orders on the medication administration record were checked by a second nurse, Nurse #5.

In an interview with the pharmacist on 12/03/2015 at 1:40 PM, he stated that generally, if a medication was ordered from the pharmacy before 5:00 PM, it would be supplied the same day, and that if it is ordered after 5:00 PM, it would probably be delivered the next day. The pharmacist also stated that an order could still be filled after 5:00 PM on the same day if the nurse in the facility called to alert the pharmacy that it was needed. In addition, the pharmacist stated that medication orders for new admissions would usually be filled the same day.

In an interview with the Medical Director on 12/03/2015 at 1:55 PM, he stated that he would expect for medications to be given as ordered, and that if a medication for a new admission needed clarification, he would expect the nurse to contact him. The Medical Director also stated that if a clarification needed to be made with the pharmacy so that a medication could be supplied, he would expect the nurse to contact the pharmacy. The Medical Director also stated that if a resident had previously been taking a different eye drop than what was ordered, he would want to be notified so that he could evaluate whether the new eye drop medication was necessary, or if the resident ' s eye drops were sufficient.

An interview was conducted with the pharmacy technician on 12/03/2015 at 2:22 PM. During the interview, she stated that the pharmacy received an order for Tobradex eye drops on 12/01/2015,

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but did not know what time the order was received. The pharmacy technician stated that the order had not been supplied to the facility because the pharmacy was still waiting for clarification of the order. She explained that the original order was to instill 0.3 drops of Tobradex ointment, which did not make sense. The pharmacy technician added that the order was updated with the pharmacy on 12/03/2015 to instill 1 drop for each eye instead of 0.3 drops, but that the order was still written as an ointment instead of drops. She explained that an alert was placed with the facility electronically after the original order on 12/01/2015 to clarify the order so that the eye drops could be supplied to the facility. The pharmacy technician stated she spoke with Nurse #3 on 12/03/2015 and that she informed her that the Tobradex eye medication might be discontinued.

In an interview with Nurse #5 on 12/03/2015 at 2:52 PM, she stated that Nurse #4 had completed the first check of admission orders and that she had completed the second check of the orders. Nurse #5 explained that the medication orders for Resident #224 ' s Tobradex eye drops were transposed from the hospital discharge summary onto the medication administration record (MAR.) Nurse #5 stated that Resident #224 was the first resident to be admitted using the electronic medication system instead of using the old paper system by writing the physician orders on an order sheet which then became the medication administration record (MAR). She explained that she tried to be accurate with the physician orders whether they were written on paper or electronically. She explained that Nurse #4 must have entered the eye drop strength (0.3-0.1 %) instead of the correct number of eye drops (1) to

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F 281	Continued From page 4 be administered in the electronic system. Nurse #5 stated she did not see this error when she checked the orders for the second time. Nurse #5 also stated she did not see the incorrect form of the eye drop medication as an ointment instead of eye drops on the MAR when she checked the order. In addition, she reviewed the original order from the discharge summary and noted that there was no indication for the Tobradex eye drops to be " dry eyes, " as was reflected on the MAR. In an interview with the Director of Nursing on 12/03/2015 at 3:00 PM, she stated that there was an action plan in place to facilitate the transition from the paper MAR to the electronic MAR. The Director of Nursing also stated the medications for a new admission should be processed and administered as ordered.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the nursing assistant did not thoroughly clean the resident of stool during incontinent care and did not report sacral and perineal redness to the nurse after the care was provided for one of two residents observed for incontinent care services, Resident #217. Findings included:	F 312	After prompting by the surveyor Resident #217 was cleaned appropriately by the RCS and the stool was removed from buttocks area. Licensed nurse was informed of redness and appropriate medication was ordered by attending physician on 12-2-15.	12/31/15

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F 312	Continued From page 5 A review of the quarterly minimum data set assessment dated 09/09/2015 revealed Resident #217 had multiple diagnoses of hypertension and dementia, that she was severely cognitively impaired, and that she was always incontinent of urine and bowel. The same assessment indicated she was completely dependent upon nursing staff for toilet use. Resident # 217's nursing care plan which was initiated on 03/15/2015 and last updated on 09/14/2015 included goals that her incontinent episodes would be managed without signs and symptoms of potential complications, such as skin breakdown or urinary tract infections, and that the resident would have her dignity maintained with her incontinent care. One of the approaches regarding the management of the incontinent episodes was to provide perineal care daily and as needed. In an observation of incontinent care provided for Resident #217 by Nursing Assistant (NA) #1 and NA #2, NA #1 used dampened washcloths to remove soft stool from the resident's perineal area and buttocks using front to back wiping. After removing some of the stool, NA #1 applied an ointment to the sacral area and buttocks where redness and multiple small dime size circles of redness and inflammation were noted. Soft stool remained in the perineal area and buttock area as NA #1 began to apply a clean disposable brief to the resident. The surveyor then asked NA #1 to check the lower buttocks, inside the buttock folds, and in the perineal folds for stool. NA #1 observed the buttocks and found there was stool remaining in the buttock folds, along the perineum, and inside the labial folds. NA #1 then asked NA #2 to go get more clean washcloths so that she could clean the remaining stool. When NA #2 returned to the room with	F 312	Facility resident identified as incontinent residents have been assessed for skin conditions and appropriate treatment orders obtained as needed by Administrative nurses thru 12-23-15. Nursing assistant providing incontinent care to the residents have been observed performing incontinent care to make sure that the care rendered was appropriate by administrative nurses thru 12-31-15. The facility nursing assistance will be re-educated on proper incontinent care and reporting any changes in the resident skin condition by the licensed nurse by 12-31-15. Newly hired nursing assistance will receive education during orientation. The Infection Control Nurse or designee will observe facility nursing assistants performing incontinent care to make sure they are following proper procedures. The SDC (Staff Development Coordinator), Infection Contorl Nurse or designee will perform random audits on six residents per week X 4 weeks utilizing a Perineal skills check off form to ensure proper incontinent care is being provided. Results of the audits will be brought to the QAPI committee meeting for further recommendations if needed	

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F 312	Continued From page 6 extra washcloths, NA #1 continued to clean the resident until all remaining stool was removed. In an interview with NA #1 after the incontinent care was provided on 12/02/2015 at 5:20 PM, she stated that she usually cleaned her residents more thoroughly when stool was present, but she did not this time. NA #1 also stated that the nurse already knew about the redness and round rash-like areas in the perineal area, buttocks, and sacrum and that there was no need to report it. NA #1 explained those same areas were present the last time she had provided incontinent care for the resident on another day. In an interview with the Director of Nursing (DON) on 12/02/2015 at 5:30 PM, she stated she expected for all nursing assistants to clean all of stool thoroughly when providing incontinent care, and that she also expected for the nursing assistants to report any inflammation or new areas of redness, rash, or blisters to the nurse, and that if such redness was present, it should be assessed and treated. In an interview with Nurse #2 on 12/03/2015 at 4:09 PM, she stated that NA #1 did not report to her that Resident #217 had redness or any skin issues on the sacral or perineal areas on 12/02/2015. Nurse #2 stated that she found out about it late on 12/02/2015 and that the areas of redness and inflammation were not present when she completed her skin assessment on 11/30/2015. She stated she assessed the area late on 12/02/2015 and placed an order for a medicated cream to treat the inflammation, but that it had not arrived as of 12/03/2015 at 4:09 PM.	F 312		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		12/31/15

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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.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(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.
(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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

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F 441	Continued From page 8 Based on observation, record review and staff interviews, the facility failed to post an isolation sign outside a resident ' s door for 1 of 5 residents observed for isolation precautions (Resident #223). Findings included: A review of the Issues in Infection Control for Nursing Homes provided by the Statewide Program for Infection Control and Epidemiology (SPICE) revealed that isolation signs must be posted on the door to the resident's room. The SPICE program has been considered a standard by the Centers for Disease Control (CDC) as a tool for communicating the procedures that healthcare workers, family and visitors should follow to prevent cross transmission. Resident #223 was admitted to the facility from the hospital on 11/23/15 with the following diagnoses: acute pancreatitis, enterocolitis, pneumonia, and acute kidney failure. Resident #223's hospital discharge summary dated 11/23/15 revealed patient ' s abdomen and pelvic computerized axial tomography (CT) scan on admission was positive for acute infectious colitis, and lab sample for C-difficile toxin in stool was positive. Review of the Physician Telephone Orders dated 11/23/15 showed Resident #223 was on Enteric Contact Isolation Precautions for Clostridium difficile (C-Diff) in the stool. An observation on 11/30/15 at 9:55 AM showed a knee level plastic cart with drawers next to Resident #223's room. No signage was seen on the wall above the plastic cart or on the door or doorframe of the room. Closer inspection of the cart showed no Contact Isolation sign on top of the plastic cart or underneath the cart. In an interview on 11/30/15 at 10:00 AM with	F 441	A Contact Isolation sign was placed on the door of resident #223 room on 11-30-15 when we discovered the sign was missing. All residents on isolation precautions have the potential to be affected by the alleged deficient practice. All residents in the facility that are on isolation have been checked to make sure that a sign was placed on the door to identify appropriate precautions. All staff have been in-serviced on how to set up appropriate isolation precautions including the posting of the sign to identify type of precautions in place. The DON of designee will audit all residents on isolation weekly x 4 weeks to ensure appropriate isolation set up and techniques are in place. Results of the audits will be brought to the QAPI committee meeting for further recommendations if needed.	

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F 441	Continued From page 9 Nurse #1 who was re-stocking all the isolation rooms personal protection equipment (PPE) stated Resident #223 was possibly on isolation for an infection, and would check with the Assistant Director of Nursing (ADON) to ask what infection it was. She also indicated that there should have been a Contact Isolation Precaution sign posted on the door, and would go get one to place on Resident #223's door, which she did. Nurse #1 returned with and isolation sigh and indicated she had been informed by the ADON that the resident was on isolation for C-diff. She indicated the purpose of the sign was to let staff know the resident was on isolation. She stated the sign should be on the wall above the cart or hanging on the door. In an interview on 12/2/15 at 9:10 AM the Infection Control Nurse (ICN) confirmed that Resident #223 was on Enteric Contact Isolation Precautions. She indicated the Contact Isolation sign was not posted either above the plastic isolation cart or on the resident's door the morning of the initial facility tour on 11/30/15. In an interview on 12/2/15 at 9:21 AM the Director of Nursing (DON) stated it was her expectation that an isolation sign would be posted on the door or door frame of a resident's room. She indicated the purpose of the sign was to protect the staff and the public.	F 441		