STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 12/02/2016

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BRIAN CENTER SOUTHPOINT	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to engage with Resident #11 when fed. This was evident in 1 of 2 meals observed in the dining room. Findings included: Resident #11 was readmitted to the facility on 6/10/16 with cumulative diagnoses which included dementia and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated 11/16/16 revealed a brief interview for mental status could not be conducted due to being rarely or never understood with severely impaired long and short term memory problems. Under the functional status Resident #11 was coded as requiring extensive assistance from staff for eating. Review of the care plan revised 11/23/16 revealed problems of total dependence on staff for feeding. One of the intervention included " Meal assistance: total dependence. " Continuous observation in the dining room on 11/30/16 starting at 8:30 AM until 8:50 AM of the breakfast meal revealed Resident #11 was being fed by Nurse Assistant #2 (NA). Resident #11 ' s eyes were noted to be closed. NA #2 fed grits to the resident several times. This NA never explained or spoke to the resident about what she was doing or what food was being placed in her mouth. At 8:32 AM NA #2 placed a straw in the	F 241	Resident #11 was assessed by the Social Service Director with no psychosocial needs noted related to her dining experience. Nursing Management monitors meals for active staff engagement with Resident #11. All residents requiring extensive feeding assistance have the potential to be affected by the allegedly deficient practice. Beginning 12/2/16 facility staff was re-educated by the Staff Development Coordinator regarding staff interaction with the resident, explaining items being offered, and not talking over the resident they are assisting to ensure each resident is provided for with dignity and respect during dining service. Education will be included as part of new employee orientation. Nursing Management to be present during meals to monitor appropriate feeding procedures including staff interaction while feeding a resident. Managers will	12/30/16

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

Electronically Signed | 12/20/2016

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 241	Continued From page 1 resident ' s mouth to drink orange juice. She never spoke to Resident #11 about placing the straw in her mouth or what beverage was served. At 8:34 AM alternate spoonsful of eggs and pureed meat were placed in the resident ' s mouth. Again NA #2 had not engaged nor spoken to Resident #11 to explain what she was doing or what food items or beverages were given. At 8:37 AM NA # 2 supported the resident head and placed a sippy cup of milk to her mouth with talking with the resident. Continued observation on 11/30/16 at 8:40 AM revealed NA #2 placed a sippy cup of juice in the resident ' s mouth. At no time did she communicate with the resident. However, at this time NA #2 looked in the direction of NA #3 and NA #4 and engaged in a conversation with them. At 8:45 AM, NA #2 removed the food ware and utensils then washed her hands. At 8:50 AM, NA#2 begun to engage with Resident #11 and explained that she was going to transport her back to her room. Interview on 12/01/16 at 1:45 PM with NA #2 revealed Resident #11 cannot tell you what she wants. An inquiry was made about the lack of engagement with Resident #11 during meal time. NA #2 stated she was sorry that she had not spoken with the resident while being fed. Interview on 12/01/16 at 11:36 AM with the Director of Nurses revealed she expected staff to talk with a resident about what they are doing when feeding.	F 241	correct any deficient practice immediately and provide follow up to the Director of Nursing utilizing the "Feeding Observation" Audit Sheet. Director of Nursing/Unit Coordinators will conduct random observations of feeding during meals to ensure compliance 3 x wk x 4 wks, 2 x wk x 4 wks and 1 x wk x 4 wks. The Director of Nursing will report the findings of the observations to the monthly Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. Additional interventions will be implemented as recommended by the Committee with ongoing evaluation of effectiveness.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination	F 278		12/30/16

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F 278	Continued From page 2 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set to reflect the medications the resident received for 1 of 3 resident reviewed for unnecessary medications (Resident # 5). Finding included: Resident #5 was admitted on 3/22/16 with the diagnosis of sepsis, acute embolism,	F 278	Resident #5 was discharged from the facility on 9/23/16, no corrective action can be taken for the identified resident. All residents receiving anticoagulant medications have the potential to be affected by the allegedly deficient practice.	

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F 278	Continued From page 3 hypertension and chronic obstructive pulmonary disease. Resident #5 discharge Minimum Data Set (MDS) dated 9/23/16 revealed the resident was moderately cognitively impaired and had memory problems. The MDS revealed the resident was on an antidepressant medication for seven days. The resident had a care plan in place dated 7/22/16 for a past Cerebral Vascular Event and psychotropic medications. Review of the resident Medication Administration Record dated 9/1/16 through 9/30/16 revealed the resident received Eliquis, an anticoagulant medication, for the following dates 9/19, 9/20/16, 9/21/16, and 9/22/16. The resident was also receiving Sertraline, an antidepressant medication. The MDS nurse #1 was interviewed on 12/2/16 at 8:51 AM. She stated there was a discharge MDS on 9/23/16 and the look back period would have been 9/17/16 through 9/23/16. Another MDS nurse coded this MDS but was not in. She stated the resident had an antidepressant coded on the MDS. She stated the resident was started on Eliquis on 9/20/16 and it was an anticoagulant medication. They would typically code that medication on the MDS. When they code the MDS, they look at the administration of medications to see if the medication was actually given. The Director of Nursing was interviewed on 12/2/16 at 12:40 PM. She stated she expected for the MDS to be coded correctly.	F 278	Resident Care Management Director conducted an audit of all residents receiving anticoagulant medications to ensure accurate MDS coding, one MDS modification was completed per CMS correction policies. Audit completion date 12/20/16. Resident Care Management Director re-educated MDS Coordinators on 12/5/16 related to MDS Accuracy. Re-education included full review of the resident's record, review of all new orders, review of MAR/TAR and all other documentation (both electronic and hard chart) prior to coding assessment. All MDS Coordinators completed the MYLearning education modules related to Section N, Medications and obtained a passing grade of 80% or greater. Modules completion date 12/12/16. Resident Care Management Director will conduct random audits of MDS' for residents with anticoagulant medications (from physicians orders in Point Click Care) utilizing the "Anticoagulant MDS Coding Accuracy" Audit Tool. Audits will be conducted weekly x 4, bi-weekly x 4 and monthly x 1 and the results reported to the monthly Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. Additional interventions will be implemented as recommended by the Committee with ongoing evaluation of effectiveness.	
F 279	483.20(d);483.21(b)(1) DEVELOP	F 279		12/30/16

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F 279 SS=D	Continued From page 4 COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 279		

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F 279	Continued From page 5 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to create a care plan for a resident with a pressure ulcer for 1 of 3 residents reviewed for wound care (Resident #1). The facility failed to develop a careplan addressing constant yelling behavior for 1 of 1 sampled resident with yelling behavior. (Resident #6) Findings included: 1. Resident #1 was readmitted to the facility on 3/14/16 with diagnoses including diabetes, and chronic kidney disease. Resident ' s #1 Admission Minimum Data Set (MDS) assessment dated 3/21/16 revealed the resident was moderately cognitively impaired and was at risk for pressure ulcers and had a pressure reducing device for the bed and chair.	F 279	Resident #1 no longer resides in facility. Resident #6 has been discharged from the facility and no corrective action can be taken for identified resident. All residents with wounds/behaviors have the potential to be affected by the allegedly deficient practice. Resident Care Management Director to review all current residents on the Weekly Pressure/Non-Pressure Wound Report and a list of residents being followed by Psychiatric Services for Behaviors ie: yelling, to ensure they have active care plans with appropriate interventions, care	

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F 279	Continued From page 6 The resident ' s Pressure Ulcer Care Area Assessment (CAA) dated 3/26/16 stated that pressure ulcers and functional status would be addressed in the care plan. The overall objective for this care plan was to improve, avoid complications and minimize the risk of pressure ulcers. Under pressure ulcers, the CAA description stated the resident ' s skin was intact with a scaly area to the lower left leg around ankle. It also indicated there was a pressure reducing mattress in place on the bed. The resident was discharge to the hospital on 9/13/16 and was readmitted to the facility on 9/16/16. The resident ' s readmission nursing Data Collection assessment dated 9/16/16 stated the resident had a left heel stage 3 ulcer with a small amount of drainage. Resident ' s #1 plan of care was last updated on 6/9/16. Resident #1 care plan was not updated to reflect the Stage 3 pressure ulcer or planned interventions for a current pressure ulcer. Resident #1 was discharged from the facility on 11/28/16. MDS nurse #1 was interviewed on 12/2/16 at 8:35 AM. She stated the MDS nurses created the care plans and then anyone could update them. The MDS nurse stated the resident returned on 9/16/16 and they should have picked up on it to do a pressure ulcer care plan at that time. The Director of Nursing was interviewed on 12/2/16 at 12:40 PM. The DON stated the resident should have had a care plan for pressure ulcers. 2. Resident #6 was admitted to the nursing home on July 31, 2016. Physician orders dated 8/2/16 included " constant attention seeking " . Resident #6 had an initial Minimum Data	F 279	plans that requires updates are being made per policy. Review to be completed by 12/27/16. Resident Care Management Director re-educated MDS Coordinators on 12/5/16 related to Comprehensive Care plans. Re-Education included: required completion timeframes, review of documentation and resident assessment to determine care plan needs and changes. All MDS Coordinators completed the MYLearning educations modules on MDS 3.0 CAA's and Care Plans to validate understanding and obtained a passing grade of 80% or greater. Resident Care Management Director will conduct random audits of resident care plans for inclusion of, changes to resident behaviors and/or wounds and associated care updated utilizing the "Care Plan" Audit Tool. Audits will be conducted weekly x 4, bi-weekly x 4 and monthly x 1 and the results reported to the monthly Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. Additional interventions will be implemented as recommended by the Committee with ongoing evaluation of effectiveness.	

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F 279	Continued From page 7	F 279		

Assessment with an Assessment Reference Date of 8/7/16. This assessment indicated she was cognitively intact. She was coded as being fidgety and restless nearly every day. Her bed mobility and transfer ability was coded as needing extensive assistance. She had bilateral upper extremity range of motion limitations. Her diagnoses included: cancer, anemia, atrial fibrillation, hypertension, gastroesophageal reflux disease, thyroid disorder, fracture, edema, hypertonicity of bladder and dislocated shoulder. She received scheduled and as needed pain medication. She occasionally had a score pain at 6 out of 10. She had two unstageable pressure sores on admission and was at risk of developing sores in the nursing home. She had moisture associated skin damage. She had pressure reducing devices in bed and chair. She had pressure ulcer care, surgical wound care, and application of dressing/ointments/medications, dressings to feet. She received antianxiety medication on two of seven days during the assessment period. She received an anticoagulant, antibiotic and diuretic. She received therapy for occupational and physical therapy.

She was not identified as having verbal behavior symptoms or other behaviors.

Resident #6 had a comprehensive care plan initiated on 8/10/16. It addressed numerous problems including her cancer diagnosis and risk for decline, non-pressure sores, Activities of daily living, falls, psychotropic medications, anticoagulant usage, pressure ulcers, pain and incontinence. None of the approaches for these problems was related to her constant yelling.

Geriatric Neuropsychiatry Service 9/20/16

Targeted crying and calling out all day and night. Nursing staff report that she would be calm for an

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F 279	Continued From page 8	F 279		

hour or two after receiving the clonazepam, then begin crying out for mommy and daddy. This lasted all day and night long.
On 12/1/16, when staff were asked what they recalled about this resident they said:
· She wanted someone to stay with her per Nurse #1 at 12:27 PM.
· We don ' t know why she hollered. Came here like that per the Restorative Aide at 12:32 PM.
· She was confused and yelled a lot per MDS Nurse #2 at 12:46 PM.
· She had some intentional behavior. She was lonely and wanted people around her. She would call out and nothing would be wrong. She wanted attention per MDS Nurse #1 at 12:46 PM.
· She had some calling out. Discomfort. Not sure if all pain or some behavior. She was lonely. They tried to get her to go to activities per MDS Nurse #3 at 12:46 PM.
Resident #6 ' s Ambassador 12/2/16 8:45AM office was positioned right next to Resident #6' s room. She would call me constantly. When we would ask her what you need, she would say, I need the call bell, but she would already have it in her hand. She ' d say I want to see if it is working. She was fixated on the call bell. I would sit in her room with her just to keep her company. She spoke to her family member often. She would say she just wanted to be adjusted.
On 12/2/16 at 9:15 AM, Nurse#3 said, she was very needy. She would scream, not because she needed anything.
On 12/2/16 at 9:39 AM, Nurse #4 and she was attention seeking. She continuously yelled and had no significant complaint. Very seldom did she complain of pain. She would scream uncontrollably - not for pain, but for other reasons. She would scream my name.

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F 279	Continued From page 9 On 12/2/16 at 10:12 AM, Nurse #5 said Resident #6was always yelling and screaming. We were constantly in her room. On 12/2/16 at 1:17 PM, MDS Nurse #2 said yelling is " probably not there (on the care plan) " . 	F 279		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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, record reviews and staff interviews the facility staff failed to provide thorough urinary incontinence care and rinse thoroughly off the Bath and Body Wash for Resident #7. The facility failed to wash the resident ' s back, legs and feet when providing a bed bath. (Resident #4) This was evident in 2 of 3 residents in the sample reviewed for Activities of Daily Living. Findings included: 1. Resident #7 was admitted to the facility on 04/21/2016 with cumulative diagnoses which included Parkinson ' s disease and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated 09/09/2016 revealed Resident #7 was cognitively impaired and did not reject care. Extensive assistance from staff for toilet and personal hygiene was noted. Under urinary continence the resident was coded as frequently incontinent of urine. Review of the care plan revised 09/10/2016 revealed problems with incontinence. One of the intervention included " Clean peri-area with each	F 312	Resident #7 was seen by the Nurse Practitioner on 12/9/16 and assessed to be without any signs and symptoms of infection. Resident #7 receiving perineal/incontinent care per protocol. Resident #4 was provided a complete bed bath on 12/3/16 and a shower on 12/5/16 per personal preference. All residents requiring extensive assistance with ADLs/Incontinent Care have the potential to be affected by the allegedly deficient practice. NA #5 and NA #1 were both given 1:1 re-education by the Staff Development Coordinator on 12/3/16 with return demonstration and skills validation documented. NA #5 was given 1:1 re-education as well as individualized counseling related to	12/30/16

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F 312	Continued From page 10 incontinence episode. " Review of the manufacturer ' s instructions for the use of the Bath and Body Wash revealed to " Rinse thoroughly. Pat Dry. " Observation on 11/30/16 at 6:20 AM during incontinence care performed by Nursing Assistant #5 (NA) revealed Resident #7 had experienced an incontinent episode of urine. The entire brief was urine saturated. NA #5wet two separate washcloths at the sink with water. Bath and Body Wash was placed on one of the wet washcloths. With the soaped washcloth NA #5 wiped between the resident ' s legs once in a front to back manner but never opened the resident legs completely to wash the peri-area. The other wet washcloth was used to wipe off the body shampoo. Resident #7 was repositioned on her right side and her rectum was cleansed but NA #5 did not cleanse her buttocks. A clean brief was then placed on the resident. On 11/30/16 at 6:40 AM an inquiry was made about how NA #5 knew what type of care this resident required. NA #5 indicated the nurse gives him an assignment and informs him of who should be transferred out of bed. Further interview revealed this was how he routinely provided care to female residents because he was concerned if a female resident hollers the facility may think inappropriate care had been provided. NA #5indicated he had not discussed this concern with his charge nurse. Interview on 12/01/16 at 11:36 AM with the Director of Nurses revealed she expected proper perineal care be provided by washing in between the resident ' s legs and to cleanse the buttocks. 2. Resident #4 was admitted on 1/14/16 with the current diagnosis of muscle weakness, falls, diabetes and hypertension. Resident #4 Minimum Data Set dated 10/24/16	F 312	pericare of female residents. Counseling included - to inform Charge Nurse, Staff Development coordinator or Director of Nursing immediately for any issues he may have taking care of a female resident, ask for assistance from a female co-worker with new residents on assignments until he becomes familiar with them. Staff Development Coordinator/Unit Coordinator began re-education with Direct Care Nursing Staff on 11/30/16 through 12/23/16. The education included Perineal Care Male/Female Residents, and bathing using the Lippincott Nursing Procedures. Education included: proper perineal care, washing and rinsing of the peri-area and buttocks, giving a complete bed bath, including washing the resident's back, legs and feet. Education will be included in new hire orientation. On 12/8/16 through 12/23/16 each direct care staff were observed completing perineal care for male/female residents and Bed Bath using the "Lippincott Procedure Checklist Skills Validation Perineal Care/Bed Bath Forms" by the Staff Development Coordinator. Any deficient practice was corrected immediately and ongoing education provided. DON/SDC/Unit Coordinators will conduct random observations of resident bathing/peri-care male/female to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 12/02/2016

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F 312	Continued From page 11 revealed the resident was moderately cognitively impaired and had impairment on both sides of her upper and lower extremities. The resident required total dependence with bathing. Resident #4 had a care plan dated 5/10/16 for Activities of Daily Living (ADL ' s). The resident ' s weekly shower schedule was reviewed from 11/28/16 through 11/30/16. It revealed the resident received showers on Mondays and Thursdays during first shift. The shower schedule did not reveal that the resident received a shower anytime that week and was not scheduled for a shower on 11/30/16. Resident #4 activities of daily living flow sheet dated 11/30/16 revealed the resident received bathing care, which required total assistance with bathing requiring assistance from 1 people at 2:59 AM and 1:08 PM. Nursing Assistant #1 (NA) entered resident ' s #4 room on 11/30/16 at 6:45 AM. NA #1 told the resident she was going to give her a bath and change her. NA #1 washed, rinsed and dried the resident face, chest, arms. The resident ' s shirt was then put on at 6:57 AM. The resident perineal area and buttock was washed. Barrier cream was applied to the resident buttock and the resident ' s brief and pad was changed. Lotion was then applied to the resident ' s feet and legs. Then the resident ' s socks were placed on the resident. The resident ' s back, legs and feet were not washed. NA #1 then rinsed out the resident ' s basin and took the trash out of the resident ' s room and changed her gloves. NA #1 was interviewed on 11/30/16 at 7:17 AM. She stated she typically gave four to five bathes per shift. She stated she washed the resident face, arms, hands, breast, and stomach. She stated she also washed her perineal area and changed the resident brief and applied barrier	F 312	compliance 3 x wk x 4 wks, 2 x wk x 4 wks and 1 x wk x 4 wks. The Director of Nursing will report the findings of the observations to the monthly Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. Additional interventions will be implemented as recommended by the Committee with ongoing evaluation of effectiveness.	

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F 312	Continued From page 12 cream. She stated she would wash resident ' s back, legs and feet but she was rushed. She stated the resident did not want to have pants on. Resident #4 was interviewed on 11/30/16 at 8:19 AM. She stated that she has almost been here for two years. She stated they usually wash her whole body or take her to the shower. She likes to have her back and legs washed and they usually do it most of the time. She wanted her back and legs washed this morning and was surprised they didn ' t do it. She stated that she never refused care. The Director of Nursing was interviewed on 12/2/16 at 12:40 PM. She stated she would expect for a full bath to be given to residents but that the NA may have just being doing a wash up (not a full bath) for the resident if the resident was going to get a shower that day and to check the shower schedule.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314		12/30/16

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F 314	Continued From page 13 from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete dressing changes as ordered to treat pressure ulcers for 1 of 3 resident ' s reviewed for wound care (resident # 1). Findings included: The resident was readmitted 9/16/16 to the facility with the current diagnosis of muscle weakness, diabetes, chronic kidney disease, hypertension, chronic heart failure and dysphagia. The resident was no longer residing in the facility. The resident ' s Admission MDS assessment dated 3/21/16 revealed the resident was moderately cognitively impaired and was at risk for pressure ulcers and had a pressure reducing device for the bed and chair. An entry Minimum Data Set (MDS) dated 9/16/16 revealed the resident was readmitted back to the facility. The resident had a care plan in place for nutrition updated on 11/17/16. There was no care plan in place for pressure ulcers. The resident ' s admission data collection dated 9/16/16 stated the resident had a left heel stage 3 ulcer with a small amount of drainage, there was slough at the wound base. No odor present. A physician ' s order dated 9/16/16 stated to apply a hydrocolloid dressing to the left lateral heel ulcer. To change the dressing every 5 days and as needed for wound leakage every day shift every 5 days for wound care (The order was discontinued on 9/22/16). A physician ' s order dated 9/22/16 stated to clean the resident ' s left outer heel with normal saline, to apply silver alginate and cover with dry dressing daily every day shift (The order was discontinued on 11/14/16). The Treatment Administration Record (TAR) for	F 314	Resident #1 no longer resides in facility. All residents with orders for treatments to pressure ulcers have the potential to be affected by the allegedly deficient practice. Director of Nursing/Unit Coordinators reviewing the Treatment Administration Records for the last 30 days for omissions in documentation. Follow-up with the assigned licenses nurses will be taken to include: late entry documentation if treatment was completed/appropriate disciplinary action and continued education. Documentation of Audit utilizing the "Treatment Administration Record QAPI" Form. Audit completion date 12/26/16. Director of Nursing re-educating Licensed Nursing Staff on Documentation of Treatments. Re-education included: review of Treatment Administration Records each shift, following physician orders, documentation completion of the treatment, progress note if the treatment is not done and why. Completion date 12/26/16. DON/Unit Coordinators will conduct random audits of the Treatment Administration Records to ensure compliance 3 x wk x 4 wks, 2 x wk x 4 wks and 1 x wk x 4 wks. The Director of Nursing will report the findings of the	

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F 314	Continued From page 14 September, 2016 revealed the documentation was blank indicating the dressing changes were not completed on 9/17/16 or 9/22/16. TAR documentation was blank indicting the dressing was not changed on 9/24, 9/25, 9/30/16. The Treatment Administration Record (TAR) in October, 2016 revealed the resident had orders for a left outer heel dressing to be completed every day. TAR documentation was blank indicting the dressing was not changed on 10/2, 10/4, 10/5, 10/8, 10/9, 10/11, 10/15, and 10/19. The TAR for November revealed the dressing changed had been completed as ordered. Nursing notes were reviewed from 9/16/16 through 11/28/16. One nursing noted dated 10/26/2016 at 2:56 PM stated the resident had orders to clean left outer heel with normal saline and apply silver alginate cover with a dry dressing every day shift. The resident was asked to return to his room after Physical Therapy. The nurse found him in bingo, he requested the treatment not be done today because he did not want to miss his game. There were no other notes that suggested the resident refused dressing changes to be completed. The 24 hour report/change in condition report was reviewed for the dates that wound care was not performed on the TAR. There were no notes that revealed the dressing was changed for those dates. A wound care assessment dated 9/28/16 revealed the resident had a left heel pressure ulcer that measured 3 centimeter (cm) by 3 cm. A wound care assessment dated 10/4/16 revealed the resident ' s left heel pressure ulcer measured 1.8 X 1.8 x 0.2 cm. A wound care assessment dated 10/18/16 revealed the resident pressure ulcer to his left heel measured 1. X 1.5 x 0.3 cm.	F 314	observations to the monthly Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. Additional interventions will be implemented as recommended by the Committee with ongoing evaluation of effectiveness.	

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F 314	Continued From page 15	F 314		

The emergency room notes dated 11/18/16 stated the resident had altered mental status. The left heel appeared necrotic and foul smelling. The resident responded with fluids given. Infection or sepsis was likely from source of foot.
Nurse #1 was interviewed on 11/30/16 at 12:37 PM. She stated the nurses would do wound care on Wednesdays and the weekends. She would document on the TAR if a treatment had been done or not. It may be documented in the nursing notes too. She stated if the TAR had a check mark that meant it is done. If there ' s an X that meant the dressing change wasn ' t due. If the space is left blank, she guessed that meant the wound care was not done. She doesn ' t remember doing a dressing on the resident. The treatment nurse would do the treatments. She thought she cared for him one day this month. She can ' t remember if the resident had a wound because the treatment nurse did the treatments.
The wound care nurse was interviewed on 11/30/16 at 2:00 PM. She stated she was off every Wednesday and the weekend. She did not know who specifically did the wound cared on the days she was not there. The resident came back from the hospital. The resident had a left heel wound. The wound care nurse and physician suspected the resident had poor blood flow to his legs. If she was here and was doing treatments then she is pretty sure she did it. She could not speak about happened when she was not there
Nurse #7 that worked on 10/4/16 was interviewed on 11/30/16 at 2:35 PM. She stated when she went to print off the TAR today, she noticed that she did not document (11/17/16 and 11/19/16) that she did the resident ' s dressing change that she had completed so she documented it today. She thought it would show up as a late entry but it did not. The left heel dressing had eschar

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F 314	Continued From page 16	F 314		

drainage on it and was red and had an odor.
Nurse # 6 that worked day shift on 9/7/16, 9/22/16, 9/25/16, 9/30/26 and 10/8/16 interviewed 12/1/16 at 9:18 AM. She stated the resident was alert and oriented. The resident had a wound on one of his heels. The treatment nurse would do all the dressing changes. They had another nurses that would come in and do the treatments on the weekend or the nurses would do the treatments. After she did a treatment, she would document it with a check mark. She stated that even if she ran out of time on her shift she would say after and do the dressing change. She stated that she honestly thought she always did her treatments. She used to work every other Saturday. She made a point to document when she did the dressing change but it could have been in error.
Nurse #4 that worked day shift on 10/11/16 was interviewed on 12/1/16 at 9:40 AM. She stated she worked on every unit and sometimes worked day shift but mainly works second shift. She worked with the resident a few weeks ago and the wound care nurse did his dressing change before she got here (11/25/16). She stated that she had never done the resident ' s wound care before.
Nurse #5 that worked on day shift on 10/15/16 was interviewed on 12/1/16 at 1:57 PM. The resident had two wounds on his left and right heel. She did not recall ever doing the dressing change prior to last week of thanksgiving. That was the first time she had changed the resident ' s dressing.
Nurse #3 that worked day shift on 10/2/16 and 10/9/16 was interviewed on 12/2/16 at 1:45 PM. She stated the treatment nurse changed the dressing every day and when the treatment nurse was off then the nurse would change the

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F 314	Continued From page 17	F 314		

dressing. She would chart the dressing change on the treatment sheet that they changed the dressing. She stated that she worked day shift on Sundays and would change the resident dressing because the wound care nurse was not there. She would document that she did the dressing change.
Nurse #8 who worked day shift on 10/5/16 was interviewed on 12/1/16 at 2:40 PM. He stated that he worked 7:00 AM to 3:00 PM. He stated that he could not remember this resident.
The Physician interview on 12/1/16 at 10:00 AM. She stated she tried to do a debridement on the wound. The wound was unstageable and had eschar. She checked his nutrition status and labs and debrided the wound but could not debridement it much. They were still doing Santyl and they had to debri the wound a little because it took a while to get an appointment at the wound care clinic. The resident was not eating well. She stated that they have a treatment nurse here every day. When she saw the wound a few days ago the wound had solid eschar. The wound was not open. The edges of the wound were open a bit. The resident was a brittle diabetic and they did an ultrasound. The wound was not avoidable. If the wound care nurse was not here then the nurses would do the dressing changes. She stated that if dressing changes were not being done, it would not affect that wound because the wound was full of eschar. If the wound was open then dressing changes were very important but for this wound the wound needed surgical intervention. On 11/25/16, she saw the resident. He was alert but had dementia. The resident ' s vitals were fine. The resident had stage four kidney function. The resident had Coronary Artery Disease and an ejection fraction (the percentage of blood that is pumped out of the ventricles with

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F 314	Continued From page 18 each contraction of the heart) of 25%. The resident did not have good perfusion. The Director of Nursing was interviewed on 12/2/16 at 12:40 PM. She stated she would expect if the nurses could not get to the dressing change or treatments that they would let the unit coordinator know. She never known of a time that the treatments were not completed. She did know of a time that the resident was in an activity or was outside and did not want the treatment done.	F 314		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		12/30/16

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F 441	Continued From page 19 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 20 Based on record review, staff interviews and observations the facility failed to wash their hands after providing care for 6 of 28 resident ' s on hall 200. (Rooms 214, 217, 215, 216, 214, and 207) Findings included: The facility ' s policy for Perineal care of a female resident dated 11/11/16 stated to preform hand hygiene before and after providing care. The facility ' s policy for a bed bath dated 4/15/16 stated to preform hand hygiene before and after providing care. The Nursing Assistant #1 (NA) went into room 214 B bed on 11/30/16 at 6:20 AM. She did not wash her hands but applied gloves. She provided incontinence care to the resident in 214 Bed B after the resident urinated. After cleaning the resident, she walked outside the resident ' s room with her dirty gloves (the gloves used for incontinence care) on and got clean linens from the clean linen cart. She walked back in the resident ' s room to dry the resident off with a towel and placed a brief on the resident with the same gloves on. NA #1 then walked back to the clean linen cart, which was outside of the room and got a clean pad for the bed on 11/30/16 at 6:24 AM. NA#1 had the same dirty gloves on and proceeded to change the pad on the bed. NA#1 then picked up the dirty bed pad off of the floor and placed it in the soiled linen bag and took off her gloves. Hand hygiene was not preformed. NA# 1 then walked into room 217 Bed B at 6:39 AM. NA#1 did not perform hand hygiene but applied new gloves and assisted the resident back into bed. NA#1 then removed her gloves and walked into the bathroom of room 215 without performing hand hygiene. She assisted the resident in room 215 bed A off of the toilet and walked the resident to the bed at 6:43 AM. She did not perform hand hygiene at any time. NA #1	F 441	On 12/3/16, re-education began with NA #1 who allegedly failed to wash their hands after providing care and handling soiled linen according to the standard precaution guidelines of infection prevention. NA #1 was provided re-education on proper hand washing. The 1:1 education with return demonstration and skills validation was provided by the Staff Development Coordinator. All facility staff were provided re-education on proper hand washing techniques per Lippincott Procedures on 12/8/16 through 12/28/16 by Staff Development Coordinator. Education included: washing hands before and after touching a resident, after touching a resident's surroundings, before putting on gloves and after removing gloves, do not touch clean linen with dirty gloves. Education will be included in New Hire Orientation. All facility Staff observed washing hands properly on 12/8/16 through 12/28/16. The observations were documented on the "Lippincott Hand Hygiene Skills Validation Form" by the Staff Development Coordinator. Any observations of non-compliance will be corrected immediately and additional education provided. DON/SDC/Unit Coordinators will observe at least 3 facility staff members (various shifts) to ensure compliance with proper hand washing technique 3 x wk x 4 wks, 2 x wk x 4 wks and 1 x wk x 4 wks. The	

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F 441	Continued From page 21 proceeded to walk into room 216 without performing hand hygiene or applying gloves and assisted the resident in Bed B with moving the bedside table and rolling walker at 6:44 AM. Hand hygiene was not preformed and NA#1 walked over to 216 bed A and told the resident she was going to help her get a bath. NA#1 did not perform hand hygiene but did place clean gloves on. The resident in room 216 Bed A was partially washed up and the resident ' s pad and brief was changed. NA #1 then took out the trash and took off her gloves at 7:02 AM but did not perform hand hygiene. NA #1 rinsed out and dried the resident ' s bath basin without preforming hand hygiene before or after. NA #1 then walked into room 214 Bed B without preforming hand hygiene and applied gloves at 7:15 AM. NA#1 moved the wheelchair for the resident. The NA#1 exited room 214 and did not perform hand hygiene. She then walked in room 207 without performing hang hygiene and assisted the resident in Bed B with emptying water from a cup at 7:17 AM. NA#1 then exited room 207 without performing hand hygiene. The NA did not perform hand hygiene after providing resident care and entering and exiting six resident ' s rooms from 6:20 AM to 7:17 AM on 11/30/16. NA#1 was interviewed on 11/30/16 at 7:17 AM. She stated she would wash her hands before and after resident care. She stated she had 19 residents and was rushing. She stated sometimes she would wash her hands but it hard to always do it by the book. She stated she was rushing to get linens from the linen cart and forgot sometimes to wash her hands. The Director of Nursing was interviewed on 12/2/16 at 12:40 PM. She stated there had not previously been any concerns with hand washing recently. Her expectation was for staff to wash	F 441	Director of Nursing will report the findings of the observations to the monthly Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. Additional interventions will be implemented as recommended by the Committee with ongoing evaluation of effectiveness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER SOUTHPOINT	**6000 FAYETTEVILLE ROAD DURHAM, NC 27713**

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F 441	Continued From page 22 their hands before patient care, after they remove gloves and after touching the residents.	F 441		