STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 11/18/2011

DEC 1 2 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

DEC 1 2 2011

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed prevent and identify a pressure area in a timely manner for 1 of 3 sampled residents (Resident # 4) reviewed for pressure ulcers. Findings include: Resident # 4 was readmitted to the facility on 10/22/11 after hospitalization for a right hip fracture with surgical repair. Other diagnoses included anemia, muscle weakness, history of circulatory disease and Alzheimer's dementia. The Nursing Admission Assessment, dated 10/22/11, indicated Resident # 4 had a surgical incision. No other skin impairment was identified. Resident # 4 scored an 11 on the Braden Scale (The Braden scale is used to determine the risk of a resident developing a pressure ulcer. A score of 12 or less indicated the resident was at high risk). A Physician's Order, dated 10/28/11, indicated an	F 314	**F 314** The facility will continue to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. On 11/17/11 Resident #4 wounds were re-assessed by the licensed treatment nurse. Interventions were reviewed by the Interdisciplinary Team to ensure optimal treatment was implemented and services are in place to promote wound healing and prevention. Residents at risk for pressure ulcers are at risk for the same alleged deficient practice. On 11/18/2011 the Director of Nursing, Assistant Director of Nursing and Unit Managers completed skin assessments on current residents to identify any new pressure ulcers. Results of the audit were	12/16/2011 12/16/2011 12/16/2011

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

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ›gram participation.

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F 314	Continued From page 1 air mattress had been ordered for Resident # 4. On 11/01/11, the Registered Dietician (RD) assessed Resident # 4 and documented in her notes that his intake was excellent. She added the resident's intake of food and fluid were adequate to meet daily needs. A Significant Change in Status Minimum Data Set (MDS), with an assessment reference date of 11/02/11, indicated Resident # 4 had both short and long term memory impairment and had moderately impaired cognitive skills for daily decision making. The MDS coded Resident # 4 as dependent for all activities of daily living. There were no pressure ulcers identified on the MDS. Skin and Ulcer treatments included a pressure relieving device for both bed and chair. Additionally, the MDS indicated the resident was on a turn and position program. A Nursing Daily Skilled Summary, dated 11/07/11, indicated the resident had a pressure ulcer and indicated the Weekly/Daily documentation should be reviewed. On review, the Weekly Pressure Ulcer Record, completed by the Treatment Nurse, dated 11/07/11, indicated Resident # 4 had no pressure ulcers on his right heel. The record did indicate an elbow skin tear that had digressed and was now called a pressure ulcer. Laboratory results dated 11/08/11 indicated Resident # 4's hemoglobin was low at 12.6 (normal range was 13 to 17). Nursing Daily Skilled Summary, dated 11/08/11at 6:00 PM, indicated Resident # 4 had "no	F 314	documented on the weekly skin assessment flow record. There were no newly identified pressure ulcers during this audit. All resident's previously identified with pressure ulcers were re- assessed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers to ensure that current interventions were appropriate. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will conduct re-education to licensed staff regarding accurately assessing and monitoring the skin for pressure ulcers on admission and weekly and reporting newly identified pressure ulcers. New licensed employees will be provided education regarding accurately assessing and monitoring skin for pressure ulcers and reporting newly identified areas during clinical orientation. The licensed charge nurse is to document newly identified areas on the 24-hour report, notify family/physician and implement treatment as indicated. Re-education was provided to Resident Care Specialists (RCS) regarding proper reporting of newly identified areas to licensed staff	12/16/2011 12/16/2011

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F 314	Continued From page 2 problems" with his skin. He was identified as having impairment with bed mobility and was identified as being bed/chair bound. On 11/09/11, the Treatment Nurse completed a Weekly Pressure Ulcer Record for a pressure ulcer on Resident # 4's right heel. The ulcer was classified as a Stage II measuring 3 centimeters (cm) by 2 cm with no depth. There was no undermining or exudate. The wound bed was described as dark brown with the surrounding tissue normal in color for the resident's skin. The Treatment Nurse documented under Progress Notes that this was an initial evaluation. She further documented therapy had requested she assess the resident. The Treatment Nurse documented, "client has older Stage II blister that his body has been absorbing already." She added the tissue was dark brown with a center still slightly raised with fluid. The nurse documented she applied a dry dressing. Specialty interventions included an air bed, pillows for positioning and boots. A physician's order was received on 11/09/11 to treat the right heel Stage II ulcer by monitoring daily and applying a dry dressing until healed or further treatment was needed. The order also included a pressure reduction boot to be used while Resident # 4 was in bed. On 11/14/11, the Treatment Nurse documented on the Weekly Pressure Ulcer Record that the ulcer measured 3 cm by 2.5 cm with no depth. The ulcer was classified as a Stage II that was described as having no undermining and no exudate. Under Progress Notes, the nurse documented the area was larger and had changed in shape. The tissue was described as	F 314	using a "Stop and Watch" form. A copy of this notification is to be given to the licensed charge nurse and a copy to be left in Director of Nurses' communication box. **Systemic measures implemented to ensure the same alleged deficient practice does not recur are as follows:** Upon admission skin assessments will be completed by the admitting nurse and validated by the Director of Nursing, Assistant Director of Nursing or the Unit Managers or a second licensed nurse to ensure accuracy. The Weekend Supervisor or a second licensed nurse will validate weekend admissions. Both nurses completing the assessment are to sign the admission skin assessment. The Director of Nursing, Assistant Director of Nursing or Unit Managers will monitor the weekly skin assessments daily Monday thru Friday to ensure completion. The Director of Nursing or Assistant Director of Nursing will review the new admissions skin assessments	12/16/2011

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F 314	Continued From page 3 dark brown with a soft, fluid filled center. The Daily Nursing Summary, dated 11/16/11, indicated Resident # 4 had a "decubitus" to his heel. An observation was made on 11/17/11 at 10:10 AM. Resident # 4 was reclined in a geriatric chair. Protective boots were seen on both of his feet. At 10:35, the Treatment Nurse was observed completing wound care for Resident # 4. His right heel was observed to be black and soft. The Treatment Nurse stated she would stage the resident's wound as a Stage II because the blister was intact and fluid filled. The right heel was cleansed with wound cleanser and a dry dressing applied. In interview, the Treatment Nurse stated the right heel wound was found as a dark area with a raised blister. At 12:10 PM on 11/17/11, the Treatment Nurse added the right heel ulcer had been discovered by staff in the therapy department. The therapist had requested she assess the wound. The Treatment nurse stated notification by the therapist was was the first time she had heard about a right heel wound for Resident # 4. The Director of Nursing (DON) was interviewed on 11/17/11 at 2:26 PM. The DON stated on readmission, Resident # 4 was non-weight bearing which increased his risk for skin breakdown. At 5:50 PM, the DON added it was highly unlikely a dark blister would develop in 24 hours. An interview was held with Nurse # 2 on 11/17/11 at 5:06 PM. She stated prior to hospitalization	F 314	and the results of the daily audits Monday thru Friday during the Interdisciplinary Team Meeting X 3 weeks. Random audits of a minimum of 5 residents will be conducted weekly times 4 weeks to ensure accuracy of the assessment. The Director of Nursing or Assistant Director of Nursing will review the results of the daily audits during the Interdisciplinary Team meeting Monday thru Friday and during the clinical Care Management Risk Review meetings. Negative findings will be addressed once identified. The Director of Nursing or designee will present the results of the Skin audits during the Quality Assessment and Assurance meeting monthly times 3 months. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified. Additional interventions will be developed and implemented as needed.	12/16/2011

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F 314	Continued From page 4	F 314		

Resident # 4 was more independent and would not have been at risk for pressure ulcers.

On 11/17/11at 5:11 PM, the Nurse Manger for Resident #4's unit was interviewed. The Nurse Manager stated if a resident was identified as high risk on admission an air mattress was placed. Additional interventions included turning and positioning every 2 hours, incontinent care as needed and weekly skin checks. Barrier cream would be used if needed. The Nurse Manager stated she was unsure when the protective boots had been placed for Resident #4, but she knew it had been since his re-admission.

An interview was held with the Licensed Physical Therapy Assistant (LPTA) on 11/18/11 at 9:52 AM. The LPTA stated she had discovered the wound while working with the resident on bed exercises. While moving Resident # 4's lower extremities, the resident complained of pain. The pain was identified as foot pain by Resident # 4. The LPTA stated removed the resident's sock and found a black area that was in her opinion, definitely caused by pressure. She stated the area as about 50 cent size and was directly on the resident's heel. The LPTA stated she did not notice a blister of any kind, only black tissue. The LPTA was unable to recall if Resident # 4 was wearing protective boots prior to the emergence of the pressure ulcer. She added she reported the pressure area on Resident # 4's heel both to the hall nurse and to the Treatment Nurse.

Nurse # 1 was interviewed on 11/18/11 at 10:58 AM. She stated she had worked with Resident # 4 on 11/09/11 during the 7 to 3 shift. The nurse stated she received a report from the LPTA

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F 314	Continued From page 5 regarding a pressure ulcer on Resident # 4's heel. In turn, she reported the area to the treatment nurse. Nurse # 1 stated she did not actually visualize the pressure area. She stated no one had previously reported the area to her and she was unaware the resident had a pressure area on his heel. Resident Care Specialist (RCS) # 1 was interviewed on 11/18/11 at 11:17 AM. She had cared for Resident # 4 on 11/09/11 when the right heel pressure ulcer was discovered. She stated on that morning she had not bathed the resident until after he had completed therapy. The RCS stated she had not received a report from either the 11 to 7 RCS or the nurse about a right heel pressure ulcer for Resident # 4. RCS #1 stated when she found any type of skin impairment, she was expected to report it to the charge nurse. The Nurse Manger for Resident # 4's unit was interviewed on 11/18/11 at 11:45 AM. She stated she found out about Resident # 4's pressure ulcer soon after the ulcer was discovered. The Nurse Manager for the unit stated she had not seen the ulcer. She stated the cause may be linked to the post- surgical compromised limb. The nurse manager added the ulcer appeared to be pressure and she would have hoped it had been discovered before the wound was black.	F 314		