

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

11/19/12

PRINTED: 11/13/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/23/2012
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 264 SS=E	<p>483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION</p> <p>The facility must provide clean bed and bath linens that are in good condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide linens in acceptable condition for use by residents as evidenced by stained and torn linens found on the linen shelves in the linen room and on 4 of the 4 hall linen carts in the facility. Findings include:</p> <p>Upon review of the resident council minutes for the 03/27/12 council meeting, it was noted that residents were complaining of running out of washcloths and towels.</p> <p>During an interview with Nurse Aide #1 (NA#1), on 08/22/12 at 3:30 PM, she stated the linens especially the washcloths and towels were stained to the point that she would not use them on her residents. She stated she would throw them in the trash. NA#1 commented that she had purchased washcloths from her own funds for use on the residents because of the condition of the facility's linens. NA#1 stated the linens were stained due to the bleach line not feeding into the washing machines.</p> <p>During an observation of the facility's laundry/linen room on 08/22/12 at 3:50 PM, it was noted that linens were being folded by laundry room staff (LRS#1). When questioned as to the inspection process for the facility's clean linens, she stated as she folded the linens she inspected</p>	F 264	<p>F254, SS=E</p> <p>On 8-22-12 when it was brought to our attention that some of the linen was torn and stained, all the linen was removed from the hallways and inspected. Any linen found to be torn or stained was removed and replaced with new linen.</p> <p>All residents had the potential to be affected by the alleged deficiency. The remainder of all linen in the facility was inspected prior to being used. All stained or torn linen was removed from use and replaced with new linen.</p> <p>All laundry personnel have been in-serviced as of 9-6-12 on the importance of inspecting all linens for stains and tears as they are being folded. Those linens found to be stained are to be rewashed to see if the stains can be removed. If the stains cannot be removed they are to be discarded. All torn linens are to be removed from use and discarded and/or used for cleaning rags.</p> <p>Nursing Staff were educated regarding the process for removing linen from use if it is stained or torn. This education was completed on 8-27-12.</p> <p>The Laundry Supervisor will audit the linens in the laundry room to check for torn or stained linen weekly for 3 months to ensure that no stained or torn</p>	9-20-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Den R. Cotton* TITLE: *LMAA* (X6) DATE: *11-14-12*

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 254	<p>Continued From page 1</p> <p>them for stains and torn areas. The LRS#1 stated if any were stained or torn, she had been instructed to discard those and not send them out into circulation on the halls. Upon inspection of the linens that were folded and ready for distribution out onto the halls, it was noted that there were 5 stained towels, 3 stained wash cloths and 2 stained bibs.</p> <p>The Housekeeping Supervisor (HS) inspected linens on the 100 hall linen cart on 08/22/12 at 4:00 PM. There were 16 stained towels and 1 torn towel, 6 stained washcloths and 4 stained fitted sheets and 1 torn fitted sheet.</p> <p>The HS inspected linens on the 200 hall linen cart on 08/22/12 at 4:30 PM. There were 9 stained towels and 3 torn towels, 6 stained washcloths, 6 stained pillow cases, 4 stained bibs, 9 stained flat sheets and 1 torn flat sheet, and 4 stained fitted sheets.</p> <p>The HS inspected linens on the 300 hall linen cart on 08/22/12 at 5:00 PM. There were 5 stained towels and 3 torn towels, 15 stained washcloths and 9 torn washcloths.</p> <p>The HS inspected linens on the 400 hall linen cart on 08/22/12 at 5:25 PM. There were 10 stained towels, 5 stained washcloths, and 2 stained flat sheets.</p> <p>On 08/22/12 at 5:40 PM, after the inspection of the 4 linen carts in the facility, the HS reported that he should have been checking the linens. He stated staff had been instructed to inspect the linens as they fold them. The HS stated staff should be pulling any dingy, torn or stained linens</p>	F 254	<p>linen is being sent out on the halls for resident use. The Assistant Director of Nursing (ADON) and/or designee will also audit the linen on the hallway linen carts weekly for 3 months to ensure that no torn and/or stained linen is on the linen carts for residents use. The results of the weekly audits will be discussed during the Interdisciplinary Team meeting weekly times 3 months. Negative findings will be addressed if found.</p> <p>Results of the audits will be brought to the monthly Quality Assessment Performance Improvement (QAPI) Committee meeting x 3 months to evaluate the effectiveness of the plan. Additional interventions will be developed and implemented as determined necessary by the Committee to ensure continued compliance.</p>		

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F 254	Continued From page 2 when folding to prevent unacceptable linens from being sent out for use. He also commented that the torn linens were used as cleaning rags. The HS reported that linens that were stained would usually be rewashed in an effort to remove the stains. If the stains remained after the rewashing, those linens were either used for cleaning or discarded. He stated housekeeping and laundry services were contracted. The HS stated new linens arrive at the facility on a monthly basis from the laundry service. He commented 500 - 600 washcloths and 700 towels were received on a monthly basis and stained and/or torn linens should not be out on the floor. The HS stated that staff were using the linens to clean up residents and discarding them rather than sending them to the laundry to be washed.  During an interview with NA#2 on 08/23/12 at 9:53 AM, she stated aides discard the extremely stained washcloths into the trash. She stated stained linens or not having enough washcloths was always a problem.	F 254			
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.	F 315			

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F 315	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and resident and staff interviews, the facility failed to assess 1 of 1 sampled residents (Resident #168) for scheduled toileting who would benefit from bladder re-training. Findings Include:</p> <p>Resident #168 was admitted to the facility on 3/29/12 with cumulative diagnoses of difficulty walking, blindness in one eye, and anemia.</p> <p>Resident #168's Admission Minimum Data Set (MDS) dated 4/5/12 showed that Resident #168 was cognitively aware and occasionally incontinent of the bladder. Resident #168 needed the extensive assistance of 1 person for toileting. Resident #168 did not reject care.</p> <p>A review of the Initial Behavioral Medicine/Psychiatric Assessment dated 4/27/12 showed a referral due to Resident #168 being depressed and not motivated after being admitted for post knee surgery rehabilitation. The impression of the clinician was that Resident #168 had no previous history of depression but did lack motivation. Resident #168 expressed a lack of interest but attended all activities. Resident #168 was diagnosed with depression in remission.</p> <p>Resident #168's Quarterly MDS dated 7/17/12 indicated that resident #168 was cognitively aware and was frequently incontinent of the bladder. Resident #168 needed the extensive assistance of one person for toileting. Resident #168 did not reject care.</p>	F 315	<p>F315, SS=D</p> <p>Resident #168 was reassessed on 8-23-12 and placed on a scheduled toileting program.</p> <p>All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON)/designee will reassess all SNF residents bladder function using the "Bladder Training Evaluation" tool by 9-14-12. Any resident found to need bladder retraining will be started on a bladder-retraining program.</p> <p>The MDS Department was in-serviced by the Staff Development Coordinator (SDC) on 9-7-12 regarding notification of the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Staff Development Coordinator (SDC) of any resident's decline in urinary continence. This will be communicated using the "In-House Communication" form. The Director of Nursing Assistant Director of Nursing or Staff Development Coordinator will complete a "Bladder Training Evaluation" for the noted change.</p> <p>Those residents who have been evaluated and deemed appropriate for a bladder retraining program will be placed on the program. A "Bladder Training Evaluation" form will be completed quarterly to note improvement or decline in resident's bladder function. In addition, all new admissions will have a "Bladder Training Evaluation" form completed and the</p>	9-20-12	

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F 315	<p>Continued From page 4</p> <p>A review of the undated Admission Evaluation for Bowel and Bladder Training sheet showed that on admission Resident #168 was not Incontinent.</p> <p>A review of the Nursing Admission Assessment dated 3/29/12 showed that Resident #168 was continent of urine on admission with occasional incontinence.</p> <p>A review of the Urinary Output by Shift from the assessment period of 3/29/12 through 4/5/12 showed Resident #168 as being continent of urine 15 times and incontinent of urine 2 times.</p> <p>A review of the Quarterly Bowel and Bladder Training sheet dated 7/6/12 showed that Resident #168 was incontinent. Under Evaluation; the box for unable to participate in B/B (bowel and bladder) program was checked. The reason provided was that Resident #168 was frequently incontinent of bladder and only had 1 continent episode. It was determined that due to medical conditions Resident #168 was not a good candidate for bladder training.</p> <p>A review of the Urinary Output by Shift from the assessment period of 7/10/12 through 7/17/12 showed Resident #168 as being continent of urine 3 times and incontinent of urine 21 times.</p> <p>A review of Resident #168's Care Plan dated 7/17/12 showed 1 continent episode and 16 incontinent episodes during the look back period. Approaches listed observing for incontinence episodes at regular and frequent intervals and as needed and providing perineal care daily and as needed. The boxes for prompted voiding per established toileting plan and scheduled voiding</p>	F 315	<p>Interdisciplinary Team will determine if the resident is an appropriate candidate for a bladder retraining program.</p> <p>Systemic measures implemented to ensure the alleged deficient practice does not recur include: The DON and/or designee will audit all residents who are on a bladder training program weekly x 4 weeks and then monthly x 2 months for any improvement/decline in urinary continence. The results of the audits will be reviewed during the Interdisciplinary Team meeting weekly times 4 weeks and monthly times 2 months. Negative findings will be addressed if noted.</p> <p>The Director of Nursing/designee will bring the results of all audits to the Quality Assessment Performance Improvement (QAPI) meeting monthly times 3 months. The results of the audits will be reviewed by the QAPI Committee to determine the effectiveness of this plan. Additional interventions will be developed and implemented as determined necessary by the Committee to ensure continued compliance.</p>		

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F 315	<p>Continued From page 5</p> <p>per established toileting plan were not checked and were not approaches that were being used.</p> <p>A review of the Physician Order Sheet for August 2012 listed oxybutynin chloride (a medication taken for bladder spasms with a common side effect of urinary retention) as one of Resident #168's medications.</p> <p>A review of the Kardex dated 8/23/12 which was provided to the Resident Care Specialists (RCS) daily, showed that Resident #168 was not continent and was not on a toileting program. Resident #168 needed the assistance of 1 person for transfer/ambulation.</p> <p>In an interview on 8/23/12 at 10:48 AM RCS #3 stated that Resident #168 was able to stand and pivot with assistance into a chair. She indicated that Resident #168 was always incontinent. She stated that she had worked with Resident #168 approximately 3 months and that there had been no change in her urinary status.</p> <p>In an interview on 8/23/12 at 3:10 PM MDS Nurse #1 indicated that she was the nurse who had performed Resident #168's Quarterly Bowel and Bladder training assessment. She stated that Resident #168 was not a candidate for Bowel and Bladder training due to blindness and depression. She stated Resident #168 was also taking oxybutynin (for bladder spasms) and had bladder instability. MDS Nurse #1 also indicated that Resident #168 was unmotivated.</p> <p>In an interview on 8/23/12 at 3:37 PM Resident #168 stated that it bothered her to be incontinent and that it would help if staff could provide</p>	F 315		

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F 315	Continued From page 6 assistance to the bathroom every few hours. Resident #168 stated that she had been continent of urine when she had been admitted. Resident #168 indicated that a bedpan could be used at night, and she would be agreeable to a bedside commode being placed in the room. Resident #168 indicated that she would be willing to do bladder re-training so she would no longer be incontinent.  In an interview on 8/23/12 at 4:09 PM Nurse #2 indicated that Resident #168 was not on any formal bladder training program. If on a training program Resident #168 would be offered to be taken to the bathroom every 2 hours. Nurse #2 indicated that a bladder training program would benefit an alert and oriented resident who was admitted continent and who had become incontinent during their stay at the facility.  In an interview on 8/23/12 at 5:00 PM the Director of Nursing (DON) indicated that to be on a bladder training program the resident would need to be cognitively aware, physically able, and to have had a decline in function. She indicated that Resident #168's diagnoses would not affect her being put on a bladder retraining program. She indicated that she would have expected her nurses to have put Resident #168 on a bladder training/catch program. She would expect the RCS to be checking Resident #168 frequently and to be encouraging Resident #168 to call them to use the bathroom. She indicated that the catch program needed to be initiated for Resident #168 in the care tracker for the RCS.	F 315		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 7</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview the facility failed to cover a food product to prevent contamination from pests and failed to ensure kitchenware was dry before stacking it in storage. Findings include:</p> <p>1. At 11:28 AM on 08/22/12 peach crisp in dessert bowls on a food preparation table was uncovered.</p> <p>At 11:30 AM on 08/22/12 at least two flies were seen flying through the kitchen above the peach crisp.</p> <p>At 11:33 AM on 08/22/12 a dietary aide waved her hands above the peach crisp, as if she was trying to keep flies away from the uncovered food product.</p> <p>Between 11:36 AM and 11:38 AM on 08/22/12 flies were seen landing on peach crisp in three dessert bowls, making contact with the food product and the rims of the bowls.</p> <p>At 11:40 AM on 08/22/12 a cook used a</p>	F 371	<p>F371, SS=E</p> <p>On 8-22-12 it was brought to our attention that a fly had landed on the peach crisp. The Dietary Manager immediately discarded the peach crisp. Also it was brought to Dietary Manager's attention that the pots and pans were damp, the Dietary Manager immediately rewashed the pot and pans and let them air dry before use.</p> <p>All residents have the potential to be affected by the alleged deficient practice. All dietary staff was re-educated on the proper procedure for air-drying pot and pans and proper procedure for covering food items to prevent contamination. This in-service was started on 8-22-12 and completed on 8-23-12. The Administrator checked to ensure the fly fan was working at the entrance door of the kitchen and that the water bags (to prevent flies from entering building) were still intact at the entrance door to the kitchen and to the dining room. The Housekeeping Supervisor washed down the area outside the dietary entrance door with Clorox and water.</p>	9-20-12



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F 371	<p>Continued From page 8</p> <p>calibrated thermometer to check the temperature of the peach crisp.</p> <p>At 11:48 AM on 08/22/12 a dietary aide began placing lids over the bowls of peach crisp.</p> <p>At 11:50 AM on 08/22/12 the dietary manager (DM) reported the peach crisp was going to be served cold the next day. She stated she would have concerns about serving the peach crisp after flies landed on some of the food product. According to the DM, dietary staff was supposed to place sanitized trays or parchment paper held in place by sanitized trays over food products which were cooling or waiting to be placed in storage in order to prevent contamination by pests such as flies and gnats.</p> <p>At 11:52 AM on 08/22/12 the cook who prepared the crisp stated she took it out of the oven about thirty minutes ago. She reported when she took the temperature of the peach crisp it registered 80 degrees Fahrenheit on the thermometer. She explained she made the crisp a day ahead, and it was going to be served cold with a meal. The cook commented she would have concerns about serving the peach crisp after flies landed on some of the food product because the dessert would not be heated in order to kill possible germs and bacteria.</p> <p>At 9:23 AM on 08/23/12 the DM stated she held one to two in-services for the dietary department monthly. She reported, without looking through her files, she thought the last time education was provided to dietary staff about food preparation and storage (which would have included information about keeping food covered to avoid</p>	F 371	<p>Systemic measures implemented to ensure the same alleged deficient practice does not recur include: The Dietary Manager and/or designee will audit the pots and pans to make ensure they are being air dried properly and that food items which are not attended are covered with wax paper and/or sanitized lids 4 times a week for 4 weeks and then weekly times 2 months. The Dietary Manager will also audit the cleanliness of the outside of the dietary entrance door weekly times 12 weeks. Negative finding will be addressed if noted.</p> <p>Results of all audits will be reviewed during the Interdisciplinary Team meeting weekly times 4 weeks and monthly times 2 months.</p> <p>The Dietary Manager will bring the results of all audits to the QAPI Meeting for review monthly times 3 months. The results of the audits will be reviewed by the QAPI Committee to determine the effectiveness of this plan. Additional interventions will be developed and implemented as determined necessary by the Committee to ensure continued compliance.</p>	

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F 371	<p>Continued From page 9</p> <p>pest contaminallon) was around May 2012. At that time the DM commented staff were told to cover food items with parchment paper and/or sanitized trays to keep them safe. The DM reported when she asked the dietary aide about waving her hands over the peach crisp, the aide commented she was swatting away flies which she had seen in the kitchen.</p> <p>At 9:53 AM on 08/23/12 a dietary aide, who also at times performed food preparation duties, stated staff were told to cover food items after preparing them, even when walking away for just a few minutes. She reported she was trained to place sanitized trays over food items to keep pests from contaminating them.</p> <p>2. During the 08/20/12 initial tour of the kitchen, beginning at 9:45 AM, 2 of 13 tray pans which were stacked on top of one another in a final storage area were wet inside. The dietary manager (DM) stated these tray pans were washed after the 08/20/12 breakfast meal.</p> <p>At 9:15 AM on 08/23/12 1 of 3 tray pans stacked on top of one another in a final storage area had moisture inside of them. The cook stated these tray pans were washed after the 08/23/12 breakfast meal.</p> <p>At 9:23 AM on 08/23/12 the DM stated she held one to two in-services for the dietary department monthly. She reported, without looking through her files, she thought the last time education was provided to dietary staff about placing kitchenware in storage was last week. The DM commented all dietary employees were present for this in-service. She commented that dietary</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/23/2012
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	Continued From page 10 staff were instructed to make sure kitchenware was clean and dry before placing it in storage. According to the DM, she or her assistant monitored tray pans after each meal to make sure they were clean and dry in storage.  At 9:53 AM on 08/23/12 a dietary aide stated staff was trained to completely air dry kitchenware before stacking it in storage. She reported the DM or her assistant checked to make sure tray pans were stacked dry and clean daily.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  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	F 441	F441, SS=D On 8-22-12 the fan was immediately removed from the laundry room and cleaned by Maintenance.  All residents have the potential to be affected by the alleged deficient practice. All linen on the folding table that had direct contact with the air blowing from the fan was rewashed. All linen on the hallway linen carts and resident rooms was removed immediately and rewashed. The linen carts were stocked with new linen and sent back out to the hallways for resident use.	9-20-12

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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895	
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F 441	<p>Continued From page 11</p> <p>direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to clean 1 of 1 fans blowing directly on clean linens in the laundry room which resulted in the linens being contaminated. Findings include:</p> <p>At 3:50 PM on 08/22/12 a fan with dusty blades, dusty front and rear grills, and strands of dust blowing from the front and rear grills was blowing on a table of folded linens. The linens on the table included towels, washcloths, sheets, bibs, and gowns. At this time laundry room staff member (LRS) #1 stated the linens on the table were clean, and she had just finished removing them from the driers and folding them. At this time the director of environmental services (DES) reported the LRS was responsible for wiping off the fan in the laundry room once or twice a week, and maintenance was responsible for deep cleaning the fan once or twice a month. The DES explained the LRS used a dry cloth to run across the face of the fan, and maintenance took the fan apart, hosed it down, and washed it with a</p>	F 441	<p>Systemic measures implemented to ensure the same alleged deficient practice does not recur include: On August 23<sup>rd</sup> 2012 enclosed floor fan which does not blow across the folding table in the laundry room was implemented. The Laundry Supervisor will clean the floor fan once per week. The cleaning of the fan will be documented and the Maintenance Director and/or designee will audit the cleaning of the fan weekly times 12 weeks. Negative findings will be addressed if noted.</p> <p>The Laundry Supervisor will bring the results of the audits to the Quality Assessment Performance Improvement meeting times 3 months. The results of the audits will be reviewed by the QAPI Committee to determine the effectiveness of this plan. Additional interventions will be developed and implemented as determined necessary by the Committee to ensure continued compliance.</p>	

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F 441	Continued From page 12 disinfectant solution. LRM #1 commented she was probably the last one to clean the fan, wiping the face down with a wet cloth a couple of weeks ago. The DES stated he was not sure when maintenance last cleaned the fan, but the fan was overdue to be broken down and hosed. He reported that a dirty fan blowing on clean linens contaminated them, and the linens should not be used by residents, many of whom had weakened immune systems.  At 4:07 PM on 08/22/12 the maintenance manager (MM) stated environmental services cleaned the fan used in the laundry room. He reported the maintenance department could clean the fan if environmental services was unable to or if the department was directly asked to do so. However, the MM stated his department had not been asked to clean the laundry fan any time recently. According to the MM, the laundry fan was supposed to be broken apart and hosed down every couple of months. However, after observing the laundry fan, the MM reported it looked like this had not been done in longer than two months because of the amount of dust build up on the fan face and grills.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on observation, service technician interview, and staff interview 2 of 2 washing	F 456		

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F 456	<p>Continued From page 13</p> <p>machines in the laundry room were not dispensing bleach which resulted in stains not being effectively removed from facility linens. Findings include:</p> <p>At 3:50 PM on 08/22/12 the director of environmental services (DES) stated there were problems with the bleach not feeding into the laundry washing machines on and off over the past two months. He also reported there were shortages of washcloths over this same time period. The DES explained he was told that some of the nursing assistants were disposing of the washcloths, reporting that the laundry could not remove stains from them. The DES commented he thought the bleach was feeding into the washing machines currently because the service technician made some repairs on the washing machines last week.</p> <p>At 4:07 PM on 08/22/12 the maintenance manager (MM) stated that last week the service technician replaced a gasket on a washer door to prevent leakage and replaced a check valve on the washing machines. The MM reported no repairs were made to the dispensing system into the washing machines last week. However, he commented he thought some of the tubing in the dispensing system was replaced in November 2011, but it was tubing involved in the dispensing of the detergent. According to the MM, he was not made aware that there were problems with the bleach feeding into the washing machines until about ten minutes ago when the DES informed him.</p> <p>Between 4:45 PM and 4:50 PM on 08/22/12 the bleach moved in the tubing leading to both</p>	F 456	<p>F456, SS=E</p> <p>On 8-22-12 when it was brought to our attention that the washing machines were not dispensing bleach they were immediately stopped and a technician was called to service the machines. All linens were pulled from the hallways. The technician arrived within 3 hours and repaired the machines. Although the machines were not dispensing bleach the water temperature was 160 degrees and the dryers were 180 degrees.</p> <p>All residents have the potential to be affected by the alleged deficient practice. New linen was put onto the linen carts or resident use. Once the bleach dispensing mechanisms were repaired, facility linen was re-washed, checked for stains and placed in use. Laundry personnel were educated on the bleach dispensing mechanism, its function and to report to the Laundry Supervisor or Nursing Home Administrator if system was found to not be functioning properly.</p> <p>Systemic measures implemented to ensure the same alleged deficient practice does not recur include: On August 27<sup>th</sup> a daily documentation record was posted in the laundry room where the laundry personnel are to record the temperature of the hot</p>	9-20-12	

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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895		
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F 456	Continued From page 14 washing machines, but was not able to progress far enough up the tubing to reach the dispenser and enter the washing machines.  At 6:41 PM on 08/22/12 the service technician reported that the tubing leading to one washing machine needed to be primed to get air out of the line. He stated a part of the bleach-dispensing tubing to the other washing machine needed to be replaced because it must have been cracked.	F 456	water and document that the bleach is being dispensed into the machine. The Laundry Supervisor/designee is auditing the record weekly times 12 weeks to ensure the temperature and bleach dispenser is functioning properly and that the employees are documenting correctly. Random audits will continue to be done to ensure compliance.  The Laundry Supervisor will bring the Results of all audits to the Quality Assessment and Performance Improvement (QAPI) meeting monthly times 3 months. The results of the audits will be reviewed by the QAPI Committee to determine the effectiveness of this plan. Additional interventions will be developed and implemented as determined necessary by the Committee to ensure continued compliance.		

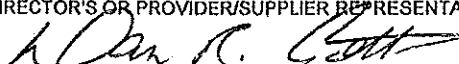
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/14/2012
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895
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K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: A. Based on observation on 11/14/2012 the smoke door at room 104 failed to close upon activation of the fire alarm . 42 CFR 483.70 (a)	K 027	K027  The smoke door at room 104 has been repaired and now closed upon activation of the fire alarm system.  All other fire doors were checked for proper closure when the fire alarm system is activated and all the doors closed properly. No other issues were identified with the fire doors.  The Maintenance Director will check all fire doors monthly during each fire drill to ensure that the doors are closing properly. Any problems will be documented with action taken to correct the problem.  The Maintenance Director and/or designee will audit the fire doors weekly x 4 weeks and then monthly x 3 months during the monthly fire drills to ensure that the fire doors are functioning properly. Results of the audits will be brought to the morning Interdisciplinary Team Meeting each week for review. Negative findings will be addressed if noted.  The Maintenance Director will bring the results of the audits to the monthly Quality Assurance and Assessment Committee (QA&A) meeting x 3 months. The QA&A committee will determine the effectiveness of the audits and if the plan needs further interventions to ensure continued compliance	12-5-12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by:	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11-30-12
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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K 029	<p>Continued From page 1</p> <p>A. Based on observation on 11/14/2012 there was both soiled linen and trash stored in the bathing area near room 405 and the door failed to close and latch.</p> <p>B. Based on observation on 11/14/2012 there were voids in the ceiling around pipe in the sprinkler riser room. 42 CFR 483.70 (a)</p>	K 029	<p>K029</p> <p>The door to the bathing area close to room 405 has been repaired and now closes and latches properly. The voids in the ceiling around the pipe in the sprinkler riser room have been repaired.</p> <p>All other doors to bathing areas and storage areas have been checked to ensure that they close and latch appropriately. All doors functioned properly. All other pipes in the facility that penetrate the ceiling tile have been checked for voids and repairs made as necessary.</p> <p>The Maintenance Director and/or designee will perform weekly audits x 4 weeks and then random audits x 3 month on all doors to bathing &amp; storage areas to ensure that they close and latch properly. The Maintenance Director and/or designee will follow up with any contractor that performs any type of work in the facility to ensure that if any penetration of the ceiling are made that they are repaired immediately before the contractor leaves the facility.</p> <p>The Maintenance Director will bring the results of the audits to the monthly Quality Assurance and Assessment Committee (QA&amp;A) meeting x 3 months. The QA&amp;A committee will determine the effectiveness of the audits and if the plan needs further interventions to ensure continued compliance.</p>	12-5-12