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

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 01/16/2015

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

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify the responsible party of a resident's (resident # 9) discharge from skilled	F 157	F157 Resident #9 no longer resides at the Brian	1/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/28/2015

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 157	Continued From page 1 therapy services for one of three residents reviewed for notification. Findings included: Resident #9 was admitted to the facility on 10/30/2014 with cumulative diagnoses including altered mental status, history of transient ischemic attack (TIA)/stroke without residual effects, hypertension, debility, diabetes, anemia, urinary tract infection (UTI), and acute kidney failure upon admission. Review of a social progress note, dated 11/06/2014, revealed that Resident #9 was admitted to the facility from the hospital status post evaluation and treatment for hypertension and cardiovascular accident and was expecting to discharge back to an assisted living facility following the completion of therapy. Review of therapy notes, dating from 10/31/14 through 11/25/14, revealed that the resident participated in occupation and physical therapy for mobility, transfers, balance, gait training, safety awareness, strengthening, and increased self performance of ADLs from 10/31/2014 through 11/25/2014, and was discharged from therapy because it was believed that the highest practical level had been achieved. The therapy department completed a discharge notification form seven days prior to the scheduled discharge and submitted the form to the rehab manager, social work department, admissions, the MDS nurse, the outpatient coordinator, and the business office. Further review of Resident #9's record did not reveal any documentation of communication of	F 157	Center Health & Rehab. The facility staff was provided re-education regarding notification to resident, physician and resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in resident physical, mental or psychosocial status; a need to alter treatment significantly; room change or decision to transfer or discharge the resident from skilled therapy and/or the facility on 1/19/15 by facility Director of Rehab and completed on 1/21/15. The facility reviewed all resident's discharged from skilled therapy over the last 90 days to ensure that resident or legal representative and attending physician had been notified. The audit began on 1/17/15 and was completed on 1/27/15 by the Director of Rehab. The facility Rehab Manager will complete In-House Communication sheet when resident is expected to be discharged from skilled therapy. The facility Rehab Manager will bring the In-house Communicator to the facility morning meeting. The facility treating therapist will communicate to the resident and/or legal representative that skilled therapy will be discontinued on specific date. The notification will be documented on the 7 day discharge notification form and in	

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F 157	Continued From page 2 the resident's discharged from therapy to the resident's responsible party. Resident #9's 30-day Minimum Data Set (MDS), dated 12/2/2014, indicated the resident was severely cognitively impaired, extensively to totally dependent with all activities of daily living (ADLs), used a wheelchair and walker to ambulate, and received speech, occupational, and physical therapies that were initiated on 10/31/2014 and ended on 11/25/14. In a social progress note, dated 12/10/2014, it was revealed that there was a care plan meeting that took place with the resident, resident's responsible party, social work, and a nurse manager during which the responsible party expressed that no communication was made in regards to the resident being discharged from therapy. The note also stated that therapy indicated that 7 day notice was given and that the social work department was to communicate information regarding the discharge to the family. On 1/16/2015 at 12:30 PM, the Director of Social Work Services stated that the he did not remember if anyone notified the responsible party about the resident's therapy ending, but he knew that the social work department had not provided the resident or responsible party with a written Medicare notice of non coverage of therapy services. At 1:24 PM on 1/16/2015, the Director of Therapy said that communication regarding therapy discharge was always sent to the social work department no less than 7 days prior to a planned discharge and that the social work department was responsible for communicating this	F 157	the treating therapist notes. The Director of Rehab will utilize a weekly Audit of D/C Notification Form and audit at least 5 discharge charts weekly times four and monthly times 90 days to ensure that resident/family notification of discharge from therapy. The facility Director of Rehab will report results observations to the Quality Assurance Committee (QAPI) meeting weekly times four weeks and monthly times ninety days. Additional interventions will be implemented as recommended by the QAPI Committee with ongoing evaluation of effectiveness.	

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F 157	Continued From page 3 information to the responsible party and family. She also stated that a notice of therapy discharge had been provided to the social work department at least 7 days prior to Resident #9's discharge from therapy. At 1:38 PM on 1/16/2015, the therapist who worked with Resident#9 stated that the resident was discharged from therapy on 11/25/2014 because the max potential had been reached at that time. She stated that a form with discharge information had been sent to all necessary departments and personnel including social work, admissions, medical records, and the director of rehab so that the information could be communicated to the family. The therapist reported that she had a conversation with the responsible party in the early part of December regarding Resident #9's progress in therapy and the responsible party wanted to know when Resident#9 had been discharged from therapy and why.	F 157		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide thorough perineal care to minimize the risk of urinary tract infections for one of two residents observed for	F 312	F312 Resident #6 was seen by MD on 1/15/15 and assessed to be without any signs or	1/28/15

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incontinent care, Resident #6. Findings included:

A review of the quarterly Minimum Data Set (MDS) Assessment dated 12/22/2014 revealed Resident #6 was severely cognitively impaired and required extensive assistance from staff for personal hygiene and toileting, and complete assistance for her bathing needs. The same assessment indicated Resident #6 was frequently incontinent of her bladder and bowel. A partial list of her diagnoses included dementia and a urinary tract infection in the previous 30 days.

Resident #6's nursing care plan included goals and interventions to address her incontinence and her urinary tract infection. Some of the interventions included in the plan were to provide perineal care daily and as needed, and to observe for signs and symptoms of infection.

In an observation of incontinent care on 01/13/2015 at 10:00 AM, nursing assistant (NA) #1 gathered a clean disposable adult brief, a towel, and multiple washcloths, and then washed his hands and donned cleaned disposable gloves. After NA #1 explained the incontinent care procedure to Resident #6, he pulled back Resident #6's disposable brief. A large amount of reddish brown discoloration was noted on the brief and on the resident's perineal area. NA #1 dampened a washcloth, added body wash soap to it, then washed from the front of the perineal area toward the back. NA #1 folded the washcloth to a clean area, then washed again front to back, and continued this process four more times. Reddish brown residue was noted on the washcloth after each stroke to cleanse the resident. NA #1 then used a damp washcloth to

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symptoms of infection.

All residents requiring extensive assistance with ADLs/incontinent care have the potential to be affected by the allegedly deficient practice.

Direct Care Nursing Staff were provided re-education beginning on 1/13/15 through 1/20/15. The education included Perineal Care for Female/Male Residents according to the standard of care, proper handling of linen, use of gloves and hand washing was completed by Director of Nursing and Director of Staff Development.

On 1/16/15 - 1/27/15, each direct care staff were observed completing perineal care for male/female resident and hand hygiene using the Lippincott Procedure checklist skills validation form by the Director of Nursing and Director of Staff Development. Any deficient practice was corrected immediately and ongoing education provided.

The Director of Nursing will report results of observations to the Quality Assurance Committee (QAPI) meeting weekly times 4 weeks and monthly times ninety days. Additional interventions will be implemented as recommended by the QAPI Committee with ongoing evaluation of effectiveness.

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F 312	Continued From page 5 remove the soap from the perineal area. After NA #1 completed the washing and rinsing, he picked up a dry towel and began to pat dry the perineum. NA #1 was then asked to separate the labia. As NA #1 separated the labia, more reddish brown discoloration was noted. NA #1 placed the towel aside and obtained a clean washcloth, dampened it, and added soap. NA #1 cleansed the perineal area in between the labia, using a front to back strokes six times, and a back to front stroke one time. The resident was turned to her side, where there was more reddish brown discoloration noted on the soiled disposable brief. NA #1 used another washcloth with soap to cleanse the buttocks area and in between the gluteal fold. When the gluteal fold was separated, a small amount of soft brown stool was noted. NA #1 cleansed the stool from the resident and removed the soiled brief. NA #1 dried the resident's buttocks using dry washcloths, then applied a barrier cream to the sacrum, buttocks, and the skin in the folds between the perineal area and the thighs, all while wearing the same gloves he was wearing to remove the stool. NA #1 applied a clean disposable brief and a clean draw sheet, and then repositioned the resident in the bed, also while wearing the same pair of gloves. An interview was conducted with NA #1 on 01/13/2015 at 10:25 AM, after the care was provided. NA #1 stated the purpose of wiping front to back was to prevent infections. NA #1 also stated that he was aware that he did not wash his hands or change his gloves in between handling the stool-soiled washcloths and handling the clean draw sheet, and that he applied the barrier cream without washing his hands or changing gloves after handling the soiled	F 312		

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washcloths. In addition, he stated he knew it was important to wash hands and change gloves at both those times, and he did not know why he did not. NA #1 stated he was aware that Resident #6 had a recent urinary tract infection. NA #1 also stated he was not sure why the resident's urine was discolored.

A review of the facility's procedure for Perineal Care of the Female Patient stated in part:

" Assess the patient's perineal area for color changes, skin breakdown, drainage, discharge, or tenderness. If any are present, notify the practitioner ... "
" Separate the patient's labia with one hand and was with the other, using gentle downward strokes from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina ... "

In an interview with the infection control nurse on 1/14/2015 at 10:35 AM, she stated that it was her expectation that for female residents, the perineal area should be cleaned using front to back strokes, and that the labia should be separated to clean completely between the labial folds. In addition, she stated that the caregiver's hands should be washed and gloves changed in between contact with resident stool or urine and the application of lotions or barrier creams to the resident or clean linens applied to the resident's bed. The Infection Control Nurse also stated that she had begun to conduct in-service education on perineal care for males and females on 01/13/2015 after she received reports that there were concerns regarding perineal care for Resident #6.

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F 312	Continued From page 7 In an interview with the Director of Nursing on 01/16/2015 at 4:00 PM, she stated that it was her expectation that the policy for perineal care be followed as well as the hand washing/hand hygiene policy during the provision of perineal care.	F 312		
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 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		1/28/15

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F 441	Continued From page 8 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based upon observation, record review, and staff interviews, the facility failed to dispose of soiled linens and soiled briefs according to the standard precaution guidelines for infection prevention for one of two residents observed for incontinent care, Resident #6. Findings included: A review of the facility's Standard Precautions in the Infection Prevention Manual for Long Term Care, page 5 of 2012 ICP Associates, stated in part, "Gloves should be worn whenever exposure to the following is planned or anticipated: feces, urine, wound drainage, non-intact skin." In addition, it stated that standard precautions should be used for all residents. A review of the facility's Glove Use policy in the Infection Prevention Manual for Long Term Care, page 21 of 2012 ICP Associates, Incorporated, stated in part, "Gloves should be used when touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin, when handling potentially contaminated items, and when it is likely that hands will come in contact with blood, body fluids, or potentially infectious material." A review of the facility's Hand Hygiene Policy in the Infection Prevention Manual for Long Term Care, page 26, stated in part that the purpose for hand hygiene was to decrease the risk of transmission of infection by appropriate hand	F 441	F441 On 1/13/15, in-servicing began with NA #1 who allegedly failed to dispose of soiled linens and briefs according to the standard precaution guidelines for infection prevention. The re-education included using the appropriate PPE to include wearing of gloves when planned or anticipated exposure to feces, urine, wound drainage, non-intact skin, secretions, blood and other body fluids. NA #1 was also provided re-education on proper hand washing. The education was provided by Director of Staff Development. The facility staff were provided re-education beginning on 1/13/15. The education included properly disposing of soiled linens and briefs, wearing of gloves when anticipated contact with feces, urine, wound drainage, non-intact skin, secretion, blood and other body fluids. The facility staff were also provided education on proper hand washing techniques. The education was provided by The Director of Staff Development and completed on 1/20/15.	

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F 441	Continued From page 9 hygiene. In addition, in Part I of the policy on page 26 stated, "When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, after going to the restroom, ... perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water." An observation of incontinent care for Resident #6 was made on 01/13/2015 at 10:00 AM. As the nursing assistant (NA) #1 removed the adult brief which was soiled with urine and stool, he placed it inside a plastic bag in the resident's room. NA #1 also discarded the soiled washcloths, towel, and draw pad in a separate plastic bag. After providing the incontinent care, NA #1 removed his gloves, then picked up both plastic bags, and exited the room without washing his hands or donning clean gloves. NA #1 tied the plastic bags with his bare hands outside of the resident's room, removed the soiled linen bin lid and discarded the soiled linen bag inside. NA #1 also removed the lid to the trash bin and discarded the plastic bag of soiled items. The soiled linen bin and the trash bin were located in the hallway outside the resident's room. In an interview with NA #1 after the incontinent care at 10:25 AM on 10/13/2015, he stated he realized he forgot to wash his hands after he completed the incontinent care procedure, and that he should have donned gloves after washing his hands to tie up the plastic bags filled with soiled trash and soiled linens. In addition, he stated that he should have worn gloves to place the plastic bags in the hallway bins. An interview was conducted with the facility's infection control nurse on 01/14/2015 at 10:35 AM. During the interview, she stated that handwashing should occur before and after handling items contaminated with feces or urine,	F 441	Each direct care facility staff was observed disposing of soiled linen or briefs and hand washing on 1/16/15 and completed on 1/27/15. The observations were documented on skill validation form by facility Director of Staff Development and Director of Nursing. The facility's Director of Nursing/Director of Staff Development will observe at least 3 direct staff members (various shifts) weekly times four and monthly times 90 days to ensure that all staff are using the appropriate PPE, performing proper hand washing/dis-infection techniques, and disposing all materials contaminated or possibly contaminated. The observation will be documented on Hand Hygiene and Glove Use Monitoring Form. Any observations of possible cross contamination or non-compliance will be corrected immediately by the Director of Nursing or the Director of Staff Development. Additional Education will be provided to staff as needed by the facility Director of Nursing and Director of Staff Development. The facility Director of Nursing will report results observations to the Quality Assurance Committee (QAPI) meeting weekly times four weeks and monthly times ninety days. Additional interventions will be implemented as recommended by the QAPI Committee with ongoing evaluation of effectiveness.	

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F 441	Continued From page 10 such as soiled diapers or soiled linens used to provide care. In addition, she stated that hands should be washed inside the resident's room after completing incontinent care and that clean gloves should be worn to tie plastic bags inside the resident's room and to discard the plastic bags in the bins located in the hallway. The Director of Nursing (DON) stated in an interview on 01/16/2015 at 4:00 PM that standard infection control procedures should be followed when providing care for all residents and when disposing of soiled items.	F 441		