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 07/07/2016

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

(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 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow an admission physician ' s order to flush a Port-a-Cath (central intravenous line) monthly for 1 of 3 resident ' s (Resident #1) reviewed for accurate assessment. The findings included: Resident #1 was admitted to the facility on 6/10/15 with diagnoses which included diabetes mellitus and cellulitis of left toe. The quarterly Minimum Data Set (MDS) of 6/22/16 showed Resident #1 to be severely cognitively impaired. It further showed she required extensive assistance dressing and personal hygiene. She was totally dependent on staff for bathing. A review of the May 2016 orders revealed an order for Heparin Lock (needle/catheter tubing placed in the vein with blood thinner to keep the blood from clotting) Flush Solution, which was originally ordered June 2015 for a once a month flush for an existing Port-a-cath. A review of the May 2016 medication	F 328	Resident #1 port-a-cath has been flushed per MD orders since 5/26/16. All current residents were assessed by the director of nursing and the unit managers on 7/21/16 and completed on 7/27/16 to identify any resident's that have a port-a-cath and that care and treatment is ordered and provided per policy and MD order. In-servicing by the director of nursing or designee began on 7/21/16 and will be completed by 7/28/16 for current licensed nurses. Newly hired licensed nurses will be inserviced during new hire orientation and all other licensed nurses will receive the inservices prior to working their next shift. In-service will include the expectation that nurses properly assess for and document port-a-cath sites on skin assessments and ensure maintenance	7/29/16

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

Electronically Signed | 07/29/2016

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F 328	Continued From page 1 administration record (MAR) showed an order for Heparin Lock Flush Solution 100unit/milliliters, Use 5 cubic centimeters (cc) intravenously (IV) one time a day for Vancomycin Antibiotic IV patency until 6/25/16. Order date was 5/26/16. The MAR also included an order for Normal Saline Flush 0.9% Use 10 cc intravenously one time for Vancomycin until 6/25/16. Order date was 5/26/16. A review of MARs from December 2015 to May 26, 2016 revealed no record of intravenous flush of Resident #1 ' s Port-a-cath. A review of the May 2016 orders revealed and order for Vancomycin (antibiotic) HCL in Dextrose solution 1 Gram (gm)/200 milliliters, use 1.5 GM intravenously one time a day for MRSA (Methicillin-resistant Staphylococcus aureus) in left foot. An interview was conducted on 7/7/16 @ 11:55 AM with Nurse #1. She stated she had called Resident #1 ' s Responsible Party (RP) on 5/26/16 to notify him of the new order for insertion of a PICC (a form of intravenous access that can be used for a prolonged period of time) line for administration of intravenous Vancomycin. She stated the RP questioned why Resident #1 needed a PICC line if she already had a Port-a-Cath. She explained she had immediately notified her supervisor regarding the RP ' s concern. An interview was conducted 7/7/16 @ 12:15 PM with Nurse #3 who was the supervisor on 5/26/16. She stated she had contacted the physician who ordered the PICC line and Vancomycin to notify him of Resident #1 ' s Port-a-cath and that it had not been flushed since admission. She stated the physician gave an order to flush the Port-a-cath and check for a return (pull back on the syringe to see if blood comes through the line). Nurse #3 stated the Port-a-cath was flushed without	F 328	orders are received and followed. Nurse managers and director of nursing will audit all new admits weekly x4 then monthly times two beginning 7/26/16 to ensure that port-a-cath sites were identified and care and maintenance orders were documented on admission. Nurse managers will audit their residents identified with port-a-caths weekly skin assessments beginning on 7/26/16 every week x4 then monthly x2 to ensure assigned nurse is documenting port-a-cath site on weekly skin assessment. Nurse managers will then audit residents identified with port-a-caths monthly orders x2 to ensure orders are carried over from the previous month. The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 328	Continued From page 2 difficulty and had a good return. Nurse #1 stated the intravenous antibiotic was given without complications for the entire course through the Port-a-cath. An interview was conducted on 7/7/16 @ 1:20 PM with the Director of Nursing. She stated the admission order for the Port-a-cath flush had not been transferred to the MAR after the initial handwritten note and there was no indication that the Port-a-cath had been flushed until 5/26/16. She stated it was her expectation that nurses properly assess and document all intravenous access sites on skin assessments and ensure maintenance orders were included and followed. She provided an in-service document dated 5/26/16 regarding assessment of port-a-caths, pacemakers, and IV accesses. Nurse #1 and Nurse #3 had signed the in-service attesting their awareness of the subject covered.	F 328		
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.	F 441		7/29/16

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F 441	Continued From page 3 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to wash hands and change gloves between dirty and clean tasks for 1 of 3 residents (Resident #3) observed for incontinent care. The findings included: Nursing Assistant (NA) #2 was observed providing incontinent care for Resident #3 on 7/6/16 at 1:45 PM. NA #3 assisted with turning and positioning. NA #2 obtained protective barrier cream from Resident #3 ' s bedside table and placed it on the bed and donned gloves. NA#2 and NA #3 positioned Resident #3 on his right side. NA #2 cleaned the buttocks area of urine with moist wipes from front to back. Protective barrier cream was applied to Resident #3 ' s buttocks. NA #2 and NA #3 then positioned	F 441	One to one inservicing by the director of nursing with NA#2 occurred on 7/7/16. Inservicing included failure to change gloves after performing a dirty task greatly increases the risk of spread of infections and that staff are to remove gloves immediately after performing a dirty task, perform hand hygiene, then apply clean gloves before performing a clean task. NA#2 was observed by a licensed nurse and demonstrated successful perineal care to a female resident on 7/11/16 observing proper steps to include changing gloves and performing hand hygiene between dirty and clean tasks.	

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F 441	Continued From page 4 Resident #3 on his back. NA #2 used moist wipes to clean urine from the front of the resident ' s perineal area and barrier cream was applied. NA #2 then placed the top back on the barrier cream and returned it to Resident #3 ' s bedside table. NA #2 and NA #3 applied a new brief. NA #2 positioned the resident ' s linens over him and placed his bed control and call light within reach. NA #2 placed the used brief in the trashcan, tied the bag closed and removed her gloves and transported the trash to a receptacle in the hall way. She then applied hand sanitizer from a dispenser located over the trash receptacle. An interview was conducted with NA #2 immediately after the observation. She stated she did not change her gloves after providing incontinent care and applying barrier cream. She stated she didn ' t notice she had not removed her gloves before touching the resident ' s clean linens or call light/bed controls. NA #2 stated she was new to the facility and did not recall any in-services on hand washing. An interview was conducted 7/7/16 at 10:30 AM with the Director of Nursing. She stated she and the nursing managers are responsible for training and monitoring staff in proper technique for changing gloves and hand washing. She further stated nurses are instructed in staff meetings to remind NAs to wash hands and change gloves between dirty and clean tasks. She stated it was her expectation that NAs would change gloves after applying barrier cream and before touching linens or bed control/call light.	F 441	In-servicing by the director of nursing or designee began on 7/7/16 and will be completed by 7/28/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include that failure to change gloves after performing a dirty task greatly increases the risk of spread of infections and that staff are to remove gloves immediately after performing a dirty task, perform hand hygiene, then apply clean gloves before performing a clean task. Director of nursing, assistant director of nursing/100 and 300 nurse manager, 400 and 500 nurse manager or designee will monitor compliance by observing incontinent care on 2-3 staff members on various shifts weekly times four then monthly times two beginning on to ensure the process includes when to change gloves and appropriate hand hygiene when performing clean and dirty tasks. Director of nursing or designee will observe all newly hired clinical staff hired after 7/25/16 within a week of their hire date perform incontinent care on a resident to ensure the process includes when to change gloves and appropriate hand hygiene when performing clean and dirty tasks. The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee	

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F 441	Continued From page 5	F 441	weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented	F 520	The Quality Assurance and Performance Improvement (QAPI) committee met on 7/8/16 to discuss potential complaint	7/29/16

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F 520	Continued From page 6 procedures and monitoring practices to address interventions put into effect after the 5/6/16 complaint survey. During the survey of 5/6/16 the facility was cited at F441 for failure to change gloves between dirty and clean tasks. During complaint survey of 7/6/16, the facility was recited at F441 failure to wash hands and change gloves between dirty and clean tasks. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: F441: Infection Control. Based on observation and staff interviews, the facility failed to wash hands and change gloves between dirty and clean tasks for 1 of 3 residents (Resident #3) observed for incontinent care. During the complaint survey of 5/6/16, the facility was cited at F441 for failure to change gloves between dirty and clean tasks for 1 of 4 residents (Resident #10) reviewed for infection control practices. On the current complaint survey of 7/7/16, the facility failed to wash hands and change gloves between dirty and clean tasks for 1 of 3 residents (Resident #3) observed for incontinent care. On 7/7/16 at 2:30 PM and interview was conducted with the Director of Nursing. She stated the facility had completed in-service training and was continuing to monitor the staff for proper procedure for hand hygiene and changing gloves. She provided an in-service training report and staff attendance roster dated 5/27/16. The roster included Nursing Assistant #2 as having been in-serviced on hand hygiene and changing gloves.	F 520	survey results to include discussion of repeat citation related to F441. The committee met on 7/22/16 and discussed final results of the complaint survey from 7/6-7/7. Discussion included actions already taken to correct procedures involved in the citations and plan for alledging compliance. The Division Director of Clinical Service will provide re-education to facility department managers and medical director regarding the Quality Assurance and Performance Improvement process on 7/26/16. The Division Director of Clinical Service and/or the Division Director of Operations will attend QAPI meeting weekly times four and monthly times two if possible to ensure that plan of correction has been implemented and maintained. If either are unable to attend the meeting; minutes and supporting documentation will be emailed to them weekly. The facility QAPI committee will meet weekly times four and monthly times two to discuss results of audits related to the plan of correction for complaint survey 6-7 June. The committee will analyze and trend the data to determine if revision to the plan of correction is needed.	