

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

PRINTED: 07/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHABI HICK			STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602		
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E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 557 SS=D	<p>Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to ensure a resident was spoken to with dignity while requesting assistance to wheel her back to the room while in the hallway for 1 of 1 resident (Resident #3).</p>	F 557	<p>F557</p> <p>Director of Nursing completed a 24 hour initial report on 6/25/2020 and suspended NA # 4 until complete investigation could be completed for possible abuse. DON</p>	7/29/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/21/2020

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 557	<p>Continued From page 1</p> <p>Resident #3 was admitted to the facility on 01/04/17 with diagnoses that included contractures of the lower extremity, dialysis dependence, muscle weakness.</p> <p>A review of the physician's order dated 05/29/18 revealed Resident #3 is to receive dialysis treatments on Monday, Wednesday, and Friday weekly.</p> <p>A quarterly Minimum Data Set (MDS) dated 04/06/20 revealed Resident #3 was cognitively intact, mood indicators reflecting feeling tired/having little energy on 2-6 days and required extensive assistance of one staff member for locomotion off the unit and supervision with locomotion on her unit.</p> <p>A review of the care plan for self-care deficits dated 03/23/20 indicated Resident #3 required assistance of completion of ADL tasks and a psychosocial care plan dated 06/26/19 revealed Resident #3 was a long-term care resident and would have all needs met while a resident in the facility.</p> <p>An interview with Resident #3 on 06/25/20 at 11:45 AM revealed she received dialysis three days per week on Monday, Wednesday, and Fridays. She stated her treatment lasted several hours and often she had less energy when she returned from her treatments. She stated a local transportation company had been taking her to her appointments since the pandemic began and they were not allowed to help push her back to her room when they brought her back which caused her some days to need more help getting to her room from being more fatigued. Resident #3 indicated she returned yesterday from dialysis</p>	F 557	<p>interviewed resident #3 and resident #4 regarding incident and no indication of abuse was found.</p> <p>Investigation was completed on 6/30/2020 with abuse found to be unsubstantiated. NA # 4 was educated on dignity and respect by DON on 6/30/2020.</p> <p>Staff were all educated that Resident #3 would need additional assistance on days of dialysis and at any time she requested assistance.. This was also placed in her care plan. Staff were also educated that although we encourage residents to be as independent as possible that if resident ask for assistance we should always be willing to assist after positively encouraging them .Education included that Residents should never be spoken to in a undignified manner. All education was completed by the DON.</p> <p>Residents in the facility have the potential to be affected by the alleged deficient practice. Director of Nursing, Administrator, Unit Managers and Assistant Director of Nursing spoke to alert and oriented residents on 7/17/2020 and no dignity or respect issues were verbalized.</p> <p>Director of nursing will educate all staff on dignity and respect by 7/22/2020. Ambassadors will interview 1 of their alert and oriented assigned residents weekly for 12 weeks to ensure residents have no issues with dignity and respect.</p> <p>The Director of Nursing will analyze the</p>		

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F 557	<p>Continued From page 2</p> <p>on 06/24/20 and requested assistance from Nurse Aide #2 to wheel her wheelchair to her room. When no staff member assisted her, another resident began pushing her towards her room. She reported Nurse Aide (NA) #2 refused to help her and told Resident #4 to stop pushing her because Resident #3's arms weren't broken, and she needed to be pushing herself. Resident #3 stated it made her very sad that the only person that would help her get to her room was a resident even though there are plenty of staff that saw me needing help. She stated Nurse Aide #2 was rude to her and she felt like she didn't care about helping her.</p> <p>An interview with NA #2 on 07/01/20 at 8:10 AM revealed she had cared for Resident #3 on many occasions including 06/24/20 and knew she was able to self-propel in her wheelchair independently. She stated she had instructed Resident #4 to stop pushing Resident #3 because her arms weren't broken. She indicated she was not aware it made Resident #3 feel sad when she made that comment and she only wanted her to maintain her independence. NA #2 acknowledged she should not have said that when Resident #3 asked for help because it could have been taken wrong by Resident #3.</p> <p>An interview on 06/25/20 at 12:00 PM with Resident #4 revealed he was the resident identified by staff to be pushing Resident #3 on 06/24/20. He overheard Resident #3 ask NA #2 to help assist her to the room but NA #2 refused so he offered to help her. While assisting her, he was instructed by NA #2 to stop pushing Resident #3 because her arms weren't broken. He stated the staff didn't help Resident #3, so he decided to help her instead.</p>	F 557	<p>data obtained and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 3 months.</p> <p>The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance. Date of Compliance 7/29/2020</p>		

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F 557	Continued From page 3 An interview on 06/25/20 at 12:15 PM with the Director of Nursing and the Administrator revealed they were unaware Resident #3 had been denied assistance or spoken to by staff in an undignified way. The Director of Nursing revealed she believed Resident #3 could push herself to her room without assistance after dialysis services and staff were only trying to preserve her independence by not helping push her to her room, but she would investigate the incident further because the language reported was an unacceptable manner to speak with Resident #3.	F 557			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		7/29/20	

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F 880	<p>Continued From page 4 accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>	F 880			

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F 880	<p>Continued From page 5</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, review of the facility's infection control documents and Centers for Disease Control and Prevention (CDC) guidelines for individuals on Droplet Precautions, the facility failed to ensure proper Personal Protective Equipment (PPE) was donned before touching residents on Droplet Precaution for 1 of 2 resident (Resident #1) and failed to ensure staff performed hand hygiene between interacting with 2 of 2 residents who were on Droplet Precautions (Resident #1 and Resident #2). These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents in the facility through the transmission of COVID-19.</p> <p>Findings included:</p> <p>A review of the CDC recommendations for patients on Droplet precautions currently available on the CDC website, under section "IV.B.2.a" read in part, gloves are to be worn when there is potential to contact potentially infectious materials, mucous membranes, nonintact skin, and potentially contaminated intact skin.</p> <p>According to the facility protocol document titled "Managing COVID-19 in your facility" dated 04/23/20 read in part: under the topic of care considerations residents placed on droplet based transmission precautions are suspected to be</p>	F 880	<p>F880 Nurse aide #1 and therapy assistant were educated individually on Infection control and preventing COVID-19 on 7/17/2020 Resident # 1 had a COVID 19 test performed on 7/1/2020 on her 12th day per facility protocol and received negative results on 7/6/2020.</p> <p>All new admissions placed on Droplet Precautions until testing on day 12 have the potential to be affected by this alleged deficient practice. All other residents and staff in facility have the potential to be affected by contamination.</p> <p>All new admissions are encouraged to remain in room until tested negative for COVID 19. If isolation in room can not be maintained due to residents cognitive status it will be care planned along with interventions.</p> <p>All new admissions will have a red bracelet placed on them until a negative COVID test has been obtained to alert staff that they are still under quarantine and on droplet precautions.</p> <p>First shift unit managers and Infection control nurse will monitor 3 residents on Droplet Precautions weekly for 12 weeks to ensure proper PPE, Bracelet alert</p>		

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F 880	<p>Continued From page 6</p> <p>infected by COVID-19 are considered positive until testing confirms otherwise and all staff must be meticulous with hand hygiene and the use of PPE.</p> <p>A continuous observation on 06/25/20, from 10:10 AM to 10:20 AM, revealed Resident #1 was wheeling herself in the hallway on the unit she resided. She had on a mask that she was observed frequently tugging, touching her face with her hands, then touching the handrails and walls. Resident #1's door revealed signage that indicated she was on Droplet Precautions. Nurse Aide #1 approached Resident #1 and touched her with her bare hands to ask her if she needed anything and assisted Resident #1 to make adjustments to her face mask then Resident #1 continued wheeling down the hallway and Nurse Aide #1 did not perform hand hygiene and was not wearing gloves during this observation. A therapy assistant then stopped to speak to Resident #1 in the hallway. As he approached Resident #1, he began talking to her and touched the arm of her wheelchair with his right hand and put his left hand on her right shoulder touching her shoulder and right cheek near her mouth. He was explaining to Resident #1 that her therapy session would be around lunchtime and he would be providing her treatment today. Following this interaction, Therapy assistant #1, who was not wearing gloves did not perform hand hygiene before donning a gown and entering Resident #2's room. Observations of the door to Resident #2's room revealed signage that indicated he was on Droplet Precautions.</p> <p>An interview with Nurse Aide #1 on 06/25/20 at 10:55 AM revealed she acknowledged she touched Resident #1 out of habit of the home-like</p>	F 880	<p>identified and hand washing is performed by staff.</p> <p>Director of Nursing will educate Nursing and therapy staff on infection prevention, proper PPE, hand washing, systematic change with red arm bands that indicate droplet precautions and preventing COVID- 19 by 7/22/2020</p> <p>All new admissions, Residents with potential symptoms and staff with potential symptoms of Covid19 have been tested. All have tested negative. 100% staff and Residents will be tested on August 3rd. Routine testing will then continue in conjunction with CDC recommendations and guidelines.</p> <p>The Director of Nursing will analyze the data obtained and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 3 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan and will add additional interventions based on the outcomes identified to ensure continued compliance. Date of Compliance: 7/29/2020</p>		

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F 880	<p>Continued From page 7</p> <p>environment. She stated she did not think about Resident #1 being on infection control precautions when she adjusted her mask. She acknowledged Resident #1 had been wandering in the hallway pulling at her mask and touching environmental surfaces and she had stopped to ask if Resident #1 needed assistance. She stated she should have re-directed Resident #1 back to her room, worn gloves if adjusting the mask, and perform hand hygiene following the removal of her gloves. She further stated she should have cleaned the handrails or asked housekeeping to clean to decrease the risk of potentially spreading infections.</p> <p>An interview with Therapy Assistant #1 on 06/25/20 at 10:20 AM revealed he acknowledged he was in the hallway talking to Resident #1. He stated he had not worked with Resident #1 before and did not know she was on any infection control precautions therefore he did not apply gloves before touching Resident #1 or perform hand hygiene before donning a gown and entering Resident #2's room to provide care.</p> <p>An interview with Nurse #1 on 06/25/20 at 10:25 AM revealed all new admissions were placed on Droplet/Contact Precautions for the first 14 days following admission pending facility COVID-19 testing. He further stated Resident #1 and Resident #2 were new admissions, who resided on the facility's rehab hallway, and were on Droplet/Contact Precautions. Nurse #1 specified that all staff were to wear mask, gown, and gloves when interacting with or touching Resident #1 and Resident #2. He also stated staff should have re-directed Resident #1 back to her room when in the hallway as much as possible to decrease the potential spread of infection due to</p>	F 880			

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F 880	Continued From page 8 her fidgeting with her face covering, touching her mouth and face, and touching environmental surfaces. An interview with the Administrator on 07/02/20 at 12:08 PM revealed she was unaware that staff were interacting with Resident #1 and Resident #2 without wearing PPE or performing hand hygiene following touching Resident #1. She acknowledged Resident #1 and Resident #2 were on Droplet Precautions and stated all staff should wear PPE and perform hand hygiene between resident interactions to decrease the spread of infection.	F 880			