

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

PRINTED: 04/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2021
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUCE PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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	
E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 880 SS=E	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§483.80(a) Infection prevention and control program.</p>	F 880		5/14/21	

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

TITLE

(X6) DATE

Electronically Signed

04/26/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2021
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUCE PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 880	<p>Continued From page 1</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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 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> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2021
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUCE PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 880	<p>Continued From page 2</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <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> <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 record reviews, observations and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 2 staff members (Nurse Aide #1) failed to discard her mask and clean her goggles after providing resident care to 11 of 11 residents on the quarantine hall and went to care for 8 of 8 residents on a non-quarantine hall reviewed for infection control practices. This failure occurred during a COVID-19 pandemic.</p> <p>The findings included:</p> <p>The Centers for Disease Control and Prevention (CDC) guidance entitled, "Preparing for COVID-19 in Nursing Homes," updated on 11/20/20 indicated the following statement under the section "Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown":</p>	F 880	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."</p> <p>F880</p> <p>On 4/6/21 the facility failed to implement the Centers for Disease Control and Prevention (CDC) Guidelines for the use of Personal Protective Equipment (PPE) when 1 of 2 staff members (Nurse Aide #1) failed to discard her mask and clean her goggles after providing resident care to 11 of 11 residents on the quarantine hall and went to care for 8 of 8 residents on a non-quarantine hall observed for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2021
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUCE PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 880	<p>Continued From page 3</p> <p>*HCP (Healthcare personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.</p> <p>The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/23/21 indicated the following statements under the section "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection":</p> <ul style="list-style-type: none"> * Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse. * Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. * Remove eye protection after leaving the patient room or care area, unless implementing extended use. * Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse. <p>Review of the facility infection control manual revealed the facility did not have a specific policy related to changing mask between a quarantine and non-quarantine unit or disinfecting between</p>	F 880	<p>infection control practices.</p> <p>On 4-6-21 the Administrator validated that she expected staff to follow the facility's current policies and procedures regarding the extended use of faces masks and goggles unless damaged or soiled as part of the facilities strategy to optimize PPE use which was approved by local Health Department, Medical Director, and QAPI committee per the CDC recommended guidelines.</p> <p>On 4-6-21, the Administrator, instructed Nurse Aide #1 to change her mask and to clean goggles when leaving quarantine area to prior to entering non-quarantined resident care areas to provide care. Aide #1 was re-educated on 4-7-21 by the Director of Nursing on required PPE, donning and doffing of PPE and the newly established neutral zone.</p> <p>Facility has identified all residents are at potential risk depending on outbreak status, fluctuation in resident census, time of shift, current staffing and attendance which all effect facility staffing patterns.</p> <p>On 4-7-21 the facility established a designated neutral zone between the exit from the quarantined hall exit/entrance and the exit/entrance of the non-quarantined resident care areas of the facility to provide staff an area to don and doff the appropriate PPE upon entrance/exit of these areas. Sanitizer, PPE supplies, and a waste receptacle will be stored in this area for staff to don and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2021
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUCE PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 880	<p>Continued From page 4 the two.</p> <p>During an observation on 4/06/21 at 11:25 AM of the quarantine hall, all resident doors had posted signage for enhanced droplet isolation precautions requiring mask, gown, gloves and face shield or goggles. Plastic bins containing N95 masks, surgical masks, gowns, gloves, and disinfectant wipes were in the hallway outside the doors in the quarantine hall.</p> <p>On 4/06/21 at 9:35 AM, Nurse Aide (NA) #1 was observed entering resident rooms on the quarantine hall. She was wearing an N95 mask and goggles. NA #1 was observed wearing the same N95 mask and goggles throughout the quarantine unit. At 11:35 AM, NA #1 was observed leaving the quarantine hall and going to care for residents on the non-quarantine 200 hall. She was still wearing the same N95 mask and eye protective gear when she left the quarantine hall at 11:35 AM.</p> <p>An interview with NA #1 on 4/06/21 at 11:44 AM revealed she was assigned to work on the quarantine hall and a non-quarantine hall due to staffing. NA #1 stated she wore the same N95 mask and goggles when going in and out of resident rooms on the quarantine hall and non-quarantine hall during her shift. NA #1 stated nobody had told her she should change her mask in between the two halls or clean her goggles in between resident rooms. She stated she usually discarded her mask at the end of her shift and cleaned her goggles at the end of each shift.</p> <p>An interview with Nurse #1 on 4/06/21 at 12:35 PM revealed she was assigned to the quarantine hall which currently had eleven residents. She</p>	F 880	<p>doff PPE as needed to continue providing resident care.</p> <p>On 4-7-21 the Director of Nursing conducted re-education of facility staff on transmission-based precautions including personal protective equipment the changing masks/cleaning goggles prior to entering/exiting quarantine hall and entering/exiting non-quarantine halls to provide care. Staff were also educated on the neutral zone the facility implemented to provide a neutral zone for donning and doffing of the appropriate PPE prior to entering/exiting quarantined or non-quarantined halls to provide resident care. Additionally, facility Director of Nursing or Infection Prevention/SDC will provide re-education on personal protective equipment and the neutral zone at next scheduled all staff in-service no later than May 7,2021.</p> <p>Administrator initiated root cause analysis on 4-7-21 with team members consisting of Nurses, Nurse Aides, Physical Therapy Assistant, Housekeeping and members of the facility's management team in an effort to identify root causes and assist in the development of a sustainable plan of correction. Facility initiated re-education of facility staff on PPE policies and PPE strategies. Re-education included, but was not limited to, location and purpose of the neutral zone, and the need to change all PPE including mask and cleaning of goggles prior to entering/exiting quarantined and non-quarantined halls to provide resident care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2021
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUCE PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 880	<p>Continued From page 5</p> <p>was also assigned to 200 hall which was a non-quarantine hall with eight residents. Nurse #1 stated she usually discarded her N95 mask when leaving the quarantine unit to go to the non-quarantine unit, put on a surgical mask and cleaned her goggles. Nurse#1 stated she had observed NA #1 wearing the same N95 mask on the quarantine hall going in and out of resident rooms and on the non-quarantine hall. She stated she informed NA #1 she could not wear the same mask and needed to change however felt NA #1 had gotten busy and forgot.</p> <p>An interview with the Administrator on 4/06/21 at 11:57 AM revealed that she expected her staff to follow the infection control policies and procedures set forth by the CDC but she admitted that she would need to review the most recent updates from CDC because they were always changing and the facility policy on face mask and PPE.</p>	F 880	<p>The Director of Nursing or designee will conduct personal protective equipment audits to ensure staff are wearing the appropriate required PPE based on location they are providing care, monitor the neutral zone to ensure PPE is available for donning and doffing, and question staff regarding facilities current PPE requirements to ensure staff is clear on facility's PPE policy. Audits will be conducted by the Director of Nursing or designee 5 x's a week for 4 weeks, 3 times a week for 4 weeks, and 2 x week for 4 weeks. The Director of Nursing will review the results of the audits, and those results will be reported at the QAPI meeting for 3 months and then quarterly for 3 quarters until substantial compliance has been achieved.</p> <p>The DON will be responsible for the implementation of the acceptable plan of correction.</p> <p>Date when corrective action will be completed: 5/14/21</p>		