STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 04/15/2021

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BRIAN CENTER HEALTH & REHAB/GASTONIA	969 COX ROAD GASTONIA, NC 28054

(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 An unannounced recertification survey was conducted 04/12/21 through 04/15/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ESYC11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted 04/12/21 through 04/15/21. There were 17 allegations investigated and all were unsubstantiated. Event ID #ESYC11.	F 000		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		5/6/21

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

Electronically Signed | 05/05/2021

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F 761	Continued From page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to remove 14 blister cards (contained 265 tablets) and 1 bottle (contained 500 tablets) of expired medications for 3 of 6 medication carts (100, 200 and 500 B) reviewed for medication storage. The findings included: 1. An observation was made on 04/13/21 at 3:14 PM, the following expired controlled medications were being stored in the medication cart for 200 Hall and available for use: - 1 used blister card contained 10 tablets of hydrocodone/acetaminophen 5/325 milligram (mg) expired on 03/17/21. - 1 used blister card contained 15 tablets of diazepam 5 mg expired on 02/28/21. During an interview with Nurse #1 on 04/13/21 at 3:25 PM she stated she had checked the 200 Hall medication cart for expired medication at least once every other day. In addition, the Unit Manager (UM) or the Director of Nursing (DON) would check the medication cart randomly and the consultant pharmacist would check at least one medication cart during the monthly visit. Nurse #1 explained the expired controlled medications were used as needed only and they had not been utilized by the resident frequently. 2. An observation was made on 04/13/21 at 4:08 PM, the following expired medications were being store in the medication cart for 100 Hall and available for use:	F 761	All identified expired medications removed from the facility and returned to the pharmacy for destruction on 4/16/21. Director of Nursing notified the Medical Director of residents who may have been affected by the identified expired medications in the facility on 4/14/21. All residents identified as having the potential to be affected by expired medications. Inservice related to expired medications, including the impact it could cause and the process of removing from the facility, completed by the Staff Development Coordinator (RN)for all Licensed Nursing Staff including Medication Aides on 4/28/21. Content of training included the expectation of the licensed nurse or medication aide administering medication to review each medication for expiration date and ensure medication is active and not discontinued prior to the administration of each medication. Expired Medication Monitoring Tool implemented and to be completed by the ADON once weekly for 12 weeks on each Medication Cart (6) and each Medication Storage Room (2). Expired Medication Monitoring Tool will validate that there are no expired medications being stored or maintained in the facility in order to prevent the potential for expired medications to be administered.	

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F 761	Continued From page 2 - 1 used blister card contained 12 tablets of Ondansetron 4 mg expired on 02/28/21. - 1 used blister card contained 8 tablets of Ondansetron 4 mg expired on 01/31/21. - 1 used blister card contained 24 tablets of Furosemide 20 mg expired on 03/31/21. - 1 used blister card contained 26 tablets and 4 unused blister cards contained 120 tablets of Ondansetron 4 mg expired on 03/31/21. - 2 used blister card contained 35 tablets of Metoprolol tartrate 25 mg expired on 02/28/21. - 1 used blister card contained 1 tablet of Clopidogrel 75 mg expired on 02/28/21. - 1 used blister card contained 14 tablets of Promethazine 25 mg expired on 02/28/21. During an interview with Nurse #2 on 04/13/21 at 4:15 PM she stated she would check the expiration date of each medication every time before administering the medication. She denied she had been instructed by the facility to check her medication cart on regular basis. During an interview with Nurse #3 on 04/13/21 at 4:21 PM she stated as the UM, she had instructed each Hall nurse to check their respective medication cart for expired medication once every shift. The UM expected all the nurses to check their respective medication cart as ordered. 3. An observation was conducted on 04/13/21 at 4:46 PM, 1 opened bottle contained 500 tablets of Sodium Bicarbonate 650 mg expired on 02/28/21 was being stored in the medication cart B for 500 Hall and available for use. During an interview with Nurse #4 on 04/13/21 at 4:54 PM she stated she had checked her	F 761	The results of the Expired Medication Monitoring Tool will be presented by the DON for 3 months at the monthly facility QAPI Meeting to evaluate effectiveness. The QAPI Committee will make changes and recommendations as indicated. The completion date for this Plan of Correction is 5/6/21. The Administrator is responsible for implementing the plan of correction.	

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F 761	Continued From page 3 medication cart at least once per shift. She explained it was her oversight that she missed the expired Sodium Bicarbonate. During an interview with the DON on 04/14/21 at 10:25 AM she stated it was her expectation for the night shift nurses to check their respective medication cart at least once weekly to ensure the facility free of expired medications. During an interview with the Administrator on 04/15/21 at 10:33 AM she stated some of the expired medications were used as needed and had not been utilized frequently. The nursing staff had been instructed to check their respective medication cart at least once weekly. It was her expectation for the facility to be free of expired medications.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, and staff interviews, the facility failed to serve food that was at an appetizing temperature to 3 of 5 residents reviewed for food palatability (Residents #105, #184 and #174).	F 804	Interviews conducted with Resident #105, Resident #184, and Resident #174 by Food Service Manager to gather more information regarding appetizing food temperatures upon meal tray delivery on 5/5/21.	5/6/21

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F 804	Continued From page 4 The findings included: 1a. Resident #105 was readmitted to the facility 6/10/19. Diagnoses included in part, dysphagia, severe protein calorie malnutrition, gastritis, and gastrointestinal reflux disease. An annual Minimum Data Set (MDS) dated 3/29/21 assessed Resident #105 with adequate hearing and impaired vision, intact cognition and independent with eating. Review of his medical record revealed a physician's order for a regular diet. Resident #105 was interviewed on 4/12/21 at 3:10 PM. She stated during the interview that her food was "always cold when it arrived." 1b. Resident #184 was admitted to the facility 3/30/21. Diagnoses included, in part, anemia, gastrointestinal reflux disease, and arthritis. An admission MDS dated 4/6/21 assessed Resident #184 with intact cognition and limited assistance with eating. Review of his medical record revealed a physician's order for a regular diet. Resident #184 was interviewed on 4/12/21 at 11:51 AM. He stated during the interview that the hot foods were not hot, and he had not received a hot breakfast since he arrived. He further stated he did not ask the staff to heat his food. 1c. Resident #174 was admitted to the facility 3/8/19. Diagnoses included in part, chronic pancreatitis. A quarterly MDS dated 3/29/21 assessed Resident #174 with intact cognition and independent with eating. Review of his medical record revealed a physician's order for a regular diet.	F 804	All residents identified as having the potential to be affected by unappetizing food temperatures upon meal tray delivery. Inservice completed by Food Service Manager on 5/5/21 to Dietary Staff regarding meal service tray delivery resulting in appetizing, satisfying food temperatures and the process for maintaining appetizing food temperatures upon meal tray delivery. Food Temperature Satisfaction Monitoring Tool implemented to ensure meal trays are being delivered at an appetizing food temperature. Food Temperature Satisfaction Monitoring Tool will include interviewing 5 random residents on each hallway to ensure the meal tray is being delivered at an appetizing temperature and the resident is satisfied with the food temperature of the meal upon meal tray delivery. Food Temperature Satisfaction Monitoring Tool will be completed on each Resident Hallway (5 Hallways) for 5 random Residents on each hallway, 5 times weekly for 4 weeks; then 3 times weekly for 4 weeks; then once weekly for 4 weeks. The Food Temperature Monitoring Tool will be completed by the Food Service Manager. The results of the Food Temperature Monitoring Tool will be presented by the Food Service Manager for 3 months at the facility QAPI Meeting to evaluate effectiveness. The QAPI Committee will	

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F 804	Continued From page 5 Resident #174 was interviewed on 4/13/21 at 8:40 AM. During the interview, he stated hot foods are served to him cold and he did not request staff to reheat. 1d. A continuous observation of the breakfast tray line began on 4/14/21 at 7:38 AM and ended at 8:04 AM. Temperature monitoring of the following foods occurred by the Certified Dietary Manager (CDM) on 4/14/21 at 7:38 AM with the following temperatures obtained: -Grits, 188 degrees F -Scrambled Eggs, 180 degrees F -Sausage patties, 147 degrees F -Bacon, 150 degrees F A test tray was requested on 4/14/21 at 7:55 AM. The test tray was plated at 8:00 AM and placed on an open delivery cart. The delivery cart arrived on the 100 hall at 8:05 AM. Staff arrived to pass out the breakfast trays at 8:07 AM and the last breakfast tray was delivered to a resident at 8:16 AM. The CDM was present and the test tray was sampled at 8:18 AM in the dining room, 18 minutes after it was plated. Both the CDM and surveyor observed the foods with the following results: -Sausage patties. There was no visible steam observed. -Scrambled eggs. There was no visible steam observed. -Grits. The grits were congealed, the butter melted and there was no visible steam. -Toast, no temperature was taken. There was no visible steam observed. -Bacon. There was no visible steam. During an interview on 4/14/20 at 8:24 AM, the	F 804	make changes and recommendations as indicated. The completion date for this plan of correction is 5/6/21. The Administrator is responsible for the implementing the plan of correction.	

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F 804	Continued From page 6 CDM stated "I would be upset if I received this." She further stated the cause of cold food was due to the open cart system the kitchen used to deliver meal trays to the halls. The CDM revealed she researched the closed cart to preserve the heat, but she was denied the request to change delivery systems. The kitchen Account Manager (AM) was interviewed on 4/14/21 at 1:15PM. He stated his expectation was for residents to receive adequate temperature foods at all meals, especially hot foods. He further stated the cause of the cold food delivered could potentially be the open cart system and this facility was the only building he had seen not using insulated closed carts. An interview occurred on 4/14/21 at 4:32 PM with the Administrator. She stated she was not aware of any resident concerns regarding inadequate temperature of the food served. She further stated her expectation was for residents to receive food at proper temperatures (hot food hot, cold food cold). The Administrator indicated the cause of the cold food could have been related answering to residents' requests upon tray arrival to the hall or the non-insulated, uncovered carts that hold the meal trays from the kitchen to the hall. The Administrator additionally stated on 4/15/21 at 11:20 AM that even though they had not received complaints from residents regarding cold food, the facility plans to go ahead and purchase insulated meal carts. She further stated they had been so used to serving residents in the dining room for so long and sending 30 meal trays to the halls was a new procedure due to COVID restrictions.	F 804		
F 880 SS=D	Infection Prevention & Control	F 880		5/6/21

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F 880	Continued From page 7 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 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F 880		

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F 880	Continued From page 8 resident; including but not limited to: (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 observations, record review, staff interviews, and review of the facility's policies and procedures, the facility staff failed to follow infection control policies and procedures by not sanitizing the injection site with antiseptic pad for 1 of 2 sampled residents observed for insulin administration (Resident #84). These failures occurred during a COVID-19 pandemic. The findings included:	F 880	MD notified by DON on 4/14/21 regarding failure to sanitize the injection site prior to administering insulin subcutaneously for Resident #84. All Residents receiving injectable medication identified as having the potential to be affected. One to one in-service provided to Nurse	

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F 880	Continued From page 9 A review was completed of a facility policy titled, "Subcutaneous injection", revised 08/21/20. The policy stated in part, "Clean the injection site with an antiseptic pad, beginning at the center of the site and moving outward in a circular motion. Allow the skin to dry". During a medication pass observation on 04/14/21 at 9:05 AM, Nurse #3 was observed administering 38 units of insulin Lantus subcutaneously to Resident #84's left upper quadrant of abdomen in her room without sanitizing the injection site with antiseptic pad prior to the injection. During an interview with Nurse #3 on 04/14/21 at 9:10 AM she stated she had forgotten to sanitize the injection site with alcohol pad before administering the insulin subcutaneously. Nurse #3 explained she was nervous when the surveyor was watching her administering the insulin. During an interview with the Director of Nursing (DON) on 4/14/21 at 10:25 AM she stated it was her expectation for all the nurse to sanitize the injection site with antiseptic pad before administering insulin subcutaneously. During an interview with the Administrator on 04/15/21 at 10:33 AM she stated it was her expectation for all the nursing staff to follow facility's infectious disease control policies and procedures when administering insulin subcutaneously.	F 880	#3 by the Infection Preventionist, RN on 4/14/21 regarding sanitizing the injection site with an alcohol swab prior to administering any injectable medication. Directed Inservice completed by Infection Preventionist to all Licensed Nursing Staff (RNs, LPNs, Unit Managers, and Unit Coordinators) on 5/3/21 specifically related to Infection Prevention and the proper administration of injectable medication, including the use of an alcohol swab on the skin at the injection site prior to administering the injectable medication. Injectable Medication Monitoring Tool implemented and completed by Infection Preventionist to ensure proper infection control measures are completed when administering injectable medications. Injectable Medication Monitoring Tool will be completed on 2 Residents on each Hallway (5 Halls) 5 times weekly for 4 weeks; then 3 times weekly for 4 weeks; then once weekly for 4 weeks. The results of the Injectable Medication Monitoring Tool will be presented by the Infection Preventionist for 3 months at the facility QAPI Meeting to evaluate effectiveness. The QAPI Committee will make changes and recommendations as indicated. The completion date for this Plan of Correction is 5/6/21. The Administrator is responsible for	

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F 880	Continued From page 10	F 880	implementing the plan of correction.	