STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	C 04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTRR HEALTH & REHABILITATION WALLACE	647 S RAILROAD STREET BOX 966 WALLACE, NC 28466

(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 on 04/05/21 through 04/14/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6ZNL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/05/21 through 04/14/21. Event ID#6ZNL11. 1 of the 53 complaint allegations was substantiated.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		4/29/21

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

Electronically Signed | 05/07/2021

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews the facility failed to maintain dignity by failing to knock on doors or ask permission to enter for 3 of 6 residents (Resident #32, Resident #26 and Resident #33). Findings included: 1. Resident #32 was admitted to the facility on 09/16/2019. The most recent quarterly Minimum Data Set (MDS) dated 02/09/2021 had Resident #32 coded as moderately cognitively impaired with the ability to express his ideas and wants. During an observation of the 300 Hall breakfast pass on 04/05/2021 at 8:19 AM, NA #1 was seen walking into Resident #32's room with a food tray without knocking and waiting to enter.	F 550	"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." What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, on 4/5/2021, NA #1 was observed entering 3 separate resident rooms during morning tray pass; resident	

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F 550	Continued From page 2 During an interview with NA #1 on 04/06/2021 at 8:36 AM, NA #1 stated she knows she was supposed to knock on the resident's doors and wait to be told to come in before entering their rooms. NA #1 also stated she didn't know why she did not do it. During an interview with Resident #32 on 04/06/2021 at 8:39 AM, the Resident stated that he would expect staff to knock on the door before coming into his room. During an interview with the Administrator on 04/06/2021 at 4:20 PM, the Administrator stated she expects the staff to knock and wait to get permission to enter all resident's rooms. During a telephone interview with the Director of Nursing (DON) on 04/08/2021 at 10:33 AM, the DON stated she had a meeting with the 3-11 shift staff on 04/07/2021 and asked, "What should you do before entering a residents room" and everyone stated, "Knock on the door before entering", so they all know that it is expected of them to knock before entering a residents room. 2. Resident #26 was admitted to the facility on 01/28/2020. The most recent annual Minimum Data Set (MDS) dated 02/04/2021 had Resident #26 coded as cognitively intact. During an observation of the 300 Hall breakfast pass on 04/05/2021 at 8:23 AM, NA #1 was seen walking into Resident #26's room with a food tray without knocking and waiting to be invited in. During an interview with NA #1 on 04/06/2021 at 8:36 AM, NA #1 stated she knows she was supposed to knock on the resident's doors and	F 550	#32, resident # 26, and resident #33; and did not knock or wait prior to entering the resident room. Upon identification of NA #1 entering resident rooms prior to knocking and waiting, education on Resident rights including knocking on the resident door prior to entering was completed immediately with NA #1. No adverse outcomes were identified. Element #2 All residents have the potential to be affected by the deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Education was provided to all staff by the Director of Nursing on 4/8/2021 on Resident rights to include knocking on resident room doors and waiting to enter prior to entering a resident room. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing and/or designee will conduct compliance audits weekly x 12 weeks to ensure staff are knocking on resident doors and waiting to enter prior to entering a resident room. The facility will	

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F 550	Continued From page 3 wait to be told to come in before entering their rooms. NA #1 also stated she didn't know why she did not do it. During an interview with Resident #26 on 04/06/2021 at 8:39 AM, the Resident stated that he would expect staff to knock on the door before entering his room. During an interview with the Administrator on 04/06/2021 at 4:20 PM, the Administrator stated she expects the staff to knock and wait to get permission to enter all resident's rooms. During a telephone interview with the Director of Nursing (DON) on 04/08/2021 at 10:33 AM, the DON stated she had a meeting with the 3-11 shift staff on 04/07/2021 and asked, "What should you do before entering a residents room" and everyone stated, "knock on the door before entering", so they know that it is expected of them to knock before entering a residents room. 3. Resident #33 was admitted to the facility on 08/22/2019. The most recent quarterly Minimum Data Set (MDS) dated 02/17/2021 had Resident #33 coded as severely cognitively impaired. During an observation of the 300 Hall breakfast pass on 04/05/2021 at 8:25 AM, NA#1 was seen walking into Resident #33's room with a food tray without knocking and waiting to be invited in. During an interview with NA #1 on 04/06/2021 at 8:36 AM, NA #1 stated she knew she was supposed to knock on the resident's doors and wait to be told to come in before entering their rooms. NA #1 also stated she didn't know why she did not do it.	F 550	provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 4/29/2021	

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F 550	Continued From page 4 During an interview with the Administrator on 04/06/2021 at 4:20 PM, the Administrator stated she expects the staff to knock and wait to get permission to enter all resident's rooms. During a telephone interview with the Director of Nursing (DON) on 04/0/2021 at 10:33 AM, the DON stated she had a meeting with the 3-11 shift staff on 04/07/2021 and asked, "What should you do before entering a residents room" and everyone stated, "knock on the door before entering", so they know that it is expected of them to knock before entering a residents room.	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		4/29/21

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F 585	Continued From page 5	F 585		

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being

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F 585	Continued From page 6 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide written responses to grievances for 1 (Resident #20) of 3 residents reviewed for grievances. Findings included:	F 585	"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	

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F 585	Continued From page 7 Record review revealed Resident #20 was last admitted 06/28/2019. Review of the quarterly Minimum Data Set (MDS) dated 01/22/21 indicated Resident #20 was cognitively intact and required extensive assistance for her activities of daily living (ADLs). Record review of grievances indicated Resident #20's family member filed a written grievance on 10/29/20. The grievance was investigated by the Receptionist. The Administrator completed the follow up on 11/03/20. The grievance form listed the grievance as resolved on 10/29/2020 and indicated the investigation findings were reported to the family member on 10/29/20. There was no evidence of a written response/summary provided to the family member who filed the grievance. Record review of grievances indicated Resident #20's family member filed a written grievance on 12/23/20. The grievance was investigated by the Director of Nursing. The Administrator completed the follow up on 12/24/20. The grievance form listed the grievance as resolved on 12/24/2020 and indicated the investigation findings were reported to the family member on 12/24/20. There was no evidence of a written response/summary provided to the family member who filed the grievance. Record review of grievances indicated Resident #20's family member filed a written grievance on 01/18/21. The grievance was investigated on 01/20/21 by the Administrator. The grievance form listed the grievance as resolved on 01/20/2021 and indicated the investigation findings were reported to the family member on 01/20/21. There was no evidence of a written	F 585	it the required by the provisions of federal and state law." What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, the facility failed to provide a written response to grievances for 1 (Resident # 20) of 3 residents reviewed for grievances. The facility immediately contacted the family member who filed the grievance, the family stated the concerns were all immediately resolved and no written response was needed. Education was conducted on 4/7/2021 with the Administrator by the District Director of Clinical Services on providing a written response on all grievances filed. No Adverse outcomes were identified. Element #2 All residents have the potential to be affected by the deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Education was provided by the District Director of Clinical Services on 4/8/2021 to the Interdisciplinary team on the Grievance policy and regulation 483.10(j)(4)(v) stating that a written response must	

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F 585	Continued From page 8 response/summary provided to the family member who filed the grievance. Record review of grievances indicated Resident #20's family member filed a written grievance on 04/01/2021. The grievance was investigated by the Administrator on 04/01/2021. The grievance form listed the grievance as resolved on 04/01/2021 and indicated the investigation findings were reported to the family member on 04/01/21. The documentation revealed the grievance was completed by the Administrator. There was no evidence of a written response/summary provided to the family member who filed the grievance. An interview was conducted with the Administrator and the District Director of Clinical Services on 04/07/2021 at 11:38 AM. The Administrator revealed the grievances were resolved and indicated the investigation findings were reported to the family member verbally, but no written summary/documentation had been provided. The Administrator revealed it had been brought to her attention by her corporate official that there needed to be written documentation to the family members who initiated the grievance. In an interview on 04/07/2021 at 2:17 PM, the Administrator stated the added comments at the bottom of all the forms was updated. She explained she annotated the updates after calling each of the family members. She explained she would provide written letters to the family in the future and maintain a copy in the records. In a telephone interview on 04/07/21 at 2:26 PM with Family Member #1, she revealed she had not received a written summary from the facility	F 585	be provided to the resident/family who filed the grievance. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits weekly x 12 weeks to ensure a written response is provided by the facility. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 4/29/2021	

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F 585	Continued From page 9 regarding grievances submitted on 10/29/20, 01/20/21, and 04/01/21. She stated a woman from the facility had called her earlier the morning of 04/07/21 to ask if she wanted a copy of the written summary for her grievances.	F 585		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews the facility failed to provide dressing changes according physician's order for a bilateral lower extremity (BLE) and a left lower extremity (LLE) Venous Ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #50). Findings included: Resident #50 was admitted 7/2/2019 with diagnoses of Congestive Heart Failure (CHF) and Peripheral Vascular Disease (PVD). The quarterly Minimum Data Set (MDS) dated 03/11/2021 had Resident #50 coded as cognitively intact needed limited assistance with activities of daily living (ADL). The MDS also showed Resident #50 had a venous ulcer. The care plan dated 03/11/2021 had focus' of a	F 684	"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." What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, based on observation, record review, staff and resident interviews the facility failed to provide	4/29/21

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F 684	Continued From page 10 venous stasis ulcer of the left lower extremity (LLE) related to (r/t) CHF and PVD with interventions to include documentation of the location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements weekly, evaluate wound for: size, depth, margins, peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar and gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated, give medications as ordered for pain, observe/document/report as needed (PRN) for signs and symptoms (s/s) of infection: green drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, fever, refer to therapy prn and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The Treatment Administration Record (TAR) dated 01/2020 had an order for an application of an Unna boot to LLE with vertical rotation for wrapping, on day shift, on every Monday, Wednesday and Friday for Vascular Ulcer. The order was dated 01/03/2020 and there were missed dates on 01/17/2020, 01/24/2020 and 01/27/2020. The order was discontinued 01/30/2020. The TAR dated 02/2020 had an order for an application of an Unna boot to BLE, on day shift, on every Monday and Thursday for Vascular Ulcer. The order was dated 02/10/2020 and there was a missed date on 02/14/2020. The order was discontinued 03/03/2020.	F 684	dressing changes according to physician's order for a bilateral lower extremity (BLE) and a left lower extremity (LLE) Venous Ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #50). The facility immediately validated that dressing changes for Resident #50 current, completed according to physician order and documented on the treatment record. No Adverse outcomes were identified. Element #2 An audit was completed on 4/12/2021 to ensure all residents with physician orders for treatments had been completed and were documented on the treatment record. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 On 4/12/2021 current licensed nursing and licensed agency staff were educated by the Director of Nursing on following physician orders for treatments and documentation of treatments on the treatment record, prior to continuing work. Licensed Agency staff and New Licensed Nursing Hires will be educated on treatment documentation and following of physician orders for treatments during orientation by the Director of Nursing or Designee. How the corrective actions will be	

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F 684	Continued From page 11 The TAR dated 03/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday for Vascular Ulcer. The order was dated 03/03/2020 and there were missed dates on 03/16/2020, 03/23/2020 and 03/30/2020. The order was discontinued 05/12/2020. The TAR dated 04/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday for Vascular Ulcer. The order was dated 03/03/2020 and there were missed dates on 04/06/2020, 04/13/2020 and 04/20/2020. The order was discontinued 05/12/2020. The TAR dated 05/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday for Vascular Ulcer. The order was dated 03/03/2020 and there was a missed date on 05/04/2020. The order was discontinued 05/12/2020. The TAR dated 05/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. The order was dated 05/12/2020 and there was missed dates on 05/15/2020, 05/18/2020, 05/22/2020 and 05/27/2020. The TAR dated 06/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. The order was dated 05/12/2020 and there was missed dates on 06/01/2020, 06/03/2020, 06/05/2020, 06/10/2020, 06/12/2020, 06/15/2020 and 06/29/2020. The TAR dated 07/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for	F 684	monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing and/or designee will conduct random compliance audits weekly x 12 weeks to ensure physician ordered treatments are being completed and documented on the treatment record. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 4/29/2021	

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F 684	Continued From page 12	F 684		

Vascular Ulcer. The order was dated 05/12/2020 and there was missed dates on 07/03/2020 and 07/17/2020.

The TAR dated 08/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. The order was dated 05/12/2020 and there was missed dates on 08/10/2020 and 08/28/2020. The order was discontinued 08/28/2020.

The TAR dated 09/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. The order was dated 08/31/2020 and there was a missed date on 09/04/2020.

The TAR dated 11/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. There was a missed date on 11/30/2020.

The TAR dated 12/2020 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. There was a missed date on 12/23/2020.

The TAR dated 01/2021 had an order for an application of an Unna boot to BLE, on day shift, every Monday, Wednesday and Friday for Vascular Ulcer. There were missed dates on 01/01/2021, and 01/11/2021.

During an observation of Resident #50 on 04/05/2021 at 8:38 AM, Resident #50 was sitting in his wheelchair and his BLE were not wrapped.

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F 684	Continued From page 13 During an observation of Resident #50 on 04/05/2021 at 4:48 PM, resident did not have Una boot applied to his LLE. During an observation of Resident #50 on 04/06/2021 at 9:27 AM, resident was in wheelchair and had Unna boot to LLE he stated it was done at 7:00 PM 04/05/2021 on 3-11 shift. During an interview with Resident #50 on 04/05/2021 at 8:38 AM, Resident #50 stated his Unna boot was removed with his morning bath and would be replaced soon. Resident #50 also stated there had been times when the facility had missed his treatments and he did not mention it to staff because he knew they were busy and he figured they will get to it when they get to it. Resident #50 further stated the areas to his lower legs have gotten better over time. During an interview with the Treatment Nurse (TN) on 04/06/2021 at 3:44 PM, the TN stated if she was called to the floor and she was working the floor the nurses were supposed to do the treatments but she did her treatments when she worked as a treatment nurse. During an interview with Nurse #1 on 04/06/2021 at 8:19 AM, Nurse #1 stated she had Resident #50 on 01/01 and 01/11/2021 and she did do his treatments but didn't document it because she was used to the treatment nurse doing them. During an interview with the Administrator on 04/06/2021 at 4:20 PM, the Administrator stated she expects nursing staff to follow the orders from the Physicians.	F 684		

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F 684	Continued From page 14 During a telephone interview with the Director of Nursing (DON) on 04/07/2021 at 3:07 PM, the DON stated Nurse #1 stated she did do the treatments that were missing for Resident #50 on 01/1/2021 and 01/11/2021. The DON also stated she was not aware of the other missing treatments and her expectations are for the nursing staff to administer treatments and document them when they are done as ordered on the TAR.	F 684		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Pharmacy Consultants interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 31 opportunities, resulting in a medication error rate of 6.45% for 2 of 5 sampled residents observed during medication administration. (Resident #47 and Resident #6) Findings included: 1. Resident #47 was admitted 03/13/2020 with diagnoses including Heart Failure, Non-Alzheimer's Dementia and Malnutrition. The quarterly Minimum Data Set (MDS) dated 03/12/2021 had Resident #47 coded as moderately cognitively impaired needing limited	F 759	"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." What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, based on observation, record review, staff and Pharmacy	4/29/21

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F 759	Continued From page 15 assistance with her activities of daily living (ADL). The care plan dated 01/27/2021 had focus' of ADL self-care performance deficit related to (r/t) Confusion, Fatigue, sometimes, she did not want to bathe, go to activities, take medications, or change clothes, has impaired cognitive function or impaired thought processes r/t Dementia. The facility's medication administration procedures dated June 2008 read in part: Observe that the resident swallows' oral drugs. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication. The April 2021 Medication Administration Record (MAR) revealed an order for Polyethylene Glycol Powder (MiraLAX) by giving 17 grams by mouth one time a day for Constipation and mix with 8 ounces of juice or water. During an observation of a medication administration for Resident #47 on 04/07/2021 at 8:26 AM, Resident #47 was in her room sitting in her chair by her bed. Nurse #1 entered the resident's room to administer morning medications which included MiraLAX in 8 ounces of water. She explained what medications she was administering and informed Resident #47 there was MiraLAX in the cup on her table. Resident #47 took the medication in the small cup and reached for her MiraLAX. Resident #47 took several sips and put the cup down with ¾ of the medication left in the cup. Nurse #1 also told Resident #47 she did not have to finish the whole thing now and left the room. During an interview with Nurse #1 on 04/07/2021 at 8:28 AM, Nurse #1 stated Resident #47 likes to	F 759	Consultants interviews, the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 31 opportunities, resulting in a medication error rate of 6.45% for 2 of 5 sampled residents observed during medication administration. (Resident #47 and Resident #6) The facility immediately provided education to the licensed Nurse observed during medication administration on Medication Administration and Medication Errors. No Adverse outcomes were identified. Element # 2 All residents receiving medications have the potential to be affected by the deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 On 4/12/2021 current licensed nursing and licensed agency staff were educated by the Director of Nursing on Medication Administration and Medication Errors. Licensed Agency staff and New Licensed Nursing Hires will be educated on Medication Administration and Medication Errors during orientation by the Director of Nursing and/or Designee. How the corrective actions will be	

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F 759	Continued From page 16 sip on her MiraLAX and moved on to another resident to begin another medication administration. During a telephone interview with the Pharmacy Consultant (PC) on 04/08/2021 at 9:39 AM, the PC stated medication was supposed to be completely administered before the nurse left the room and should never be left with the resident. During a telephone interview with the Director of Nursing (DON) on 04/08/2021 at 11:14 AM, the DON stated Resident #47 had not been assessed to self-administer medications. The DON also stated she expected that all medications are administered before leaving a resident's room and they are not to be left with the resident to finish on their own. During a telephone interview with the Administrator on 04/08/2021 at 3:15 PM, the Administrator stated her expectations were for staff to follow all policies and procedures related to medication administration. 2. Resident #6 was admitted 01/12/2020 with diagnoses including Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, and Dysphagia following Cerebral Infarction. Resident #6 was coded as severely cognitively impaired and needed extensive assistance with his activities of daily living (ADL). He was also coded for Parenteral/IV feeding and Feeding tube - nasogastric or abdominal (PEG). The care plan dated 01/14/2021 had focus' of ADL self-care performance deficit related to (r/t) Stroke and Immobility. He has Altered Gastrointestinal (GI) function r/t Dysphagia as evidenced by nothing by mouth status with	F 759	monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing and/or designee will conduct random compliance audits weekly x 12 weeks to ensure the facility is free from Medication error rates greater than 5%. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 4/29/2021	

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enteral feeding to meet nutrition nutrition/hydration needs.

The facilities procedures for enteral tube drug instillation with revised date of May 15, 2020 read in part: Discuss any unresolved concerns with the resident's practitioner. Consult the pharmacist to determine the safest dosage form of the drug to administer, if needed. Crush simple compressed tablets to a fine powder using a mortar and pestle or other pill-crushing device and mixing with purified water.

The 03/2021 MAR revealed and order for Calcium (600 MG)/Vitamin D3 (10 MCG/ 400 IU) tablet daily.

During an observation of a percutaneous endoscopic gastrostomy (PEG) tube medication administration for Resident #6 on 04/07/2021 at 9:41 AM, Nurse #1 was observed crushing Resident #6's medications individually. Nurse #1 put a Calcium (600 MG)/Vitamin D3 (10 MCG/ 400 IU) tablet in a plastic envelope and crushed the medication using a pill crusher. The medication was not fully crushed, and pieces of the pill were sticking out of the crushed medication. Nurse #1 took a spoon and scooped out medication that was not crushed and decarded it in the trash. Nurse #1 finished preparing all the medications and administered them to Resident #6.

During an interview with Nurse #1 on 04/07/2021 at 9:44 AM, Nurse #1 stated she knows that may have been a mistake, but she scoops out the pieces of medication that did not crush and throws it out because she didn't want to clog Resident #6's tubing. Nurse #1 also stated she

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F 759	Continued From page 18 could have also put it in warm water to dissolve it but didn't. Nurse #1 further stated she did not report that the medication is hard to crush to anyone. During a telephone interview with the Pharmacy Consultant (PC) on 04/08/2021 at 9:39 AM, the PC stated if the medication was difficult to crush and if she knew about it, she could have changed the order to a liquid form. The medication could have been dissolved in warm water and it would have been able to be administered without clogging the tubing. The PC also stated she would expect a call regarding the medication, and it should have been reported, but parts of a residents medication should never be discarded because they are expected to receive the full dosage of a medication. During a telephone interview with the Director of Nursing (DON) on 04/08/2021 at 11:14 AM, the DON stated she did not expect any amount of medication to be discarded because it was hard to crush. Residents are expected to receive their full dosages of medication. The medication should have been dissolved in warm water and the issue should have been reported. During a telephone interview with the Administrator 04/08/2021 at 3:15 PM, the Administrator stated her expectations were for staff to follow all policies and procedures related to medication administration.	F 759		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		4/29/21

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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 resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 20 (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 observation, staff interviews, and record reviews, the facility staff failed to ensure one of one staff members (Dietary Aide #2) wore their facial covering over their mouth and nose while working in the facility and one of one staff members (Dietary Aide #1) wore a cloth mask not authorized by the facility. The failures occurred during a COVID-19 pandemic. Findings included: 1. Facility records indicated an in-service was conducted on 03/09/21. The in-service was provided to all staff members/departments and educated staff on use of Personal Protective	F 880	"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." What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	

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F 880	Continued From page 21 Equipment (PPE). Another in-service was also conducted on 03/31/21 on the use of N95 and face shields. During the initial tour of the kitchen on 04/05/21, Dietary Aide #1 (DA#1) was observed wearing a cloth mask. During an interview with Dietary Aide #1 on 04/05/21 at 8:02 AM, she explained she could wear the mask and would disinfect it at home and bring it back. She stated she only used it at work. On 04/05/21 at 9:00 AM during re-entry to the kitchen, Dietary Aide #1 had changed to a N95 face mask. During an interview with the Dietary Manager (DM) on 04/05/21 at 9:01 AM, the Dietary Manager stated he monitored his employees daily for proper personal protection equipment. He explained he corrected DA#1 when he arrived because the cloth mask was not acceptable for staff working in the facility. She now had on a N95 face mask. He stated he would review mask coverings with all his staff again. During an interview with the Director of Nursing (DON) on 04/06/21 at 1:52 PM, she explained the facility was allowing the surgical mask for all staff throughout the building unless you were on the quarantine hall. The quarantine hall staff would use a N95 mask and a face shield for care of those residents. She explained cloth masks were not permitted or allowed for any staff in the facility. She explained they receive their guidance from their corporate office, the Center for Disease Control, and the County Public Health Department.	F 880	Element #1: Dietary Aide #1 failed to follow proper face mask usage while working in the dietary department. She was wearing a cloth mask. Element #2: Dietary Aide #2 failed to follow proper face mask usage and proper face mask placement while exiting the kitchen to push the dietary cart to a resident hall. Her mask was only covering her mouth and not covering her nose. A Fishbone/root cause analysis was conducted on 4/28/21 to identify root cause of the area identified in the 2567. The Root cause analysis was facilitated by the Administrator, Director of Nursing, District Director of Clinical Services, and the Infection Preventionist. The Root cause analysis was reviewed with the QAPI committee on 4/23/21 & 4/29/21 and incorporated into the facility plan of correction below. The Directed Plan of Correction will be completed by 4/29/21 with training conducted by the Director of Nursing and the Infection Preventionist. Element #1 the Dietary Aide use of a cloth mask had no adverse outcome from the incident. She was educated immediately by her Manager and Director of Nursing on 4/5/21, and provided with a surgical mask to use at all times while in the facility. Element #2 Dietary Aide wearing a surgical mask only covering her mouth and not her nose while delivering meal trays had no adverse outcomes from the incident. She was educated immediately by the DON on 4/5/21 and immediately properly fixed her surgical mask to cover	

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F 880	Continued From page 22 During an interview with the Infection Control Nurse (ICN) on 04/06/21 at 4:01 PM she stated all staff were trained on how to don and doff Personal Protective Equipment (PPE), including placing the facemask over their mouth and nose. She stated all staff in the facility should have on the surgical mask at a minimal. She stated the cloth mask worn by the Dietary Aide was not acceptable. She continued and stated the staff assigned to the quarantine unit would be wearing a N95 and a face shield along with their full PPEs. She added staff were monitored daily regarding PPE usage. The ICN expressed the facility were following the guidelines and recommendations of the Center for Disease Control for Nursing Homes and the county public health guidance. During an interview with the Administrator on 04/06/21 at 4:21 PM, the Administrator stated they take the infection control protocols seriously and she knew all staff were trained and knew the importance of wearing PPE properly. 2. During an observation in the hallway by the conference room on 04/05/21 at 8:10 AM, Dietary Aide #2 (DA#2) was observed pushing the dietary cart to the resident hall with her surgical face mask covering only her mouth - her nose was not covered. During an interview with DA#2 on 04/05/21 at 8:24 AM she explained the mask slips down sometimes and she forgets to pull it back up. She stated she was trained to make sure it covers her mouth and nose but had forgot to pull it up. During an interview with the Dietary Manager	F 880	her nose and mouth. Educated if the mask slips down, she must adjust it immediately to maintain proper face mask policy and procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Element #1 In-service education was provided by the Director of Nursing, SDC/Infection Preventionst beginning 4/5/21 and will be completed by 4/23/21 on proper policies and procedures related to face mask usage and proper placement. A full house audit of all staff was performed and was conducted by the Director of Nursing, and Infection Preventionist to ensure all Brian Center of Wallace staff are appropriately wearing surgical face masks and are properly covering their nose and mouth. Multiple areas throughout the facility, including the dietary department have an abundant supply of surgical face masks for staff usage. What measures will be put into place to ensure the deficient practice does not reoccur: Mandatory all staff education on policies and procedures related to face mask usage and proper placement to ensure nose and mouth are covered, and enforcement of no cloth masks to be used in the facility, which includes all Departments (Housekeeping, Laundry, Dietary, Therapy, Maintenance and Nursing. Immediate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	C 04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 (DM) on 04/05/21 at 9:01 AM, the Dietary Manager stated he monitored his employees daily for proper personal protection equipment and DA#2 knew she was supposed to wear her facemask over her nose and her mouth at all the times. He stated he would review mask coverings with all his staff again. During an interview with the Director of Nursing (DON) on 04/06/21 at 1:52 PM, she explained the facility was allowing the surgical mask for all staff throughout the building unless you were on the quarantine hall. The quarantine hall staff would use a N95 mask and a face shield for care of those residents. She explained cloth masks were not permitted or allowed for any staff in the facility. She explained they receive their guidance from their corporate office, the Center for Disease Control, and the County Public Health Department. During an interview with the Infection Control Nurse (ICN) on 04/06/21 at 4:01 PM she stated all staff were trained on how to don and doff Personal Protective Equipment (PPE), including placing the facemask over their noses. She stated all staff in the facility should have on the surgical mask at a minimal. She continued and stated the staff assigned to the quarantine unit would be wearing a N95 and a face shield along with their full PPEs. She added staff were monitored daily regarding PPE usage. The ICN expressed the facility were following the guidelines and recommendations of the Center for Disease Control for Nursing Homes and the county public health guidance. During an interview with the Administrator on 04/06/21 at 4:21 PM, the Administrator stated	F 880	education/intervention was provided to the Dietary aides #1 & #2 on 4/5/21. Full house Education initiated on 4/6/21 and completed 4/23/21. All new hires will have this mandatory education prior to working on the unit. Daily ongoing observation and education will be provided also to maintain compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #1 to ensure ongoing compliance, the Director of Nursing and Infection Preventionist and/or designee will conduct random audits 3x weeks x 12 weeks to ensure proper utilization of surgical face masks on all staff, monitoring for proper placement over nose and mouth, and monitoring of no cloth masks for staff use. If there are any areas of concern, the appropriate education/in-servicing will be immediately provided to staff. All new hires/All contract agency staff will be educated on this policy and procedure during the orientation process prior to initiating work. The results of our auditing process will be reported to monthly QAPI until such time that substantial compliance has been achieved x 3 months Compliance date 4/29/21.	

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F 880	Continued From page 24 they take the infection control protocols seriously and she knew all staff were trained and knew the importance of wearing PPE properly.	F 880		