STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE** **CONCORD, NC 28025**

(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 5/10/21 through 5/13/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Evernt ID # REY611.	E 000		
F 000	INITIAL COMMENTS A unannounced Recertification Survey was conducted 5/10/21 through 5/13/21. Past non-compliance was identified at: CFR 483.25 at tage F689 at a scope and severity of G.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to determine a resident ' s ability to self-administer medications for one of one resident observed to have medications in his room (Resident #22). Findings Included: Resident #22 was admitted on 8/10/18 the resident ' s cumulative diagnoses included: Gout, glaucoma, diabetes, chronic pain, skin inflammation, and anxiety. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 2/26/21 indicated Resident #22 had	F 554	Resident #22 assessment and care plan was completed. Resident #22 was unable to comply with requirements for self administration. Medications were removed from the bedside. All residents have the potential to be affected. All resident rooms were audited for medications at bedside on 5/31/21. No additional issues were identified. The Director of Nursing/Designee completed reeducation for all staff/agency staff on 6/1/21 related to medication self-administration policy including reporting any type of medications	6/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/05/2021

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 554

Continued From page 1

moderate cognitive impairment.

Review of Resident #22 ' s care plan, which had been most recently updated on 4/28/21 revealed a focus area which documented the resident had impaired cognitive function or impaired thought process related cognitive communication deficit and altered mental dysfunction. The review revealed no focus area for medication self-administration.

Review of Resident #22 ' s Medication Administration Record for the Month of May up till 5/10/21 revealed Triamcinolone Acetonide Cream 0.1%, apply to both lower extremities topically every day and evening shift for atopic dermatitis for 10 days, which had an order date of 5/10/21. Review of the May MAR for Resident #22 did not reveal an orde for instantr oral pain relief, nor an order medicated anti-itch lotion.

Review of Resident #22 ' s Treatment Administration Record for the month of May up till 5/10/21 revealed no order for instant oral pain relief, nor an order medicated anti-itch lotion.

An observation conducted of Resident #22 was conducted in conjunction with an interview with the resident on 5/10/21 at 1:24 PM. The resident was observed to have had a tube of Triamcinolone Acetonide Cream 0.1% (with a prescription label on it for Resident #22), a small glass bottle of instant oral pain relief, and 2 yellow bottles of medicated anti-itch lotion. The resident stated he kept the items at his bedside because he had a sore tooth and he used the cream on his legs.

An interview was conducted on 5/11/21 at 2:37

F 554

observed at the bedside and removing medications. This education will be included for all new and agency employees.

Residents that want to self-administer medications will be
assessed to verify if they qualify to self-administer. An order will be obtained, the medications will be locked at bedside and the resident will document usage of medications.

The Director of Nursing/Designee will conduct room audits on all rooms (3) three times a week for (4) four weeks, (2) two times a week for (4) four weeks, once weekly for (4) four weeks for medications at the bedside.

The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated.

The Administrator is responsible for implementing the plan of correction.

The completion date for this plan of correction is 6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 554	Continued From page 2 PM with Nursing Assistant (NA) #3 who was assigned to Resident #22 and she stated she was not aware of any medications which were supposed to be left at the bedside of Resident #22. She further stated she had not observed any medications at the bedside of Resident #22. An interview was conducted on 5/11/21 at 2:41 PM with Nurse #6, who was the treatment nurse. She stated she only provided a wound treatment to the resident ' s foot and she did not provide antifungal cream application for Resident #22. During an interview conducted on 5/13/21 at 3:36 PM with the Administrator and the Regional Clinical Consultant (RCC), the RCC stated residents were allowed to self-administer medications if they were screened and deemed appropriate to self-administer medications. She further stated the medications would have to be properly secured and the resident would be care planned for medications self-administration. She stated Resident #22 was not approved to self-administer medications and the observed medications should not have been at his bedside. The Administrator stated Resident #22 should not have had those medications as he was not evaluated for medication self-administration.	F 554		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to	F 563		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 563	Continued From page 3 a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, observation, family member interview, and staff interviews, the facility limited visitation to the lobby or front entrance and failed to allow private, unsupervised, visits for one of one resident reviewed for visitation (Resident #39). Findings included: Resident #39 was admitted to the facility on 2/5/21. The resident was residing in a private room at the time of the recertification. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date	F 563	Facility updated visitation to have open visitation to include in room visits 7 days a week starting on 5/13/21. Resident #39's family was notified of updated visitation policy on 5/13/21. Family visited resident #39 in room on 5/19/21. All residents have the potential to be affected. Residents and their Responsible Parties have been notified of open visitation, screening process and education on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 563	Continued From page 4 (ARD) of 4/6/21 indicated Resident #39 was in a persistent vegetative state with no discernable consciousness. Review of Resident #39's care plan, updated on 4/22/21 revealed a focus area which documented the resident's family was very supportive and involved. The focus area provided further information the resident's family visits the resident often through video conferencing. There were two goal areas listed in the care plan which included Resident #39 will receive one on one weekly visits for sensory and video conferencing with the resident's family and to continue outdoors in-person visits as tolerated and able. The second goal was, due to COVID-19 restrictions, he receives one on one weekly visits for sensory as tolerated, no outside vendors, nor guest, openly permitted indoors. Scheduled "restricted" in-person visitation only during this time. Further review of the care plan revealed a focus area documenting the resident had restricted visitation secondary to COVID-19 precautions. The goal was for the resident to maintain psychosocial well-being during the restricted visitation period. The listed intervention was to provide an alternative method of communicating with family and friends. An undated document from the facility identified as a corporate supplied "Tool kit" for resident visitation was reviewed. There was a page titled, In-Room Visitation. On that page it documented facilities could allow in room visitation under specific circumstances (end of life, resident is bed bound, equipment necessary for the resident's health cannot be easily moved). The document provided further information regarding there must be sufficient space to social distance and staff	F 563	masks, social distancing, hand hygiene, vaccinated and unvaccinated recommendation/requirements on 6/1/21. The Director of Nursing/Designee conducted education with all staff on updated visitation policy to include in room visits on 6/1/21. This education will be included for any new staff and agency staff. The Administrator/Designee will randomly audit (4) screening logs weekly x (12) twelve weeks to ensure in room visitation is allowed. The Administrator/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated. The completion date for this plan of correction is 6/4/21. The Administrator is responsible for implementing the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 563	Continued From page 5	F 563		

was to be available to stay with the resident during the visit to ensure safety and infection control practices were followed. Additionally, it was documented staff must be present during the visit to assure social distancing and appropriate infection control processes.

A phone interview was conducted on 5/11/21 at 9:29 AM with a family member of Resident #39. The family member stated she was not allowed to visit the resident in his room. She further stated the facility mandated all visits to occur in the front lobby of the facility at the entrance. She said she would like to be able to go to the resident's room and visit with him in private.

During an interview conducted on 5/11/21 at 2:08 PM with Nurse #8 she stated the family of Resident #39 came to the facility once a week or so to visit with the resident. She explained visitors, such as family members were not allowed in the general part of the facility. She said if a family member wanted to visit with a resident, it would have to be at the front of the facility either in the lobby or just outside the lobby at the front entrance.

On 5/11/21 at 3:11 PM an observation of the lobby at the front entrance of the building revealed two separate groups of residents and family members visiting outside of the front entrance and no resident and family members visiting inside at the lobby. The receptionist was at the desk in the lobby and was able to observe the visitation.

An interview was conducted on 5/11/21 at 3:53 PM with the receptionist. He stated all visitation for residents was allowed in the lobby and outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 563	Continued From page 6 at the front entrance. Unit Manager #1 stated during an interview conducted on 5/11/21 at 3:59 PM Resident #39 had met with his family outside. She explained all visitors were screened at the front entrance and all visitations took place up front, at the lobby, at the front entrance. An interview was conducted with the Social Worker (SW) on 5/11/21 at 4:03 PM. She said all family visits with residents must be scheduled, the visits are limited to once per week, and are limited to 30 minutes. However, she explained, if the family would like more visits or more time, it was open to them, because the weather was getting nicer, and it allowed them to have additional visitation areas outside of just inside the lobby, where they could only have two visitations at a time. The SW further stated they had not received a new "tool kit" from corporate regarding in room visits so they could not proceed with in room visits at this time. She said they had to await guidance from corporate regarding visitation for residents past the front entrance. She said the facility was awaiting the new "tool kit" which would explain how visitation was going to be conducted. She said there had been families who had asked about visiting residents in the facility, but until the new "tool kit" was received they could not allow any visitation beyond the front lobby and outside at the front entrance. The SW stated there was no date as to when corporate would release the new "took kit." The SW added she felt visitation was based on the county positivity rate and how corporate was addressing visitation. During an interview conducted on 5/13/21 at 3:36	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 563	Continued From page 7 with the Administrator and the Regional Clinical Consultant (RCC), the RCC stated Resident #39 was in a private room and should be allowed to have visits in his room. The administrator stated family visits with residents were being conducted outside at the front entrance, in the front lobby, and the guidance was to limit the visitations to 30 minutes. The administrator explained the facility had received a new "tool kit" from corporate and it was going to "open things up" regarding family visitation. The administrator said, however, the facility was not able to put the new "tool kit" into place regarding family visits into place due to the recertification. The administrator stated each facility in the company had to await directives from corporate on how to proceed with certain matters, and visitation was one of those matters.	F 563		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to provide an on-going activity program which met the individual interests and needs to enhance the quality of life for one of one resident reviewed for activities	F 679	Resident #30 activity plan was reviewed and revised to provide one on one activities at least twice weekly and as needed on 6/3/21 by Activities Director.	6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 679	Continued From page 8 (Resident #30). The findings included: Resident #30 was admitted to the facility on 11/29/18. The resident ' s cumulative diagnoses partly included: Alzheimer ' s disease, depression, dementia, and anxiety. Review of an undated Activities profile sheet of Resident #30 it was documented the resident preferred independent time, one-on-one visits are offered as tolerated, watching television, relaxing in room/common areas, supportive family, music, and it was noted the resident had cognitive, communication impairments, needed assistance and redirecting. The Minimum Data Set (MDS) significant change comprehensive assessment with an Assessment Reference Date (ARD) of 10/10/20 indicated Resident #30 had severe cognitive loss. A resident interview was conducted for Daily and Activity Preferences and revealed it was very important to her: to listen to music, do things with groups of people, do her favorite activities, and to participate in religious services or practices. Review of Resident #30 ' s care plan, which had been most recently updated on 4/14/21 revealed a focus area which documented the resident actively observed group activities, bingo, music, movies, pretty nails, and social events. The focus area also documented the resident was alert with confusion, she knew herself, and her family, but was confused to time, place, and placement. The resident was documented as enjoying watching television, would benefit from group activity participation, and being around other residents to	F 679	All residents have the potential to be affected. A 100% audit of residents requiring one on one activity plans and participation documentation was completed on 6/3/21 by Activities Director. Any residents with identified needs had their activity plan/care plan revised and activity participation documentation was completed. Activities Director was educated by Staff Development Coordinator on 5/17/2021. The Administrator will randomly audit (10) ten participation records of residents that require one on one activities weekly for (12) weeks and report results of audit to the facility monthly QAPI meeting x (3) three months. The QAPI committee will make changes and recommendations as indicated. The completion date for this plan of correction is 6/4/21. The Administrator is responsible for implementing the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 679	Continued From page 9	F 679		

increase social function. The goals listed were for the resident to participate in one-on-one weekly visits for activities, however due to COVID 19 restrictions the resident was offered one-on-one weekly visits as well as leisure material as tolerated. The resident could participate in small group activities, no outside vendors, nor guests openly permitted indoors. Scheduled in-person visitations only during this time. An intervention listed was the resident needed one-on-one bedside/in room visits and activities if unable to attend out of room events.

Review of Resident #30 ' s individual participation record for the month of April 2021 revealed the resident was documented as having participated in television/radio/music and talking to herself on 4/1/21, on 4/14/21 and 4/23/21 it was documented the resident had participated in live music outdoors, and on 4/19/21 it was documented the resident had participated in an ice cream truck event which was also outdoors. There was no documentation of any other activity participation for Resident #30 including one-on-one activity.

An Activities note dated 4/2/21 and timed 6:29 PM by the Activities Director (AD) documented Resident #30 remained alert to her surroundings with episodes of confusion. The resident was able to communicate some needs verbally. Due to COVID 19 the resident was offered one-on-one weekly visits and leisure materials as tolerated, small group activities were offered, however no outside vendors nor guest openly permitted indoors at this time.

There was no individual participation record for Activities for the month of May 2021 available for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 679	Continued From page 10	F 679		

review for Resident #30.

During multiple observations were conducted on 5/10/21, which started at 12:25 PM and ended at 4:08 PM, Resident #30 was seen out in the hallway near her room. During these observations she was observed to be sitting in her wheelchair, appeared distressed, anxious, and she was calling out for your help to staff who were passing her.

Multiple observations were conducted on 5/11/21 and 5/12/21 of Resident #30. Although the resident was not observed to have been as distressed, anxious, or requesting attention, she was observed to be out in the hallway, often sitting by the nurse ' s cart. Through none of the observations was the resident provided one-on-one activity time by the activity staff or other facility staff. The resident was not observed to have participated in any group activities.

An interview was conducted with the Activities Director (AD) on 5/13/21 at 9:35 AM. The AD stated they started back doing activities in the facility on 3/10/21. The AD explained Resident #30 participated or would watch small group activities, and she enjoyed music. She said they have been doing outside activities such as music and they had an ice cream truck. She said Resident #30 goes about as she pleases, will go to different areas in the facility, and enjoys talking. She said the resident ' s cognitive loss is significant enough that she was unable to do an activity like BINGO and she did better in small group activities or one-on-one. She stated the resident did have times when she would become anxious and when she would become anxious, she would try to calm her down by doing things

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 679	Continued From page 11 like combing her hair, and spending time with her, which helped to settle and calm her down. The AD stated Resident #30 needed one-one-one activity. The AD stated she did not have any documentation of one-on-one visitation or activity thus far for the month of May and did not have any documentation for the month of April. The AD was observed to have had one-on-one documentation for other residents for the requested time period. The AD was unable to identify what days or how often she had one-on-one activity time with Resident #30. During an interview conducted on 5/13/21 at 3:36 PM with the Administrator and the Regional Clinical Consultant (RCC), the RCC stated the expectation was for there to be appropriate activities for the residents. The Administrator stated the Nursing Assistants on the hall do interact with Resident #30 to help ease her anxiety.	F 679		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and nurse practitioner interviews and record review, the facility failed to prevent a resident from falling off the bed during care for 1 of 3 residents, Resident	F 689	Past noncompliance: no plan of correction required.	6/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 12	F 689		

Continued From page 12

#60, reviewed for supervision to prevent accidents. Resident #60 was turned to her side, rolled off the bed sustaining pain and bruising to her elbow and shoulder.

Findings included:

Resident #60 admitted to the facility on 2/20/2019 and her diagnoses included chronic kidney disease and congestive heart failure.

A Care Plan revised on 3/27/2021 stated Resident #60 required extensive to total assistance of one staff member for incontinence care and extensive assistance of one staff member to turn and reposition in bed due to impaired mobility and obesity. The Care Plan further stated Resident #60 was at risk for falls due to deconditioning, immobility, and incontinence.

Review of Resident #60's Quarterly Minimum Data Set (MDS) assessment dated 4/16/2021 revealed she was cognitively intact; required extensive assistance of one person for turning in bed; and had not had any falls since the previous assessment.

A Nurses Note by Nurse #1 written 5/2/2021 at 5:13 pm stated Resident #60 fell from the bed to the floor when Nurse Aide #1 was changing the resident's bed pads. The note further stated Resident #60 had hit the floor with her right shoulder and was complaining of right shoulder and elbow pain; and Nurse Practitioner #1 was notified.

A Physician's Order dated 5/2/2021 at 4:13 pm written by the Nurse Practitioner for Lidocaine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 689	Continued From page 13	F 689		

Patch 5% apply to right shoulder topically every 24 hours was written due to the injury and pain Resident #60 had due to the fall on 5/2/2021.

A review of the Medication Administration Record for 5/2021 revealed Resident #60 had complained of pain after the fall on 5/2/2021:

A review of the Medication Administration Record for 5/2021 revealed Resident #60 was administered Hydrocodone/Acetaminophen 10/325 milligrams one tablet at 12:41 am, 9:14 am and 5:24 pm on 5/3/2021 for pain relief. Resident #60 had rated her pain at 6 on a scale of 1 to 10 at 12:41 am; 5 on a scale of 1 to 10 at 9:14 am; and 4 on a scale of 1 to 10 at 5:24 pm. Resident #60 was also administered a Lidocaine Patch 5% to her right shoulder at 9:22 am on 5/3/2021 for pain relief, she rated her pain at a 3 on a scale of 1 to 10.

On 5/4/2021 at 5:10 am and 3:52 pm Resident #60 was administered Hydrocodone/Acetaminophen 10/325 milligrams one tablet and a Lidocaine Patch 5% was placed on Resident #60's right shoulder for pain per the Medication Administration Record for 5/2021 at 9:08 am. According to the Medication Administration Record Resident #60 rated her pain at 5 at 5:10 am, 5 at 9:08 am, and there was no rating recorded for 3:52 pm.

On 5/5/2021 Resident #60 was administered Hydrocodone/Acetaminophen 10/325 milligrams one tablet at 5:15 am and 8:15 pm. Resident #60 had rated her pain at 5 on a scale of 1 to 10 with both doses.

Further review of the Medication Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 14	F 689		

Record revealed Resident #60 received Hydrocodone/Acetaminophen 10/325 milligrams one tablet at 7:30 pm on 5/9/2021 after rating her pain at 4 on a scale of 1 to 10.

On 5/10/2021 at 9:11 am Resident #60 was administered Hydrocodone/Acetaminophen 10/325 milligrams one tablet after rating her pain at 5 on a scale of 1 to 10.

During an observation of Resident #60 on 5/10/2021 at 11:07 am a bruise was noted to her right elbow. The bruise extended from the middle of Resident #60's upper arm to below her elbow on her right posterior arm. Resident #60 stated Nurse Aide #1 was providing incontinence care and turned her to her side and she fell from the bed and hit her elbow. Resident #60 stated the fall occurred a week ago and she still had a lot of pain in her right shoulder and elbow. Resident #60 further stated the Nurse Practitioner had ordered an x-ray on the day she fell and another x-ray on 5/10/2021 and the nurse had told her there was not a fracture.

Nurse #2 was interviewed on 5/12/2021 at 9:33 am. She stated she had not worked when Resident #60 fell on 5/2/2021 but she had cared for her since the fall. Nurse #2 stated Resident #60 had complained of pain to her right shoulder and elbow since the fall and the Nurse Practitioner had changed her pain medication and ordered a follow up x-ray since she continued to have pain. Nurse #2 stated she was not aware of Resident #60 having falls before 5/2/2021.

An interview was conducted with Nurse #1 on 5/12/2021 at 4:38 pm. Nurse #1 stated Resident #60 was assigned to him on 5/2/201 when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 15	F 689		

fell from the bed. Nurse #1 stated Nurse Aide #1 was providing incontinence care for Resident #60 and was turning her on her side when she slipped from the bed and fell to the floor. Nurse #1 stated the Nurse Practitioner who was in the facility at the time of the fall was notified and she evaluated Resident #60 before she was moved back to the bed. Nurse #1 further stated Resident #60 is alert and oriented and told him how the fall occurred.

On 5/13/2021 at 10:02 am an interview was conducted with Nurse Aide #1 who is no longer employed with the facility. Nurse Aide #1 stated she had provided care for Resident #60 several times before she fell on 5/2/2021 and was not aware she should have two staff members to turn her until after Resident #60 fell from the bed. Nurse Aide #1 stated several staff had told her after the fall on 5/2/201 that Resident #60 required two staff members for turning in the bed. Nurse Aide #1 stated she had never seen a care plan or Nurse Aide Care Instructions for Resident #60 that told you how many staff were required to turn her in the bed. Nurse Aide #1 stated she was turning Resident #60 to her side to provide incontinence care when she slipped from the bed and she could not catch her. Nurse Aide #1 stated she could have asked someone to help her turn Resident #60 if she had known she should have had two staff to assist.

During an interview with Nurse Aide #2 on 5/13/2021 at 10:26 am she stated she had cared for Resident #60 several times before she fell on 5/2/2021. Nurse Aide #2 stated she usually got another Nurse Aide to help her because she felt Resident #60 needed two staff members.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 16 The Interim Director of Nursing was interviewed on 5/13/2021 at 10:42 am and stated Resident #60 required extensive assistance of one staff member for turning in the bed. The Interim Director of Nursing stated after Resident #60's fall on 5/2/2021 the staff were in-serviced on turning and repositioning residents and the staff were educated they should ask for assistance any time they felt they could not handle a resident during bed mobility or any other assistance they provided. The Interim Director of Nursing stated Nurse Aide #1 should have asked for help when turning Resident #60 but the Care Plan had stated she only needed assistance of one staff member. The Interim Director of Nursing stated Nurse Aide #1 was small and she felt she would have a hard attempting to turn Resident #60. The Nurse Practitioner was interviewed on 5/13/2021 at 2:02 pm and stated she assessed Resident #60 after her fall on 5/2/2021 and Resident #60 told her she fell from the bed and landed on her right side. The Nurse Practitioner stated Resident #60 had complained of right shoulder and elbow pain. The Nurse Practitioner stated she obtained an x-ray of Resident #60's right shoulder and elbow which did not show a fracture or dislocation. The Nurse Practitioner stated she saw Resident #60 again on 5/9/2021 because she continued to complain of pain in the right shoulder and elbow and she order another x-ray. On 5/13/2021 at 4:36 pm an interview was conducted with the Administrator and he stated although Resident #60 had not required two staff members to turn her before the fall but he wanted the staff to ask for assistance before turning and repositioning any resident they felt required	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 17	F 689		

another staff member to provide care rather than have a resident fall.

Validation of Past Non-compliance:

The Brian Center Health and Rehabilitation Cabarrus submitted a Plan of Correction with a compliance date of 5/3/2021:

Nurse #1 was interviewed on 5/12/2021 at 4:38 pm and stated Resident #60 was assessed for injury, pain medication was provided immediately after the fall for right shoulder pain, and an x-ray was ordered of the right shoulder. Nurse #1 further stated the Nurse Practitioner assessed Resident #60 immediately after the accident.

Nurse Aide #1 was educated on turning and repositioning and requesting assistance on 5/2/2021. This was validated by review of the in-service attendance form dated 5/2/2021 and an interview with Nurse Aide #1 on 5/13/2021 at 10:02 am.

On 5/3/2021 the Director of Nursing and Staff Development Coordinator re-educated staff regarding turning and repositioning, resident Kardek and Care Plan, and asking for assistance. This was validated through record review of the in-service attendance form dated 5/3/2021.

The Director of Nursing completed a Fall Risk Assessment for all current residents for accuracy and validation of interventions which was dated 5/3/2021.

Review of the Turning/Repositioning/Bed Mobility and Kardex/Care Plan Review Audits revealed the Director of Nursing had audited 3 Nurse Aides

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 18 weekly since 5/3/2021. The Plan of Correction dated 5/3/2021 stated the Director of Nursing would report the results of the audits during the Quality Assurance Meetings monthly for three months. Compliance was achieved on 5/3/2021. Validation included interviews with Nurse #1, Nurse Aide #1, and review of in-service education and auditing tool provided by the facility.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE** **CONCORD, NC 28025**

(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 693

Continued From page 19

Based on observation, record review and staff interviews, the facility failed to separate the tube feeding syringe components stored for use, which creates the potential for bacterial growth, for one of one resident reviewed for tube feeding (Resident #39).

Findings included:

Resident #39 was admitted to the facility on 2/5/21 with multiple diagnoses which included a gastrostomy.

The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 4/6/21 indicated Resident #39 was in a persistent vegetative state with no discernable consciousness. The resident was coded as having a feeding tube, receiving 51% or more of his total calories via tube feeding, and more than 501 cubic centimeters of fluid via tube feeding.

An observation conducted on 5/10/21 at 12:25 PM revealed a clear plastic bag hanging on an intravenous (IV) pole at resident #39 ' s bedside. Inside the clear plastic bag, a 2-ounce syringe was observed with the plunger fully depressed into the barrel of the 2-ounce syringe. Visible droplets of clear moisture were observed in the tip of the syringe.

An interview was conducted with Nurse #4 on 5/13/21 at 2:37 PM in conjunction of an observation of Resident #39 ' s tube feeding pole. The nurse stated she had been assigned to Resident #39 during the day shift (from approximately 7:00 AM to 3:00 PM). The nurse stated she did store the plunger, inside the barrel of the syringe, in the bag hanging on the IV pole.

F 693

The Unit Coordinator removed and discarded the tube feeding syringe that was incorrectly stored on 5/13/21.

The Unit Coordinator reviewed all residents with physician order for tube feeding to ensure proper storage of the piston and syringe on 5/13/21. No other issues were noted.

The Director of Nursing/Designee conducted reeducation with all Licensed staff and Licensed Agency staff on 6/1/21 on proper storage of tube feeding syringe. This education will be included for all new Nurses and Licensed Agency employees,

The Director of Nursing/Designee will audit all residents with physician's orders for tube feeding to ensure proper storage of syringe (5) five times a week for (4) four weeks, (3) three times a week for (4) weeks, and once weekly for (4) four weeks.

The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated.

The completion date for this plan of correction is 6/4/21.

The Administrator is responsible for implementing the plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 693	Continued From page 20 The nurse stated after she had finished utilizing the syringe she rinsed with syringe with water, inserted the plunger in the barrel of the syringe, and then placed the 2-ounce syringe into the plastic bag with the plunger depressed into the barrel of the syringe. The nurse said that was how she stored the syringe, with the plunger inside of the barrel of the syringe. She further stated she did not separate the plunger from the barrel when she would place the syringe in the plastic bag for storage. The 2-ounce syringe was observed with the plunger fully depressed into the barrel of the 2-ounce syringe and stored in a plastic bag. Visible droplets of moisture were observed in the tip of the syringe. The nurse stated she had returned the syringe to the plastic bag earlier after she had administered the resident his medication via the feeding tube and flushed the feeding tube. During an observation which was conducted in conjunction with an interview on 5/13/21 at 2:43 PM the Regional Clinical Consultant (RCC) stated the plunger should be stored removed from the barrel of the syringe in the plastic bag to minimize bacterial growth. The RCC made the statement after she observed the plunger in the barrel of the syringe with moisture in the tip in the room of Resident #39. During an interview conducted on 5/13/21 at 3:36 PM with the Administrator and the Regional Clinical Consultant (RCC), the RCC stated the expectation was for the plunger to be stored removed from the barrel of a syringe. The Administrator stated it was his expectation for the tube feeding syringe to be stored properly.	F 693		
F 726 SS=D	Competent Nursing Staff	F 726		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 726	Continued From page 21 CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to check agency nurse competencies for 1 of 1 agency nurses observed for medication administration (Nurse #3).	F 726	Nurse #3 was reeducated on safe injection practices, including Heparin administration by Infection Preventionist on 5/12/21. Nurse #3 was employed at facility from March 2018 through March	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 726	Continued From page 22	F 726		

F 726 — Summary Statement of Deficiencies:

Continued From page 22

Findings included:

Nurse #3 was observed preparing Heparin for injection for Resident #130 on 5/12/2021 at 8:54 AM. Nurse #3 removed two insulin syringes from the medication cart and withdrew Heparin into both syringes.

The syringe that Nurse #3 used was observed as a 50-unit insulin syringe and was labeled as ½ milliliter (ml) in volume. A syringe used for heparin administration would be labeled in volume of greater than 1 ml.

Nurse #3 was stopped as she went into the room and questioned if using insulin syringes was a standard of practice for the administration of Heparin. Nurse #3 reported she did not know what type of syringe to use for the Heparin injection because she did not have a small enough needle in the cart. Nurse #3 asked Nurse #6 to get her a syringe to administer the heparin with because she didn ' t know what syringe to use.

Nurse #3 was interviewed on 5/12/2021 at 11:22 AM. Nurse #3 reported 5/12/2021 was her first day working for the facility as an agency nurse. Nurse #3 reported she had received a packet of papers and she signed that she received the papers. Nurse #3 reported she had not read all the papers given to her and no nurse checked medication competency with her.

Unit manager (UM) #2 was interviewed on 5/12/2021 at 2:15 PM. UM #1 reported she provided a packet of information for Nurse #3. UM #2 reported she and Nurse #3 signed the

F 726 — Provider's Plan of Correction:

2021 with multiple medication pass observations/competencies completed. Nurse #3 worked as an Agency LPN and will not be returning to the facility.

On 5/12/21 the Nurse Practitioner reviewed all residents that had orders for Heparin. Orders were changed as appropriate.

All residents have the potential to be affected. Reeducation was provided to all Licensed Nursing/Agency staff regarding safe injection practices, including Heparin administration by the Infection Preventionist on 5/12/21. This education will be included for all new Nurses and Licensed Agency employees.

All new hired Nursing staff and Agency staff will have competencies completed during orientation process, to include Medication Pass Observations and safe injection practices.

The Director of Nursing/Designee will audit all new Nursing and Agency employees to ensure competencies are completed during orientation weekly as indicated x (12) twelve weeks.

The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated.

The completion date for this plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 726	Continued From page 23 checklist, but UM #2 did not check Nurse #3 ' s competency with medication administration or any other tasks. The DON and the District Director of Clinical Services (DCS) were interviewed on 5/12/2021 at 5:03 PM. The DCS and DON reported the UM provided information to the agency nurses but did not perform competency checks for agency nurses. The DON and DCS reported they were not aware competencies needed to be checked for agency staff.	F 726	correction is 6/4/21. The Administrator is responsible for implementing this plan of correction.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 732

Continued From page 24

residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to post accurate staffing information as compared to the Staff Schedule/ Assignment Sheets for 5 days of the 5 days reviewed.

Findings included:

The Daily Staffing Form for 5/1/21 revealed the posted staffing for first shift (7:00 AM to 3:00 PM) had 5 Nursing Assistants (NAs) for a total of 37.5 hours. Further review revealed the second shift (3:00 PM to 11:00 PM) had 4 NAs for a total of 30 hours and 2 Registered Nurses (RNs) for a total of 16 hours. The third shift (11:00 PM to 7:00 AM) had 2 NAs for 15 hours.

The facility nursing schedule for 5/1/21 revealed for first shift there were 5 NAs for 37.5 hours. Further review revealed for second shift there were 6 NAs for 45 hours and 3 RNs for 20.5 hours (one RN worked an abbreviated shift). The third shift had 3 NAs for 22.5 hours.

The Daily Staffing Form for 5/2/21 revealed the

F 732

The staff posting was corrected and posted on 5/13/2021. The Scheduler was immediately educated on the process for correcting staff posting by Staff Development Coordinator.

There was no direct adverse outcome to any resident as a result of this finding. All residents who reside in the facility have the potential to be affected.

The Director of Nursing/Designee conducted education with the scheduler, Nursing Administration and Nursing Supervisors on 6/1/21 on the process for correcting staff postings as changes occur. This education will be included for any new hires for Scheduling, Nursing Administration/Supervisor.

The Director of Nursing/Designee will audit with Posted Staffing Monitoring Tool, posting of staff (5)five times a week for(4)four weeks,(3)three times a week for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 732	Continued From page 25 posted staffing for first shift had 6 NAs for a total of 45 hours. The facility nursing schedule for 5/2/21 revealed for first shift there were 5 NAs for 37.5 hours. The Daily Staffing Form for 5/3/21 revealed the posted staffing for first shift had 7 NAs for a total of 52.5 hours. Further review revealed the second shift had 5 NAs for a total of 37.5 hours. The third shift had 5 NAs for 37.5 hours and two LPNs for 16 hours. The facility nursing schedule for 5/3/21 revealed for first shift there were 6 NAs for 45 hours. Further review revealed for second shift there were 7 NAs for 52.5. The third shift had 4 NAs for 30 hours, 1 LPN for 8 hours, and 1 RN for 8 hours. The Daily Staffing Form for 5/4/21 revealed the posted staffing for first shift had 6 NAs for a total of 45 hours. Further review revealed the second shift had 8 NAs for a total of 60 hours. The third shift had 5 NAs for 37.5 hours. The facility nursing schedule for 5/4/21 revealed for first shift there were 7 NAs for 52.5 hours. Further review revealed for second shift there were 6 NAs for 45. The third shift had 4 NAs for 30 hours. The Daily Staffing Form for 5/5/21 revealed the posted staffing for first shift had 8 NAs for a total of 60 hours. Further review revealed the third shift had 5 NAs for 37.5 hours. The facility nursing schedule for 5/5/21 revealed for first shift there were 7 NAs for 52.5 hours.	F 732	(4) four weeks, and once weekly for (4) four weeks. The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meeting x (3) three months. The QAPI committee will make changes and recommendations as indicated. The completion date for this plan of correction is 6/4/21. The Administrator is responsible for implementing the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 732	Continued From page 26 Further review revealed the third shift had 3 NAs for 22.5 hours. An interview was conducted in conjunction with a record review on 5/12/21 at 2:46 PM with the scheduler. She said she made changes to the posted staffing sheets, such as call outs, no call no shows, when she came to the facility in the mornings based on what had happened the day before. She explained she would correct the staffing sheet for Monday on Tuesday, and she would correct the staffing sheets for Friday, Saturday, and Sunday, when she came in on Monday. She said there was no one assigned, such as the charge nurse to update the staffing sheets throughout the day. The posted staffing sheets were reviewed with the nursing schedule from 5/1/21 through 5/5/21 and she stated she had made all of the changes on the posted staffing sheets the following day and then she had entered the changes into a software staffing management program in her computer. During an interview conducted on 5/13/21 at 3:36 PM with the Administrator he stated he expected for the posted staffing sheets to updated throughout the day.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 755	Continued From page 27 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a system of disposition of controlled substances for 1 of 6 residents reviewed for medication administration (Resident #15). Findings included: A physician order for Resident #15 dated 12/21/2020 ordered Clonazepam 0.25 milligrams (mg) orally twice per day. The order was transcribed as Clonazepam 0.5 mg ½ tablet orally twice per day. The controlled medication utilization record for	F 755	Nurse #6 was immediately reeducated on how to waste narcotics, including documentation/signatures by Staff Development Coordinator. There was no adverse outcome to Resident #15 as a result of this finding. All residents have the potential to be affected. The Director of Nursing/Designee conducted reeducation for all Licensed Nurses and Agency staff on 5/12/21 on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE** **CONCORD, NC 28025**

(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 755

Continued From page 28

Resident #15 ' s Clonazepam revealed 0.5 mg tablets had been dispensed.

The administration of clonazepam on 5/8/2021 documented ½ tablet had been administered to Resident #15. One nurse ' s signature was noted on 5/8/2020 to indicate that ½ tablet had been administered to Resident #15. No waste amount of the medication was documented, and no witness signature was documented.

The administration of clonazepam on 5/11/2021 documented ½ tablet had been administered to Resident #15. One nurse ' s signature was noted on 5/11/2020 to indicate that ½ tablet had been administered to Resident #15. No waste amount of the medication was documented, and no witness signature was documented.

Unit manager (UM) #1 was interviewed on 5/12/2021 at 2:15 PM. UM #1 stated that two nurses should sign on any wasted narcotic. UM #1 reported if ½ tablet of Clonazepam was administered on 5/8/2021 and 5/11/2021, the tablet had been split and one half of the tablet had been discarded (wasted). UM #1 reported she did not know why the nurses did not have a witness to the discarded half of Clonazepam.

The Director of Nursing (DON) and the District Director of Clinical Services (DCS) were interviewed on 5/12/2021 at 5:03 PM. The DCS reported that all narcotic waste should be performed by one nurse and witnessed by another nurse. The DCS reported the controlled medication utilization record should have signed by two nurses to show the disposition of the wasted Clonazepam. The DON reported she did not know why the Clonazepam had not been

F 755

how to properly waste Narcotic medications, including documentation/signatures. This education will be included for any new hires for Licensed Nurses and Agency Licensed staff.

The Director of Nursing/Designee will audit (10) ten random Narcotic Count Records weekly x (12) twelve weeks to ensure wasted narcotics are witnessed and documented appropriately.

The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated.

The completion date for this plan of correction is 6/4/21.

The Administrator is responsible for implementing this plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 755	Continued From page 29 witnessed by a second nurse for 5/8/2020 or 5/11/2020.	F 755		
F 759 SS=E	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 record review, observations, staff, physician and nurse practitioner interviews, the facility failed to ensure the medication error rate was less than 5% as evidenced by 5 medication errors out of 25 opportunities for a medication error rate of 20% (Resident #16, Resident #130, and Resident #15). Findings included: 1. A medication pass was observed on 5/11/2021 at 4:16 PM. Nurse #2 prepared Resident #16 ' s medications and administered furosemide 20 milligrams (mg) to Resident #16. Nurse #2 did not check Resident #16 ' s blood pressure. A physician order for Resident #16 dated 2/15/2021 for furosemide (a diuretic) 20 mg by mouth twice per day, hold if systolic blood pressure less than 100. Nurse #2 was interviewed on 5/12/2021 at 10:51 AM. Nurse #2 reported she was not aware she should have checked Resident #16 ' s blood pressure prior to administering the furosemide.	F 759	Nurses #2, #3 and #6 were immediately reeducated on Medication Administration including verifying orders before administration by Staff Development Coordinator. Residents #16, #130, #15 had no negative effects as a result of the alleged deficient practice. All residents have the potential to be effected. Nurse Practitioner was immediately notified for Residents #16, #130 and #15. Orders were clarified and changed as appropriate. The Director of Nursing/Designee conducted reeducation for all Licensed Nurses and Licensed Agency staff on Medication Administration including to verify orders before administration on 5/17/21. This education will be included for any new hires for Licensed Nurses and Agency Licensed staff.	6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 759

Continued From page 30

Nurse #2 read the order and reported she had never read the entire order and she had not checked Resident #16 ' s blood pressure. Nurse #2 reported the order had not been entered to trigger a pop-up box to document the blood pressure, and because there was not a reminder/pop-up box, she did not check Resident 16 ' s blood pressure.

The Director of Nursing (DON) was interviewed on 5/12/2021 at 5:03 PM. The DON reported she did not know why Nurse #2 would have missed checking Resident #16 ' s blood pressure.

2. Resident #130 was admitted to the facility 5/11/2021.

a. Nurse #3 was observed administering amantadine 10 ml to Resident #130 by mouth on 5/12/2021 at 8:54 AM.

Physician orders for Resident #130 were reviewed. An order dated 5/11/2021 ordered amantadine syrup 10 milliliters (ml) via PEG-tube (feeding tube) once per day.

An interview was conducted with Nurse #3 at 5/12/2021 at 11:22 AM. Nurse #3 reported after she had administered the amantadine, she noticed the order read to administer the medication by the PEG-tube. Nurse #3 reported she needed to get a physician order to administer the amantadine by mouth.

The DON was interviewed on 5/12/2021 at 5:03 PM. The DON did not know why Nurse #3 would have administered the amantadine by mouth instead of by PEG-tube.

F 759

The Director of Nursing/Designee will conduct Medication pass observations (2) two times weekly x (12) twelve weeks.

The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated.

The completion date for this plan of correction is 6/4/21.

The Administrator is responsible for implementing this plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 759 Continued From page 31 F 759

b. Nurse #3 was observed administering Vancomycin 2.5 ml to Resident #130 by mouth on 5/12/2021 at 8:54 AM.

Physician orders for Resident #130 were reviewed. A physician order dated 5/11/2021 ordered Vancomycin 2.5 ml by PEG-tube every 6 hours.

Nurse #3 was interviewed on 5/12/2021 at 11:22 AM. Nurse #3 reported she had not noticed the physician order to administer the medication by PEG-tube until after she had given the Vancomycin.

The DON was interviewed on 5/12/2021 at 5:03 PM. The DON did not know why Nurse #3 would have administered the Vancomycin by mouth instead of by PEG-tube.

c. Nurse #3 was observed preparing Heparin (a blood thinning medication) for injection for Resident #130 on 5/12/2021 at 8:54 AM. Nurse #3 removed two insulin syringes from the medication cart and withdrew Heparin into both syringes. Nurse #3 was stopped as she went into the room and questioned if using insulin syringes was a standard of practice for the administration of Heparin. Nurse #3 reported she did not know what type of syringe to use for the Heparin injection because she did not have a small enough needle in the cart. Nurse #3 asked Nurse #6 to get her a syringe to administer the Heparin with because she didn ' t know what syringe to use. Nurse #6 obtained a TB syringe and Nurse #3 prepared Heparin 5,000 units 1 ml and administered to Resident #130.

Physician orders for Resident #130 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 759	Continued From page 32 5/11/2021 ordered Heparin 5,000 units (1 ml) to be injected subcutaneously (into the fatty layer) every 8 hours. An insulin syringe used observed and it was a 50-unit syringe and was labeled as ½ ml in volume. Nurse #3 was interviewed on 5/12/2021 at 11:22 AM. Nurse #3 reported she knew Heparin had to be administered with a small needle and because she could not find a small needle in her cart, she thought that using the small needle on the insulin syringe would be fine. Nurse #3 reported she thought it was odd she was going to have to use 2 insulin syringes to administer one dose of medication, but she did not know which syringe to use. The DON and the District Director of Clinical Services (DCS) were interviewed on 5/12/2021 at 5:03 PM. The DCS and DON reported it was not a nursing standard to use an insulin syringe for the administration of heparin and Nurse #3 should not have attempted to use the insulin syringe. The facility physician (MD) was interviewed on 5/13/2021 at 3:41 PM. The MD reported that insulin syringes were not used for heparin administration because there was a difference between units and milliliters. The MD reported because the syringes were ½ milliliters by volume, Resident #130 would have most likely received the correct dosage of Heparin, but typically insulin syringes were used for only insulin. 3. Nurse #6 was observed administering	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 759	Continued From page 33 Clonazepam 0.5 mg 1 tablet to Resident #15 on 5/12/2021 at 10:13 AM. Nurse #6 administered a full tablet of Clonazepam to Resident #15. Resident #15 medication orders were reviewed. A physician order for Clonazepam 0.5 mg, ½ tablet orally twice daily was ordered on 12/21/2021. The narcotic count sheet for Resident #15 ' s Clonazepam was reviewed. The sheet noted that Resident #15 received 1 full tablet of clonazepam on 5/12/2021. A nurse practitioner note dated 12/21/2021 indicated a gradual dose reduction would be attempted for Resident #15 with Clonazepam and she planned to halve the dose from 0.5 mg to 0.25 mg to see how Resident #15 tolerated the lower dose. Nurse #6 was interviewed on 5/12/2021 at 11:38 AM. Nurse #6 checked the order for Resident #15 and reported she was confused by the way the order was written, and because all other nursing staff had administered a full tablet of Clonazepam 0.5 mg, she did not think to double check the dosage. The Director of Nursing (DON) and the District Director of Clinical Services (DCS) were interviewed on 5/12/2021 at 5:03 PM. The DON reported the order for Clonazepam for Resident #15 had been transcribed incorrectly and this led to nurses incorrectly administering the medications.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 760	Continued From page 34 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, physician and Nurse practitioner interview, the facility failed to prevent significant medication errors for 1 of 6 residents observed for medication administration (Resident #130). Findings included: Physician orders for Resident #130 dated 5/11/2021 ordered Heparin (a blood thinning medication) 5,000 units (1 milliliter [ml]) to be injected subcutaneously (into the fatty layer) every 8 hours. Nurse #3 was observed preparing Heparin for injection for Resident #130 on 5/12/2021 at 8:54 AM. Nurse #3 removed two insulin syringes from the medication cart and withdrew Heparin into both syringes. Nurse #3 was stopped as she went into the room and questioned if using insulin syringes was a standard of practice for the administration of Heparin. Nurse #3 reported she did not know what type of syringe to use for the Heparin injection because she did not have a small enough needle in the cart. Nurse #3 asked Nurse #6 to get her a syringe to administer the heparin with because she didn ' t know what syringe to use. Nurse #6 obtained a TB syringe and Nurse #3 prepared Heparin 5,000 units 1 ml and administered to Resident #130. The syringe that Nurse #3 used was observed as a 50-unit insulin syringe and was labeled as ½ ml in volume.	F 760	Nurse #3 was immediately reeducated on safe injection practices to include proper syringe usage for Heparin by Staff Development Coordinator. Nurse #3 worked as an Agency LPN and will not be returning to the facility. There was no direct adverse outcome to Resident #130 as a result of this finding. All residents have the potential to be affected. Nurse Practitioner was immediately notified for interaction pertaining to Resident #130. Orders were changed as appropriate by Nurse Practitioner. The Director of Nursing/Designee completed reeducation for all Licensed Nurses and Licensed Agency staff on Medication Administration to included safe injection practices on 5/17/21. This education will be included for any new hires for Licensed Nurses and Agency Staff. The Director of Nursing/Designee will conduct Medication pass observations to include safe injection practices (2) two times weekly for (12) twelve weeks. The Director of Nursing/Designee will report results of audits in the facility's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 760	Continued From page 35 Nurse #3 was interviewed on 5/12/2021 at 11:22 AM. Nurse #3 reported she knew Heparin had to be administered with a small needle and because she could not find a small needle in her cart, she thought that using the small needle on the insulin syringe would be fine. Nurse #3 reported she thought it was odd she was going to have to use 2 insulin syringes to administer one dose of medication, but she did not know which syringe to use. The DON and the District Director of Clinical Services (DCS) were interviewed on 5/12/2021 at 5:03 PM. The DCS and DON reported it was not a nursing standard to use an insulin syringe for the administration of heparin and Nurse #3 should not have attempted to use the insulin syringe. The facility physician (MD) was interviewed on 5/13/2021 at 3:41 PM. The MD reported that insulin syringes were not used for heparin administration because there was a difference between units and milliliters. The MD reported because the syringes were ½ milliliters by volume, Resident #130 would have most likely received the correct dosage of Heparin, but typically insulin syringes were used for only insulin.	F 760	monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated. The completion date for this plan of correction is 6/4/21. The Administrator will be responsible for implementing this plan of correction.	
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	F 880		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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	Continued From page 36 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 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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	Continued From page 37 (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 and staff interviews the facility failed to maintain infection control when 1 of 4 nurses (Nurse #4) was observed administering medications and failed to perform hand hygiene between residents (Resident #7, Resident #3, and Resident #13). Findings included: Nurse #4 was observed preparing medications for Resident #7 on 5/12/2021 at 4:21 PM. Nurse #4 was observed applying gloves to her hands and entering Resident #7 ' s room, administering oral medications and obtained a blood glucose level on Resident #7. Nurse #4 returned to her medication cart and removed her gloves. Nurse #4 did not perform hand hygiene.	F 880	Nurse #4 was immediately reeducated by Staff Development Coordinator on hand hygiene. All residents have the potential to be effected. The Director of Nursing/Designee completed reeducation for all staff on Infection Control Practice to include Hand Hygiene on 5/20/21. This education will be included for any new staff and agency staff. The Director of Nursing/Designee will conduct hand hygiene observations (5) five times weekly for (4) four weeks, (3)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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	Continued From page 38 Nurse #4 prepared medication for Resident #3 on 5/12/2021 at 4:29 PM. Nurse #4 administered the medication to Resident #3 and returned to her medication cart. Nurse #4 did not perform hand hygiene. Nurse #4 returned to her medication cart and prepared medication for Resident #13 on 5/12/2021 at 4:31 PM. Nurse #4 administered medication to Resident #13 and returned to her medication cart. Nurse #4 did not perform hand hygiene. Nurse #4 was interviewed on 5/12/2021 at 4:35 PM. Nurse #4 reported she was not aware she had not performed hand hygiene after administering medication to each of the 3 residents. Nurse #4 reported she should have used alcohol-based hand sanitizer (ABHS) after each resident and medication administration. The Director of Nursing (DON) and District Director of Clinical Services were interviewed on 5/12/2021 at 5:03 PM. The DON reported Nurse #4 should have used ABHS or washed her hands in a sink with soap and water after each medication administration. The DON reported the nursing staff had been provided with education regarding hand hygiene and infection control measures. The DON reported she expected all nurses to maintain infection control measures during medication administration.	F 880	three times weekly for (4) four weeks, once weekly for (4) four weeks. The Director of Nursing/Designee will report results of audits in the facility's monthly QAPI meetings x (3) three months. The QAPI committee will make changes and recommendations as indicated. The completion date for this plan of correction is 6/4/21. The Administrator is responsible for implementing the plan of correction.	