STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	C 09/23/2022

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/20/2022 through 09/23/2022 . The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # TY6W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/20/2022 09/23/2022. Event ID# TY6W11. The following intakes were investigated NC00189246, NC00187808, NC00187693, NC00191673 and NC00187591. 10 of the 10 complaint allegations were not substantiated.	F 000		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 04/14/2021 recertification survey. This was for a recited deficiency in the area of infection control. This deficiency was cited again on the current recertification survey. The continued failure	F 867	F 867 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, based on staff interview and	10/14/22

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

Electronically Signed | 10/14/2022

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F 867	Continued From page 1 during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F880 - Based on record review, observation and staff interviews, the facility failed to ensure staff followed the facility's infection control procedures by not performing hand hygiene when donning and doffing Personal Protective Equipment (gloves) during wound care for 1 of 1 resident observed for pressure ulcer wound care (Resident #60). During the recertification survey of 04/14/21, the facility was cited F880 Infection Control for failure to ensure staff wore Personal Protective Equipment (face masks) correctly while working in the facility. During an interview with the Administrator on 09/23/22 at 2:26 p.m., the Administrator indicated the QAA Committee meets on the last Friday of every month and the Director of Nursing and the Infection Control are included in attendance.	F 867	record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 04/14/2021 recertification survey. This was for a recited deficiency in the area of infection control. This deficiency was cited again on the current recertification survey. The continued failure during two federal surveys of record shows a pattern of the facility□s inability to sustain an effective QAA program. This tag is cross referenced to: F880 □ Based on record review, observation and staff interviews, the facility failed to ensure staff followed the facility□s infection control procedures by not performing hand hygiene when donning and doffing Personal Protective Equipment (Gloves) during wound care for 1 of 1 resident observed for pressure ulcer wound care (Resident # 60). The District Director of Operations has provided 1:1 education with the Administrator on 10/11/2022. No Adverse outcomes were identified. Element # 2 All residents receiving wound care have the potential to be affected by the deficient practice. The District Director of Operations has provided 1:1 education with the Administrator on 10/11/2022. In-service education was provided by the Director of Nursing, SDC/Infection Preventionist beginning on 9/22/2022 and will be completed by 10/11/2022 on proper	

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F 867	Continued From page 2	F 867	policies and procedures related to hand hygiene when donning and doffing personal protective equipment (Gloves). A full house audit of all staff was performed and was conducted by the Director of Nursing, and Infection Preventionist to ensure all Wallace Rehabilitation and Healthcare Center staff are appropriately following hand hygiene techniques when donning and doffing personal protective equipment (Gloves). What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Mandatory all staff education on policies and procedures related to hand hygiene when donning and doffing personal protective equipment (Gloves), which includes all Departments (Housekeeping, Laundry, Dietary, Therapy, Maintenance and Nursing) has been completed. Immediate education/intervention was provided to the Nurse #1 9/22/2022. Full house Education initiated on 9/22/2022 and completed 10/11/2022. All new hires and all contracted agency staff will have this mandatory education prior to working on the unit. Daily ongoing observation and education will be provided also to maintain compliance. The District Director of Operations and/or Designee will attend the facilities QAPI monthly meetings to ensure hand hygiene	

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F 867	Continued From page 3	F 867	compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the District Director of Operations and/or designee will attend the facilities monthly QAPI meeting and monitor the results from the Hand Hygiene Audits. The District Director of Operations and/or designee will provide education on any areas of concern. The results of the hand hygiene audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 10/14/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		10/14/22

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F 880	Continued From page 4 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. (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	F 880		

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F 880	Continued From page 5 (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 record review, observation and staff interviews, the facility failed to ensure staff followed the facility's infection control procedures by not performing hand hygiene when donning and doffing Personal Protective Equipment (gloves) during wound care for 1 of 1 resident observed for pressure ulcer wound care (Resident #60). The findings included: Review of the facility's "Infection Control: Hand Hygiene" policy, released January 2022, read in part, "Effective hand hygiene reduces the incidence of healthcare associated infections ... B. Indications for Hand Hygiene Using Alcohol-based Hand Sanitizer include: #7 Before donning gloves; #8 After removing gloves ..." An observation of Resident #60's wound care was conducted on 09/22/22 at 9:42 a.m. Nurse #1 administered the wound care to the resident's	F 880	F880 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Element #1: Nurse #1 failed to perform hand hygiene when donning and doffing personal protective equipment (Gloves) during wound care. A Fishbone/root cause analysis was conducted on 10/11/2022 to identify root cause of the area identified in the 2567. The Root cause analysis was facilitated by the Administrator, Director of Nursing, District Director of Clinical Services, and the Infection Preventionist. The Root cause analysis was reviewed with the QAPI committee on 10/11/2022 & 10/14/2022 and incorporated into the facility plan of correction below. The Directed Plan of Correction will be	

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F 880	Continued From page 6 left buttock area, assisted by Nursing Assistant (NA) #1; also in attendance was the facility's wound care medical doctor who assessed Resident #60s wound once the soiled dressing had been removed. Upon the start of the wound care, Nurse #1 washed her hands and donned gloves and set up wound care supplies on the covered overbed table. Nurse #1 removed the soiled dressing from the resident and disposed the soiled dressing. Nurse #1 then doffed her gloves and donned clean gloves. Nurse #1 then cleansed the wound. At 9:46 a.m., Nurse #1 doffed her gloves and donned clean gloves and did not wash her hands in between the glove change. Nurse #1 applied a petroleum dressing over wound. At 9:47 a.m., doffed her gloves and donned clean gloves, did not washing her hands and applied additional petroleum dressings to the wound bed. At 9:48 a.m., Nurse #1 doffed her gloves and donned clean gloves and did not wash her hands. At 9:51 a.m., Nurse #1 doffed her gloves and donned clean gloves, did not wash her hands, and cleared the overbed table of wound care supplies, sanitized her bandage scissors with an alcohol wipe, doffed her gloves and then went into the bathroom located in the resident's room and washed her hands. During an interview with Nurse #1 on 09/22/22 at 10:05 a.m., Nurse #1 was asked what she should do after doffing and before donning gloves and she did not answer. After prompting if she should have washed her hands after doffing and before donning clean gloves during the wound care procedure, Nurse #1 stated "no" and explained she had followed the new company's policy which she kept on a clipboard located on her treatment cart and proceeded to show this surveyor the policy. The worksheet Nurse #1 produced was a	F 880	completed by 10/14/2022 with training conducted by the Director of Nursing and the Infection Preventionist. Element #1: Nurse #1 failed to perform hand hygiene when donning and doffing personal protective equipment (Gloves) during wound care had no adverse outcome from the incident. Nurse #1 was educated immediately by the Director of Nursing on 9/22/2022 and return demonstration was conducted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Element #2: In-service education was provided by the Director of Nursing, SDC/Infection Preventionist beginning on 9/22/2022 and will be completed by 10/11/2022 on proper policies and procedures related to hand hygiene when donning and doffing personal protective equipment (Gloves). A full house audit of all staff was performed and was conducted by the Director of Nursing, and Infection Preventionist to ensure all Wallace Rehabilitation and Healthcare Center staff are appropriately following hand hygiene techniques when donning and doffing personal protective equipment (Gloves). What measures will be put into place to ensure the deficient practice does not reoccur: Element #3: Mandatory all staff education on policies and procedures related to hand hygiene when donning and doffing personal	

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F 880	Continued From page 7 piece of paper with a check-list on it which was titled "16. Wound Dressing Change Observation." There was no author listed and no created/revised date noted on this worksheet. Nurse #1 referred to the third column on the worksheet which heading read as "Hand Hygiene before and after dressing change" and to the fourth column which heading read as "Clean gloves donned before and doffed after dressing change." Nurse #1 further explained because of these instructions, she only had washed her hands before beginning the wound care and after the wound care was completed. A second interview with Nurse #1 was conducted on 09/22/22 at 10:20 a.m., at her request. Nurse #1 stated she knew she was supposed to wash her hands before donning and after doffing gloves and had become distracted while she provided wound care and had forgotten to do so. An interview was conducted with the Administrator on 09/22/22 at 1:27 p.m. When asked why she thought Nurse #1 did not wash her hands after doffing the soiled gloves and before donning the clean gloves, the Administrator thought Nurse #1 had become distracted during the wound care observation secondary to being observed by a surveyor, a medical doctor, a nursing assistant and the resident. The Administrator explained staff education regarding hand hygiene had already begun and stated the following week a public health nurse from the North Carolina Department of Health & Human Services, Division of Public Health, would be in the facility to monitor handwashing techniques by the staff. The Administrator stated it was her expectation the staff follow facility policy and procedure for	F 880	protective equipment (Gloves), which includes all Departments (Housekeeping, Laundry, Dietary, Therapy, Maintenance and Nursing). Immediate education/intervention was provided to the Nurse #1 9/22/2022. Full house Education initiated on 9/22/2022 and completed 10/11/2022. All new hires and all contracted agency staff will have this mandatory education prior to working on the unit. Daily ongoing observation and education will be provided also to maintain compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4: To ensure ongoing compliance, the Director of Nursing and Infection Preventionist and/or designee will conduct 5 random staff audits 2x per week for 12 weeks to ensure proper hand hygiene when donning and doffing personal protective equipment (Gloves). If there are any areas of concern, the appropriate education/in-servicing will be immediately provided to staff. All new hires/All contract agency staff will be educated on this policy and procedure during the orientation process prior to initiating work. The results of our auditing process will be reported to monthly QAPI until such time that substantial compliance has been achieved x 3 months Compliance date 10/14/2022.	

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F 880	Continued From page 8 handwashing when donning and doffing gloves.	F 880		