| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE** | **516 WALL STREET WAYNESVILLE, NC 28786** |

| (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 |
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| F 166 SS=C | 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br><br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their | F 166 | | 8/8/17 |

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

Electronically Signed | 08/08/2017

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| F 166 | Continued From page 1 | F 166 | | |

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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| F 166 | Continued From page 2<br>Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to ensure a grievance investigation and resolution was provided in writing to 1 of 1 sampled resident and/or their family member (Resident #8), and the facility's grievance policy failed to contain the following residents' rights: to file grievances anonymously, to receive a written summary of the grievance resolution; the written grievance resolution should contain the contact information of independent entities with whom grievances may be filed such as the pertinent State agency, State Long Term Care Ombudsman or Quality Improvement Organization; and the contact information of the grievance official including their name, physical and e-mail address and business phone number.<br><br>Findings included:<br><br>A review of the facility's grievance policy titled "Truly Listening to our Customers (TLC) Program", which was undated, revealed in part the facility investigated, resolved and documented all concerns submitted orally or in writing to any staff member without fear of threat or reprisal in any form.<br><br>Resident #8 was admitted to the facility on 09/14/16 with diagnoses that included diabetes, | F 166 | "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."<br><br>F166<br>1.) The plan correcting the deficiency. The plan should address the processes that lead to the deficiency cited:<br>a). The facility failed to provide written follow up to the resident or the resident responsible representative regarding the May 8, 2017 completed concern form.<br>b.) On August 8, 2017, resident #8's grievance investigation and resolution was provided in writing by the Administrator on a "concern decision form".<br><br>2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:<br>a). On July 31, 2017, the revised (May 2017), Truly Listening to our Customer policy #OP2 0306.00 was posted in the | |

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| F 166 | Continued From page 3<br>depression and age-related physical debility. The significant change Minimum Data Set (MDS) dated 06/12/17 indicated Resident #8 was cognitively intact.<br><br>Review of the facility's Concern Form (CF) dated 05/08/17 revealed Resident #8's family member had verbalized concerns related to bed pads and an eye doctor appointment. The facility's action to the concerns were to order Resident #8 the bed pads suggested by their family member and arrange for Resident #8 to see the facility's Optometrist. Further review of the CF revealed the Administrator had indicated follow-up had been made to the family member on 05/09/17 and they had been satisfied with the resolution. There was no indication Resident #8 or their family member had been provided a written summary of the grievance resolution.<br><br>An interview with the Administrator on 07/21/17 at 4:19 PM revealed he or the Director of Nursing verbally followed up with the resident and/or their family member on every concern. The Administrator stated he had received training on the new regulations by the corporate office and was instructed residents could receive a copy of the written grievance resolution when requested. He was unaware a written summary of the grievance resolution was to be provided to the resident and/or their family member after the grievance had been investigated. The Administrator stated he "was shocked" to learn the facility's grievance policy did not contain all the elements of the new grievance regulations that went into effect November 2016. | F 166 | front lobby area by the Administrator.<br>b). The facility administrator posted in the lobby area, a “Filing a Concern” Poster outlining each of the resident’s rights, grievance officer contact information, anonymous reporting information, as well as other required state agencies and contact information.<br>c). The resident council received information on July 26, 2017, from the Administrator, Director of Nursing, and Activity Director regarding the Grievance/Concern policy.<br>d). On August 8, 2017, the District Director of Clinical Services provided education to the Administrator on policy #OP2 0360.00. On August 8, 2017,<br>e). the department managers were in-serviced on policy #OP2 0360.00 by the Administrator on August 8, 2017.<br><br>3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:<br><br>a). The Administrator will ensure required Grievance/Concern Policy” & “Filing a Concern Poster” remain posted in the lobby 5 x per week.<br>b). The Administrator will complete weekly audits of the Grievance/Concern Log to ensure the Grievance/Concern Form is completed and the Concern Decision Form is provided in writing as required.<br>c). The Administrator will report findings of audits monthly to the QAPI committee x 2, | |

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| F 166 | Continued From page 4 | F 166 | then quarterly x 2.<br><br>4.) The title of the person responsible for implementing the acceptable plan of correction;<br><br>The administrator will be responsible for the implementation of the acceptable plan of correction.<br><br>5.) Dates when corrective action will be completed:<br><br>August 8, 2017 | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(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 (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify | F 441 | | 8/8/17 |

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| F 441 | Continued From page 5 | F 441 | | |

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

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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| F 441 | Continued From page 6<br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record reviews and staff interviews, the facility failed to have a nurse perform hand hygiene, after providing bowel incontinence care and before assisting with wound care, for 1 of 3 residents reviewed for skin and wound care (Resident #8).<br><br>The findings included:<br><br>Review of a facility policy titled Hand Hygiene, copyright year 2012, referenced Centers for Disease Control and Prevention (CDC) Guidelines for Hand Hygiene in Healthcare Settings, dated 10/22/02.<br><br>Review of CDC Guidelines for Hand Hygiene in Healthcare Settings dated 10/22/02 revealed "handwashing or disinfection should be performed after glove removal."<br><br>Observation on 07/20/17 at 12:10PM revealed Resident #8 was rolled to her left side by Nurse #1, with assistance by the Unit Manager and the Wound Care Doctor. A bedside table was covered in a clean towel with dressing supplies, but no hand sanitizer was observed on the table. A large blue dressing on the resident's right buttock approximately 8 inches by 10 inches, in close proximity to the gluteal cleft, was due for a dressing change, but remained in place due to active bowel incontinence. Nurse #1 was observed wearing disposable gloves while providing incontinence care. Upon completion of providing incontinence care, Nurse #1 was | F 441 | "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."<br><br>F441<br>1.) The plan correcting the deficiency. The plan should address the processes that lead to the deficiency cited:<br><br>a). The deficient practice occurred when the nurse#1 failed to provide appropriate hand sanitation when changing from incontinent care to wound care.<br>b). The nurse #1 was in-serviced by the Director of Nursing on July 20 and July 27 on the facilities Hand Hygiene policy.<br>c). Resident #8's wounds were assessed on July 20 and July 27, 2017 by the wound care physician and were improving and showed no signs of infection.<br><br>2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:<br><br>a). The Director of Nursing began education to the nursing staff on the | |

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| F 441 | Continued From page 7<br>observed removing her gloves and, without performing hand hygiene, put on new gloves. The Wound Care Doctor was observed removing the old dressing with his gloved hands and Nurse #1 cleansed the wound with a product dispensed from a spray bottle with a squeeze trigger. Nurse #1 took off her gloves, left the resident's room, and re-entered the room. Without performing hand hygiene, Nurse #1 was observed putting on a new pair of gloves and continued assisting the Wound Care Doctor. The Unit Manager was observed leaving the resident's room and Nurse #1 continued to assist the Wound Care Doctor.<br><br>Interview on 07/20/17 at 12:20PM with the Unit Manager revealed Nurse #1 should have sanitized or washed her hands after performing incontinence care on Resident #8, and before putting on clean gloves to assist the Wound Care Doctor. She stated there was no hand sanitizer on the table in the room with dressing supplies.<br><br>Observation on 07/20/17 at 12:23PM revealed the Unit Manager bringing into Resident #8's room a bottle of hand sanitizer and placing it on the table with dressing supplies.<br><br>Interview on 07/20/17 at 4:30PM with the Director of Nursing revealed she expected nurses to sanitize or wash their hands between glove changes.<br><br>Interview on 07/21/17 at 12:08 PM with Nurse #1 revealed she was assigned to the Wound Care Doctor on 07/20/17 to assist him with wound care. She stated she should have washed her hands or use hand sanitizer between gloves changes when she was assisting Resident #8 with incontinence care and before continuing with | F 441 | facility policy for Hand Hygiene on July 20, 2017.<br><br>3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:<br><br>a). The Director of Nursing or Unit Manager will complete random observations of the nurses completing wound care to ensure Hand Hygiene compliance is maintain weekly x 4, then monthly x 2. The Director of Nursing will provide additional training to nurses when areas are identified during her observations.<br>b). The Director of Nursing will report finding of these random observations monthly x 3 to the QAPI committee.<br><br>4.) The title of the person responsible for implementing the acceptable plan of correction;<br><br>The Director of Nursing will be responsible for the implementation of the acceptable plan of correction for hand washing hygiene.<br><br>5.) Dates when corrective action will be completed: August 8, 2017 | |

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| F 441 | Continued From page 8<br>wound care assistance.<br><br>Interview on 07/21/17 at 4:19PM with the Administrator revealed his expectation that staff follow infection control procedures. | F 441 | | |
| F 520 SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the | F 520 | | 8/8/17 |

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| F 520 | Continued From page 9<br>records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2016. This was for a recited deficiency which was originally cited in October of 2016 on a recertification survey and on the current complaint investigation. The deficiency was in the area of Infection Control. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag is cross referred to:<br><br>F441, Infection Control: Based on observation, record reviews and staff interviews, the facility failed to have a nurse perform hand hygiene, after providing bowel incontinence care and before assisting with wound care, for 1 of 3 residents reviewed for skin and wound care (Resident #8).<br><br>The facility was recited for F441 for failing to have a nurse perform hand hygiene after providing | F 520 | "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."<br><br>F520<br><br>1.)The plan correcting the deficiency. The plan should address the processes that lead to the deficiency cited:<br><br>a). The facility failed to maintain compliance with infection control when the nurse #1 failed to use proper hand hygiene when providing wound care.<br>b). The facility will use their monitoring processes to assure compliance with infection control and reporting to the facility QAPI for review, trending and further recommendations.<br><br>2.) The procedure for implementing the acceptable plan of correction for the | |

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| F 520 | Continued From page 10<br>bowel incontinence care and before assisting with wound care. F441, Infection Control, was originally cited during the October 27, 2016 recertification survey for failing to wash resident clothing in water temperatures of 160 degrees or greater.<br><br>Interview on 07/21/17 at 4:19PM with the Administrator revealed his expectation that staff followed infection control procedures. He stated that at facility quality assurance meetings infections for the month were reviewed with the Medical Director and if there were problems with cross-contamination a process improvement plan was implemented.<br><br>Interview on 07/21/17 at 4:19PM with the Director of Nursing revealed she was responsible for tracking any trends in infection control concerns. | F 520 | specific deficiency cited:<br>a). See F-441<br><br>b). The Area Staff Development Coordinator re-educated the Administrator and Management Staff on implementing and maintaining an effective Quality Assurance and Performance Improvement (QAPI) Committee. The committee use the Plan, Do, Study, Act method for QAPI, including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity.<br><br>The Quality Assurance Committee consists of; Administrator, Director of Nursing, Medical Director, Dietary Manager, Rehabilitation Manager, Maintenance Director.<br>Representatives include; Activities Director, Social Services Director, Human Resources Designee, Business Office Director, and Resident Care Management Director.<br><br>3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:<br><br>a). All repeated citations were reviewed, corrected, and monitoring tools implemented to maintain compliance. (F441)<br><br>4.) The title of the person responsible for | |

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| BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE | 516 WALL STREET WAYNESVILLE, NC 28786 |

| (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 |
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| F 520 | Continued From page 11 | F 520 | implementing the acceptable plan of correction;<br><br>The Administrator and the Director of Nursing will be responsible for the implementation of the acceptable plan of correction for the QAPI to maintain the facility in compliance with infection control.<br><br>5.) Dates when corrective action will be completed:<br><br>August 8, 2017 | |