STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident representative (RR) interviews the facility failed to notify the RR of a change in condition and the need for a new treatment order for 1 of 3 residents (Resident #1) reviewed for notification of change. Findings included: Resident #1 was admitted to the facility 05/29/2020 with [DIAGNOSES REDACTED]. A review of a Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 was severely impaired for daily decision making, required the extensive assistance of one to two persons for toileting and personal hygiene and was always incontinent of bowel and bladder. A review of a nursing progress note dated 07/26/2020 at 8:45 PM indicated Resident #1 was noted to have perineal (groin area) redness and itching, her physician was notified, and a new order was received for [MEDICATION NAME] powder (an antifungal medication) for seven days. On 09/02/2020 at 11:30 AM an interview with the director of nursing (DON) indicated nursing staff should document any changes in a resident's condition and new treatment orders in a progress note and include the notification of both the resident's physician and RR. On 09/02/2020 a telephone interview with nurse #1 indicated she called Resident #1's physician on 07/26/2020 to notify him of the new skin condition and received a new treatment order for Resident #1. She stated she did not recall notifying Resident #1's RR. Nurse #1 stated she knew she was supposed to notify resident's RR of any change in condition or new treatment orders. On 09/02/2020 at 1:03 PM a telephone interview with Resident #1's RR indicated she did not recall being notified of Resident #1's new skin condition or new treatment order.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and facility staff, medical director and the facility's local health department nurse supervisor interviews the facility failed to implement the Centers for Disease Control and Prevention (CDC) practices for COVID-19 by not keeping a readmitted resident (Resident #1) under quarantine for 14 days from the date of her readmission to the facility, not keeping a resident (Resident #2) with a known exposure to COVID-19 under quarantine for 14 days from the date of her exposure and not requiring staff to wear all recommended Personal Protective Equipment (PPE) when caring for 2 of 3 residents (Resident #1 and Resident #2) under observation for COVID-19 for 14 days. This failure occurred during a COVID-19 pandemic. Findings included: The CDC guideline entitled Responding to Coronavirus (COVID-19) in Nursing Homes last reviewed on 04/30/2020 indicated the following statements: Considerations for new admissions or readmissions to the facility: * All recommended COVID-19 PPE should be worn during the care of residents under observation, which includes the use of an N95 or higher level respirator (or a facemask if a respirator is not available), eye protection (goggles or a disposable face shield that covers the front and sides of the face), gloves and a gown. * A single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. * New residents could be transferred out of the observation area if they remain afebrile and without symptoms for 14 days after their last exposure (e.g. date of admission). Resident with new-onset suspected or confirmed COVID-19: * Ensure resident is isolated and cared for using all COVID-19 recommended PPE. * Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). A review of the facility's COVID-19 Negative or Unknown COVID-19 Status Admissions or Readmissions Criteria indicated the following statements: * Residents will be closely monitored for an observation period of 14 days. Based on improvement, resolution, or the continued absence of symptoms and the completion of 14 days of isolation, residents can be moved from isolation and droplet precautions to the broader resident population. The rationale in this case is that a negative test does not rule out incubating illness that may develop during the isolation period. During the entrance conference on 09/01/2020 at 9:00 AM the director of nursing (DON) indicated the 100 Hall was the facility's new admission/readmission quarantine hall. A review of the facility's list of Admissions/Readmissions from 07/01/2020 through 09/02/2020 indicated Resident #1 was readmitted to the facility into private room [ROOM NUMBER] on 08/20/2020 after a hospitalization . A review of the facility's COVID-19 timeline indicated Resident #2's roommate was sent to the hospital on [DATE] at 1:00 PM and at 6:30 PM the facility was notified of this hospitalized resident's positive COVID-19 test. Resident #2 was moved to the 100-quarantine hall on 08/25/2020 at 9:30 PM. On 09/01/2020 at 10:08 AM an observation was made of Resident #1 on the 300 Hall in semi-private room [ROOM NUMBER] with Resident #2 as her roommate. No enhanced droplet contact precaution signage indicating the need for staff to wear COVID-19 PPE when caring for Resident #1 or Resident #2 was observed. No COVID-19 PPE supplies available for use were observed outside the room. On 09/01/2020 at 10:22 AM an interview with nurse #2 indicated both Resident #1 and Resident #2 had previously been on the 100 Hall quarantine unit and were moved to room [ROOM NUMBER] on 08/31/2020. She stated Resident #1 was a readmission to the facility and Resident #2 had a previous roommate who tested positive for COVID-19. The nurse went on to say she was providing care to both Resident #1 and Resident #2 as well as other residents on the 300 Hall that day using an N95 respirator, a face shield and gloves. She stated gowns were not required to care for Resident #1 and Resident #2. The nurse further indicated if residents required staff to wear additional PPE such as a gown, signage was posted, and the required PPE was available for use at the door. On 09/01/2020 at 2:41 PM an interview with nursing assistant (NA) #1 indicated she had been responsible for the care of Resident #1 and Resident #2 that day. She stated neither resident required any special PPE other than the N95 respirator, face shield and gloves she used when caring for all residents. She stated if a resident required additional PPE that information was posted on a sign and the needed PPE was present at the doorway to the room. On 09/01/2020 at 10:39 AM an interview with the DON indicated new admissions and readmissions to the facility resided on the 100 Hall for 14 days. She stated Resident #1 had been readmitted to the facility into room [ROOM NUMBER] on 08/20/2020, had one negative COVID-19 test from the facility wide testing done on 08/06/2020, a negative COVID-19 test on her admission to the hospital on [DATE] and a negative COVID-19 test on 08/20/2020 prior to her readmission to the facility. The DON further indicated the movement of Resident #1 off the 100 Hall into room [ROOM NUMBER] and discontinuation of COVID-19 PPE on 8/31/2020 after only 12 days must have been a miscount. She went on to say she recalled speaking with the facility's medical director about Resident #1 and being told as Resident #1 had 3 negative COVID-19 tests it would be okay to take her off COVID-19 PPE precautions and move her off the 100 Hall. The DON indicated Resident #2's previous roommate tested positive for COVID-19 in the hospital on [DATE] and after consulting with the Health Department, Resident #2 had been tested for COVID-19 on 08/25/2020 and moved to the 100 Hall into room [ROOM NUMBER] for isolation and observation and placed on COVID-19 PPE precautions. She stated Resident #2's COVID-19 test from 8/25/2020 was negative and as she remained free from any symptoms, she was moved off the 100 Hall to

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) room [ROOM NUMBER] on 08/31/2020 after 7 days. The DON went on to say she must have misunderstood the guidance regarding the length of time COVID-19 PPE was needed for Resident #2. She stated because Resident #2 was a resident and not a new admission she wanted to move her off the 100 Hall as soon as possible. She went on to say she thought after Resident #2's negative COVID-19 test on 08/25/2020 and the absence of any symptoms for 7 days this was long enough. The DON stated she did not recall consulting with the facility medical director regarding Resident #2. Further review of the facility's Admission/Discharge list from 08/01/2020 though 09/01/2020 indicated no other residents in the facility were moved off the 100 Hall after less than 14 days. On 09/01/2020 at 2:05 PM a telephone interview with the facility's local health department nurse supervisor indicated she was aware of the situation with Resident #2's exposure to a COVID-19 positive roommate. She stated she did not know why the facility would move Resident #1 off the observation unit and discontinue the COVID-19 PPE precautions after 12 days. She further indicated she also did not know why the facility would discontinue the COVID-19 PPE precautions for Resident #2 after only 7 days. The nurse supervisor stated Resident #1 should have remained on the observation unit on COVID-19 PPE precautions for 14 days. She stated Resident #2 should have remained on COVID-19 PPE precautions for 14 days from the date of her known exposure, 08/25/2020, as she could still have developed COVID-19 during this time period. The nurse supervisor went on to say she had been in frequent communication with the facility's DON providing support and guidance and thought the DON understood the CDC guidance regarding isolation and COVID-19 PPE as the DON told her 14 days of isolation and COVID-19 PPE for new admissions, readmissions and residents with a known exposure was the facility's plan. On 09/02/2020 at 1:13 PM an interview with the facility medical director indicated he was the physician for Resident #1 and Resident #2. He stated he was not consulted regarding the discontinuation of COVID-19 PPE or Resident #1's movement off the 100 Hall after 12 days or the discontinuation of COVID-19 PPE or Resident #2's movement off the 100 Hall after 7 days. He stated it was his understanding that for these residents the standard was for those measures to remain in place for 14 days. On 09/02/2020 at 1:25 PM an interview with the administrator indicated the discontinuation of COVID-19 PPE and movement off the 100 Hall after 12 days for Resident #1 and the discontinuation of COVID-19 PPE and movement off the 100 Hall after 7 days for Resident #2 was not the recommended protocol.