STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews the facility failed to ensure required Personal Protective Equipment (PPE) was worn and hand hygiene was performed when entering and exiting a resident's room with signage indicating Enhanced Droplet Contact Precautions for 3 of 3 residents reviewed for infection control (Residents #1, #2, and #3). The facility also failed to ensure proper handling of soiled linen removed from a resident's room on Enhanced Droplet Contact Precautions for 1 of 3 residents reviewed for infection control (Resident #3). These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents in the facility through the transmission of COVID-19. The findings included: According to the facility protocol document titled Managing COVID-19 in your facility dated 3/23/20 and signed by the medical director read in part: under the topic of care considerations for symptomatic residents suspected to have COVID-19 and placed on the appropriate droplet based transmission precautions, residents who are suspected to be infected by COVID-19 are considered positive until testing confirms otherwise and all staff must be meticulous with hand hygiene and the use of PPE. 1. Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 was cognitively intact and required extensive assistance from staff with bed mobility and transfer and was independent with eating. A nursing note dated 05/14/20 indicated Resident #1 was on intravenous (IV) antibiotic therapy for [MEDICAL CONDITIONS] and a nursing noted dated 05/21/20 indicated Resident #1 experienced shortness of breath. A continuous observation on 05/21/20 beginning at 09:30 AM revealed signage on the door of Resident #1's room that indicated Enhanced Droplet Contact Precautions, which listed perform hand hygiene, wear a N-95 or surgical mask, eye protection, a gown, and gloves when entering room, and to keep the door closed including picture illustrations of each item. It further revealed Nurse Aide #1 (NA) wearing a mask and one glove enter the room to retrieve Resident #1's breakfast tray. NA#1 did not don a second glove nor a gown before entering the room. She exited the room wearing the one glove with the breakfast tray held in both hands as she walked down the hall to the gray trash barrel and disposed of the trash from the tray and placed it on the cart with the other used trays. NA #1 returned to the same room labeled Enhanced Droplet Contact Precautions wearing the used glove, she proceeded to remove the soiled glove from her hand and placed it in her right pocket and retrieved another glove from her left pocket and placed one glove on her hand before proceeding to re-enter the room to retrieve the roommates tray. She did not perform hand hygiene after removing the glove or before re-entering the room to collect the roommate's tray. When NA #1 exited the room with the second breakfast tray, she disposed of the trash in the barrel using both hands, removed the one glove placing it in the trash barrel, and proceeded directly to the clean linen cart that was located on the hall without performing hand hygiene. An interview with NA#1 on 05/21/20 at 09:45 AM revealed she was aware Resident #1 was in a room labeled Enhanced Droplet Contact Precautions. She acknowledged she only wore one glove into the room to retrieve the tray and had touched the tray using her ungloved hand and her glove should have been disposed in the trash can after use. NA#1 indicated she had been educated on hand hygiene, transmission-based precautions, and donning and doffing of PPE. She further revealed she should have worn full PPE including a mask, gown, and gloves to each hand each time she entered Resident #1's room and performed proper hand hygiene using alcohol-based hand rub (ABHR) or soap and water when she removed her gloves. An interview with the Infection Control Nurse on 05/21/20 at 09:55AM revealed all staff had received education on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions during the month of March 2020 and provided education records that confirmed NA#1 had received education. The Infection Control nurse indicated NA #1 should have worn full PPE to include a gown, gloves, a mask, and eye wear when in the room of Resident #1. An interview with the Director of Nursing on 05/21/20 at 11:45 AM indicated NA #1 had been trained on the transmission-based precautions, hand hygiene, and the use of PPE. She revealed all staff are to wear full PPE to include gown, mask, a face shield, and gloves when entering a room labeled Enhanced Droplet Contact Precautions and proper hand hygiene should be performed when it is removed. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the care plan dated 03/16/20 revealed Resident #2 had restricted visitation secondary to COVID-19 exposure and another care plan dated 03/31/20 indicated Resident #2 was at risk infection for COVID-19 virus secondary to active community COVID-19 cases with interventions that included hand hygiene. A review the Quarterly Minimum (MDS) data set [DATE] indicated Resident #2 was cognitively impaired and required extensive assistance from staff for bed mobility, transfers, and eating. A continuous observation on 05/21/20 beginning at 09:30 AM revealed signage on the door of Resident #2's room that indicated Enhanced Droplet Contact Precautions. It further revealed Nurse Aide #1 (NA) wearing a mask and one glove enter the room to retrieve Resident #1's and Resident #2's breakfast tray. NA #1 did not don a second glove nor a gown before entering the room. She exited the room wearing the one glove with the breakfast tray held in both hands as she walked down the hall to the gray trash barrel and disposed of the trash from the tray and place it on the cart with the other used trays. NA #1 returned to the same room labeled Enhanced Droplet Contact Precautions wearing the used glove, she proceeded to remove the soiled glove from her hand and placed it in her right pocket and retrieved another glove from her left pocket and placed one glove on her hand before proceeding to re-enter the room to retrieve the roommates tray. She did not perform hand hygiene after removing the glove or before re-entering the room to collect the roommate's tray. When NA #1 exited the room with the second breakfast tray, she disposed of the trash in the barrel using both hands, removed the one glove placing it in the trash barrel, and proceeded directly to the clean linen cart that was located on the hall without performing hand hygiene. An interview with NA#1 on 05/21/20 at 09:45 AM revealed she was aware Resident #1 was in a room labeled Enhanced Droplet Contact Precautions. She acknowledged she only wore one glove into the room to retrieve the tray and had touched the tray using her ungloved hand and her glove should have been disposed in the trash can after use. NA#1 indicated she had been educated on hand hygiene, transmission-based precautions, and donning and doffing of PPE. She further revealed she should have worn full PPE including a mask, gown, and gloves to each hand each time she entered Resident #1's room and performed proper hand hygiene using alcohol-based hand rub (ABHR) or soap and water when she removed her gloves. An interview with the Infection Control Nurse on 05/21/20 at 09:55 AM revealed all staff had received education on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions during the month of March 2020 and provided education records that confirmed NA#1 had received education. The Infection Control nurse indicated NA #1 should have worn full PPE to include a gown, gloves, a mask, and eye wear when in the room of Resident #1. An interview with the Director of Nursing on 05/21/20 at 11:45 AM indicated NA #1 had been trained on the transmission-based precautions, hand hygiene, and the use of PPE. She revealed all staff are to wear full PPE to include gown, mask, a face shield, and gloves when entering a room labeled Enhanced Droplet Contact Precautions and proper hand hygiene should be performed when it is removed. 3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#3's use of oxygen at 5 liters via nasal cannula (L/NC) due to respiratory illness. Review of a care plan dated 03/16/20 revealed Resident #3 had restricted visitation secondary to COVID-19 exposure and further review of a care plan dated 03/31/20 indicated Resident #3 is at risk infection for COVID-19 virus secondary to active community COVID-19 cases with interventions that included hand hygiene. A review of a quarterly Minimum Data Set ((MDS) dated [DATE] indicated

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

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BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	**220 13TH AVENUE PLACE NW HICKORY, NC 28601**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #3 had cognitive impairment and required extensive assistance by staff for all bed mobility, toileting, dressing, and hygiene needs. A continuous observation on 05/21/20 beginning at 10:20 AM revealed signage on the door of Resident #3 that indicated Enhanced Droplet Contact Precautions. Nurse Aide (NA) #2 was observed to have completed incontinence care for Resident #3 and began bagging soiled linen for disposal. She was wearing a face mask, yellow disposable isolation gown, and gloves. NA #2 removed her gloves, did not wash her hands, exited the room wearing the yellow gown, and went to the isolation cart located on the unit to retrieve more plastic bags for the remainder of the soiled linen. After retrieving the bags, she returned to the room of Resident #3 without reapplying gloves or washing her hands and began to place the remainder of the soiled linen in the plastic bag. NA #2 then tied off the bag with a red tie type label to indicate to laundry it was removed from an isolation room. She exited the room carrying the bags, picked up an unsealed bag of dirty linen located next to the gray linen barrel in the hallway, opened the lid of the barrel while touching the handrail for balance and placed one of the two bags in the overflowing barrel. NA #2 proceeded to the exit door located at the end of the hall. She then opened the exit door with her hand and disposed of all soiled linen from the barrel in receptacles outside the door. An interview with Nurse Aide (NA) #2 on 05/21/20 at 10:30 revealed she acknowledged she completed incontinence care for Resident #3. She verified Resident #3's door included signage for Enhance Droplet Contact Precautions. NA #2 stated after she completed incontinence care she realized she did not have enough plastic bags for the soiled linen and needed more which were in the isolation cart in the hallway. She further revealed she removed her gloves and left Resident #3's room to get more. NA #2 indicated she returned to Resident #3's room and had bagged the remainder of the linen without reapplying gloves, picked up linen from the floor in the hallway, carried the soiled items to the end of the hall, and placed them outside the facility exit door. She acknowledged she should have gathered the correct amount of supplies before entering the room, worn full PPE that included a gown, gloves, a mask, and eyewear when in the room, removed all PPE before exiting the room, retrieve needed items from the isolation cart then, reapply gloves before re-entering Resident #3's room to collect the remaining soiled linen. NA #2 further revealed she had handled and disposed of the linen both in the room and in the hallway without gloves or washing her hands, which caused increase risk for infection transmission to other residents and staff. An interview with Nurse #2 on 05/27/2020 at 3:45 PM stated the signage on the door of Resident #3's room indicated Enhanced Droplet Contact Precautions and full PPE should be worn by any personnel that entered the room which included mask, face shield, gloves, and a gown and all soiled linen should be placed in plastic bags, tied with the red label to indicate an isolation room, and placed in the linen receptacle. She further indicated soiled linen bags should never be left on the floor nor wear a yellow isolation gown in the hall to retrieve additional supplies, but instead ask co-worker for assistance. She further indicated she observed NA #2 not wearing gloves while handling soiled laundry and wearing the yellow gown in the hallway on 05/21/20 and she educated NA #2 immediately following her observation on that date. An interview with the Infection Control Nurse on 05/21/20 at 09:55AM revealed all staff had received education on proper hand hygiene, donning and doffing of PPE, and transmission-based precautions during the month of March 2020. The Infection Control nurse indicated NA #1 should have worn full PPE to include a gown, gloves, a mask, and eye wear when in the room of Resident #1 and hand hygiene should have been performed following the removal of PPE. An interview with the Director of Nursing on 05/21/20 at 11:45 AM indicated NA #2 had been trained on the transmission-based precautions, hand hygiene, and the use of PPE and provided education records that confirmed NA #2 had received education. She revealed all staff are to wear full PPE to include gown, mask, a face shield, and gloves when entering a room labeled Enhanced Droplet Contact Precautions and proper hand hygiene should be performed upon removal.