STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CTR HEALTH & REHAB HICKORY	3031 TATE BOULEVARD SE HICKORY, NC 28602

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to ensure a resident was spoken to with dignity while requesting assistance to wheel her back to the room while in the hallway for 1 of 1 resident (Resident #3). Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED].#3 is to receive [MEDICAL TREATMENT] treatments on Monday, Wednesday, and Friday weekly. A quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #3 was cognitively intact, mood indicators reflecting feeling tired/having little energy on 2-6 days and required extensive assistance of one staff member for locomotion off the unit and supervision with locomotion on her unit. A review of the care plan for self-care deficits dated 03/23/20 indicated Resident #3 required assistance of completion of ADL tasks and a psychosocial care plan dated 06/26/19 revealed Resident #3 was a long-term care resident and would have all needs met while a resident in the facility. An interview with Resident #3 on 06/25/20 at 11:45 AM revealed she received [MEDICAL TREATMENT] three days per week on Monday, Wednesday, and Fridays. She stated her treatment lasted several hours and often she had less energy when she returned from her treatments. She stated a local transportation company had been taking her to her appointments since the pandemic began and they were not allowed to help push her back to her room when they brought her back which caused her some days to need more help getting to her room from being more fatigued. Resident #3 indicated she returned yesterday from [MEDICAL TREATMENT] on 06/24/20 and requested assistance from Nurse Aide #2 to wheel her wheelchair to her room. When no staff member assisted her, another resident began pushing her towards her room. She reported Nurse Aide (NA) #2 refused to help her and told Resident #4 to stop pushing her because Resident #3's arms weren't broken, and she needed to be pushing herself. Resident #3 stated it made her very sad that the only person that would help her get to her room was a resident even though there are plenty of staff that saw me needing help. She stated Nurse Aide #2 was rude to her and she felt like she didn't care about helping her. An interview with NA #2 on 07/01/20 at 8:10 AM revealed she had cared for Resident #3 on many occasions including 06/24/20 and knew she was able to self-propel in her wheelchair independently. She stated she had instructed Resident #4 to stop pushing Resident #3 because her arms weren't broken. She indicated she was not aware it made Resident #3 feel sad when she made that comment and she only wanted her to maintain her independence. NA #2 acknowledged she should not have said that when Resident #3 asked for help because it could have been taken wrong by Resident #3. An interview on 06/25/20 at 12:00 PM with Resident #4 revealed he was the resident identified by staff to be pushing Resident #3 on 06/24/20. He overheard Resident #3 ask NA #2 to help asssit her to the room but NA #2 refused so he offered to help her. While assisting her, he was instructed by NA #2 to stop pushing Resident #3 because her arms weren't broken. He stated the staff didn't help Resident #3, so he decided to help her instead. An interview on 06/25/20 at 12:15 PM with the Director of Nursing and the Administrator revealed they were unaware Resident #3 had been denied assistance or spoken to by staff in an undignified way. The Director of Nursing revealed she believed Resident #3 could push herself to her room without assistance after [MEDICAL TREATMENT] services and staff were only trying to preserve her independence by not helping push her to her room, but she would investigate the incident further because the language reported was an unacceptable manner to speak with Resident #3.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, staff interview, record review, review of the facility's infection control documents and Centers for Disease Control and Prevention (CDC) guidelines for individuals on Droplet Precautions, the facility failed to ensure proper Personal Protective Equipment (PPE) was donned before touching residents on Droplet Precaution for 1 of 2 resident (Resident #1) and failed to ensure staff performed hand hygiene between interacting with 2 of 2 residents who were on Droplet Precautions (Resident #1 and Resident #2). 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. Findings included: A review of the CDC recommendations for patients on Droplet precautions currently available on the CDC website, under section IV.B.2.a read in part, gloves are to be worn when there is potential to contact potentially infectious materials, mucous membranes, nonintact skin, and potentially contaminated intact skin. According to the facility protocol document titled Managing COVID-19 in your facility dated 04/23/20 read in part: under the topic of care considerations residents placed on droplet based transmission precautions 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. A continuous observation on 06/25/20, from 10:10 AM to 10:20 AM, revealed Resident #1 was wheeling herself in the hallway on the unit she resided. She had on a mask that she was observed frequently tugging, touching her face with her hands, then touching the handrails and walls. Resident #1's door revealed signage that indicated she was on Droplet Precautions. Nurse Aide #1 approached Resident #1 and touched her with her bare hands to ask her if she needed anything and assisted Resident #1 to make adjustments to her face mask then Resident #1 continued wheeling down the hallway and Nurse Aide #1 did not perform hand hygiene and was not wearing gloves during this observation. A therapy assistant then stopped to speak to Resident #1 in the hallway. As he approached Resident #1, he began talking to her and touched the arm of her wheelchair with his right hand and put his left hand on her right shoulder touching her shoulder and right cheek near her mouth. He was explaining to Resident #1 that her therapy session would be around lunchtime and he would be the providing her treatment today. Following this interaction, Therapy assistant #1, who was not wearing gloves did not perform hand hygiene before donning a gown and entering Resident #2's room. Observations of the door to Resident #2's room revealed signage that indicated he was on Droplet Precautions. An interview with Nurse Aide #1 on 06/25/20 at 10:55 AM revealed she acknowledged she touched Resident #1 out of habit of the home-like environment. She stated she did not think about Resident #1 being on infection control precautions when she adjusted her mask. She acknowledged Resident #1 had been wandering in the hallway pulling at her mask and touching environmental surfaces and she had stopped to ask if Resident #1 needed assistance. She stated she should have re-directed Resident #1 back to her room, worn gloves if adjusting the mask, and perform hand hygiene following the removal of her gloves. She further stated she should have cleaned the handrails or asked housekeeping to clean to decrease the risk of potentially spreading infections. An interview with Therapy Assistant #1 on 06/25/20 at 10:20 AM revealed he acknowledged he was in the hallway talking to Resident #1. He stated he had not worked with Resident #1 before and did not know she was on any infection control precautions therefore he did not apply gloves before touching Resident #1 or perform hand hygiene before donning a gown and entering Resident #2's room to provide care. An interview with Nurse #1 on 06/25/20 at 10:25 AM revealed all new admissions were placed on Droplet/Contact Precautions for the first 14 days following admission pending facility COVID-19 testing. He further stated Resident #1 and Resident #2 were new

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 -** Few	(continued... from page 1) admissions, who resided on the facility's rehab hallway, and were on Droplet/Contact Precautions. Nurse #1 specified that all staff were to wear mask, gown, and gloves when interacting with or touching Resident #1 and Resident #2. He also stated staff should have re-directed Resident #1 back to her room when in the hallway as much as possible to decrease the potential spread of infection due to her fidgeting with her face covering, touching her mouth and face, and touching environmental surfaces. An interview with the Administrator on 07/02/20 at 12:08 PM revealed she was unaware that staff were interacting with Resident #1 and Resident #2 without wearing PPE or performing hand hygiene following touching Resident #1. She acknowledged Resident #1 and Resident #2 were on Droplet Precautions and stated all staff should wear PPE and perform hand hygiene between resident interactions to decrease the spread of infection.