| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **425129** | A. BUILDING _____ B. WING _____ | **09/24/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **BRIAN CENTER NURSING CARE - ST ANDREWS** | **3514 SIDNEY ROAD COLUMBIA, SC 29210** |

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 0678<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interviews, the facility failed to document the cardiopulmonary resuscitation (CPR code) status for one (Resident #1) of one resident reviewed for code status. Findings included: Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #1 died at the facility on [DATE]. The resident was not given CPR per the family's wishes. Review of Resident #1's medical record revealed a physician's orders [REDACTED].#1 was a full code meaning Resident #1 should be given CPR, if needed. On [DATE] at 2:10 PM, an interview was completed with the Medical Director. The Medical Director said that about two weeks before Resident #1 died , she spoke with Resident #1's responsible party (RP) about the decline in status Resident #1 was having. The Medical Director discussed Resident #1's code status. The RP wanted to discuss the decision with other family members before deciding. The Medical Director said that she had another conversation with the RP the following week and the family's wishes where that Resident #1 change to a do not resuscitate (DNR) status and Resident #1 be referred for hospice services. The Medical Director said she wrote a referral for hospice services on [DATE]. I presumed it had been taken care of. It was an oversight. I had talked to the Social Worker about what the (RP)said. It was done verbally, but the paperwork was not done. On [DATE] at 2:32 PM, an interview was completed with the Social Worker (SW). SW said Resident #1 had a referral for hospice and she had spoken with the RP about choices of hospice providers. The RP wanted to discuss the options with family and would inform SW of the decision on [DATE]. SW said she did not discuss Resident #1's code status with the RP. Hospice would have discussed that with them. (Medical Director) may have discussed code status with them, but I don't know that. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and staff interviews, the facility failed to provide appropriate COVID-19 screening for visitors and staff. This had the potential to affect all residents in the facility. This deficiency occurred during the COVID-19 pandemic. The census was 71. Findings are: Upon entry to the facility on [DATE] at 8:00 AM, the front door was found unlocked. A sign posted on the front door directed staff to proceed to the 300-hall nurse for screening if no receptionist was present. This surveyor walked into the front lobby and had access to all resident areas. No staff were visible. The Director of Nurses (DON) escorted this surveyor into the dining room without a COVID-19 screening until she was asked if a screening should be done. On 09/24/20 at 8:21 AM, an interview was completed with Certified Nursing Assistant #1 (CNA #1). CNA #1 stated when she arrived at work each day, she would go to the 300-hall and find the nurse to do the pre-shift COVID-19 screening. An interview was completed with the Dietary Manager (DM) on 09/24/20 at 9:11 AM. DM reported that kitchen staff reported to the nurse on the hall after arriving to work for COVID-19 screening. An interview was completed with the DON on 09/24/20 at 11:17 AM. The DON stated the receptionist arrived at the facility each day around 8:00 AM. Day shift for nursing started at 7:00 AM. Staff who came to work before the receptionist arrived, come in the front door and should report to the 300-hall nurse's station for screening. The front door was locked from 8:00 PM until 6:00 AM. |

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.