STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY ROAD CLAYTON, NC 27520

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 5/5/19 through 5/9/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # POZ911.	E 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F) as evidenced by water temperatures measured of 122 degrees Fahrenheit (F) at resident hand sinks for 3 (rooms 411, 412 and 414) of 9 resident rooms on the 400 hall. The findings included: On 5/7/19 at 9:20 AM the water in rooms 411 was observed to feel hot to the touch. On 5/7/19 at 9:23 AM the water in room 412 was observed to feel hot to the touch. On 5/7/19 at 9:25 AM the water was observed to felt hot to the touch in room 414.	F 689	How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: Resident # 83 was not affected by the deficient practice. A staff member was immediately assigned for monitoring on the hall where the water temperatures were identified to be out of the range until a safe temperature was met. Continued hourly monitoring of temperatures was conducted by the Maintenance Director and assigned staff on the 400 hall where the temperatures were identified to have been out of range. How will corrective action be accomplished for those residents having the potential to be affected by the same	5/23/19

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

Electronically Signed | 05/23/2019

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F 689	Continued From page 1 During an interview with the director of maintenance (DOM) on 5/7/19 at 9:40 AM he stated he used a computerized preventative maintenance system to record water temperatures. He stated he routinely checked the water temperatures weekly and records the results into the computerized preventative maintenance system. The DOM said the facility had 2 separate hot water systems and the 400 hall was on a separate water system from the rest of the facility. He reported the water temperatures he previously recorded did not exceed the state maximum. On 5/7/29 at 9:48 AM nursing assistant (NA) #1 was observed in room 416. NA#1 stated she was giving the resident in room 416A a bath and she felt the water temperature was hotter than usual because she had to add cold water to the basin which was something she did not usually need to do. She stated she did not notify anyone. She reported she had not finished the bath yet so she had not exited the room to report the water temperature to anyone. On 5/7/19 at 9:50 AM Resident #83, who resided in room 411, was observed in his room sitting in his wheelchair in front of the sink. He had turned on the water and was rinsing out his denture cup. During the observation it was unable to be determined if he was using the hot or cold water. Resident #83 did not respond to questions. A record review of the admission minimum data set (MDS) dated 4/28/19 revealed Resident #83 was moderately cognitively impaired. He required extensive assistance for locomotion. On 5/7/19 at 9:51 AM Nurse #2 was observed to	F 689	deficient practice: An audit was conducted on residents rooms on the 400 hall identified to have the unsafe temperature range and other halls in the facility to ensure correct temperature ranges on 5/7/19 by the Maintenance Director. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: On 5/7/19 an in-service for facility staff was conducted by the Regional Staff Development Coordinator on appropriate temperature ranges and reporting of any out of range temperatures to the Maintenance Director, Administrator and or the Director of Nursing to ensure compliance with temperature ranges. Additional in-services on this requirement will be provided for all staff by the Director of Nursing or RN Unit Managers on or before 5/23/19. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the Maintenance Director will perform random audits of resident's water temperatures to ensure the appropriate temperature ranges are sustained. Five (5) resident rooms temperature will be audited twice weekly for four (4) weeks and then weekly	

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F 689	Continued From page 2 enter into Resident #83's room. On 5/7/19 at 9:52 as Nurse #2 exited Resident #83's room she stated Resident #83 was trying to use his denture cup to get water to drink. She stated he was only using cold water. Nurse #2 stated the resident was able to self-propel his wheelchair. On 5/7/19 at 9:55 AM NA #2 stated she noted the water to be hotter than it usually was. She stated she did not report it to anyone. She stated she did not know why she had nor reported the water being hotter than usual but she should have told the maintenance man. On 5/7/19 at 9:58 AM the DOM checked the water temperature with a calibrated thermometer. The water temperature in the sink in room 411 registered 122.7 degrees F. On 5/7/19 at 10:00 AM the DOM stated the temperature of the water was usually 111 degrees F. He stated he needed to turn the thermostat down and thought he should tell the nurse about the water temperature. He did not check the temperature of the other rooms on the hall as they were all from the same water source and he wanted to turn the thermostat down quickly. On 5/7/19 at 10:03 AM the Director of Nursing (DON) stated the DOM would fix the hot water and she would post a staff member to monitor the 2 residents who were cognitively impaired and also able to reach the water source in their room. She identified the resident from room 411 and the resident in room 409A as being able to access the water and having cognitive impairment. The	F 689	for eight (8) weeks to ensure compliance is achieved and maintained. Negative findings will be addressed immediately if noted. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Administrator will be responsible for the implementation of the acceptable plan of correction.	

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F 689	Continued From page 3	F 689		

DON stated none of the other residents on the 400 hall were able to access the water in their room and depended on staff to assist for transfers or locomotion.

On 5/7/19 at 10:26 AM the DOM stated he turned the water heater down and adjusted the mixing valve. He added he had checked the temperature beyond the mixing valve and it was now down to 98 degrees F. so he would have to adjust the thermostat back up again. He stated he would continue to monitor and make adjustments until it was in the acceptable range.

On 5/7/19 at 11:15 AM the DON provided a copy of the temperatures from the computerized monitoring system. A review of the temperatures revealed on 4/24/19 the water temperature recorded for the 400 hall included 4 temperatures from 109.4 to 111.8 degrees F. The next date the water temperatures were recorded was 5/3/19. The 4 recorded temperatures ranged from 109.1 to 110.9. The DON also provided a document which she identified as a log the administrator was using to monitor water temperatures as part of the facility's survey readiness preparation. The last temperature recorded on the form revealed the water temperature on the 400 hall on 5/6/19 at 9:00 PM was 106.3

On 5/7/19 at 5:05 PM the Administrator stated the staff had informed her today of the water being too hot but she was not aware of the actual temperature of the water. She stated she was aware the upper limit for hot water was 116 degrees F.

The DOM was observed to continue to check the water temperatures in various rooms on the 400

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F 689	Continued From page 4 hall throughout the day on 5/7/19 and on 5/8/19 at 9:40 AM, 12:15 PM and 3:20 PM. He was recording the temperatures on a log. During an interview on 5/8/19 at 9:30 AM the DOM stated he had monitored the water temperatures throughout the night and none of the temperatures exceeded 116 degrees F. He added the hot water tank was drained yesterday when they opened faucets to decrease the water temperature and now the water was too low so he was increasing the thermostat slowly. He added he would continue to monitor water temperatures until the water temperature was warm enough but not above 116 degrees F.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		5/23/19

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F 761	Continued From page 5 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications secured by leaving them on top of a medication cart or stored in an unlocked medication cart for 3 of 4 medication carts observed. (400 hall medication cart, 300 hall medication cart, and 200 hall medication cart) Findings included: 1. During observation on 5/6/19 at 11:17 AM the 400 hall medication cart was observed unlocked and unattended on the hall. At 11:18 AM a nurse aide was observed to walk past the unlocked medication cart. At 11:18 AM Nurse #1 was observed to return to the medication cart from the nurse's station. During an interview on 5/6/19 at 11:18 AM Nurse #1 stated she was told she had an emergency phone call so she left her cart to go to the phone at the nurse's station. She further stated medication carts were to be locked when unattended, but she had left her unlocked cart to answer the emergency phone call. During an interview on 5/8/19 at 2:20 PM the Director of Nursing stated when medication carts were left unattended staff should lock the medication carts. She concluded Nurse #1 should have locked the medication cart prior to answering the emergency phone call.	F 761	How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: The medication carts were immediately locked when the nurse became aware of it being left open. No resident was effected buy this alleged deficient practice. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of all medication carts was conducted on 5/08/19 by the Director of Nursing to ensure no other medication carts were left unlocked. No others were identified. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Licensed nurses will be educated by the Director of Nursing or RN Unit Managers on or before 5/23/19 on the facility policy on storage of medications, including maintaining locked medication carts. How the corrective actions will be	

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F 761	Continued From page 6 2. During observation on 5/7/19 at 7:53 AM Nurse #2 was observed to leave the 400 hall medication cart unlocked as she entered a resident's room during medication administration. At 7:54 AM Nurse #2 returned to her unlocked medication cart. During an interview on 5/7/19 at 8:04 AM Nurse #2 stated the facility policy was to lock medication carts when leaving the medication cart to administer medications. She concluded she should have locked the medication cart before she left it to administer medications. During an interview on 5/8/19 at 2:20 PM the Director of Nursing stated when medication carts were left unattended staff should lock the medication carts. She concluded Nurse #2 should have locked the cart prior to proceeding into a resident ' s room. 3. During observation on 5/8/19 at 8:09 AM Nurse #3 was observed pulling medications from her medication cart. A resident came to the medication cart and spoke with the nurse. The nurse was then observed to leave the 200 hall medication cart with Basaglar, Victoza, and Brinzolamide on the top of the medication cart. The nurse entered a resident's room, behind the privacy curtain, out of visual range of the cart. The resident was observed to still be next to the medication cart. At 8:09 AM Nurse #3 returned to the cart and retrieved the three medications and again enter the resident's room. During an interview on 5/8/19 at 8:23 AM Nurse #3 stated staff were to keep all unattended medications locked. She further stated normally	F 761	monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing, RN Unit Managers or Administrator will audit the medication carts weekly for twelve (12) weeks to ensure the medication carts are locked. Negative findings will be addressed if noted. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	

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F 761	Continued From page 7 she found a way to take all medications into the room at one time, however this was her first medication pass of the morning and she did not take all in at once and should have. During an interview on 5/8/19 at 2:20 PM the Director of Nursing stated staff should ensure medications were locked in the medication cart and not left unsupervised on the top of the medication cart. She concluded Nurse #3 should have placed the medications back in the cart and locked it prior to entering the resident's room. 4. On 5/7/19 at 4:10 PM Nurse #4 was observed standing with her medication cart in front of room 307. A visitor walked up to the cart began talking to Nurse #4 then the nurse was observed to walk away from the cart with the visitor. They walked across the hall and into room 314. The cart was observed to be unlocked. The nurse was inside room 314 and the cart was not visible from her location inside the room. Nurse #4 was observed to return to the cart on 5/7/19 at 4:12 PM. During this observation Nurse #4 stated she may have left the cart unlocked. She then quickly locked the medication cart and returned to room 314. She did not answer any additional questions. During an interview on 5/8/19 at 2:20 PM the Director of Nursing stated when medication carts were left unattended staff should lock the medication carts.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/23/19

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F 812	Continued From page 8 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide a barrier between ready to eat foods and the server's bare hands for 1 of 3 staff members who touched the resident's food with her bare hands while assisting the resident with breakfast in the dining room. The findings included: During an observation of resident dining on 5/7/19 at 8:25 AM Admissions Director #1 was observed as she assisted a resident with the breakfast meal to pick up the biscuit from the plate with her bare hands. She used the resident's knife to cut the biscuit in half then place butter and jelly onto the interior of the biscuit while she held the biscuit in her bare hand. Admissions Director #1 then placed the biscuit on the resident's plate.	F 812	How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: The biscuit was immediately disposed of and the resident was given another biscuit by the facility staff. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: No other residents were identified to have been affected by the same deficient practice. The staff member was immediately educated on the appropriate food handling of resident’s food items.	

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F 812	Continued From page 9 On 5/7/19 at 8:30 AM Admissions Director #1 was interviewed. She stated she assisted in the dining room whenever she was needed but she was not aware she could not touch the biscuit with her bare hands. On 5/9/19 at 2:35 PM the administrator stated she ready to eat foods should not be touched with bare hands. She said the fork and knife could be used instead of bare hands.	F 812	What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Nursing staff and the Interdisciplinary Team will be educated by the Director of Nursing or RN Unit Managers on or before 5/23/19 on the appropriate food handling of the resident's food items. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing, RN Unit Managers or Administrator will conduct random audits during meal times weekly for twelve (12) weeks to ensure the appropriate handling of the residents food items. Negative findings will be addressed if noted. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	