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	345431	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN HEALTH AND REHAB	**921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874**

(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 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		5/22/25

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

Electronically Signed | 05/23/2025

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and maintain a comprehensive Emergency Preparedness (EP) plan which contained the required information to meet the health, safety, and security needs of the residents and staff. This had the potential to affect all facility residents. The findings included: A review of the facility's Emergency Preparedness plan on 4/30/25 revealed: The EP plan had not been updated in its entirety even though it was dated as last reviewed by the Director of Nursing and Administrator on 1/10/25. A. The EP plan did not include updated contact information for facility staff, physicians, or other long-term care facilities. B. The EP plan did not include arrangements with other long-term care facilities to receive residents in the event of an evacuation. C. The EP plan did not include facility participation in a full-scale exercise that was community-based within the last 12 months. The Administrator was interviewed on 4/30/25 at 12:35 PM and stated that although the last review date was documented on 1/10/25 by the Director	E 001	Upon identification of missing components to the Emergency preparedness manual, the facility took the following actions to correct the concerns. All contacts for staff and extenders (providers) were updated as of 5/16/25 and added to the EP manual by the Administrator. Evacuation agreements were put into place for local and distance facilities to include natural disasters or emergencies. These agreements were executed by the Administrator and copies have been filed in the EP Manual. A Community MCI tabletop drill was attended on 5/20/25 to meet compliance of necessary training for the Administrator and a copy of the training was added to the EP Manual. The facility will continue monthly updates for staff and extenders and insure copies are made available to all EP manuals throughout the facility as well as the Medical Director. The facility will also review every year moving forward to validate transfer agreements are complete and no end date has been established. Additional training for a community drill is set for June 17, 2025 for both the administrator and maintenance director to further insure compliance regarding community based	

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E 001	Continued From page 2 of Nursing and the Administrator, only some sections of the EP plan had been updated but not all. The Administrator stated she must have forgotten to update the facility contacts and arrangements with other facilities when the EP was reviewed. She stated she pulled those details from the plan with the intention of updating; however, she did not follow through. The Administrator stated that she thought the full-scale exercise conducted in November 2023 was within the current survey window and did not realize that she had missed the opportunity.	E 001	drills. Upon completion, this training will be added to the EP Manual. Education provided to the Administrator, Maintenance Director, Director of Nursing and the Business Office Manager (all first-tier management) by the Board of Trustee Chairman with the expectation that the EP is to be kept up to date at all times moving forward. This education completed on 05/16/2025. Review of the EP program will be updated monthly by the Administrator, and reviewed by during QAPI no less than quarterly. There will be a signature sheet added to the EP plan for signatures and dates of those that are reviewing during QAPI. Ongoing audits by the administrator and/or designee for review to insure compliance is maintained. These audits will be weekly for four weeks, then monthly for two months. Data will be summarized and presented to the facility QAPI meeting monthly by the administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Maintenance Director, and others as deemed necessary .	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 3 A recertification and complaint investigation survey was conducted from 4/28/25 through 4/30/25. Event ID# GNJR11. The following intake was investigated: NC00228043. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		5/27/25

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F 657	Continued From page 4 by: Based on record review and staff interviews, the facility failed to revise the nutritional care plan to include significant weight loss for 1 of 1 resident reviewed for nutrition (Resident #1) and to revise the care plan in the area of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers (Resident #28). The findings included: 1. Resident #1 was admitted to the facility on 6/16/17 with diagnoses that included stroke, diabetes, and dysphagia. The care plan for Resident #1 last reviewed on 7/20/24 revealed that she received a therapeutic diet related to diabetes with finger stick blood sugar monitoring. It was noted that she had decreased left side sensation and a history of pocketing food. She has no teeth and might have discomfort when chewing, so she received mechanical soft food consistency. She had the potential for weight loss related to low intake. Interventions included: Provide adaptive equipment (Divided Plate), provide diet as ordered, provide supplements as ordered, monitor lab work to determine the effect of the therapeutic diet, and finger stick blood sugar monitoring as ordered. A review was also performed on 2/17/25 including the problem that Resident #1 had a diagnosis of diabetes (type 2). Interventions included: Administer hypoglycemic medications per doctor's order. If blood glucose is less than or equal to 60 milligrams (mg) per deciliter (dL), treat per facility policy and doctor's order. Monitor for signs of hypoglycemia and hyperglycemia. Another problem reviewed on 4/4/25 revealed that Resident #1 resisted care	F 657	Immediate correction to the care plan for resident #1 to reflect a significant weight loss with necessary and appropriate interventions. A review was completed by the RD on 4/29/25 with notes added to a current care plan. A full care plan was updated 5/19/2025. Additionally, resident #28 was immediately care planned for a stage 2 pressure injury for the wound that was initially found on 11/15/24 and updated to reflect the current status. These care plans were updated by the MDS nurse. Review of all other residents in house related to significant weight loss and any variances found, corrective plans were put into place. Likewise, a review of all skin in the facility was viewed through a two-week rotation of a skin sweep through the facility to identify any new or concerning areas for every resident. There were no further issues found and no care plans were initiated. The facility also reviewed all in house wounds that were previously known and found that all wounds had appropriate plans of care in place. These audits were completed by the DON, Wound nurse, and a floor nurse and were complete on 5/16/2025. Education was initiated for administration to include wound nurse, MDS nurse, and any other nurse managers. Additionally, charge nurses, dietary, and SLP were educated on the importance of a care plan to reference necessary goals and interventions. This education to be	

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F 657	Continued From page 5 (refused meals and medications). Interventions included: Reiterate the purpose and advantages of care for the resident, do not alienate or criticize the resident when resistant to care, convey an attitude of acceptance toward the resident, and maintain a calm environment and approach to the resident. The quarterly Minimum Data Set (MDS) assessment dated 4/23/25, revealed Resident #1 was cognitively intact and set up/cleanup assistance from staff with eating. She received a mechanical soft and therapeutic diet. She was 66 inches tall, weighed 133 pounds. The MDS indicated Resident #1 had significant weight loss and was not on a physician-prescribed weight-loss regimen. In an interview with the MDS Coordinator on 4/30/25 at 10:14 AM, she revealed that she was responsible for the care plan if a resident triggered for weight loss on the MDS assessment. As far as the gradual decline of weight, nursing and dietary were responsible for the care plan. Resident #1 was triggered for weight loss in the quarterly MDS assessment dated 4/3/25, so the care plan should have been updated then to include the weight loss. During a follow-up interview on 4/30/25 at 1:13 PM, the MDS Coordinator stated that the care plan for Resident #1 was not updated after the significant weight loss triggered in the quarterly MDS assessment dated 4/3/25 because there were a lot of assessments due at that time, and it must have been missed by mistake. An interview was conducted with the Director of Nursing (DON) on 4/30/25 at 4:20 PM. She	F 657	completed no later than 5/26/2025. Education was initiated by the Administrator and carried to floor staff by the DON. New nurses will be educated regarding the expectation of care plans at time of hire. Ongoing audits by the Administrator and/or DON for review of all appropriate care plans to be initiated related to skin or weight concerns this accomplished by documentation review as well as 24-hour documentation log monitoring. The audit will be completed daily for 5 of 7 days for 3 weeks, then weekly for 4 weeks, and monthly for 2 months. Data will be summarized and presented to the facility QAPI meeting monthly by the Administrator or DON. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Maintenance Director and others as deemed necessary.	

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F 657	Continued From page 6	F 657		

revealed the care plan for Resident #1 should have been updated when she triggered for significant weight loss.

The Administrator was interviewed on 4/30/25 at 4:25 PM. She revealed that if Resident #1 had a significant weight loss, there should have been a nursing/dietary intervention appropriate for her included in the care plan.

2. Resident #28 was admitted to the facility on 2/26/20 with diagnoses which included dementia and contractures of the lower extremities.

Review of the Wound Management Report dated 11/15/24 revealed Resident #28 was identified to have an unstageable pressure ulcer due to slough (nonviable tissue) or eschar (dead tissue) on the bottom of the right foot at the area of the right great toe. The pressure ulcer was noted to have measurements of 2 centimeters (cm) x 1 cm with no drainage noted.

The Minimum Data Set (MDS) quarterly assessment dated 2/24/25 revealed Resident #28 had severe cognitive impairment. Resident #28 was coded for stage 2 pressure ulcer and pressure ulcer treatment and care.

The care plan last reviewed on 2/27/25 revealed no care plan was in place for Resident #28's pressure ulcer.

An observation of Resident #28's right foot was conducted on 4/30/25 at 10:57 am with the Wound Treatment Nurse. Resident #28 was noted to have a pressure ulcer to the bottom of the right foot near the base of the right great toe.

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F 657	Continued From page 7 An interview was conducted with the MDS Nurse on 4/30/25 at 12:42 pm who revealed she was responsible to update Resident #28's care plan when the right foot pressure ulcer was identified. The MDS Nurse stated she was aware that Resident #28 had a pressure ulcer on her right foot but stated she must have gotten caught up in something and missed updating the care plan. During an interview on 4/30/25 at 1:35 pm the Director of Nursing (DON) stated the MDS Nurse was responsible to ensure Resident #28's care plan was updated to reflect the pressure ulcer to the right foot. An interview was conducted on 4/30/25 at 2:42 pm with the Administrator who stated the MDS Nurse was responsible to create the care plan for the management of Resident #28's right foot pressure ulcer.	F 657		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		5/27/25

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F 685	Continued From page 8 Based on observation, record review, and interviews with the resident, staff, Psychotherapist and Nurse Practitioner, the facility failed to ensure that a resident with known visual impairment was evaluated for treatment and services to maintain her vision for 1 of 1 resident reviewed for vision and hearing (Resident #2). The findings included: Resident #2 was admitted to the facility on 3/04/19 with diagnoses which included macular degeneration. The progress note dated 6/28/24 at 1:33 pm by the Social Worker revealed Resident #2 was prepared for a room change and expressed concern about knowing where things were in the new room given her eyesight deficits. The Social Worker further noted staff would assist Resident #2 to acclimate her to the new room. The Minimum Data Set (MDS) annual assessment dated 2/03/25 revealed Resident #2 was cognitively intact and was coded for moderately impaired vision with corrective lenses. Under activity preferences, Resident #2 was coded that having books, newspapers, and magazines to read were important but she was coded as not being able to do. Resident #2 had a care plan, last reviewed on 2/13/25, for impaired vision related to diagnosis of macular degeneration with interventions which included arrange ophthalmologist or optometrist consult as indicated. Review of the psychotherapy visit note dated 4/16/25 revealed Resident #2 was seen for an	F 685	Upon notification of the requested appointment, conversation with resident (#2) and family were had regarding preference of place of appointment. Both family and resident desire for resident to be seen in house only for any appointments due to her inability to sit for long periods of time. Communication was made with 360Care, for a vision appointment to be scheduled. At this time, the facility is scheduled for a visit in August of 2025 but have been added to the list for cancellations or openings so that service may be obtained as quickly as possible. In house review of all residents to insure that no other resident had been missed for a vision appointment within a one year window. The review resulted in all others had been seen in house within the one-year window or by their preferred choice of provider in an external setting. This audit was completed by the Administrator and was complete on 5/16/2025. Education was provided to department head, nurse managers, charge nurses and CNAs, as well as housekeeping staff that interact with residents daily. This education consisted of understanding the regulation around meeting the needs of those we serve as well as reporting to a nurse manager, social worker, or administrator any requested appointment or need that could not be met by their department. The Administrator will complete this education by May 26, 2025.	

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F 685	Continued From page 9 initial assessment with the Psychotherapist. The visit note revealed that Resident #2 reported being depressed and revealed her vision loss had exacerbated her depressed feelings. A telephone interview was conducted on 4/30/25 at 1:12 pm with the Psychotherapist who revealed Resident #2 had reported that she enjoyed reading her Bible and was no longer able to engage in that due to her vision loss. She stated she did not discuss this with the facility but included it in her visit note which was in Resident #2's electronic medical record. An attempt to conduct a telephone interview with the Physician on 4/30/25 at 11:41 am was unsuccessful. An interview and observation were conducted on 4/28/25 at 2:24 pm with Resident #2 who reported she had glasses but was not able to see well with them because everything was blurry. She stated she could not remember the last time she was seen by an eye doctor or if an appointment was offered. Resident #2 stated she was not sure if new glasses would help but she would like to see about getting a new pair so she could see better. Resident #2 stated staff knew she had very poor vision and they (staff) kept her things in the same spot so she would know where to find them. Resident #2's glasses were noted to be on the bedside table at the time of the interview and observation. An interview was conducted with Nurse Aide (NA) #1 on 4/28/25 at 2:28 pm who revealed Resident #2 did wear glasses when out of bed and while eating but she did not normally wear them when in bed.	F 685	Ongoing audits by the administrator and/or designee for review of a necessary appointments either inhouse or out of facility. This data will be collected through the 24-hour report and through morning meetings on week days with all department head staff. These audits will be weekly for six weeks, then monthly for two months. Data will be summarized and presented to the facility QAPI meeting monthly by the administrator or DON. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, , Maintenance Director, and others as deemed necessary.	

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An interview was conducted with Nurse #1 on 4/30/25 at 9:11 am who revealed Resident #2 did have glasses and at times did report the glasses were not working for her. Nurse #1 stated Resident #2 used to get eye injections for macular degeneration but she stated Resident #2's vision would not get better even with the injections because her vision loss was just age related.

An observation and interview were conducted on 4/30/25 at 9:12 am of Resident #2 who was observed in bed moving her hand around the top of the bed covers. Resident #2 stated she was trying to find the end of her call bell so she could ring for the nurse but she could not see the end of the call bell. The call bell was noted to be attached to the top of the blanket and within reach of Resident #2's right hand. Resident #2's glasses were observed on the bedside table at the time of the observation.

During an interview on 4/30/25 at 9:13 am with NA #2 she revealed Resident #2's vision was very poor and sometimes seemed worse than other times, but she did not report that her eye glasses were not working for her. She stated Resident #2 had glasses and they were normally on her bedside table when not worn. NA #2 stated she made sure Resident #2 had her glasses on when she was eating and out of bed. NA #2 stated Resident #2 had her personal items set up close to her in the same spot so she could know where things were by feeling for them.

An interview was conducted with the Social Worker on 4/30/25 at 10:04 am who revealed she was aware Resident #2 had previously been seen

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F 685	Continued From page 11	F 685		

by a provider out of the facility for macular degeneration. The Social Worker stated the in-house vision provider would see residents with new vision concerns or past trouble with their vision but she stated Resident #2 was not on the list to be seen. She stated she would normally sign a resident up for the in-house vision provider when notified by nursing or requested by the resident. The Social Worker confirmed she did not add Resident #2 to the in-house vision provider visit list because she was not notified of the need, but she stated Resident #2 was able to be seen if needed.

An attempt to interview Resident #2's Responsible Party on 4/30/25 at 11:13 am was unsuccessful.

A telephone interview was conducted on 4/30/25 at 1:53 pm with the Nurse Practitioner who revealed she was aware of Resident #2's macular degeneration but not aware of any other issues with her vision. The Nurse Practitioner stated if Resident #2 was having difficulty seeing she would have expected a vision evaluation to be completed.

An interview was conducted on 4/30/25 at 10:11 am with the Director of Nursing (DON) who revealed Resident #2 had previously been seen by an outside provider for injections for her macular degeneration but once she was returned from the hospital the RP no longer wanted to pursue aggressive interventions so the next appointment for the injection was cancelled and no further appointments were scheduled. The DON stated she was not sure if she would have added Resident #2 to the in-house provider vision list because she did not want to see the in-house

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345431	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN HEALTH AND REHAB	921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

(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
F 685	Continued From page 12 provider in the past. The DON stated a vision evaluation for Resident #2 was something they could talk about with the provider and Resident #2's RP. During an interview on 4/30/25 at 2:43 pm with the Administrator who revealed Resident #2 was initially admitted to the facility as an assisted living resident and had previously refused in-house services at that time. The Administrator stated she believed the in-house provider for vision was not offered to Resident #2 due to her previous refusals. The Administrator stated if Resident #2 would accept to see the in-house provider for vision she would be seen because Resident #2 had the right to be able to do the things she enjoyed.	F 685		