STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 1/6/20 through 1/9/20. The facility was found in compliance with requirments CFR.483.73. Emergency Preparedness Event ID#XIMN11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey with complaint investigation survey was conducted from 1/6/20 through 1/9/20. Event ID#XIMN11 6 of 6 complaint allegations was unsubstantiated.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 565		1/24/20

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

Electronically Signed | 01/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 565	Continued From page 1 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of resident council meeting minutes, the facility failed to address and resolve ongoing grievances about food that were reported at resident council meetings for 6 of 9 residents who were reviewed for grievances. (Resident #90, #45, #61, #84, #79 and #26). The findings included: The resident council minutes dated 10/8/19 and 11/9/19 documented continued resident concerns about the food they were being served at meals which included: Meal carts were left on the hall for a while before meals were passed, the food was not as hot as it could be, tired of rice and green peas, water sitting on top of oatmeal, okra mushy, don ' t put sugar on vegetables, pinto and lima beans are hard, food preferences were not being honored and the barbeque beef (pork) tips were not good. On 11/13/19 the Administrator, Director of Nursing, the previous Dietary Manager (DM) and Activities Director had a follow up meeting with the residents of the resident council. The minutes	F 565	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal and State Law. F565 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; An impromptu Resident Council meeting was held on 1/9/2020 which included Resident #90, #45, #61, #84, #79 and #26. The new Dietary Manager introduced herself to the Council and then listened to their concerns. She explained plans to correct and provided a timeline of the expected implementation in which all Resident Council approved. Resident Council Members were happy with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 565	Continued From page 2 from this meeting revealed the previous DM indicated the resident food concerns would be addressed with the cooks and an educational session with the cooks would be scheduled to address their food issues. Additionally, the DM announced that he would meet with residents 1 on 1 to review their food preferences. Further review of the resident council minutes revealed there was no monthly resident council meeting scheduled in December 2019. An interview with the members of the Resident Council was conducted on 1/08/20 at 10:35 AM. A total of 9 residents, who regularly attended the facility ' s monthly resident council meeting, were present at this meeting. The meeting revealed six of the nine residents present had ongoing concerns with foods being served cold at meals, meal delivery being slow, foods being served with sugar, food quality needing to improve and the same meal selection week after week for the past two months. Multiple residents reported once the meal carts were delivered to the halls, the food would sit in the cart for a long period of time, which resulted in the food being served cold at all three meals. In addition, six members of the resident council reported administration and the previous dietary manager stated they would resolve their food concerns, but they were unaware of what action was taken to resolve the issues. The residents stated the food continued to be served cold and there were no changes in the quality of the food or the selection of food choices. The residents added there had been no individual discussions held with them by dietary or administration about the changes or resolution to their food concerns.	F 565	outcome of the meeting and individually signed off the minutes as approved. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All alert and oriented residents were questioned on 1/09/2020 by the Office Assistant for any concerns surrounding dietary. All negative findings were placed on a grievance form for documented follow up. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Measures to ensure plan of correction is effective and remains in compliance are: Administrator, Activities Department, Director of Nursing, and Dietary Manager were educated on 1/09/2020 by the District Director of Clinical Services on the requirements regarding Resident/Family Group and Response. Effective January 09, 2020 all Resident Council Minutes will be reviewed on day of meeting by the Administrator and/or Director of Nursing to assure immediate response and assure appropriate action taken if required. All grievances from the Resident Council meeting will be placed on a concern form for documented follow up. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 565	Continued From page 3 Individual interviews with residents, who attend the resident council interview on 1/08/20, and were identified as alert and oriented revealed the following: During an interview on 1/8/20 at 12:30 PM, Resident #90 stated food selection is the same week after week. Resident #90 further stated the DM had not came to her to discuss her food preferences, and the meal today was luke warm. She stated there were a ton of people in the dining room to help with the meal service today, but other days we had to wait till they get to the cart which is often on the hall for 20 minutes after it was delivered. Resident #90 stated the residents shouldn ' t have to keep asking staff to reheat their food. During an interview on 1/8/20 at 12:35 PM, Resident #45 stated even when staff were asked to warm up the food by the time the food returns it was at the same temperature as it left, or the food was dried out. Resident #45 stated the DM had not asked her about her food preferences. Resident #45 added, "I end up eating what is served because it would take too long to get the meal back." During an interview 1/8/20 at 1:00 PM, Resident #61 stated she had reported her food concerns during resident council meetings about the quality of food, food temperature and limited selection in the choice of foods being served. She explained the same foods continue to be served in the same quality. Resident #61 stated there was a meeting and staff informed us what they were going to do to change things, but we have not seen any changes. Resident #61 reported she had not seen anyone from administration or	F 565	Audits of Resident Council will be completed monthly x 3 months by the Administrator and/or Director of Nursing. Five random audits weekly X 12 will be completed by Administrative Department Heads on overall Resident satisfaction with Dietary Department. Any issue voiced will be placed on a grievance form for documented follow up. All grievances received from Resident Council will be reviewed for tracking and trending. The Administrator and/or Director of Nursing will report findings of these audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Dates when corrective action will be completed; Date of Compliance January 24, 2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 565	Continued From page 4	F 565		

dietary to review her food preferences or ask any specific questions about the quality of the food.

During an interview on 1/8/20 at 1:15PM, Resident #84 stated, in resident council meetings she reported about the food being served sweet, cold and no changes in the meal selection two months ago. Resident #84 further stated the food selection process had not changed, foods continued to be served sweet and cold. Resident #84 reported no one from dietary or administration had spoken with her about her food preferences or changes in the dietary process. Resident #84 indicated they told us there would be some changes, but no changes had not occurred at this time.

During an interview on 1/8/20 at 1:20 PM, Resident #79 reported the problems with food temperatures and quality of food had been discussed in resident council meetings many times. Resident #79 stated the food was often served cold. Resident #79 reported she was tired of asking staff to reheat the food and wanted to know why, food was not being served hot when it left the kitchen. Resident #79 added the residents had been told changes would occur in dietary, but no one had spoken with her directly about her food preferences. Resident #79 reported the food concerns had not really been resolved within the resident group since everyone was still talking about the problems with the food.

During an interview on 1/8/20 at 3:00 PM, Resident #26 stated there had been several discussions in the resident council about the food temperatures, food quality and food choices. Resident #26 stated we get what we get and no one reviewed my food preferences with me. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 565	Continued From page 5 staff said they told us they were going to do all those food changes in the last meeting, but we are still served the same old rice, peas and some dried meat. Interview on 1/8/20 at 1:45 PM, the Administrator stated a follow up meeting was held with the residents on 11/13/19 to discuss the resident council concerns with dietary. The administrator explained, during the meeting the previous dietary manager presented the potential resolution for the identified food concerns. The Administrator stated in part the administrative team did test trays on the halls and a tray delivery assessment. The assessment revealed the cause of cold food was the delay in tray delivery once the carts were delivered. The Administrator confirmed she nor the dietary staff had followed up on the other concerns that was identified by the group. The administrator also confirmed there were no follow-up documented/recorded discussions held with residents individually or collectively about their dietary concerns.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the minimum data set (MDS) for therapeutic diet for 1 of 4 residents reviewed for nutrition (Resident #40) and failed to code hospice services for 1 of 1 resident reviewed for hospice (Resident #65).	F 641	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal	1/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 641	Continued From page 6 Findings Included: 1. Resident #40 was admitted to the facility on 8/17/17 and diagnoses included diabetes, cirrhosis of the liver, Parkinson ' s and depression. Review of the physician ' s orders for Resident #40 identified an order dated 8/20/19 for a mechanical soft, consistent carbohydrate, no added salt diet. A quarterly MDS dated 11/13/19 for Resident #40 identified he was on a mechanically altered diet; therapeutic diet was marked as no. An interview on 1/9/20 at 3:25 pm with MDS Nurse #1 revealed the Dietary Manager (DM)was responsible for completing Section K of the MDS. She explained the DM that completed Section K of the 11/13/19 MDS no longer worked at the facility. She stated the DM should have coded therapeutic diet for Resident #40 and she would need to do a correction. 2. Resident #65 admitted to the facility on 11/16/19 with a history of malignant neoplasm of the esophagus and brain, coronary artery disease, congested heart failure, hypertension, and type 2 diabetes. Significant change in status of the Minimum data set (MDS) dated 12/2/19 revealed Resident #65 was cognitively intact. Further review of the MDS did not identify resident was receiving hospice services. The Hospice Physician certification of terminal illness dated 11/20/19 and signed by attending physician on 11/20/19 revealed Resident #65	F 641	and State Law. F641 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A modification of the minimum data set (MDS) was completed for Residents #40 and #65 on 1/9/20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1/10/20 The Resident Care Management Director (RCMD) or MDS Coordinator completed an audit of current residents Minimum Data Set (MDS) assessment during the last thirty days to verify accurate coding of the Minimum Data Set (MDS) concerning therapeutic diets (section K)and hospice services(section O)per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and or MDS Designee. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Measures to ensure plan of correction is effective and remains in compliance are: District Director Care Management provided education to the Interdisciplinary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 641	Continued From page 7 had a life expectancy of less than 6 months. On 1/9/20 at 12:53 PM an interview was conducted with Nurse #2. She stated Resident #65 was receiving hospice services. An interview was conducted on 1/9/20 at 3:00 PM with MDS Nurse #1. She stated Resident #65 admitted to hospice services on 11/20/19 , and a significant change in status MDS assessment with a reference date of 12/2/19 was completed due to resident admitting to hospice services. She verified special treatments, procedures, and programs (section O) of the MDS did not identify resident was receiving hospice services. She stated it was an error and she would do a modification. On 1/9/20 at 4:19 PM an interview with the Director of Nursing was conducted and she stated the process was the MDS assessment should be coded accurately.	F 641	Team members who participate in MDS related to accurate coding of MDS according to the RAI Manual for therapeutic diets (section K)and Hospice services (section O) on January 9, 2020. The RCMD will randomly audit five completed MDSs weekly for 12 weeks to verify accurate coding of these areas on the MDS. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed per RAI Guidelines. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Five random MDS audits will be completed weekly X 12 weeks by the RCMD and/or MDS Coordinator to validate accurate coding of therapeutic diets (section K) and hospice services (section O). The RCMD and/or MDS Coordinator will report findings of these audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Dates when corrective action will be completed: Date of Compliance January 24, 2020	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		1/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 657	Continued From page 8 §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 by: Based on record review and staff interview the facility failed to revise a care plan to reflect significant weight loss for 1 of 4 residents reviewed for nutrition (Resident #40). Findings Included: Resident #40 was admitted to the facility on 8/17/17 and diagnoses included diabetes,	F 657	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal and State Law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 657	Continued From page 9 cirrhosis of the liver, Parkinson ' s and depression. A care plan dated 6/21/18 for Resident #40 stated he was at risk for potential nutritional problems and weight fluctuations related to therapeutic, mechanically altered diet; diagnosis of diabetes, dysphagia and dementia / Parkinson ' s disease progression. An update dated February 2018 stated significant weight loss in one month and to begin supplements. Review of the weight record for Resident #40 identified the following weights:138.5 pounds (lbs.) on 12/30/19 and 148.5 lbs. on 11/25/19. This reflected a 6.67% weight loss in 1 month. An interview on 1/8/20 at 3:45 pm with the Registered Dietitian (RD) revealed Resident #40 had a significant weight loss and was refusing most meals, supplements and medications. An interview on 1/9/20 at 3:25 pm with MDS Nurse #1 revealed the last time Resident #40 ' s care plan was reviewed was 11/12/19. She explained the Dietary Manager (DM) had signed the care plan which indicated it had been reviewed and was current. MDS Nurse #1 stated the DM that had reviewed the care plan on 11/12/19 no longer worked at the facility. She stated the resident ' s nutrition care plan did need to be updated with his current nutritional status. An interview on 1/9/20 at 3:41 pm with the Director of Nursing (DON) revealed it was her expectation that care plans were updated to reflect the current health status of the resident.	F 657	F657 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A revision to the Care Plan of Resident #40 was completed on 1/10/20 to reflect significant weight loss. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/10/20 the Resident Care Management Director (RCMD) or MDS Coordinator completed an audit of all current residents care plans to verify accurate revisions were completed concerning significant weight loss. If needed, modifications were completed by the RCMD and or MDS Coordinator. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Measures to ensure plan of correction is effective and remains in compliance are: District Director Care Management provided education to the Interdisciplinary Team members who participate in Care Plan Revisions related to significant weight loss on January 9, 2020. The RCMD will randomly audit five completed Care Plans weekly for 12 weeks to verify accuracy. One to one education will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 657	Continued From page 10	F 657	provided if opportunities for corrections are as identified as a result of these audits. Revisions to the Care Plan will be completed as needed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Five random Care Plan audits will be completed weekly X 12 weeks by the RCMD and/or MDS Coordinator to validate accuracy. The RCMD and/or MDS Coordinator will report findings of these audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Dates when corrective action will be completed; Date of Compliance January 24, 2020	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and	F 687		1/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 11 arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and Nurse Practitioner interviews and record reviews, the facility failed to provide foot care and arrange podiatry services for 2 of 2 dependent residents with thick long curled toenails(Resident #27 and Resident #22) reviewed for foot care. The findings included: 1.Resident #27 was admitted on 5/18/18. The diagnoses included diabetes and peripheral vascular disease and dementia. The quarterly Minimum Data Set(MDS) dated 11/1/19 indicated Resident #27 had cognitive impairment and required total assistance with activities of daily living. Care plan dated 11/1/19 identified the problem as Resident #27 had activities of daily living (ADL) self-care performance deficit related to dementia, muscle weakness, unsteadiness on feet, abnormal posture. The goal included Resident #27 would maintain current level of function. The interventions included Resident #27 required total assistance from staff to provide bath/shower as necessary and sponge bath when a full bath or shower cannot be tolerated. Staff would gather and provide needed supplies, observe/document/report PRN any signs or symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation to nursing. Staff would cut long toe nails, observe/document foot care needs and refer to podiatrist/foot. Review of the podiatry schedule from June 2019	F 687	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal and State Law. F687 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/9/20 Resident #27 and Resident #22 had their toenails cut by the Licensed Wound Care Nurse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 1/9/20 all residents toenails were assessed by licensed nursing staff for long toenails. Any Residents identified as requiring toenail care had their toenails cut by the Wound Care Nurse and/or Licensed Nursing Staff, or if required were referred for Podiatry. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 12 through October 2019, revealed Resident #27 was scheduled to be seen on 6/11/19 and 10/2/19, there was no consultation report or notation in chart Resident #27 had been seen. Review of skin assessments dated 12/25/19 and 1/1/20, revealed there was no documentation of the condition of Resident #27 ' s toenails. Observation on 01/06/20 4:00 PM, Resident #27 ' s toenails on his feet were extra-long pass the toe bed. They were very thick yellow/brown and curled. The toenails had large amounts of brown matter, scaly and jiggered. Observation1/7/20 at 8:30 AM, Resident #27"s toenail remained in the same condition and had not been cleaned or cut/trimmed. The toenails were thick and more than an inch longer the toenail bed. Resident presented that the toe area was sensitive to touch as he would not allow blanket to cover feet. Observation on 1/7/20 at 2:30 PM, there was no change in the condition of Resident #27 ' s toenail. Staff had provided personal care for the resident several times but did not address the condition of the toenails. Resident #27 had been observed yelling when staff touched his feet. Resident #27 just pulled his feet to the side. Observation on 1/8/20 at 8:00 AM, Resident #27 was in room lying in bed and feet were exposed from the covers and there were no changes in the condition of his toenails on both feet. Interview on 1/8/20 at 9:34 AM, NA#3 stated they were told that residents who were diabetic, the aides were not to cut the toe nails, but should report the condition of the toe nails to nursing.	F 687	recur; Measures to ensure plan of correction is effective and remains in compliance are: On 1/9/20 the Staff Development Coordinator educated all Licensed Nursing Staff and Certified Nursing Assistants on how to notify the Wound Care Nurse and Director of Nursing of any residents requiring toenail care. The Wound Care Nurse and/or Director of Nursing will request a Podiatry Consult based on residents diagnosis and toenail appearance. Podiatry visits will be scheduled monthly to assure all residents are able to be seen timely. A thorough review by the Director of Nursing and Wound Care Nurse will be completed after ever Podiatry visit to assure all residents whom require services were seen. If any resident is identified as not receiving podiatry services, the Director of Nursing will notify the facility scheduler to make a follow up appointment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Five random Observation audits will be completed weekly X 12 by the Director of Nursing, Assistant Director of Nursing (ADON) and/or Unit Managers (UM) to validate toenail care. The ADON and/or UM will report findings of these audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 13	F 687		

The diabetic residents toe nails would be done by the podiatrist. NA#3 reported when the resident ' s toe nails were observed the nails getting to long, sharp or change of condition it should be reported to the nursing staff so the resident could be scheduled for podiatrist. The NA#3 stated she had worked with Resident #27 on a regular basis and the toenails had been in the current condition for several months. NA #3 state the condition of the toenails had been reported to nursing, but she was uncertain when the podiatry appointment had been schedule.

Observation on 1/8/20 at 9:45 AM, NA #2 with permission from Resident #27 removed the resident's sock and the toe nails condition was unchanged. The resident feet were very sensitive to touch. He was cooperative in allowing the staff to remove the socks but did not want staff to touch his feet, Resident #27 stated his feet hurt. NA #2 stated diabetic residents ' toenails were cut by the podiatrist. The aides were expected to report to nursing when the toe nails needed to be cut by the podiatrist.

Interview on 1/8/20 at 9:50 AM, the Scheduler stated the podiatrist visits the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The Scheduler indicated any resident seen/refused would be documented in the chart as well as the referral form. Review of the schedule form indicated Resident #27 had been scheduled for 6/11/19 and 10/2/19, there was no documentation to indicate whether the resident had been seen or services provided.

Interview on 1/8/20 at 10:00 AM, the Director of

follow up action determined by the QAPI team.

Dates when corrective action will be completed:

Date of Compliance January 24, 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 14	F 687		

Nursing(DON) stated the podiatrist was scheduled every 3 months and it was expected that any diabetic residents who needed podiatry service be added to the schedule. The Nurse Aides were responsible for reporting to nursing when diabetic resident ' s toenails were extremely, long/sharp and needed podiatry trim/cut. DON added due to the complexity of diabetic footcare needs, podiatry was more appropriate to cut the toenails rather than nurses/nurse aide. The DON indicated there was no back up system in place for missed appointments or refusal of services The Administrator confirmed the expectation/responsibility of nurse aides/nursing and added the nurses should notify the nurse practitioner of any residents that needed toenail/footcare in between scheduled appointment to ensure residents did not get missed. The Administrator added if a resident refused or missed an appointment the NP would be notify for intermittent foot care.

Interview on 1/8/20 at 10:30 AM, the Nurse Practitioner(NP) stated during her visits she did not do routine full body checks and would not have checked a resident ' s toenail unless nursing reported there was a concern or a need for referral to podiatry. The NP added any resident could be seen for toenail care in between podiatry visits if the toenails were growing very long, had thick/long sharp edges and needed to be cut/trim before three months. In addition, staff would need too informed her when a diabetic resident needed a referral for podiatry services. The NP added she was unaware of Resident #27 toenails needed to be cut/trim.

2. Resident #22 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 15	F 687		

5/18/18. The diagnoses included diabetes, end stage renal disease and hemiplegia. The quarterly Minimum Data Set dated 10/23/19 indicated Resident #22 had some cognitive deficits. The MDS coded Resident #22 totally dependent on staff for all activities of daily living.

Care plan dated 10/23/19 identified the problem as Resident #22 had activities of daily living (ADL) self-care performance deficit r/t pelvic fracture (healed) & pain and hemiparesis to right side, right foot drop. The goal included Resident #22 would maintain or improve current level of function. The interventions included Resident #22 required total assistance from staff to provide bath/shower as necessary and sponge bath when a full bath or shower cannot be tolerated. Staff would gather and provide needed supplies, observe/document/report PRN any signs or symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation to nursing. Staff would cut long toe nails, observe/document foot care needs and refer to podiatrist/foot.

Review of the podiatry schedule from June 2019 through October 2019, revealed Resident #22 was scheduled to be seen on 6/11/19, but had not been seen or rescheduled. The podiatrist return visit was 10/2/19 and Resident #22 was not seen or scheduled.

Observation on 01/07/20 at 10:14 AM, Resident #22 was lying in bed with feet hanging out from under covers, bilateral toenails long and sharp. Resident #22 stated she needed and wanted her toes nails cut. She stated she thought staff would do them during care, but they had not been done in a month or so. Resident #22 ' s left ankle and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 16	F 687		

foot was very swollen.

Observation on 1/7/20 at 2:45 PM, Resident #22 was lying in bed with feet exposed all the toenails on both feet were very long, thick, yellowing and brown matter underneath, with some swelling around the ankles. Resident #22 stated she had told staff during her care that her toenails needed to be clipped and was told she had to be scheduled to see the podiatrist. The resident added that her toenails have gotten caught up in the covers or poked through her socks at times. "I could not tell you the last time when my toenails were cut". Occasionally they would hurt when my shoes were put on."

Observation on 1/8/20 at 9:30 AM, Resident #22 was seated in wheelchair with socks/shoes on, Nurse Aide #2 removed the shoes and sock and the toenails on both feet had not been cut/trimmed and remained in the same condition. The big toe on each foot was poking through the sock. Resident #22 stated that her toenails had been in this condition for several months, staff knew they were very long, and no-one cut them. NA #2 observed the condition of the toenails and confirmed that all toe nails were very long , thick and more than an inch beyond each toe. NA #2 stated diabetic residents toe nails were cut by the podiatrist. The aides were expected to report to nursing when the toe nails needed to be cut by the podiatrist.

Interview on 1/8/20 at 9:34 AM, NA#3 stated they were told that residents who were diabetic, the aides were not to cut the toe nails, but should report the condition of the toe nails to nursing. The diabetic residents toe nails would be done by the podiatrist. NA#3 reported when the resident '

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 17	F 687		

s toe nails were observed the nails getting to long, sharp or change of condition it should be reported to the nursing staff so the resident could be scheduled for podiatrist. The NA#3 stated she had worked with Resident #22 on a regular basis and the toenails had been in the current condition for several months. NA #3 state the condition of the toenails had been reported to nursing, but she was uncertain when the podiatry appointment had been schedule.

Interview on 1/8/20 at 9:50 AM, the Scheduler stated the podiatrist visits the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The Scheduler indicated any resident seen/refused would be documented in the chart as well as the referral form. Review of the schedule form indicated Resident #22 had been scheduled for 6/11/19 but was not seen due to another appointment. Further review of the referral form, the podiatrist had visited the facility on 10/2/19 and Resident #22 had not been seen or rescheduled. Additional review of the chart revealed there had not been any consultation notes of the resident being seen in the past 6 months.

Interview on 1/8/20 at 10:00 AM, the Director of Nursing(DON) stated the podiatrist was scheduled every 3 months and it was expected that any diabetic residents who needed podiatry service be added to the schedule. The Nurse Aides were responsible for reporting to nursing when diabetic resident ' s toenails were extremely, long/sharp and needed podiatry trim/cut. DON added due to the complexity of diabetic footcare needs, podiatry was more appropriate to cut the toenails rather than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 687	Continued From page 18 nurses/nurse aide. The DON indicated there was no back up system in place for missed appointments or refusal of services. The Administrator confirmed the expectation/responsibility of nurse aides/nursing and added the nurses should notify the nurse practitioner of any residents that needed toenail/footcare in between scheduled appointment to ensure residents did not get missed. The Administrator added if a resident refused or missed an appointment the NP would be notify for intermittent foot care. Interview on 1/8/20 at 10:30 AM, the Nurse Practitioner(NP) stated during her visits she did not do routine full body checks and would not have checked a resident ' s toenail unless nursing reported there was a concern or a need for referral to podiatry. The NP added any resident could be seen for toenail care in between podiatry visits if the toenails were growing very long, had thick/long sharp edges and needed to be cut/trim before three months. In addition, staff would need too informed her when a diabetic resident needed a referral for podiatry services. The NP added she was unaware of Resident #22 toenails needed to be cut/trim.	F 687		
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 - §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	F 812		1/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 812	Continued From page 19 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 observation and staff interviews the facility failed to keep kitchen's exhaust range hood clean to prevent food from potentially being contaminated while being prepared. The range hood which was located directly above food preparation equipment was observed to have areas of chipping and peeling paint and rusted areas. Findings include: Observations on 1/8/20 at 11:40 AM, of the kitchen's range hood system revealed the range hood was positioned directly over food preparation equipment including; a tilt skillet, food warmer and a stove. Observations of the inside of range hood revealed the inside was painted and it contained areas that were brown in color which appeared to be rust. An area on the range hood's interior that was approximately one foot wide by one foot high and directly over the kitchen's tilt skillet had cracked and chipped paint. The paint was peeling and hanging loosely from the hood. A half foot circular area on the range hood's interior that was above a food warmer also had chipped paint. The outside area of the range	F 812	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal and State Law. F812 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/9/20 the kitchen□s exhaust range hood was scrapped of any loose paint and rust then cleaned thoroughly to prevent contamination. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Residents whom receive nutrition from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

(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 812	Continued From page 20 hood was also observed. The area was painted and had brown colored areas which appeared to be rust. During an interview on 1/8/20 at 12:00 PM, the cook stated she had not observed the paint chipping on the kitchen's range hood and had not placed any work orders for maintenance regarding the hood system. During an interview on 1/8/20 at 12:17 PM, the district dietary manager stated he was unsure why the kitchen's range hood was painted and was unaware of the paint chipping and rusted areas of the hood system. He stated the entire range hood needed to be replaced. During an interview on 1/8/20 at 1:55 PM, the maintenance director indicated that the facility had a contract with external service company to clean the kitchen's range hood vents and this service was last performed in September 2019. He indicated he was unaware that the range hood was painted and unaware of the paint chipping and rust areas on the range hood system. During an interview on 1/9/20 at 5:02 PM, the administrator indicated the kitchen's range hood system was painted long ago and was unsure why it was painted. The administrator stated the facility will remove any loose paint and rust from the range hood and be working to replace the entire range hood.	F 812	dietary department have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/9/20 the Maintenance Director scrapped the paint and rust off the kitchen hood and thoroughly cleaned the exhaust range to eliminate the possibility of contamination. The external contract cleaning company will be scheduled monthly until a replacement kitchen exhaust hood is installed. Dietary staff was educated on 1/10/2020 on reporting any chipped paint or rust to the Maintenance Director or Administrator immediately. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Three observation audits will be completed weekly X 12 by the Administrator and/or Maintenance Director to assure cleanliness of the Kitchen□s Exhaust Range Hood and observing for loose paint or rust. The Administrator and/or Maintenance Director will report findings of these audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	**226 N OAKLAND AVENUE EDEN, NC 27288**

(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 812	Continued From page 21	F 812	Dates when corrective action will be completed: Date of Compliance January 24, 2020	