PRINTED: 01/05/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
		345339	B. WING _				09/ 2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET WINDSOR, NC 27983	·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	Ē	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
F 000	was conducted on 12 found to be in compli		FC	000			
F 580	Control Survey and of conducted on 12/08/2. The facility was found CFR §483.80 infection has implemented the Disease Control and recommended practic COVID-19. Event ID 1 of the 3 complaint a substantiated resultin Notify of Changes (Irr	ces to prepare for # 1CNN11. allegation(s) were ng in deficiencies. njury/Decline/Room, etc.)	F 5	580			12/31/20
SS=D	CFR(s): 483.10(g)(14) Notifi (i) A facility must immonsult with the residuence consistent with his or representative(s) who (A) An accident involvesults in injury and his physician intervention (B) A significant charmental, or psychosod deterioration in health	cation of Changes. nediately inform the resident; lent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or					
AROBATORY	DIDECTOR'S OR DROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITI F			(X6) DATE

Electronically Signed 12/23/2020

Facility ID: 922993

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345339	B. WING _			12/	09/2020
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHAI	В			306 SOUTH KING STREET		
				٧	VINDSOR, NC 27983		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580	a need to discontinue treatment due to adve commence a new form (D) A decision to transpersident from the facility 8483.15(c)(1)(ii). (ii) When making notiful (14)(i) of this section, all pertinent information is available and proving physician. (iii) The facility must a resident and the reside	reatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ins as specified in paragraph tecord and periodically mailing and email) and	F	580			
	Based on record revi representative intervi	ew, staff, family ews, the facility failed to esentative of the resident ' s			F580 - D Notification of Changes The Licensed nurse #1, that received weight on 11/25/20 for resident #1, did		

STREET ADDRESS. CITY, STATE_ZIP CODE 1908 COPPOUNDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB SIMMARY STATEMENT OF DEFICIENCIES 1908 SOUTH KING STREET WINDSOR, NC. 27983 D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG FOR CONTINUED FROM THE APPROPRIATE TAG CONTINUED FROM THE APPROPRIATE TAG FOR CONTINUED FROM THE APPROPRIATE TAG CONTINUED FROM THE APPROPRIATE TAG FOR CONTINUED FR	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
BRIAN CENTER HEALTH & REHAB SOUTH KING STREET PRODECTION			345339	B. WING		C 12/09/2020	
Image					STREET ADDRESS CITY STATE ZIP CODE	12/03/2020	
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F 580 Continued From page 2 significant weight loss. Resident #1 was doing fine. He stated the nurse during the 7 day looms representative on 12/8/2020. An interview with the family representative on 12/8/2020. Nurse #1 caled to inform him Resident #1 was not eating well on 11/30/2020. The Director of nursing or designee. Current nursing single determination is made within 72 hours of the identified significant weight conditions and to determine based on reweights if a significant weight toss for 1 to 1 resident reviewed for weight loss. Resident #1 was admitted to the facility on 4/24/2020 with the diagnosis of dysphagia (difficulties). A quarterly Minimum Data Set (MDS) dated 10/6/2020 showed Resident #1 was moderately cognitive impaired, alert and able to make her needs know. Resident #1 at meals with setup and supervision, had no weight gain or loss with in the last 6 months, and no rejection of care during the 7 day look back assessment period. Resident #1 weight was recorded at 131 pounds. Review of the weight record showed Resident #1 sweethed and the provident and the provided to any neight the family representative with the family representative with the family representative with the family representative was told Resident #1 was doing fine. He stated the nurse did not inform him Resident #1 was not eating well or had loss any weight. The family representative stated on 11/30/2020. Nurse #1 caled to inform him Resident #1 was not eating well or had loss any weight. The family representative stated on 11/30/2020. Nurse #1 caled to inform him Resident #1 was not eating well or had loss any weight. The family representative stated on 11/30/2020 showed Nurse #1 attempted to notify the family representative to the weight loss on 11/30/2020 at the definition of the weight loss on 11/30/2020 at the service well weight loss and the weight loss and t	BRIAN CE	NTER HEALTH & REHA	В	1			
F 580 Continued From page 2 significant weight loss for 1 of 1 resident reviewed for weight loss. Resident #1 are more deficiency of the weight loss for 1 of 1 resident reviewed for weight loss. Resident #1 are more deficiency of the weight loss for 1 of 1 resident reviewed for weight loss for 1 of 1 resident reviewed for weight loss but the notification was not accomplished until 12/1/20. A voice mail was left for the resident representative on 11/30/20. Licensed Nurse #1 received education by the Director of Nursing on 12/24/20 of the plan of correction related to this citation. All residents could be affected, therefore all current residents were weighed, re-weighed if indicated and reviewed by Director of Nursing on 12/24/20 of the plan of correction related to this citation. All residents could be affected, therefore all current residents were weighed, re-weighed if indicated and reviewed by Director of Nursing on designee. This was completed for any identified significant weight loss by the Director of nursing or designee. This was completed on 12/14/20. The Director of nursing or designee will review all weights obtained three times a week to identify need for a reweight, and to determine based on reweights if a significant weight changes by the Director of nursing or designee. Current nursing staff by the Director of Nursing or Designee will recipied to spin or significant weight changes by the Director of nursing or designee. Current nursing staff by the Director of Nursing or Designee and will be completed by 1/2/24/20. The nurse progress note dated 11/30/2020 showed Nurse #1 attempted to notify the family representative stated on 11/30/2020. Nurse #1 called to inform him Resident #1 hat explication on 11/30/2020 and was told Resident #1 at tempted to notify the family representative on 11/30/2020 and was took and the weight loss on 11/30/2020 at 100 prevails and the provided to any new nursing staff by the Director of Nursing or designee and will be completed by 1/2/24/20. The Director of Nursin	(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		
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			•		determine if significant weight losse		
note on 12/1/2020 at 9:28 am showed Nurse #1 occurred and to ensure Responsible							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345339	B. WING		1	C 2/09/2020	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET WINDSOR, NC 27983		2/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE		
F 580	and informed him of R The physician orders dietary supplement the twice a day, weights or consult for weight loss complete blood count panel, thyroid stimula on 12/1/2020 speech 12/3/2020 Regular dietexture, regular texture. Nurse #1 on 12/9/2020 worked with Resident weight was taken. Nut the family representate weight loss. Nurse #1 weight until the weeket the family representate came back to work. During an interview we (DON) on 12/9/2020 are sident #1's family resident #1's family resident weight	Resident #1's weight loss. dated 11/30/2020 included aree times a day, Marinol every Friday, and dietary is. Labs work ordered: it, comprehensive metabolic ting hormone test. Orders consult for weight loss, et with mechanical soft ite. 20 at 2:45 pm stated she is #1 on 11/25/2020 when the larse #1 said she did not call tive at that time to report the said she forgot about the end of 11/28/2020 and called tive on 11/30/2020 when she weight loss. She said the re obtained by the DON said significant weight would be reported to splaced in the computer by aid any nurse could report a to a family representative. Physician on 12/9/2020 at believed a nurse notified is on 11/25/2020 or sician stated he gave new	F 58	party notification occurred for significant weight losses. The be reviewed in QAPI for 3 more The Director of Nursing is respinglementing this plan of care 12/31/20.	e results will nths. consible for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 580	was unavoidable due failure to thrive, swalle schizophrenia. The Administrator sta 12/9/2020 at 4:00 pm completed the notifical late. She said Nurse was reweighted on 11 the family represental there was no staff me reweigh Resident #1 weights were monitor	to her diagnoses of adult owing difficulties, and ted during an interview on she felt the nurse ation correctly even if it was 141 waited until the resident 130/2020 before contacting ive. The Administrator said	F 5	80			