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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 (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 [DATE], 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 [DATE], so the care plan should have been updated then to include the weight loss. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 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 [DATE] 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 [DATE] 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. 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.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.