STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 Emergency Preparedness survey was conducted 8/08/2022 through 8/11/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 8/08/22 through 8/11/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three (3) complaints were investigated during the survey: 1. VA00051751 - Unsubstantiated 2. VA00051753 - Unsubstantiated 3. VA00055357 - Substantiated with deficiency The Life Safety Code survey/report will follow. The census in this 56 certified bed facility was 53 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 5 closed record reviews.	F 000	F684 Quality of care • LPN# 2 on duty notified attending MD of missed medication and residents' refusal immediately upon identification with no new orders received. • Education of all nurses was completed by the DON of The Five rights of medication administration and LPN #2 was also assigned additional in-service in Relias of Avoiding Medication-Related Problems on 9/1/22 by the DON. An audit of the medical records of all residents with orders for Perdix was completed to ensure proper dispensing was completed by the ADON on 8/10/22. • An audit of the medical records of all residents with orders for Peridex was completed to ensure proper dispensing had been completed. Audit conducted by ADON • The nurse on duty will administer medications per MD orders on assigned unit. The Five rights of medication administration will be followed for each order (right medication, right dose, right time right route, right resident).	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684	• The ADON and or designee will complete 5 medication pass audits weekly to ensure compliance with any correction needed occurring immediately x 3 months. The ADON will report all findings to the DON weekly. • The DON will monitor the entire process and report findings to Quality Assurance Committee monthly, and on going making any changes as needed. • All corrective action was completed on 9/1/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Flynn	Administrator	9/6/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 684	Continued From page 1	F 684		

by:
Based on staff interview, clinical record review, and during a medication pass and pour observation the facility staff failed to follow the providers order in regards to administering the medication Peridex for 1 of 3 residents observed during the medication pass and pour observation, Resident #44.

The findings included:

Resident #44's diagnosis included, but were not limited to, chronic respiratory failure, candida stomatitis, and encounter for attention to tracheostomy.

Section C (cognitive patterns) of Resident #44's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/07/22 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

Resident #44's care plan included the focus area requires assistance with oral care. Interventions included, but were not limited to, provide oral hygiene.

08/09/22 8:15 a.m., the surveyor observed Licensed Practical Nurse (LPN) #2 prepare and administer Resident #44's morning medications.

Resident #44's clinical record included an order for Peridex solution give 15 ml by mouth two times a day the start date was documented as 06/01/22.

The surveyor did not observe the administration of Peridex.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 684	Continued From page 2 08/09/22 9:40 a.m., LPN #2 stated respiratory therapy would usually give this medication 08/09/22 9:47 a.m., LPN #2 stated they had spoken with respiratory therapy and it was not something they would give. LPN #2 stated they offered the Peridex to the Resident but they declined. 08/09/22 4:45 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing and Unit Manager (UM), the issue with the Peridex was reviewed. 08/10/22 9:05 a.m., the UM provided the surveyor with a copy of their policy titled "Safe medication administration practices, long term care." With a revision date of 05/20/22, this policy read in part, "To promote a culture of safety and prevent medication errors, nurses must adhere to the "rights of medication administration." These rights are to...select the right medication, give the right dose, give the medication at the right time...The term medication error refers to a mistake that occurs during the medication administration process. When a mistake occurs, it's considered an error regardless of whether it harmed a resident..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 689	Continued From page 3 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure 1 of 18 current residents, Resident #9 was free of accident hazards. Resident #9 did not have their provider ordered bilateral floor mats in place. The findings included: Resident #9's diagnoses included, but were not limited to, anoxic brain damage, bipolar disorder, and restlessness and agitation. Section C (cognitive patterns) of Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/22/22 was coded to indicate the resident was severely impaired in cognitive skills for daily decision-making. Section G (functional status) was coded to indicate Resident #9 was totally dependent on two staff for bed mobility and transfers. Resident #9's fall risk assessment completed 07/20/22 included a documented score of 8. Per the preprinted code on this document 8=medium risk. Resident #9's comprehensive care plan included	F 689	F689 Free of Accidents • The fall mats were placed beside residents # 9 bed per the physician order on 8/1/22 by ADON. • The ADON did an audit of all residents with physician orders for fall mats on 8/10/22 and no other residents were identified as being affected by the deficient practice. had fall mats in place. • The assigned c.n.a on duty will ensure ordered devices are in use per plan of care throughout the shift. The nurse on duty will monitor every shift that fall mats are in place per plan of care with corrective action occurring immediately if needed. • The unit manager will monitor fall mats usage five times a week times three months to ensure compliance and report all findings to DON weekly • All corrective action will be competed on 9/16/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 689	Continued From page 4 the focus area at risk for falls related to motor agitation, inability to stand or bear weight. Interventions included bilateral fall EZ mats date initiated 08/18/17. Resident #9's clinical record included a physicians order dated 10/15/20 for bilateral floor mats for safety. 08/10/22 8:05 a.m., resident observed resting on bed no floor mats in place. 08/10/22 8:37 a.m., checked room for floor mats with the Assistant Director of Nursing (ADON) the ADON acknowledged there were no floor mats in place and was unable to locate the floor mats in the room. 08/10/22 8:45 a.m., the ADON stated the floors mats were now in place. 08/11/22 7:56 a.m., observed bilateral floor mats in place beside of Resident #9's bed. 08/10/22 04:10 p.m., the missing floor mats were reviewed in and end of the day meeting with the Administrator, Director of Nursing (DON), ADON, and Unit Manager. The ADON stated they had acquired the mats from maintenance and they were for safety. No further information regarding the missing floor mats was provided to the survey team prior to the exit conference.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 690	Continued From page 5 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record reviews, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure indwelling urinary catheter care orders	F 690	F690 Catheter Care orders • RN on duty contacted the attending MD and obtained orders for indwelling foley catheter care for resident #15. Resident #102 no longer resides in the facility and the resident's chart is closed. • The Unit Manager and DON audited all residents with foley catheters orders on 8/11/22 to ensure they had appropriate catheter care orders in place. No other residents were identified as being affected by the deficient practice. • The Admitting nurse on duty will obtain physician orders for foley catheter care upon admission or readmission to ensure any residents with a foley catheter has appropriate orders in place with any corrections occurring immediately as needed. The ADON will report all finding to DON weekly. • The ADON or designee will review all admission/re-admission to ensure any residents with a foley catheter has appropriate orders in place with any corrections occurring immediately as needed. The ADON will report all finding to DON. • The DON will monitor the foley catheter process and make changes to the process as needed and report any negative findings to the Quality Assurance Committee monthly and ongoing. • All corrective action was completed on 8/11/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 690	Continued From page 6	F 690		

were obtained and indwelling urinary catheter care was provided for two (2) of 20 sampled residents (Resident #15 and Resident #102).

The findings include:

1. The facility staff failed to have current orders to address Resident #15's indwelling urinary catheter care. Consistent documentation of Resident #15 receiving indwelling urinary catheter care between the dates of 8/1/22 and 8/9/22 was neither found by nor provided to the surveyor.

Resident #15's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/4/22, was dated as being completed on 5/11/22. Resident #15 was assessed as able to make self understood and as able to understand others. Resident #15's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. Resident #15 was assessed as requiring assistance with bed mobility, transfers, dressing, eating, toilet use, personal hygiene, and bathing. Resident #15's diagnoses included, but were not limited to: anemia, paraplegia, anxiety disorder, respiratory failure, and pressure ulcers.

Resident #15 was observed to have an indwelling urinary catheter during the survey. Review of Resident #15's clinical documentation, on 8/10/22, failed to reveal current orders for the care of the indwelling urinary catheter.

The following information was found in a facility policy titled "Foley Catheter Insertion, Male Resident" (this document was not dated): "Catheter Care ... 2. Provide catheter care every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 690	Continued From page 7	F 690		

shift, and as indicated after defecation... 8. Assess condition every shift."

Registered Nurse (RN) #2 was interviewed, on 8/10/22 at 3:40 p.m., about Resident #15's indwelling urinary catheter orders. RN #2 reported they were unable to find orders current orders addressing Resident #15's indwelling urinary catheter. RN #2 reported they would have to contact a medical provider to obtain indwelling urinary catheter orders. RN #2 was able to find an order to discontinue the indwelling urinary catheter on 7/27/22. (Documentation indicated the indwelling urinary catheter was discontinued on that date but subsequently reinserted at a local hospital.)

On 8/11/22 at 8:05 a.m., the Unit Manager provided the survey team with copies of the following medical provider telephone orders, for Resident #15, dated 8/10/22 at 3:52 p.m.:
- "Flush catheter with 50cc sterile water (every) shift. [sic] two times a day until 08/12/2022 23:59".
- "Foley catheter care every shift and after each (incontinent) episode every shift until 08/12/2022 23:59".
- "Monitor foley anchor for placement. Replace if soiled or not in place. every [sic] shift until 08/12/2022 23:59".

On 8/11/22 at 9:45 a.m., the facility's Director of Nursing (DON) and Unit Manager were interviewed related to Resident #15's indwelling urinary catheter. The DON acknowledged Resident #15's indwelling urinary catheter had been inserted at a local hospital. The DON stated that orders addressing indwelling urinary catheter care and anchoring should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 690	Continued From page 8	F 690		

obtain upon Resident #15's return to the facility.

The failure of facility staff to have orders for and documentation of Resident #15's indwelling urinary catheter care was discussed with the facility's Administrator, Director of Nursing (DON), Assistant DON, Area Operations Manager, and Chief Nursing Officer during a survey team meeting on 8/11/22 at 12:18 p.m. No additional information related to this issue was provided to the surveyor.

2. The facility staff failed have orders addressing Resident #102's indwelling urinary catheter care. Consistent documentation of Resident #102 receiving indwelling urinary catheter care between the dates of 6/1/21 and 7/10/21 was neither found by nor provided to the surveyor.

Resident #102's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/3/21, was dated as being completed on 6/7/21. Resident #102 was assessed as having short-term and long-term memory problems; Resident #102 was documented as not having a Brief Interview for Mental Status (BIMS) interview completed due to "rarely/never" being understood. Resident #102 was assessed as being dependent on others for bed mobility, dressing, toilet use, personal hygiene, and bathing. Resident #102's diagnoses included, but were not limited to: anemia, neurogenic bladder, thyroid disorder, respiratory failure, intracranial hemorrhage, and functional quadriplegia.

Resident #102's documentation indicated the resident had an indwelling urinary catheter during June 2021 and the first part of July 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 690	Continued From page 9 On 8/11/22 at 9:45 a.m., the facility's Director of Nursing (DON) and Unit Manager were interviewed related to Resident #102's indwelling urinary catheter. The Unit Manager reported they were unable to find medical provider orders to address the resident's indwelling urinary catheter for the month of June 2021 and for July 1, 2021 through July 10, 2021. The DON reported there should have been orders to address indwelling urinary catheter care and anchoring. The failure of facility staff to have orders for and documentation of Resident #102's indwelling urinary catheter care was discussed with the facility's Administrator, Director of Nursing (DON), Assistant DON, Area Operations Manager, and Chief Nursing Officer during a survey team meeting on 8/11/22 at 12:18 p.m. No additional information related to this issue was provided to the surveyor. This is a complaint deficiency.	F 690	F880 Infection Prevention and Control • The DON placed the correct isolation signage on the resident room's doorways for resident #2, and resident #105 per MD isolation orders on 8/9/2022. • The DON/ADON completed an audit on 8/11/22 of all residents with orders for isolation precautions and all other residents had the correct isolation signage posted at their doorways. • The admitting nurse on duty will obtain physician orders for appropriate isolation and place the sign on the resident's door immediately upon resident arrival to the facility.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	• The ADON or designee will review all admission, and readmissions to ensure isolation signage is in compliance within 24 hours of admission. All finding will be reported to the DON weekly. • The DON will report any negative findings to the Quality Assurance Committee monthly and then on-going making changes to the process as needed to ensure compliance. • All corrective action will be completed on 9/16/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 880	Continued From page 10 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 880	Continued From page 11	F 880		

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, clinical record review, and facility document review, the facility staff failed to ensure infection control isolation precautions signage was posted for two (2) resident rooms that housed residents requiring infection control precautions; one (1) of the rooms housed a newly admitted/readmitted resident that was not fully vaccinated for COVID-19.

Resident #105's room did not have an isolation precaution sign posted outside their room. After the missing isolation precaution sign was discussed with facility staff, Resident #105 had an incorrect isolation precaution sign initially posted outside their room.

Resident #2's room did not have an isolation precaution sign posted outside their room.

The findings include:

On 8/8/22 at 7:39 p.m., it was noted that two (2) rooms had infection control personal protective equipment (PPE) placed in the hallway at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 880	Continued From page 12	F 880		

entrance to the rooms; no signage was posted to indicate what kind of isolation precautions were required to be taken when entering these rooms. (One of these rooms was Resident #105's; the other room was Resident #2's.) The facility's Administrative Staff Member (ASM) #2 was asked if these rooms required isolation precautions. After reviewing Resident #105's and Resident #2's information, ASM #2 posted a "CONTACT PRECAUTIONS" signs on the door frames leading into each of the aforementioned residents' room. ASM #2 stated a N95 mask was not required to enter the rooms. These "CONTACT PRECAUTIONS" signs stated that prior to entering the rooms one must: wear an isolation gown, wear gloves, and perform handwashing / sanitizing hands prior to entering and upon exiting the rooms.

The following information was found in a facility policy titled "Isolation" (this document did not include a date):
- "Isolation precautions will be initiated when there is reason to believe that a resident has an infectious or communicable disease."
- "When isolation precautions are implemented, the charge nurse in the section where isolation precautions are instituted shall: ... Post the appropriate isolation notice on the room entrance door and above the bed so that all personnel will be aware of isolation precautions ..."
- "Isolation Notices ... Signs will be used to alert staff of the implementation of isolation precautions, while protecting the privacy of the resident."

Resident #2's clinical documentation indicated the resident had a current, active order for 'Contact Precautions' at the time of the aforementioned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 880	Continued From page 13	F 880		

observation. Resident #2 was care planned for "contact isolation related to: CRE". One (1) of the interventions for this care plan is for "isolation signage posted". (Carbapenem-resistant Enterobacteriaceae (CRE) are bacteria that are resistant to many common antibiotics, including the carbapenem class of antibiotics.)

On the morning of 8/9/22, it was noted a different isolation precaution sign had been placed at the entrance to Resident #105's room. The "CONTACT PRECAUTIONS" sign had been replaced with a "Contact+Modified Droplet Precautions" sign. On 8/9/22 at 10:07 a.m., ASM #2 was asked if there had been a change with Resident #105 resulting in the change of the isolation precaution sign. ASM #2 reported the resident had not had a change in condition; AMS #2 stated they had placed an incorrect sign on the evening of 8/8/22. The "Contact+Modified Droplet Precautions" sign indicated an individual entering the room should wear: an isolation gown, gloves, a respirator (N95 or higher), and eye protection.

Resident #105's clinical documentation indicated the resident had yet to receive their first COVID-19 vaccine. Resident #105's clinical documentation included an order for "Contact and modified droplet isolation" which was a current, active order during the times of the aforementioned observations. Resident #105's baseline care plan included an intervention for modified droplet precautions for COVID-19 precautions.

The following information was found in the facility's "Covid [sic] Program" (with a revised date of 6/29/22):

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 880	Continued From page 14 - Under the heading of "Admissions / Readmissions / ER Visits / Leave of Absence Visits" was the following information: " ... NO [sic] proof of being up to date [sic] and the resident is COVID-19 Negative [sic] within the past 90 days, the resident should be quarantined in a private room, if possible, and quarantined for 7 days." - Under the heading of "Personal Protective Equipment (PPE) for COVID-19" was the following information: "Have PPE [sic] gloves, gowns, surgical mask or KN95, N95 or higher grade respirators, and eye protection." - "Quarantine (Potential or Known Exposure) Contact (plus) Modified Droplet Precautions" included the following bulleted items: - Respirator: N95 or higher; - Eye Protection; - Gown; - Gloves ..." The absence of isolation precautions signs being posted at the entrance of Resident #105's room and Resident #2's room was discussed with the facility's Administrator, Director of Nursing (DON), Assistant DON, Area Operations Manager, and Chief Nursing Officer during a survey team meeting on 8/11/22 at 12:18 p.m.; the posting of the incorrect sign for Resident #105 was also discussed during this meeting. No additional information was provided related to these issues.	F 880		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 888	Continued From page 15 a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for	F 888	F888 Vaccination • LPN #5 received the second dose of Pfizer on 8/10/22 by the Infection Preventionist making her up to date with vaccine. • An audit was completed by Human Resources 8/11/2022 of all employees to assure they are fully vaccinated or have religious and /or medical exemptions on file. • The Human resources Director/designee will monitor all new hires to make sure that they are fully vaccinated or have an approved exemption prior to starting to work. The Administrator or designee will review all new hires weekly to ensure employee vaccine status is in compliance. • The Administrator/designee will review the process and any negative findings in QAA monthly and then on-going making changes to the process as needed to ensure compliance. • All corrective action was competed on 8/26/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 888	Continued From page 16	F 888		

whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 888	Continued From page 17	F 888		

applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and facility document review, the facility staff failed to implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 888	Continued From page 18	F 888		

infection control prevention and control processes related to the vaccination status of one of three sampled staff members (LPN #5), as part of the plan to decrease the risks of the development and transmission of COVID-19.

For licensed practical nurse (LPN#5), the facility staff failed to ensure the nurse was fully vaccinated for COVID-19 resulting in the facility's staff vaccination rate being less than 100% (99.2%).

The findings were:

On 08/09/2022, the administrator provided the facility's COVID-19 Staff Vaccination Status information. After multiple discussions about the facility's staff vaccination statistics, the administrator provided a final staff vaccination status log. The facility's percent of current staff who were fully vaccinated was 99.2%. Out of 118 total staff, there was one staff member who had received one dose of a two-dose series of the Pfizer COVID-19 vaccine. This staff member, LPN #5, did not have an exemption of any kind and was not listed as having a temporary delay. The administrator acknowledged LPN #5 had been hired in May 2022 when at that time, she had received one dose of the Pfizer COVID-19 vaccine on 10/18/2022 according to administrator's records. Upon hire, the nurse was supposed to either obtain the second dose of the vaccine or apply for a waiver, neither of which occurred. The administrator acknowledged that it was the facility administration's responsibility to ensure the staff were completely vaccinated or had been granted a waiver.

On 08/10/2022 during a discussion with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 888	Continued From page 19	F 888		

administrator and the facility's area operations manager (AOM) regarding LPN #5's vaccine status, the AOM reported their corporate letter dated 08/26/2021 was provided to all employees. The letter read, in part, "As a result of President Biden announcing the COVID-19 vaccine mandate in skilled nursing settings last week, effective immediately, Kissito Healthcare will require all new hires to be vaccinated as a condition of employment. Newly hired employees will be required to be vaccinated prior to onboarding or be willing to participate in the first available vaccine clinic held at the facility."

LPN #5 received the second dose of the Pfizer COVID-19 two-dose vaccine at the facility on 08/10/2022. The administrator provided a copy of the nurse's CDC COVID-19 Vaccination Record Card as verification.

Upon entrance, there were no residents positive for COVID-19. On 08/11/2022, the unit manager reported the facility's last resident who tested positive for COVID-19 was on 01/23/2022 and was cleared on 02/03/2022.

LPN #5 was interviewed via phone on 08/11/2022 at 11:59 a.m. LPN #5 acknowledged the facility informed her of the requirement to be completely vaccinated when she was hired on approximately 5/20/2022 and for various reasons, the nurse had not received the second dose until 08/10/2022. The nurse reported having a baby in March of 2022 and had originally considered a medical waiver due to breastfeeding. LPN #5 never submitted a waiver request with the facility and did not sign a declination form since she intended to receive the vaccine. The nurse reported that due to not being completely vaccinated, she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495218	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 888	Continued From page 20	F 888		

required to wear an N-95 mask and eye protection while at work.

The facility's unit manager (UM) provided LPN #5's work time for the last two weeks via the nurse's employee time card. The nurse worked on 07/25/2022, 07/26/2022, 07/30/2022, 07/31/2022, 08/04/2022, and 08/05/2022. The nurse's screening documentation was provided for each of the days worked.

At an end of day meeting on 08/10/2022 at 4:16 p.m., the administrator, director of nursing, assistant director of nursing, and unit manager were informed of the findings described above.

No further information was provided prior to the exit conference.