STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 5/27/25 through 5/29/25. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections are required. The census in this 56 certified bed facility was 52 at the time of the survey. The survey sample consisted of 19 current resident reviews and 3 closed record reviews. One (1) complaint was investigated during the survey.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This STANDARD is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for Licensure of Nursing Facilities. Resident Assessment and Care Planning 12 VAC 5-371-250 (A)(2) - cross reference to F641 12 VAC 5-371-250 (G)- cross reference to F656 Nursing Services 12 VAC 5-371-220 (A) - cross reference to F689, F700 12 VAC 5-371-220 (B) - cross reference to F697, F760	F 001	F641 Accuracy of Assessments: 1. Immediately modified MDS Assessment dated 3/12/25 for resident #15 and MDS Assessment dated 4/23/25 for resident number #46. 2. Review of current residents most recent MDS completed to ensure accurate coding of falls in sections J 1700, J1800 and J1900. 3. To prevent recurrence of this deficient practice, MDS coordinator and Social Worker educated on accurate coding and ensuring coding falls within the ARD Lookback. Education was completed by Chief Administrative Officer on 5/30/2025	6/18/25

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

Electronically Signed | 07/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 1 Diagnostic Services 12 VAC 5-371-310 (A) - cross reference to F776 Clinical Records 12 VAC 5-371-360 (E)(4) - cross reference to F842 Infection Control 12 VAC 5-371-180 (A) - cross reference to F880	F 001	4. Regional MDS Coordinator or designee to monitor MDS assessments completed weekly for accuracy x 4 weeks, then monthly x 3 months, then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. F656 Develop and implement Comprehensive Care plan 1. Immediately added activities care plan to resident #256 2. Reviewed care plans for current residents of the center on 5/28/2025 to ensure activities care plan was present. 3. To prevent recurrence, MDS Coordinator and Activities Director were educated on ensuring complete and comprehensive care plans are present for residents residing within the facility for greater than 21 days. Education was completed by the Chief Administrative Officer on 5/30/2025. 4. Regional MDS Coordinator or designee to monitor care plans weekly x 4 weeks, then monthly x months, and then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 2	F 001	F689 Free of Accidents Hazards/Supervision/Devices 1. On 12/13/2024, at the time of the incident, resident was immediately assessed for injury. Resident was transferred to the Emergency Room for further treatment and intervention. The broken lift pad was immediately taken out of circulation. 2. Residents transferred with mechanical lifts have potential to be affected. Assessment of current lift slings completed on 12/13/2024 to ensure no rips, tears, or frays were present on remaining lift slings. Identified slings were removed from use. Mechanical lifts were inspected on 12/13/2024 and were found to be in proper working order. 3. Educated current nursing and laundry staff on inspecting lift pads for signs of wear/fraying when laundering and prior to each use. Lift pads found to have signs of wear to be removed from use immediately. Educated laundry staff on manufacturer recommendations of not using bleach or drying of lift pads. Initial education of staff was completed by 12/14/2024, with the exception 5 members of the nursing staff. Those 5 staff members were immediately educated on 5/28/2025. Due to the lapse of time, reeducation of nursing and laundry staff completed to ensure proper understanding of safety practices regarding mechanical lift slings. 4. To ensure continued compliance, laundry supervisor or designee to review current lift pads weekly x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 3	F 001	biweekly x 4 weeks, and monthly thereafter to ensure staff are removing lift pads from circulation with signs of fraying/wear. DON or designee to interview 5 random staff members for knowledge of proper care of lift slings and inspection prior to use. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. F697 Pain Management 1. No immediate action for resident #14 as timeframe has already passed. 2. Residents requiring treatment for pain is at risk of this occurrence. Pain assessment completed for current residents with physician notification for any report of uncontrolled pain on 5/29/25. 3. Current nurses educated on treatment and intervention of pain to include reviewing Omnicell inventory, notifying the provider when ordered pain medication is not available, and utilization of standing orders. Also educated on appropriate time frame. 4. DON or designee to monitor timely treatment of acute pain 5 x weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 2 months, then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 4	F 001	determines the problem no longer exits, then review will be completed on a random basis. F700 Bedrails 1. Immediately lowered and secured side rail for resident #13 on 5/27/25. No immediate intervention for residents #31, #46, and #28 as timeframe had already passed. 2. Current residents with side rails and grab bars are at risk of this occurrence. These residents were reviewed for attempted alternatives prior to the initiation of siderails. 3. Current nursing and therapy staff educated on 6/3/25 on the requirement of attempting alternatives prior to the use of bedrails of any sort. Education also to include the need for assessment, order, and consent prior to initiation. Current Bed Rail Assessment updated to prompt staff to attempt alternatives and document reasons for failure prior to the initiation of bed rails. 4. DON or designee to monitor bedrail orders versus bed presentation weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 2 months, then randomly thereafter. DON or designee to monitor new orders for side rails to ensure that alternatives were attempted prior to the initiation of bed rails. This monitoring should occur weekly x 4 weeks, biweekly x 4 weeks, monthly x 2 months and then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 5	F 001	discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. F760 Residents are Free of Significant Med Errors 1. No immediate action for resident #46 as time frame to administer medication had already passed. Physician was notified of medication not being administered as ordered with no new orders. 2. To identify others at risk of this practice, current residents with medication parameters were reviewed with any discrepancy immediately reported to the physician. 3. Current nurses educated on 6/3/25, class completion on 6/18/25, adhering to parameter orders. medication administration training completed with current nurses with posttest completion to ensure understanding. 4. DON or Designee to monitor medications with parameters three times weekly to ensure proper administration according to physicians order. This frequency of monitoring will occur x 4 weeks, then weekly x 4 weeks, monthly x 2 months, then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 6	F 001	F776 Radiology/Other Diagnostic Services 1. No immediate action for resident #50 as timeframe had already passed and physician indicated no further need for treatment. 2. Residents requiring in-house radiology services are at risk of this occurrence. Audit completed on 6/10/25. Diagnostic orders for the previous 30 days reviewed for current residents to ensure obtainment of proper diagnostic and body location. 3. Current Nurses educatedon 6/3/25 to ensure ordering of current body location and diagnostic with the mobile imaging service upon receipt of physician orders. Additionally, nurses are to review results to ensure proper body location was competed and immediately notify the physician and imaging service if a discrepancy is noted. 4. DON or Designee to monitor diagnostic orders and results for accuracy 5 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months, then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. F842 Resident Records/Identifiable Information 1. Immediately removed order for isolation for resident #13 on 5/27/25. 2. Current residents are at risk of this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 7	F 001	occurrence. Review of current residents with a physicians order for isolation precautions completed to ensure accuracy on 5/27/25. 3. Infection Prevention Nurse educated by the Director of Nursing on 5/27/25 to ensure accuracy of isolation orders to include timely obtainment and discontinuance. Infection Prevention nurse to utilize infection prevention module in electronic medical record to alert for residents currently requiring isolation. 4. DON or Designee to monitor isolation orders weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 2 months, and then randomly thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. F880 Infection Control 1. Immediately educated RN #1 on hand hygiene practices with different routes of medication administration on 5/28/25. 2. Current residents are at risk of this practice. 3. To prevent recurrence, medication administration training completed with current nurses with posttest completion to ensure understanding. 4. To ensure continued compliance, DON or Designee to monitor three nurses weekly during medication pass to ensure proper hand hygiene practices. Monitoring should occur at this frequency x 4 weeks, then monthly x 3 months, then randomly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0045	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER OF FINCASTLE	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) COMPLETE DATE
F 001	Continued From page 8	F 001	thereafter. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis.	