

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2018  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345339</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>08/24/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIAN CENTER HLTH &amp; REHAB</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1306 SOUTH KING STREET</b><br><b>WINDSOR, NC 27983</b>  |   |
| (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 557<br>SS=D  | <p>Respect, Dignity/Right to have Prsnl Property<br/>CFR(s): 483.10(e)(2)</p> <p>§483.10(e) Respect and Dignity.<br/>The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based upon observation, record review, and staff and resident interviews, the facility failed to provide respect and dignity during a bath for 1 of 4 residents reviewed who required extensive to total assistance with bathing, Resident #6. The findings included:</p> <p>Resident #6 was admitted to the facility on 11/24/2017 with diagnoses which included hypertension, diabetes mellitus, depression, and others.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated 07/20/2018 revealed Resident #6 was totally dependent upon one staff person for bathing and she was moderately cognitively impaired. The same assessment indicated that it was very important to her to choose what to wear.</p> <p>In an interview with Resident #6 on 08/23/2018 at 3:10 PM, she stated some staff treat her as though she "has the plague" when they provide incontinent care or a bath. Resident #6 added that she felt as though she was treated like "baggage" and that she just wanted to be treated</p> | F 557   | <p>F557 Respect, Dignity, Right to have personal property</p> <p>NA #1 failed to provide Resident #6 with dignity and respect during her bath. It was expected that resident #6 be allowed to choices related to clothing, be offered the bedpan or transfer to the toilet with expressions to go to the bathroom and to do so with a compassionate manner.</p> <p>NA #1 was removed from her assignment when the Administrator was informed of the surveyors' observations on 8/23/18. The Assistant Director of Nursing and Director of Nursing reviewed the concerns related to the observation of care and services provided when she was bathing resident #6 with NA#1.<br/>NA #1 was provided 1:1 education on Residents Rights to include being treated with dignity and respect by the Assistant Director of Nursing on 8/23/18 via lecture and viewing Video related to Resident rights.<br/>The Director of Nursing observed the NA</p> | 9/14/18   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/31/2018

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.

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| F 557  | <p>Continued From page 1<br/>like a human.</p> <p>An observation of a bath provided by Nursing Assistant (NA) #1 for Resident #6 was made on 08/23/2018 at 8:05 AM. NA #1 used a washcloth with soapy water to briefly wash Resident #6's lower legs, then dry them with a towel. NA #1 continued to provide a bath using a soapy washcloth and drying with a towel, and Resident #6 stated, "I think I'm going to have a bowel movement." NA #1 replied, "Can I finish the bath?" NA #1 did not offer the bedpan, a bedside commode, or assistance to the bathroom and continued to bathe Resident #6. After NA #1 had completed the bath and had applied a clean brief, Resident #6 stated, "I had a bowel movement." NA #1 then provided incontinence care and applied another clean brief. NA #1 asked Resident #6, "What are you putting on?" Resident #6 stated, "blue jeans and a t-shirt." NA #6 got a pair of blue sweatpants and a sweatshirt from Resident #6's drawer and then assisted Resident #6 with dressing.</p> <p>In an interview with NA #1 after the bath on 08/23/2018 at 8:33 AM, she stated that routinely she assisted Resident #6 with getting to the bathroom, with bathing, and with reminding her to call for help with transfers. NA #1 also stated she selected the sweatpants for Resident #6 to wear because she (Resident #6) could more easily participate in her care by pulling them up. NA #1 added she did not think she was rushing through the bath, and she did not think to offer the bedpan when Resident #6 stated she needed to have a bowel movement.</p> <p>Resident #6 stated in an interview on 08/23/2018 at 9:15 AM that she felt as though she was being</p> | F 557   | <p>#1 provide a bath to a dependent resident on 8/23/18 to validate at bedside that she treated resident with dignity and respect.</p> <p>The Administrator met with the resident on 8/23/18 and the resident indicated to the Administrator that she felt safe in the facility and did not feel that she had been abused or neglected. Administrator informed resident to reach out to her if she had any concerns related to not being treated with dignity and respect or to the social worker.</p> <p>Residents with a BIMS score of 8 or greater will be educated on a Resident Right to be treated with consideration, respect, and full recognition of personal dignity and individuality. They will also be educated on the grievance process by 9/14/18 by the Activities Director or Social worker or Administrator.</p> <p>Staff education was started on 8/23/18 for current licensed nurses and nurse assistants by the District Director of Clinical services, Administrator and Assistant Director of nursing on treating residents with dignity and respect to include resident choice, offering of bathroom assistance if indicated and to do so in a compassionate manner. This education will be ongoing for licensed nurses and nurses assistants and completed by 9/14/18. Education on Residents rights related to dignity and respect will be part of the general orientation for newly hired licensed nurses and nursing assistants.</p> |                      |   |

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| F 557  | Continued From page 2<br>handled like baggage and that she was viewed as a job to get done. Resident #6 stated she would have used the bedpan if it had been offered to her. Resident #6 stated the staff had no feelings and were "cold" when they provided care.<br><br>In an interview with the administrator on 08/23/2018 at 10:50 AM, she stated she had spoken with Resident #6 after her bath that morning and that she sent the Social Worker in to talk with her about her bathing experience. The Administrator stated she encouraged Resident #6 to report any time she was not treated with respect. She added that in-service education regarding providing care with dignity and respect was started for NA #1 and additional staff that morning after she became aware of the problems during Resident #6's bath. | F 557   | The Social worker or Administrator will visit with Resident #6 weekly to provide support and follow up related to being treated with dignity and respect x one month and then monthly for 2 months.<br><br>The Assistant Director of Nursing or Director of Nursing will do random observations of ADL care of a resident that requires assistance weekly for one month and monthly for 2 months to evaluate if resident is treated with dignity and respect to include choice, bathroom assistance and compassionate care.<br><br>The Director of Nursing and Assistant Director of nursing are responsible for implementing the plan of correction by September 14, 2018. |                      |   |
| F 677<br>SS=D  | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based upon observation, record review, and staff interviews, the facility failed to rinse soap during a bath for 1 of 4 residents reviewed who required extensive to total assistance with activities of daily living, Resident #6. The findings included:<br><br>Resident #6 was admitted to the facility on 11/24/2017 with diagnoses which included  | F 677   | F677 ADL Care Provided for Dependent Residents<br><br>NA #1 failed to rinse soap off of resident during a bath for Resident #6 on 8/23/18.<br><br>NA #1 was removed from her assignment when the Administrator was informed of  | 9/14/18              |   |

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| F 677  | <p>Continued From page 3</p> <p>hypertension, diabetes mellitus, depression, and others.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated 07/20/2018 revealed Resident #6 was totally dependent upon one staff person for bathing and she was moderately cognitively impaired</p> <p>Resident #6's nursing care plan initiated on 11/24/2017 and last revised on 05/03/2018 included a goal and interventions to address her need for total assistance with bathing. In addition, there were interventions in place to address her urinary incontinence related to a history of urinary tract infections. One of the interventions in place was to check Resident #6 for incontinence, and wash, rinse, and dry the perineum.</p> <p>An observation of a bath provided by Nursing Assistant (NA) #1 for Resident #6 was made on 08/23/2018 at 8:05 AM. NA #1 drew a basin of warm water, and gathered [Brand Name] shampoo/body wash, a wash cloth, and a towel. (Directions on the shampoo/body wash bottle specified, "Rinse thoroughly.") NA #1 poured the shampoo/body wash into the water, and placed a washcloth into the soapy water. NA #1 used the soapy washcloth to wash Resident #6's lower legs, and then dry her legs with a towel. NA #1 continued to provide the remaining bath using a soapy washcloth, including the perineum. Slight redness was noted on Resident #6's perineal area and gluteal folds when NA #1 provided the perineal care with the soapy washcloth. NA #1 did not rinse the perineal area or any other parts of Resident #6's body during the bath.</p> | F 677   | <p>the surveyor observations on 8/23/18. The Assistant Director of Nursing and Director of Nursing reviewed the concerns related to the observation of care and services provided when she was bathing #6 with NA#1 on 8/23/18.</p> <p>NA #1 was provided 1:1 education on rinsing the resident off after applying soap during a bath by the Assistant Director of Nursing and the Director of Nursing on 8/23/18.</p> <p>The Director of Nursing observed NA #1 provided a bath to a dependent resident on 8/23/18 to validate at bedside that NA #1 rinsed the soap off of the resident.</p> <p>Staff education was started on 8/23/18 for current licensed nurses and nurses assistants by the District Director of Clinical services, Administrator and Assistant Director of nursing on rinsing soap off of a resident during a bath. This education will be ongoing for licensed nurses and nurses assistants and completed by 9/14/18. Education related to rinsing soap off of a resident during ADL care will be part of general orientation.</p> <p>The Assistant Director of Nursing or Director of Nursing will do random observations of ADL care of a resident that requires assistance weekly for one month and monthly for 2 months to ensure the soap is rinsed off of the resident during the bath.</p> |                      |   |

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| F 677  | <p>Continued From page 4</p> <p>In an interview with NA #1 after the bath on 08/23/2018 at 8:33 AM, she stated that routinely she assisted Resident #6 with bathing when she was assigned to care for her. NA #1 also stated she did not realize the type of shampoo/body wash she was using required rinsing. NA #1 also stated she was planning to provide Resident #6 with a thick cream to address the redness in her perineal and buttocks area.</p> <p>In an interview with the administrator on 08/23/2018 at 10:50 AM, she stated she had spoken with Resident #6 after her bath that morning about her bathing experience. The Administrator added that in-service education regarding bathing was started for NA #1 and for additional staff that morning after she became aware of the lack of rinsing soap during Resident #6's bath.</p> | F 677   | The Director of Nursing and Assistant Director of nursing are responsible for implementing the plan of correction by September 14, 2018. |                      |   |