STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 08/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to deliver medication in the time requested by the resident for 1 of 3 sampled residents (Resident #111) and failed to address the resident by the preferred name for 1 of 3 residents (Resident #111) reviewed for dignity and respect. Findings included: Resident #111 was admitted on 7/6/15 with diagnoses that included diabetes, congestive heart failure and kidney disease. The Admission Minimum Data Set (MDS) for Resident #111, dated 7/13/15, indicated she was cognitively intact and had no behaviors. Review of the grievance logs for July and August 2015 revealed there were no grievances filed on behalf of Resident #111. On 8/11/15 at 2:58 PM, Nurse #1 stated Resident #111 was being discharged home. The nurse added Resident #111 was alert and oriented. She had received no concerns regarding staff interactions from the resident. During an interview with Resident #111 on 8/11/15 at 3:03 PM, she stated during her stay she had problems with only one nurse. The resident stated she rang her call bell to request a pain medication. The resident was unsure of the date or time, but knew it was on the 11:00 PM to 7:00 AM shift. The nursing assistant (NA) came into	F 241	Resident #111 discharged from the facility on August 11, 2105. Resident #111 was called and interviewed by the director of nursing on 8/17/15 and 8/24/15 regarding actions taken during her stay in the facility to ensure this allegation had been addressed to her satisfaction. Resident #111 was satisfied with the resolutions of the event. The nurse who was alleged to have violated the dignity/respect of the resident was telephoned at home. She denied the allegation, but she also refused to return to the facility. She resigned via email. All residents have the potential to be affected when dignity and respect are not protected. Accordingly, Eastern AHEC will provide a two hour in-service training in the facility on September 2, 2015 on Dignity and Respect. All staff (licensed nurses, CNA, housekeeping, laundry, therapy and department heads) will be directed to attend this mandatory in-service. Video taping of this in-service will also occur for viewing by staff and all new hires. Facility staff that are unable to attend will receive education via video prior to scheduled shift. Facility newly	9/2/15

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

Electronically Signed | 08/21/2015

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F 241	Continued From page 1 her room and told the resident she would tell the nurse she had requested pain medication. Resident #111 stated the NA returned to the room and reported she had reported the request for pain medication to the nurse. Resident #111 stated she waited and waited and the nurse did not deliver the pain medication. Resident #111 stated she rang the call bell again, the NA answered the call bell and reported the nurse would be there shortly. Resident #111 stated she waited again. She added the pain got worse, so she started screaming. At this point, Resident #111 stated Nurse #2 came in and told her she did not know why she, the resident, was screaming like an idiot. The resident added the nurse told her she had pains in her legs, but she was still working and was not screaming. Resident #111 added when Nurse #2 walked out of the room she stated she was " tired of this " and could not stand it. Resident #111 added she could not remember the NA ' s name and could not remember when the incident occurred, other than it was during the 11 to 7 shift. She stated she did not know the nurse's name but was able to physically describe the nurse. Resident #111 stated Nurse #2 really hurt her feelings and humiliated her when she called her an idiot. The resident added she had reported the incident to the Director of Nursing (DON). She added the DON handled the issue because she had not seen the nurse again. The resident stated she had not asked a lot of staff, but added the pain was so bad that night it woke her up out of her sleep. Review of the grievance log revealed there had been no concerns logged for Resident #111. NA #1 was interviewed on 8/12/15 at 7:00 AM. The NA stated she worked at times with Resident #111 on the 11 to 7 shift. She stated Resident	F 241	hired staff will receive the education during orientation. Facility concerns regarding dignity and respect will be addressed and followed up on by the administrator. The Administrator, DON or Social worker will interview 4 cognitive residents per week times four weeks and then monthly times 3 months to validate that staff are treating residents with dignity and respect. These interviews will be documented on the respect interview form. On 8-12-15, NA #3 was in-serviced by the DON regarding the reporting concerns related to dignity and respect. In-servicing also began on 8/12/15 with Department Heads, licensed nurses, CNA, therapy, housekeeping and dietary regarding residents' rights related to dignity and respect. The re- education included right to privacy, handling residents gently, encouraging residents to assist you, residents' right to choose their own schedule for personal care, and good communication. Four alert and oriented residents were interviewed by the director of nursing on 8/20/15 regarding dignity and respect and no other issues were found. On 8/26/15, and additional 4 alert and oriented residents were interviewed by the social worker regarding dignity and respect, and no other issues were found. Any concerns regarding possible issues with dignity and respect will be reported to the Administrator and progressive disciplinary actions will be taken as	

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F 241	Continued From page 2 #111 was alert and oriented. She described the resident as nice and easy to get along with. The NA stated there was one nurse on the 11 to 7 shift that was loud and did not talk very nice to people. She stated while the nurse may not mean for her tone to be rude, it sounded rude to her. She stated she was unaware Resident #111 had problems with nursing staff. NA #2 was interviewed on 8/12/15 at 7:10 AM. The NA stated she rotated assignments and worked with Resident #111 at times. The NA stated Resident #111 was alert and oriented. The NA stated she was unaware Resident #111 had problems with anyone from the nursing staff. On 8/12/15 at 7:25 AM, NA #3 was interviewed. NA #3 worked with Resident #111 on the 11 to 7 shift. She stated she had heard the resident state someone had spoken rudely to her and would not bring pain medication. The NA added she was not in the room at the time and did not want to say anything more. She added she would talk to the DON and discuss the issue with her. The DON and Administrator were interviewed on 8/12/15 at 7:59 AM. After sharing the concern about NA #3 with the DON, she and the Administrator had a conference call with NA #3. The DON and Administrator reported NA #3 had told them, while she was not in the room, she overheard Nurse #2 talking rudely to Resident #111. According to the DON, NA #3 stated when Nurse #2 took the pain medication to the resident's room, the nurse told her, "here's your pain medication so now you can quit screaming like an idiot." The DON stated Resident #111 had reported to her after she and Nurse #2 had their altercation about the pain medication, adding Resident #111 had not told her Nurse #2 had called her an idiot. The DON stated she had identified the date as 7/23/15, using the nursing	F 241	warranted. Additional education will be provided to staff as needed by the facility Administrator or the Staff Development Coordinator. The facility Administrator will report results of the interviews weekly at Interdisciplinary Team stand up meeting and the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly times three months. Additional interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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F 241	Continued From page 3 schedule, to determine that was when Nurse #2 had worked with Resident #111. The DON stated at that time she removed Nurse #2 from the resident's assignment. The Administrator stated while the NA may not have considered it abuse, he would have expected the NAs to complete a concern form or call the DON or him regarding the events of the night. After speaking with NA #3, the DON stated she had called Nurse #2 to ask her to come in for a conference to discuss the 7/23/15 interaction she had with Resident #111. The DON reported Nurse #2 had refused to come into the facility and had denied Resident 111 ' s allegations she had called her an idiot. The DON added Nurse #2 stated she would not be returning to the facility. Nurse #2 would not answer the phone or return calls when attempted by the surveyor.	F 241		