

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Bryan Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews with the resident and staff, the facility failed to ensure a dependent resident could access a call bell that was out of reach for 1 of 21 residents reviewed for accommodation of needs (Resident #16). Findings included: Resident #16 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was severely cognitively impaired and needed assistance with activities of daily living. During an observation on 6/15/2026 at 11:26 a.m., and at 11:31 a.m. Resident #16 was observed sleeping and the call bell button was clipped to the call cord and hanging from the outlet on the wall, away from Resident #16's reach. In an interview with Resident #16 on 6/15/2026 at 11:32 a.m. she stated she was sleeping and did not know who moved the call bell button from her side and clipped it to the call cord. Resident #16 stated she could not reach the call bell button where it was currently placed. During an interview with Nurse Aide (NA#1) on 6/15/2026 at 11:33 a.m. she stated that she did not know who clipped the call bell button to call cord on the wall and out of reach for Resident #1. NA#1 stated that she had a rough morning with Resident #1 who was resisting care and focused on the resident hence not noticing that the call bell was out of reach for Resident #16. NA#1 revealed that Resident #16 does use the call bell to ask for help. NA #1 placed the call bell on the bed to where Resident #16 could reach it. In a telephone interview with Nurse #1 on 6/16/2026 at 10:26 a.m. she revealed she was Resident #16's nurse on 6/15/2026 during the first shift and was not aware that the call bell was out of reach. She stated that she remembers Resident #16 was difficult in the morning not agreeing to be changed as she was soiled, and NA#1 had come to her seeking help with the resident. Nurse #1 stated that she accompanied NA#1 to Resident #16's room and focused on getting Resident #16 up and did not notice the call bell button was clipped to the call cord and hanging from the wall. Nurse #1 stated that the call bell button is supposed to be placed where Resident #16 would access it. During an interview conducted on 6/16/2026 at 1:28 p.m., the Director of Nursing (DON) revealed she was not sure why Resident #16's call bell was out of reach. She stated that Resident #16 can walk to the nursing station if she needs something. The DON stated that she expected the call bell to be placed where a resident would reach it if they wanted to use the call bell. An interview was conducted with the Administrator on 6/17/2026 at 11:04 a.m. The Administrator stated that she expected nursing staff to have the call bells placed within reach of the residents.		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, the facility failed to ensure the resident call light system was functioning properly for 1of 21 residents observed for resident call system (Resident #16). Findings included:Resident #16 was admitted to the facility on [DATE] with diagnoses that included depression, dementia and facial weakness.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was severely cognitively impaired and needed assistance with activities of daily living. An observation of Resident #16's call light was conducted on 6/15/2026 at 11:26 a.m. and at 11:31 a.m. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.In an interview with Resident #16 on 6/15/2026 at 11:32 a.m. she stated she sometimes does use the call bell and was not aware that it was not working. Resident #16 used the call bell at the time, but the call light did not come on.During an interview with Nurse Aide (NA#1) on 6/15/2026 at 11:33 a.m. she stated that she was not aware the call bell was not working. NA#1 further revealed that if she had observed a non-working call bell she would report immediately to the maintenance manager. In a telephone interview with Nurse #1 on 6/16/2026 at 10:26 a.m. she revealed she was Resident #16's nurse on 6/15/2026 during the first shift and stated that she was not aware the call bell was not working until NA#1 alerted her and they replaced it with a new one.An interview was conducted with the Environmental Services Director (ESD) on 6/16/2026 at 1:04 p.m. He stated that he conducts monthly checks on all call bells in all rooms and was surprised that Resident #16's call bell was not working. He further stated that he had done call bell audits for the month of June. The ESD stated that nursing staff would report to him if a call bell was not working and he would replace as they had enough replacements in stock. During an interview conducted on 6/16/2026 at 1:28 p.m., the Director of Nursing (DON) revealed she was not sure why Resident #16's call bell was not working. She revealed that call bell audits are done monthly to make sure they are working. She stated that she always expects the call bell light to be working.An interview was conducted with the Administrator on 6/17/2026 at 11:04 a.m. The Administrator stated that the facility conducts monthly call bell checks to make sure they are working properly. She further stated that she is not sure if staff knew the call bell was not working and sometimes things do happen.		