| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345266 | A. BUILDING _____ B. WING _____ | C 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROANOKE LANDING NURSING AND REHABILITATION CENTER | 1084 US 64 EAST PLYMOUTH, NC 27962 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation survey of 7/24/14. Event ID# 2KC611. | F 000 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record reviews, resident and staff interviews, the facility staff failed to prevent exposure for 1 of 1 resident prior to shower, Resident #41.<br><br>The findings included:<br><br>Resident #41 diagnoses included muscle weakness and lack of coordination. Resident #41's last Minimum Data Set (MDS) was dated 6/13/2014 and indicated Resident #41's cognition was moderately impaired. Resident #41 needed extensive assistance with Activities of Daily Living (ADL's).<br><br>A review of Resident #41's Interdisciplinary Care Plan facility form dated 6/17/14 revealed that identified 'Focus Areas' included, Assistance for Dressing and Bathing related to debility.<br><br>On 7/22/14 at 5:15 pm an observation of Resident #41 revealed her door was half way open and Resident #41 was viewable from the | F 241 | Roanoke Landing Nursing and Rehab acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance.<br><br>The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Roanoke Landing. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.<br><br>Resident #41 was redraped to prevent exposure by the nurse on the hall at the | 8/21/14 |

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

Electronically Signed | 08/11/2014

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| F 241 | Continued From page 1<br>hallway. Resident #41 was seated in a shower chair with a flat sheet in her lap below her waist and breast exposed. Resident #41 was attempting to lift the sheet with her fingers, her hands and arms were shaking and unsteady. When Resident #41 looked up, she made eye contact with the observer and immediately put her arms up towards her chest. Her arms were shaking. Resident #41 was alone in the room.<br><br>On 7/22/14 at 5:16 pm Nurse #1 asked Nurse Assistant (NA) #1 to come with her to Resident #41's room. Nurse #1 and NA #1 entered Resident #41's room and immediately covered her torso and shoulders. Nurse #1 asked NA #1 who Resident #41's NA was for this evening. NA #1 stated NA #2 was assigned to Resident #41. At Nurse #1's directions, NA #1 left the room to find NA #2. Resident #41 remained in the shower chair, was covered and appeared less shaky, but still upset. Nurse #1 talked with Resident #41 in an attempt to comfort her. NA #2 arrived at 5:20 pm, entered the room and shut the door.<br>NA #3, assigned to the 'Shower Team', entered Resident #41's room at 5:25 pm and came out of the room at 5:30 pm with Resident #41 whom was fully covered with a sheet over the front of her body and a fleece wrap over her shoulders and the back of her body. Resident<br>#41 appeared calm at this time. NA #3 rolled Resident #41 to the shower room for her shower.<br><br>On 7/22/14 at 5:35 pm an interview with NA #2, assigned to Resident #41's care, revealed that she had prepared Resident #41 for her shower, covered her up with a sheet and left the room to get another resident ready for a shower. NA #2 stated that "I thought the Shower Team NA was coming right away to get her so I left her to go to | F 241 | time<br><br>8-1-2014<br><br>All nursing staff inservices to prevent exposure of resident during and after shower times.<br><br>8-1-2014<br><br>Halls on which showers are being done will be audited by administrative nurses to prevent further exposure weekly x 2 months then quarterly x4 using QI tool.<br><br>Results of these audits will be forwarded to Executive QI committee with follow up action as deemed necessary<br><br>8-21-2014 | |

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| F 241 | Continued From page 2<br>another resident. I should not have left her there. I did not leave her unwrapped. I should not have left her alone."<br><br>On 7/22/14 at 5:45 pm an interview with Nurse #1 indicated that when a resident is prepared for a shower, she expected the NA assigned to that resident to fully cover the residents and to stay with the resident until the Shower Team NA takes the resident to the shower room.<br><br>On 7/22/14 at 5:55 pm an interview with the Administrator and DON revealed that their expectation of any resident being prepared for a shower would be that the resident would be fully and securely covered and not left alone in a their room in a shower chair. The DON stated "It is standard policy that residents are not left alone in shower chairs and that they are not exposed." The DON indicated that all NA's would be re-educated on resident dignity, shower preparation and safety expectations of the facility.<br><br>On 7/23/14 at 2:45 pm an interview with NA #4 who was assigned to Resident #41 at this time, revealed that is was standard practice for NA's preparing a resident for a shower to get them up to the shower chair, make sure they are fully covered and wait with the resident until the shower team aide comes to get them or either to escort the resident to the shower room if the shower team is ready to receive the resident. NA #4 stated "We have to communicate with each other to make sure the patient is up to the shower chair in time for a shower and that they are not waiting too long in the shower chair. That is what I do with Resident #41 as well." NA #4 indicated that she and other NA's were re-educated today by the DON about resident dignity, and shower | F 241 | | |

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| F 241 | Continued From page 3 | F 241 | | |

preparation expectations which included, securely covering the resident for transportation to the shower room and not leaving the resident alone in the shower chair.

On 7/23/14 at 2:50 pm an interview with Resident #41 revealed she was exposed prior to her shower the day before. Resident #41 grimaced and stated "Yes, I remember last night before my shower when the sheet came off of me and my whole top (chest) was exposed. I was trying to get the sheet back up on me, but my hands do not work well. The aide usually covers me up better than that, it was just a sheet laid over me last night and it was not tied in the back by that NA like it usually is done. It made me nervous and upset to be sitting there with my breast exposed and someone seeing me like that."

On 7/23/14 at 2:58 pm an interview was conducted with NA#3 who worked primarily on the Shower Team. NA#3 stated "I remember Resident #41 last night. I took her to the shower right after the incident happened, she was upset and a little shaky. I asked if she was okay to get her shower and she said yes but that it had upset her to be sitting in the chair and her breast exposed and someone seeing her. We talked a few minutes before her shower, I mostly listened, she was not upset after she talked about it and she seemed to be relaxed when she got her shower. She asked me to check on her again before I left last night. I checked on her before I left and she said she was okay." NA#3 indicated that NA's are expected to fully cover residents with a shower gown. If a shower gown is not available an NA could use a sheet for the front cover and a heavier cover, like a blanket, for the back. NA's should make sure that residents are

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| F 241 | Continued From page 4<br>covered securely, monitored and never left alone. | F 241 | | |