STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	C 12/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(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 record review, observations and staff interviews, the facility failed to serve 2 of 16 residents sitting at the same dining table(s) concurrently at each table. Residents #6, Resident #13. Findings included: 1. On 12/05/15 from 12:00pm until 1:00pm, observations of 16 residents served meal trays in the locked unit dining room revealed: a.) Table 2 - Resident #4 and #5 were served their meal trays consecutively at 12:05pm and began eating independently. Resident #6 seated at the same table watched residents #4 and #5 eating their meals. Resident #6 facial expression changed from a flat affect to frowning and burrowed forehead. Resident #6 used her left arm to motion towards resident #5s tray by shaking her arm towards the tray and asked loudly " How come I ain ' t got none?. "The charge nurse (Nurse#1), who was observing the meal tray pass turned towards Resident #6, retrieved her tray from the food cart, approached the table with resident #6s tray and stated "I have it right here." Nurse #1 cut up the meat on the tray, resident #6 was now speaking in a loud voice and appeared agitated. Resident #6 started repeating loudly, " I have to go feed him, this is his food, that boy needs to eat it, well why don't you eat it." Resident #6 did not eat the meal.	F 241	Submission of the response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 241 DIGNITY AND RESPECT OF INDIVIDUALITY Criteria #1- Resident #6 declined to eat meal on first attempt. Her tray was reoffered and she consumed 50% of her meal. Resident #13 was served a meal tray and was fed by staff. 12/05/15 Criteria #2- All residents have the potential to be affected by this alleged deficient practice, therefore,all residents were viewed by the Director of Nursing and Assistant Director of Nursing,on alternate shifts, at alternate meals to include breakfast, lunch and supper to ensure that	12/31/15

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

Electronically Signed | 01/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	C 12/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(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	Continued From page 1 b.) Table 5 - Resident #14 and #15 were served their meal trays at 12:07pm and ate independently. At 12:27pm, resident # 13 seated at the same table reached for a tray that had been finished by resident #14. Resident #13 who was non-verbal, made 3 attempts to reach for the tray and was successful in pulling it towards her on the third attempt. When Resident #13 had the meal try, she began to reach for food on the tray. NA #2, who was in proximity noticed and removed the tray from resident #13's reach, the tray remained on the table. Resident #13 attempted to reach the tray two more times while NA#1 and NA #2 served other residents. NA#1 delivered Resident #13 meal tray at 12:33pm and assisted Resident #13 to eat the meal by feeding her. Attempted interviews with all residents attending the lunch dining meal revealed that no residents were interviewable. On 12/05/15 at 1:30pm, an interview conducted with NA #1 indicated at meal time NAs take residents to a vacant dining table, tables were not assigned and all residents ' were assembled in the dining area prior to food trays being served. NA #1 indicated residents that needed total assistance to eat were sometimes at the same table but not always. NA #1 indicated residents' who needed to be feed were served last because that is when the NAs had completed serving all other residents and were free to sit down with the resident that needed to be feed. NA #1 revealed that Resident #13 needed to be fed by an NA and is served last or next to last after all other meal trays have been delivered and set-up. NA #1 was unsure of why Resident #13 was at a table with 2 other residents that could eat independently and had finished their meals while Resident #13 watched. NA #1 indicated that each table ' s residents should be offered their meal trays at the	F 241	meal trays were served and residents were fed in such a manner as to maintain the resident's dignity and respect. 12/07/15 Criteria #3- In-service was provided to all Nurses and Nursing Assistants by Director of Nursing,Assistant Director of Nursing and Staff Development Coordinator regarding dignity in relation to dining. Dignity Related To Dining Post Test was issued and completed by all Nursing Staff. One-hundred percent pass rate was required. Retesting was completed if the required pass rate was not achieved. Staff that has not been in-serviced by the compliance date will be removed from the schedule until the required in-servicing is obtained. 12/31/15 Criteria #4- Observation of 2 breakfasts, 2 lunches and 2 Suppers will be completed weekly for six weeks, then every two weeks for two months and monthly for two months to ensure that dignity is maintained. These observations will be conducted by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or RN Supervisor. The auditor will record the results on the Dignity and Respect of Individuality Meal Observation audit tool. Education will be given with any concerns identified. The Director of Nursing will incorporate the Plan of Correction into the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	C 12/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(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	Continued From page 2 same time so they would not have to watch others eat. On 12/05/15 at 1:40pm, an interview was conducted with NA #2 indicated residents typically sit at the same table daily, but not always. NA #2 indicated residents that are totally assisted to eat are served last because NAs were busy serving other resident tables. Residents that needed total assistance to eat should be at the same table so that they can all be served at the same time. NA #2 indicated it was important to serve residents sitting at a table together at the same time and no resident should have to watch another resident complete their meal when they did not have a meal of their own. On 12/05/15 at 2:00pm, an interview was conducted with the locked unit charge nurse. The charge nurse (CN) indicated all residents are placed in the dining room prior to the 12:00 pm meal time. The CN indicated she observed Resident #6 get agitated when the resident noticed she did not have a meal tray when other residents at the same table were eating their meals. The CN revealed she then retrieved Resident #6 meal tray and encouraged her to eat. The CN indicated residents who could eat their meals independently were typically served first, followed by the residents who needed assistance with preparing their meal to eat and then residents who needed total assistance to eat were served last related to the need for a one-on-one NA to assist them to eat their meals. The CN indicated she was not present when Resident #13 reached for another resident ' s tray. The CN indicated a resolution may be residents who needed total assistance to eat should be at the same table together in order to serve them and assist to feed them concurrently. The exception would be if behaviors were evident	F 241	facility's monthly QAA meeting to evaluate effectiveness and compliance. 12/31/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	C 12/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	911 WESTERN BOULEVARD TARBORO, NC 27886

(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	Continued From page 3 and residents needed to be separated. On 12/05/15 at 2:25pm, an interview was conducted with the weekend nurse supervisor (NS) who indicated she made rounds throughout the facility including the locked unit. The NS indicated residents in the locked unit have one scheduled meal time for lunch at 12:00pm; all residents are brought into the dining area prior to 12:00pm and placed at tables which can accommodate 4 residents per table. The NS revealed she was unsure if residents had assigned seating. The NS indicated residents that required total assistance to eat in the unlocked main dining room were served last, sat at one long table together and were fed at the same time. The NS indicated she thought the same dining plan was in place for residents that needed assistance to eat in the locked unit On 12/05/15 at 2:45 pm, an interview was conducted with the Director of Nursing (DON) who indicated the seating of residents in the locked unit needed improvement in order to serve residents sitting at the same dining table(s) concurrently. The DON indicated residents that needed assistance to eat could benefit from seating at the same table so they could be served and fed at the same time. The DON indicated a resident should not have to watch another resident eat a meal when they do not have a meal of their own.	F 241		