

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

PRINTED: 05/08/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2019
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573		
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F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the</p>	F 550		4/22/19	

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

TITLE

(X6) DATE

Electronically Signed

04/14/2019

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 550	<p>Continued From page 1</p> <p>exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident, staff, and family interview the facility failed to provide care in a dignified manner for 2 (Resident's #3 and #7) of 5 dependent care residents reviewed for provision of care. Resident #3 was left wet and Resident #7 had staffing concerns discussed in front of her while she was in bed. Findings included:</p> <p>1. Resident #3 had diagnoses of Alzheimer's disease, diabetes mellitus, legal blindness, and a pressure ulcer in the sacral region.</p> <p>Documentation on the most recent quarterly minimum data set assessment dated 3/14/19 coded Resident #3 as severely cognitively impaired and requiring extensive to total assistance with all activities of daily living. Resident #3 was also coded as always incontinent of bowel and bladder with one unstageable pressure ulcer.</p> <p>The documentation in the care plan for Resident #3, last reviewed on 6/12/19, had a problem area for "a self-care deficit related to decreased mobility, generalized weakness, Advanced Alzheimer's disease and continued mental and physical decline. Resident has been picked up by Hospice services." Some of the interventions were to provide incontinent care as needed and provide dignity at all times.</p> <p>An interview was conducted with a family member of Resident #3 on 3/30/19 at 12:00 PM. The family member related that she came into the</p>	F 550	<p>Resident #3 will be checked at the beginning and end of each shift 3x/week for 4 weeks by a member of the nursing management staff, or as designated by the Director of Nursing, to assess for incontinence and to ensure care is provided in a dignified manner. The family of resident #3 will be educated that if there are any concerns about the resident being wet, they should immediately notify the Director of Nursing or Administrator, regardless of the day of the week or the time of the day.</p> <p>The Social Worker will offer counseling services to resident #7 and maintain services as requested by the resident. The staff members working with the resident will be educated on Resident Rights and treating residents with respect and dignity, in particular -- not discussing subjects that could cause the resident to feel distressed. The nurse aide who was involved in the incident referenced is no longer employed at our facility.</p> <p>The facility will interview alert and oriented residents to determine if they feel they are being left wet for an unreasonable amount of time. The facility will also review the grievance log to determine which families have expressed concern over their loved one being left wet.</p> <p>The facility will interview alert and oriented</p>		

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F 550	<p>Continued From page 2</p> <p>room of Resident #3 at lunch time on 3/17/19 and found her mother starting to change the incontinence brief of Resident #3. She said that at that time she observed the incontinence brief to be very full and heavy with urine and some dried feces. She stated that a dried ring of urine was on the pad underneath the resident. She stated that the bandage covering the pressure sore had come off because it was so wet. The family member immediately went to get help to clean up Resident #3. She said she found a nurse aide who told her she would be there as soon as she could.</p> <p>An interview was conducted with another family member of Resident #3 on 3/30/19 at 1:59 PM. This family member stated she came to the facility around 11:00 AM or 11:30 AM on 3/17/19. She stated she found Resident #3 in a very full, wet, and "dirty" incontinence brief. The family member stated the incontinence brief and the resident had a strong smell of urine and there were dried rings on the pad underneath him. She stated she could not find the aide for Resident #3 so she started to clean up Resident #3 herself. She stated that her daughter arrived and went to get help. She stated the nurse aide did come in and clean up the resident and changed the pad but did not have time to change the bedding which still smelled.</p> <p>NA #2 was interviewed via the telephone on 3/30/19 at 11:58 AM. NA #2 stated she only worked at the facility for 4 hours on 3/17/19 and she started at 11:00 AM. She stated the family wanted Resident #3 changed, dressed, and out of bed. NA #2 stated when she arrived at the facility, two nurse aides were in the back halls of the facility. NA #2 stated she told the family she</p>	F 550	<p>residents to determine if staff are discussing facility concerns in front of them. We will also review the grievance log to determine if families have expressed similar concerns.</p> <p>Facility staff will be in-serviced on Resident Rights and providing care in a dignified manner. They will also be educated as to which topics are not appropriate to discuss in front of the residents as to not cause the residents any undue distress.</p> <p>The nursing management staff will conduct assessments of residents to determine wetness and to ask the alert and oriented residents if they feel they were left wet for an unreasonable amount of time during the shift. This will be done at the beginning and end of each shift -- weekly for each hall for 90 days.</p> <p>The alert and oriented residents will be interviewed weekly for 90 days to determine if staff are having conversations in front of them that relate to facility issues that might cause the resident undue distress.</p> <p>The facility's grievance log will be reviewed by management staff weekly for 90 days to determine if families are expressing concerns regarding residents being left wet and/or staff members discussing inappropriate topics in front of residents.</p> <p>Any issues identified during these checks</p>		

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F 550	<p>Continued From page 3</p> <p>would help and she left to go ask the two other nurse aides what to do. NA #2 stated NA #1 changed the resident and she went in to dress him later. NA #2 stated she left the facility at 3:00 PM on 3/17/19 and she checked on the resident before she left.</p> <p>NA #1 was interviewed on 3/30/19 at 12:32 PM. NA #1 stated she worked on the back halls from 7:00 AM to 3:00 PM on 3/17/19. She said she did provide incontinent care to Resident #3 but he was "not that wet." NA #1 did not recall when the last time the resident was provided incontinent care prior to the family's request for the resident to be changed. NA #1 stated, "I try to keep him dry. It was impossible. I mean impossible that day. A lot of people didn't get done. I had to prioritize."</p> <p>An interview was conducted with the Director of Nursing on 3/30/19 at 1:48 PM. She stated she was not aware of the circumstances on 3/17/19 regarding Resident #3. She stated that the third nurse aide working with NA #2 and NA #1 was not available for interview due to being out on medical leave.</p> <p>An interview was conducted the facility Administrator on 3/31/19 at 12:00 PM. The Administrator stated that the resident might have been left wet but nobody called him, the Director of Nursing, or the unit supervisor.</p> <p>An additional interview was conducted with the Administrator on 4/1/19 at 11:18 AM during which he provided the information the facility had a census of 116 residents with 55 residents residing on the 400, 500, and 600 halls on 3/17/19. NA #1 was caring for approximately 27 residents from</p>	F 550	<p>will be addressed with direct-care and nursing management staff promptly.</p> <p>All issues identified will be presented, monthly for 90 days, to the QAA Committee, to determine the effectiveness of this Plan of Correction and to make any changes to the plan if needed.</p>		

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F 550	<p>Continued From page 4</p> <p>7:00 AM to 11:00 AM, prior to the arrival of NA #2.</p> <p>2. Resident #7 had a diagnosis of a neurological disorder.</p> <p>Documentation on an Admission minimum data set assessment dated 1/21/19 coded Resident #7 as cognitively intact and requiring extensive to total assistance with all activities of daily living except for eating. Resident #7 was coded as incontinent of bowel and had a urinary catheter. Resident #7 was coded as having range of motion impairment on both sides.</p> <p>Documentation on the care plan for Resident #7 revealed the resident required total care for all activities of daily living except for eating and was able to make her wishes known. One of the interventions was to protect dignity during activity of daily living care.</p> <p>An interview was conducted with Resident #7 on 3/30/19 at 3:30 PM when a nurse aide (NA #3) entered the resident's room. NA #3 stated to Resident #7, "We only have three people on tonight. You know what kind of a night it is gonna be." NA #3 and Resident #7 discussed the difficulty in trying to care for everyone with only three nurse aides. NA #3 left the room. Soon after, NA #4 entered the room of Resident #7 inquiring of the surveyor what the ratio of nurse aides to residents needed to be. NA #4 explained she was assigned to care for 20 people for the 3:00 PM to 11:00 PM shift. She also indicated, to the surveyor and Resident #7, she received a text from another nurse aide the night before stating an intention to quit the job if the increased work load continued. NA #4 left the room. Resident #7 was asked if it bothered her that the nurse aides</p>	F 550			

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F 550	Continued From page 5 came in the room discussing inadequate staffing. Resident #7 stated, "It just hurts. It is just sad." Resident #7 explained she was concerned about the residents who could not speak or express their care needs after listening to the nurse aides talk in her room. An interview was conducted with the Director of Nursing and the Administrator on 3/31/19 at 12:00 PM. The Director of Nursing explained Resident #7 was a former nurse aide who worked at the facility. The Administrator explained he felt the relationship between Resident #7 and the nurse aides was friendlier than professional but agreed conversations about staffing should not be held in front of the resident.	F 550			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interview the facility failed to accommodate a resident's preference for showers for one (Resident #7) of three residents reviewed for accommodation of needs. Findings included: Resident #7 had a diagnosis of a neurological disorder. Documentation on the most recent admission minimum data set assessment dated 1/21/19	F 558	Resident #7 was showered and was interviewed to confirm her shower preferences -- time, frequency, and type. She was put on a schedule based on her preferences. All residents or resident representatives (where appropriate) were interviewed to confirm their shower preferences -- frequency, times, and type of shower.	4/22/19	

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F 558	<p>Continued From page 6</p> <p>revealed Resident #7 was cognitively intact and required total assistance of two or more people with bathing.</p> <p>Documentation on the care plan dated as last reviewed on 1/22/19 had a problem/need area which stated, "[Resident #7] is able to voice her needs. Stated her preferences during interview." One of the interventions under this problem/need area stated, "[Resident #7] stated her personal care is important to her, prefers showers and it is important to go to bed when she chooses."</p> <p>Documentation on an additional problem/need area stated Resident #7 was total care for all activities of daily living. One of the accommodations stated a mechanical lift with two people to assist was required for all out of bed transfers.</p> <p>Review of the hygiene, bath, and skin check records for Resident #7 revealed she was provided a shower on 3/1/19 and 3/16/19 with the rest of her bathing being bed baths.</p> <p>An interview was conducted with Resident #7 on 3/30/19 at 3:30 PM. Resident #7 stated she was supposed to get a shower on second shift (3:00 PM to 7:00 PM) every Monday, Wednesday, and Friday. Resident #7 stated she can't get a shower anymore. She was told by her nurse aide that the shower bed needed to be reinforced before she could be given a shower. She indicated she had to rely on the nurse aides for bathing but she would love to have a shower if she could.</p> <p>An interview was conducted with NA (nurse aide) #3 on 3/30/19 at 3:36 PM in the shower room. NA #3 indicated she did not think the shower bed could hold the resident without breaking, creating</p>	F 558	<p>The direct-care staff will be in-serviced on accommodation of resident preferences for showers. The shower schedule was updated based on the resident/RP interviews. The Director of Nursing or designated person will review the shower schedule weekly x12 weeks to ensure accuracy with resident stated preferences. The DON will review documentation that showers were given according to stated preferences weekly x12 weeks.</p> <p>The results of the audits will be presented to the Quality Assurance Committee at a minimum of monthly for 3 months and until such time that consistent substantial compliance has been achieved. The QA Committee will assess the Plan of Correction to determine effectiveness and make any changes that may be needed.</p>		

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F 558	Continued From page 7 a safety issue. NA #3 had not yet reported her safety concern to anyone but she intended to notify the maintenance man so the shower bed could be reinforced. An interview was conducted with the Director of Nursing on 3/31/19 at 12:00 PM. The Director of Nursing indicated the shower bed was secure enough to hold Resident #7 and the shower chair could also be used. The Director of Nursing was not aware of any safety concerns with the use of the shower bed for Resident #7.	F 558			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		4/22/19	

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F 656	<p>Continued From page 8</p> <p>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on Record review, observation, resident, and staff interview the facility failed to implement the care plan by transferring a resident with only one person assist when assistance of two people was care planned for one (Resident #5) of 4 residents reviewed for implementation of the care plan. Findings included:</p> <p>Resident # 5 was admitted on 11/9/18 with diagnoses of dementia depression, and anxiety.</p> <p>Documentation on the most recent quarterly minimum data set assessment dated 1/18/19 coded the resident as severely cognitively impaired requiring total assistance of two or more people with transfers.</p> <p>The documentation on the care plan, last reviewed on 11/9/18, revealed a scheduled task for the nurse aides which stated, "Staff X 2 for all</p>	F 656	<p>The care plan of resident #5 was reviewed and transfer status was confirmed with the Rehabilitation Department Director. The direct-care staff working with resident #5 were educated as to her transfer status.</p> <p>The Rehabilitation Director reviewed the transfer status of all residents and worked with the MDS Coordinator to ensure all care plans were updated and accurate.</p> <p>Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinators. All care plans will be updated as indicated. The Director of Nursing or designated person will complete random weekly audits of care plans for six consecutive weeks. Random audits will be completed</p>		

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F 656	<p>Continued From page 9 transfers."</p> <p>An interview was conducted with Resident #12 on 3/29/19 at 1:41 PM. Resident #12 indicated she was concerned about her roommate (Resident #5), who had just received care behind the privacy curtain. Resident #12 indicated that a nurse aide was pulling on her roommate while her roommate was calling out, "Leave me alone." Resident #12 stated the nurse aide was overheard stating she was going to put Resident #5 in the chair and take her to the nurse's station. Resident #12 pointed to the nurse aide (NA #1) as she walked into the room and indicated the nurse aide was who provided care to Resident #5.</p> <p>Documentation on the most recent quarterly minimum data set assessment dated 2/15/19 revealed Resident #12 was coded as cognitively intact.</p> <p>An interview was conducted with NA #1 on 3/29/19 at 1:44 PM. NA #1 revealed she was assigned to care for 18 residents on the morning shift (7:00 AM to 3:00 PM). NA #1 was questioned if she would be able to provide for the care needs of the 18 people she was assigned. NA #1 responded and said, "No." NA #1 stated, "I'm stressed. I haven't eaten lunch. People wanting this, wanting that. I'm stressed."</p> <p>Resident #5 was observed in a reclining chair at the nurse's station on 3/29/19 at 1:53 PM.</p> <p>An interview was conducted with NA #1 on 3/31/19 at 9:04 AM. NA #1 indicated Resident #5 would complain if she was moved or even touched. NA #1 stated she did get Resident #5 up</p>	F 656	<p>to ensure the comprehensive care plans contain accurate and complete information on resident transfer status. Direct-care staff will be in-serviced on the facility's policy on following care plans and safe resident transfers/transfer status.</p> <p>The results of the audits will be presented to the Quality Assurance Committee at a minimum of monthly for 3 months and until such time that consistent substantial compliance has been achieved. The QA Committee will assess the Plan of Correction to determine effectiveness and make any changes that may be needed.</p>		

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NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573		
(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 656	<p>Continued From page 10</p> <p>and into the reclining chair on 3/29/19 and she was "fine." NA #1 revealed she had transferred Resident #5 by herself into the reclining chair. NA #1 indicated she did not require help in lifting Resident #5 because the resident's weight would not hurt the back of NA #1. NA #1 stated, "Why are you asking me?" The care plan requirement of two people for transfers for Resident #5 was explained. NA #1 stated, "I don't need help with her. I just pick her up."</p> <p>An interview was conducted with the facility Director of Nursing and the Administrator on 3/31/19 at 12:00 PM. The Director of Nursing confirmed Resident #5 required two people to transfer her as stated in the care plan. The Administrator expressed concern for the safety of Resident #5 being transferred by one person as opposed to the possible injury to the back of NA #1.</p>	F 656			