STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

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F 557 SS=G	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to treat a resident in a dignified manner, when a Nursing Assistant made disrespectful comments to a resident when providing incontinent care for 1 of 3 residents reviewed for dignity (Resident#2). Resident #2 said the NAs comments made her feel awful, like a dog, or not really like a human being, like she was less than a person or a person without feelings. The findings included: Resident #2 was readmitted to the facility on 9/9/18 and the resident ' s cumulative diagnoses included: Anxiety, depression, chronic pain, lower back pain, and pain in the left and right shoulders. Review of Resident #2 ' s most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/3/20. The resident was coded as having been cognitively intact. The resident was coded as having had no hallucinations or delusions and the resident was coded as requiring extensive assistance of one to two people for all activities of	F 557	1. The corrective action was to suspend the Certified Nursing Assistant on 2-10-20 (the employee no longer works at our facility) and began investigation of allegation by interviewing Resident #2 ensuring her emotional state and that she did feel better. 2. All residents have potential to be affected by this practice. After the State findings the facility did Dignity and Respect interviews on all interviewable residents and there were no further findings. 3. Assistant Director of Nursing will do an All Staff in-service on Resident Rights, Dignity and Respect by March 6th, 2020. Social Services will perform Customer Service/Dignity and Respect interviews on 10 residents 3 x a week for 4 weeks, then 1 x a week for 2 months and then 1 x a month for 3 months. 4. The findings will be reviewed by the Quality Assurance Improvement	3/6/20

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

Electronically Signed | 02/28/2020

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F 557	Continued From page 1 daily living (ADLs) including: Bed mobility, transfer (such as transfer from the bed to the wheelchair, dressing, toileting, and personal hygiene, except for eating, where the resident was coded as independent with setup help. The resident was coded as having been always incontinent of both bowel and bladder. The care plan for Resident #2, which was most recently revised on 12/19/19, specified the resident had "Focus" areas which included: a self-care performance deficit and altered bowl elimination related to impaired mobility and incontinence. Further review revealed another focus area related to incontinence care which was the resident had altered bowl elimination related to impaired mobility and incontinence. One of the interventions for the potential for skin breakdown and bowel and bladder incontinence included: Check for soiling frequently, provide incontinent care post incontinent episode. During an interview with Resident #2 on 2/4/20 at 7:47 AM the resident stated one evening in January 2020 she was incontinent of stool and two nursing assistants (NAs) provided incontinent care for her. While the NAs were providing the care one of the NAs made comments regarding how she had a Bowel movement (BM) that upset her. The resident specified the NA ' s comments about her included; she did not even know how to have a BM, and the resident did not know how to "s**t" on herself and was nasty. Resident #2 stated the NA just went on and on about it. The resident stated it had occurred about a month ago. The resident identified the NA who had made the comments as NA #1. The resident said NA #1 had not made comments to her like that before, but the NA felt like she could talk to	F 557	Committee monthly and any findings from the interviews will be followed up with by the appropriate Department. The Quality Assurance Improvement Committee meets monthly and as needed. Executive Director and Director of Nursing are responsible for plan of Correction 5. Date of Compliance March 6, 2020	

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residents any way she would like. The resident stated NA #2 who was also providing the incontinent care was training with NA #1 and did not say anything when NA #1 made the comments. The resident stated the comments which were made by NA #1 made her feel awful, felt like a dog, or ... not really like a human being. The resident stated she told Nurse #1, who worked during the night shift (11:00 PM to 7:00 AM), about what had happened.

A phone interview was conducted with NA #1 on 2/4/20 at 8:20 AM. NA #1 said she and NA #2 were providing incontinent care for Resident #2 on 1/9/20 and had not disrespected Resident #2. The NA stated she and the resident were "tight," they were close, and "she talked to her like she would talk to her." The NA stated the facility had told her she had hurt the resident ' s feelings very bad; she did not remember saying anything which would have offended the resident, and the facility had not investigated the allegation. The NA stated she had not said anything about the resident having been stupid or she had "s**t" on herself.

Review of a statement completed by NA #2, dated 1/10/20, revealed during second shift (3:00 PM to 11:00 PM), she and NA #1 were providing care for Resident #2 and when NA #1 opened Resident #2 ' s brief and there was stool "everywhere." The NA documented NA #1 stated, "This "s**t" is ridiculous" and that a grown woman should not sit in her own stool. When NA #1 left the room to obtain additional supplies, NA #2 noted the resident started telling her nobody should be treated that way, she was a human being, and not an animal.

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NA #2 was interviewed via phone on 2/4/20 at 1:15 PM and stated she was present on 1/9/20 when NA #1 had made comments to Resident #2 regarding her bowel movement and incontinence care. The NA said it was her first day working at the facility and she was training and was assigned to work with NA #1. The NA remembered her, and NA #1 went to Resident #2 ' s room, she was incontinent of BM and NA #1 was not happy. NA #1 told the resident her a** should not look like that, and if she would roll over, she wouldn ' t have BM on her. The NA clarified NA #1 had not said BM but had said "s**t" and had said it in a manner which was not in a joking tone but an aggravated tone. NA #2 continued when NA #1 left the room for supplies the resident told her NA #1 should not talk to residents like that, like a dog, and the resident was crying. The NA continued when she went in the following day the Director of Nursing and Administrator had interviewed her and she explained to them she did not know what to do because it was her first day working on the floor.

During a second interview conducted with Resident #2 on 2/4/20 at 2:07 PM the resident stated the comments made by NA #1 made her feel worthless, made her cry, tear up, feel very sad, and she felt like it was verbal abuse. The resident said she had told Nurse #1 because she had felt comfortable talking with her and she had told the nurse she felt like she had been verbally abused.

A phone interview was conducted with Nurse #1 on 2/5/20 at 9:28 AM. The nurse stated Resident #2 told her that NA #1 said something to her, and it had hurt her feelings. The resident told her that NA #1 said something and laughed at her and

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she felt awful about what was said.

During an interview conducted on 2/5/20 at 10:40 AM with Social Worker (SW) #2 he said on 1/10/20 he and the Administrator met with Resident #2 about the concern. The SW remembered Resident #2 shared a problem she had about NA #1, who she had felt uncomfortable with, but she did not want the NA to lose her job. The resident said she had diarrhea during the evening of 1/9/20 and NA #1 became angry with her.

An interview was conducted with the Unit Manager (UM) on 2/5/20 at 11:01 AM. The UM stated she spoke with Resident #2 shortly after lunch on 1/10/20 and the resident told her about an incident that occur on 1/9/20, when she had diarrhea, which was chronic for her, and she had needed to be changed. The UM said the resident informed her that NA #1 and NA #2 came into change her and NA #1 was verbally inappropriate with her and made comments such as; "No grown woman should be s**tting herself like this," and a grown woman should not have "s**t" all over herself. The resident had told her when NA #1 went to obtain additional supplies she had told NA #2, that ' s not how you talk to somebody. The UM stated she felt the statement made to Resident #2 by NA #1 was terrible, the language used was demeaning, it negatively impacted the resident ' s dignity, it had been said in front of new employee who she was responsible for training, and the behavior was unacceptable. The UM said she could tell it made the resident feel really bad and it bothered her. The UM said the resident told her it made her feel like she was less than a person or a person without feelings.

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F 557	Continued From page 5 On 2/4/20 at 3:39 PM the administrator was interviewed, and she said it was reported to her on 1/10/20 that Resident #2 alleged someone had been mean to her and spoken "ill" to her. She explained she and SW #2 interviewed Resident #2, and the resident alleged NA #1 said nasty things to her, but she did not want to get anyone into trouble. The administrator stated she asked the resident how the comments from NA #1 made her feel and the resident responded she was hurt by the comments.	F 557		