

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

PRINTED: 09/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/21/2012
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF HENDERSONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792		
(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	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on family, resident, staff interviews and a record review, staff failed to treat residents in a dignified and respectful manor for one (1) of four (4) sampled residents reviewed for dignity and respect (Resident #1).</p> <p>The findings are:</p> <p>Resident #1 was admitted to the facility with diagnoses which included Neurogenic Bladder. The most recent Minimum Data Set (MDS), a quarterly assessment dated 8/12/12, indicated the resident is cognitively intact.</p> <p>An interview with a family member of Resident #1 on 8/17/12 at 3:00 p.m. revealed that she had been on speaker phone with Resident #1 when a Nursing Assistant (NA) had come into the room to provide care for Resident #1. The family member stated that she was upset because she heard the NA speak to Resident #1 in a loud and rude tone, asking her in an accusatory tone "Why is your sheet wet?" and then told Resident #1 she was leaving and wouldn't come back until Resident #1 was calm. The family member stated she did not hear Resident #1 raise her voice or sound upset but she did hear the NA raise her voice and sound rude and angry.</p>	F 241	<p>The Laurels of Hendersonville wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is 09/18/2012.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F 241</p> <p>The facility will provide care to ensure that each resident is treated in a manner that will maintain or enhance each resident's dignity.</p> <p>1. Resident #1 is currently satisfied with the care being provided and Social Services/designee will follow up with the Resident weekly for the next 30 days to assure continued satisfaction.</p> <p>The identified Nurse Aide (NA) will receive additional education regarding resident dignity and sensitivity by the DON/designee.</p>		

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

Gary R. Lli

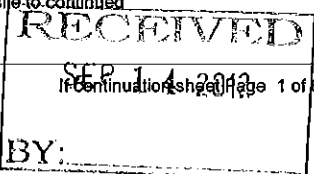
TITLE

Administrator

(X6) DATE

9-14-12

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 241	<p>Continued From page 1</p> <p>An interview with the director of nursing at 11:45am on 8/20/12 revealed that after her investigation of the incident, she had concluded that Resident #1 and the NA had been mutually rude to each other. The director of nursing said when she interviewed Resident #1 about the incident, the resident had reported that the NA had not been abusive, but rude. The director of nursing also said that although they had done an investigation, it was not an abuse investigation because they had not perceived it as an allegation of abuse. The result of the investigation was that the NA did not work with Resident #1 for the remainder of the night.</p> <p>An interview with Resident #1 on 8/20/12 at 1:45pm revealed she felt the NA had been verbally abusive to her. Resident #1 said "She laid into me and my sister heard it. It was bad." Resident #1 said that NA is frequently boisterous and loud and she doesn't like the way she talks to her. When asked how she felt when the NA was talking to her, resident #1 said she felt stupid and bad about herself for the NA to be yelling about her needing to be changed.</p> <p>The Guest Satisfaction/Concern/Suggestion form regarding this incident was reviewed. The investigation included the following: 1. Statements from the NA, the nurse who had spoken to the family member of Resident #1 the night of the incident, and the completed Guest Satisfaction form which was signed by the administrator and the director of nursing on 8/15/12, as well as a summary by the director of nursing. For resolution, the form says "see attached" and in the statement of the director of nursing, the</p>	F 241	<p>2. Current residents have the potential to be affected. Residents who are able to verbalize/communicate were interviewed and no other residents communicated any concerns relating to dignity.</p> <p>All Staff will be provided additional education regarding treatment of residents in a dignified and respectful manner by the Staff Development Coordinator or designee.</p> <p>3. The Social Services Director or designee will randomly interview residents who are interviewable to ensure staff treatment is in a dignified and respectful manner weekly x 3 weeks and then monthly x 3 months. Resident council will be queried during the Resident Council meeting and any concerns will be reported to the Administrator.</p> <p>4. Results will be reviewed by the QA Committee monthly x 3 months to ensure ongoing compliance with further education, monitoring or appropriate action if indicated.</p> <p>5. Continued compliance will be monitored through random resident interviews, daily review of resident satisfaction/concern forms, monthly Resident Council queries, and through</p>		

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F 241	<p>Continued From page 2</p> <p>following is written: "I asked her (Resident #1) if it was her preference that the NA not provide care for her. She (Resident #1) stated they had worked together for many years and had never had a problem, and she felt like the NA was very good, they just had a bad night. (Resident #1) stated she would not have issue with the NA caring for her in the future." The investigation did not include interviews with other residents, other than Resident #1, or interviews with peer NA staff.</p> <p>Interview with the wound nurse, on 8/21/12 at 11:20 a.m. revealed that the family member of Resident #1 had told her on the phone the night of the incident that she had heard the NA being rude and inappropriate with Resident #1 and the family member wanted something done about it immediately. The wound nurse said the family member had not said the NA was abusive, but rude. The wound nurse said the family member had told her she did not want the NA taking care of Resident #1. The wound nurse reported after she finished the call with the family member, she then talked to Resident #1, who was very upset and said the NA had raised her voice to her and didn't need to be yelling at her. The wound nurse said she had notified the director of nursing and the administrator, who both instructed her to move the NA to another hall. The wound nurse reported she remembered another incident when another resident's daughter had reported that the same NA had been rude to her mother. In regards to the NA, the wound nurse said she is forceful, matter of fact, and talks a little bit louder than most people. The wound nurse said the NA "might need to tone her voice down because</p>	F 241	the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	09/18/2012	

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F 241	<p>Continued From page 3 some people may perceive that as yelling".</p> <p>Interview with family member of Resident #1 on 8/21/12 at 12:11p.m. revealed that she had heard the NA say to Resident #1 in a loud and rude voice "How come your sheet's wet?" The family member said she heard Resident #1 say to the NA "well, I guess it's because it hasn't been changed". The family member said she next heard the NA say in a loud and rude voice "Don't talk to me in that tone of voice. Now when you can talk to me, I will come back." The family member said she could hear the NA's voice was much louder than Resident #1's voice and more angry-sounding.</p> <p>Interview with director of nursing at 8/21/12 at 12:30p.m. revealed there have been incidents in the past when people, especially those who were new have said this NA was aggressive. The director of nursing said the NA had one of those voices that is very commanding. When asked about training staff to work with Resident #1, the director of nursing said what has worked best for them is that they have learned what kind of people trigger her behavior and they have avoided assigning those kind of people to work with Resident #1. The director of nursing said they have not done any training on working with people with the type of diagnosis Resident #1 has or therapeutic communication. The director of nursing said the NA would most likely benefit from training on therapeutic communication but that training had not been provided. The director of nursing also said the NA could benefit from some care courses and learning more about Resident #1's diagnosis and to be counseled about how she can be perceived because she</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>needs to be made aware of that. At the time of the interview, this training had not been provided for the NA. The director of nursing said the staff member is responsible when both resident and staff member are rude and loud.</p> <p>Interview with administrator at 8/21/12 at 1:45 p.m. revealed he handled any complaint of a staff member being rude to a resident as a guest concern/grievance and not as an abuse investigation. The administrator reported that his desired outcome in such a case would be the satisfaction of the resident that the incident has been resolved. The administrator said he would expect this investigation would have included interviews with other residents to see if a pattern of rudeness toward residents existed, as well as interviews with other NAs to see if other NAs had witnessed the NA being rude to residents in the past. The administrator reported he understood the resident had simply had a bad night with the NA. The administrator said if there were repeated concerns from more than one resident or family member regarding one NA and rudeness, he would expect that would be handled through the disciplinary process. When asked why this incident was not handled through the disciplinary process, the administrator reported that he assumed that through the interviews that took place with the NA's staff/peers and other guests, a trend had not been discovered and so the disciplinary process was unnecessary. The administrator said the NA had been accused of abuse by another resident recently. The administrator said he had not spoken to the family of the resident to find out what they had heard over the telephone the night of the incident. The administrator said the NA is not a "people</p>	F 241			

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