| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345558 | A. BUILDING _____ B. WING _____ | C 08/11/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NC STATE VETERANS HOME-BLACK MOUNTAIN | 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 |

| (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 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 review and staff interview the facility failed to maintain dignity during a dinner meal when staff stood over 3 of 3 dependent residents while providing feeding assistance on 1 of 4 units. (Residents #7, #8 and #9).<br><br>The findings included:<br><br>1. Resident #7 was admitted to the facility on 04/23/14 with diagnoses which included dementia without behavioral disturbance. The most recent Minimum Data Set (MDS) dated 07/29/14 indicated Resident #7 was severely cognitively impaired and required extensive assistance with 1 staff member for assistance with eating.<br><br>During an observation of the dinner meal service on 08/10/14 at 6:08 PM Resident #7 was seated in his wheelchair at a table in one of the unit dining rooms and Nurse Aide (NA) # 1 was standing up beside Resident #7 providing him fluids and feeding him. There were 3 empty chairs available around the table and NA #1 continued to stand and feed the resident and did not attempt to secure a chair to sit down by Resident #7. At 6:14 PM NA #1 stopped feeding Resident #7. | F 241 | The Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements by State and Federal Laws.<br><br>The North Carolina State Veterans Home-Black Mountain, will promote the dignity and respect of veterans that require assistance with meals by ensuring that all staff are seated when providing meal assistance; staff will make eye contact while providing meal assistance; staff will attempt to engage the resident with conversation while providing meal assistance. A Seating device will be available for staff in all dining rooms<br><br>1. Veterans #7, #8, and #9 will have staff who assist with meals to be seated, attempt to engage the Veteran in conversation and make eye contact during assisted meals.<br><br>2. Audit will be performed to identify | 9/3/14 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/27/2014 |

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| F 241 | Continued From page 1<br>On 08/10/14 at 6:14 PM Nurse Aide (NA) #2 was observed to take over feeding assistance for Resident #7. NA #2 offered Resident #7 fluids and continued feeding him during the rest of the meal by standing over him. NA #2 had not secured an available chair to sit down and feed Resident #7. NA #2 finished feeding Resident #7 at approximately 6:40 PM.<br><br>An interview was conducted with NA #2 on 08/10/14 at 7:01 PM. NA #2 stated he should have sat down and provided feeding assistance to Resident #7. He revealed he had been instructed to sit down and maintain eye level and conversation with a resident while providing feeding assistance. He provided no further explanation why he had not seated himself while feeding Resident #7.<br><br>An interview was conducted on 08/11/14 at 7:17 PM with the Director of Health Services. She said she expected staff providing feeding assistance to be seated to make eye contact with the resident and encourage them to eat. She revealed it was not acceptable for staff to stand while providing feeding assistance to residents who were seated at a lower level.<br><br>2. Resident #8 was admitted to the facility on 01/22/13 with diagnoses which included Alzheimer's disease. The most recent Minimum Data Set (MDS) dated 06/30/14 indicated Resident #8 was severely cognitively impaired and required extensive assistance with 1 staff member for assistance with eating.<br><br>During observation of the dinner meal service on 08/10/14 at 6:14 PM, NA #1 provided feeding assistance to Resident #8 who was seated in a | F 241 | any other veterans who have the potential to be affected. New Admissions or Re-Admissions will be identified and monitored to ensure dignity and respect are maintained during meals. The validation process will be ongoing observation and monitoring of dignity and respect during meal times.<br><br>3. A) All Nursing staff including NA's #1, #2, and #3, were in-serviced regarding dignity and respect during feeding assistance by Administrator on 8/14/2014. Education includes staff being seated during assistance, staff attempt to engage and make eye contact during assisted meals<br><br>B) Education will be provided to new nursing partners, by the Clinical Competency Coordinator/Designee during initial orientation and job specific orientation. Education includes staff being seated during assistance, staff attempt to engage and make eye contact during assisted meals.<br><br>4. A) Monitoring of compliance of dignity and respect during feeding assistance will be performed by the Administrative Team, RN Supervisors +/or Designee.<br><br>B) Monitoring Schedule will be:<br><br>3x/week for 4 weeks<br>2x/week for 4 weeks<br>1x/week for 4 weeks | |

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| F 241 | Continued From page 2<br>high back wheelchair at the other end of the table from Resident #7. NA #1 was standing up over Resident #8 feeding him with a spoon. NA#1 continued to feed Resident #8 standing up for the entire meal and made no attempt to use an available empty chair to sit down with Resident #8. He finished feeding Resident #8 at approximately 6:36 PM.<br><br>An interview was conducted with NA#1 on 08/10/14 at 6:36 PM. He stated the two dependent residents should have been placed together around the table to make it easier to provide feeding assistance. He reported there used to be rolling stools to sit down on and he did not know what happened to the stools. NA #1 noted that there were empty chairs available and he said he should have used a chair to sit down and feed Resident #8.<br><br>An interview was conducted on 08/11/14 at 07:17 PM with the Director of Health Services. She said she expected staff providing feeding assistance to be seated to make eye contact with the resident and encourage them to eat. She revealed it was not acceptable for staff to stand while providing feeding assistance to residents who were seated at a lower level.<br><br>3. Resident #9 was admitted to the facility on 09/27/13 with diagnoses which included Alzheimer's disease. The most recent Minimum Data Set (MDS) dated 07/21/14 indicated Resident #9 was severely cognitively impaired and required extensive assistance with 1 staff member for assistance with eating.<br><br>During an observation of the dinner meal service on 08/10/14 at 06:23 PM Resident #9 was | F 241 | Monthly for 4 months or until substantial compliance deemed met by QAPI Team<br><br>C) The monitoring results will be submitted by the Administrative Team, RN Supervisors +/or Designee to QAPI monthly for review and or modification as indicated for continued compliance. | |

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| F 241 | Continued From page 3<br>observed at a table by himself with 3 empty chairs available. Nurse Aide (NA) #3 stood over Resident #9 while providing fluid and feeding assistance to him. NA #3 finished feeding Resident #9 at approximately 6:31 PM.<br><br>An interview was conducted with NA #3 on 08/10/14 at 6:31 PM. She said she did not know why she stood and provided feeding assistance to Resident #9 because she had been instructed to sit down and she usually did sit down.<br><br>An interview was conducted on 08/11/14 at 07:17 PM with the Director of Health Services. She said she expected staff providing feeding assistance to be seated to make eye contact with the resident and encourage them to eat. She revealed it was not acceptable for staff not to be seated while providing feeding assistance to residents who were seated at a lower level. | F 241 | | |