

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345292</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/26/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANTSBROOK NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>290 KEEL ROAD</b> <b>GRANTSBORO, NC 28529</b>		
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F 241 SS=E	<p>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>(a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews and record reviews the facility failed to provide a dignified dining environment for 5 of 5 dependent residents by referring to residents who required assistance with meals as "feeders" (Resident #8, Resident #38, Resident #47, Resident #63, and Resident #81).</p> <p>Findings included:</p> <p>1) Resident #47 was admitted to the facility on 12/31/17. Active diagnoses included dementia, and chronic kidney disease.</p> <p>Review of Resident #47's most recent quarterly Minimum Data Set dated 6/12/17 revealed Resident #47 was assessed as severely cognitively impaired and was totally dependent on staff for eating.</p> <p>During an observation on 7/23/17 at 5:27 PM the Medical Records Director was standing at the 200 hall entrance from the nurse's station. Nurse #1 was approximately 10 feet away from the Medical Records Director down the 200 hall. The Medical Records Director asked Nurse #1 if Resident #47 was a "feeder" and Nurse #1 replied yes, Resident #47 was a "feeder."</p>	F 241	<p>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY F241</p> <p>The Medical Records Director, Nurse #1 and Nurse #2 were in-serviced by the Administrator on 07/23/2017 regarding Dignity and Respect: inappropriate labeling verse appropriate verbiage to promote dignity to include residents that requires assistance with feeding verse "feeders". All staff will continue to ensure labels are not used such as "feeders" to promote dignity in the facility for all residents to include resident #8, #38, #47, #62, and #81.</p> <p>100% of all staff to include dietary staff, license nurses, CNAs (certified nursing assistants), housekeeping staff, maintenance staff, central supply, receptionist, department managers (social workers, therapy, activities, bookkeeping, payroll), Medical Records Director, Nurse #1 and #2 will answer a questionnaire given by the Director of Nursing and Administrator by 08/17/2017 regarding the appropriate name for residents that requires assistance with feeding to ensure understanding of not using inappropriate</p>	8/17/17	

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

TITLE

(X6) DATE

Electronically Signed

08/11/2017

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>During an interview on 7/23/17 at 5:39 PM the Medical Records Director stated that she normally called resident's "feeders" in order to keep them separate in her mind because she was not allowed to assist the "feeders." She further stated that "feeders" were residents who needed help with eating and could not eat by themselves.</p> <p>During an interview on 7/23/2017 at 5:50 PM Nurse #1 stated that staff often referred to residents who required feeding assistance as "feeders" while in the halls. She further stated that residents and families were able to hear these statements. She stated she could see it was a dignity concern and that she would think of another way to address these residents.</p> <p>During an interview on 7/26/17 at 1:47 PM the Director of Nursing stated she did not expect the staff to use the term "feeders" and would expect her staff to use the correct terms. She further stated she could see how this was a dignity concern and that some residents might take offense to being called a "feeder."</p> <p>2) Resident #63 was admitted to the facility on 8/2/16. Active diagnoses included Alzheimer's disease, and dementia.</p> <p>Review of Resident #63's most recent quarterly Minimum Data Set dated 5/3/17 revealed Resident #63 was assessed as severely cognitively impaired and was totally dependent on staff for eating.</p> <p>During an observation on 7/23/17 at 5:31 PM the Medical Records Director and Nurse #1 were on the 200 hall outside of an occupied and opened</p>	F 241	<p>labels. 100% of all staff to include dietary staff, license nurses, CNAs (certified nursing assistants), housekeeping staff, maintenance staff, central supply, receptionist, department managers (social workers, therapy, activities, bookkeeping, payroll), Medical Records Director, Nurse #1 and #2, will be observed by the Director of Nursing and QI Nurse by 08/17/2017 during meal times to include breakfast, lunch, and dinner to ensure all staff are using appropriate verbiage to include residents that requires assistance with feeding verse "feeders" to promote dignity to all residents to include residents #8, #38, #47, #62, and #81. Any employee who uses inappropriate verbiage during the observations and/or answers the questionnaire incorrectly will be immediately retrained by the Director of Nursing and/or Administrator during the audit.</p> <p>100% of all staff (dietary staff, license nurses, CNAs, housekeeping staff, maintenance staff, central supply, receptionist, department managers (social workers, therapy, activities, bookkeeping, payroll) the Medical Records Director, nurse #1 and #2, will be in-serviced by the administrator on 07/23/2017 and will be completed by 08/17/2017 regarding inappropriate labeling verse appropriate verbiage to promote dignity to include residents that requires assistance with feeding verse "feeders". All newly hired dietary staff, license nurses, housekeeping staff, therapy staff, and department managers will be in serviced</p>	

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F 241	<p>Continued From page 2</p> <p>resident's room that was not Resident #63's room. The Medical Records Director asked Nurse #1 if Resident #63 was a "feeder" and Nurse #1 replied, "yes."</p> <p>During an interview on 7/23/17 at 5:39 PM the Medical Records Director stated that she normally called resident's "feeders" in order to keep them separate in her mind because she was not allowed to assist the "feeders." She further stated that "feeders" were residents who needed help with eating and could not eat by themselves.</p> <p>During an interview on 7/23/2017 at 5:50 PM Nurse #1 stated that staff often referred to residents who required feeding assistance as "feeders" while in the halls. She further stated that residents and families were able to hear these statements. She stated she could see it was a dignity concern and that she would think of another way to address these residents.</p> <p>During an interview on 7/26/17 at 1:47 PM the Director of Nursing stated she did not expect the staff to use the term "feeders" and would expect her staff to use the correct terms. She further stated she could see how this was a dignity concern and that some residents might take offense to being called a "feeder."</p> <p>3) Resident # 8 was admitted to the facility on 7/5/16 with diagnoses which included atrial fibrillation, dysphagia, cerebral infarct and glaucoma.</p> <p>The quarterly Minimum Data Set (MDS) dated 4/14/17 revealed Resident #8 was severely cognitively impaired and required total assistance for eating.</p>	F 241	<p>during orientation by the Staff Facilitator or Administrator regarding inappropriate labeling verse appropriate verbiage to promote dignity to include resident's that require assistance with feeding verse "feeders".</p> <p>100% of all staff to include license nurses, CNAs, dietary staff, housekeeping staff, therapy staff, and department managers, to include Medical Records Director, nurse #1 and #2, will be observed, by the Director of Nursing or QI Nurse during meal times, to include breakfast, lunch, and dinner, to ensure residents, to include resident's #47, #63, #8, #38, and #81, aren't being labeled and appropriate verbiage is being utilized to promote dignity, to include residents that requires assistance with feeding verse "feeders" weekly x 8 weeks then monthly x 1 month utilizing a Non-Labeling Resident Care Audit Tool. Any concerns will be immediately addressed by the Administrator and/or Staff Facilitator with re-education of staff during the time of the audit. The DON will review and initial the Non-labeling QI Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed.</p> <p>The Director of Nursing will be responsible for forwarding the results of the Non-labeling QI Audit Tools to the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Non-labeling QI Audit Tools and address any issues, concerns, and/or trends as well as make</p>		

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F 241	Continued From page 3  The resident's care plan revised on 1/28/17 identified a concern of a history of progressive weight loss and one of the interventions was to feed the resident. During an observation of staff passing out trays for the evening meal on 7/23/17 at 5:35 PM Nurse #2 was heard to call Resident #8 a "feeder."  On 7/23/17 at 6:33PM Nurse #2 stated she called the residents feeders because she knew the residents and she was telling the Nursing Assistant which residents were feeders. Nurse #2 then stated she did not see this as a dignity concern.  On 7/26/17 at 1:47 PM the Director of Nursing (DON) stated she did not feel the staff should use the term "feeders" and she expected the staff to use the correct terms. She said she could see how this was a dignity concern and some residents might take offense to being called that.  4) Resident #38 was admitted to the facility 12/29/16 with diagnoses which included dementia, dysphagia and a contracture. The quarterly MDS dated 7/5/17 revealed Resident #38 was severely cognitively impaired and required total assistance with all activities of daily living including eating.  The care plan for Resident #38, revised on 7/19/17, identified a concern of being significantly below their ideal body weight with the intervention of "provide assistance with meals as indicated." During an observation of staff passing out trays for the evening meal on 7/23/17 at 5:38 PM Nurse #2 was heard to refer to Resident #38 a	F 241	changes as needed to include continued frequency of monitoring monthly x 3.		

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F 241	<p>Continued From page 4</p> <p>"feeder."</p> <p>On 7/23/17 at 6:33PM Nurse #2 stated she called the residents feeders because she knew the residents and she was telling the Nursing Assistant which residents were feeders. Nurse #2 then stated she did not see this as a dignity concern.</p> <p>On 7/26/17 at 1:47 PM the Director of Nursing (DON) stated she did not feel the staff should use the term "feeders" and she expected the staff to use the correct terms. She said she could see how this was a dignity concern and some residents might take offense to being called that.</p> <p>5) Resident #81 was admitted to the facility on 5/5/16 with diagnoses which included subarachnoid hemorrhage, dementia and dysphagia.</p> <p>The quarterly MDS dated 6/8/17 revealed Resident #81 was severely cognitively impaired and needed extensive assistance with eating.</p> <p>The care plan for Resident #81 revealed a concern of weight loss with an intervention of provide assistance with meals. The care guide dated 5/5/16 included "Feed Patient."</p> <p>During an observation of staff passing out trays for the evening meal on 7/23/17 at 5:40 PM Nurse #2 was heard to call Resident #81 a "feeder."</p> <p>On 7/23/17 at 6:33PM Nurse #2 stated she called the residents feeders because she knew the residents and she was telling the Nursing Assistant which residents were feeders. Nurse</p>	F 241			

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

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