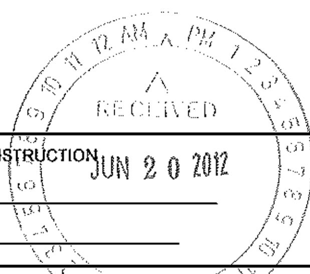
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES




PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345092 | A. BUILDING ______<br>B. WING ______ | C<br>05/25/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE HEALTHCARE OF WINSTON SALEM | 1900 W 1ST STREET<br>WINSTON-SALEM, NC 27104 |

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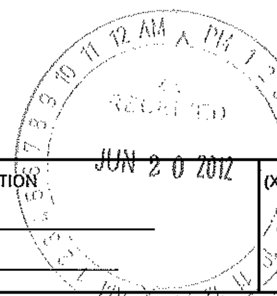
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff and resident interviews, the facility failed to ensure that 1 (Resident #4) of 3 residents in the survey sample was not disrespected.<br><br>The findings are:<br>Resident #4 was admitted to the facility on 4/25/12 for rehabilitation. The 5/2/12 Minimum Data Set (MDS) revealed the resident had intact cognition and no behavior issues. The MDS also indicated the resident was independent for all Activities of Daily Living including locomotion on and off the unit. The resident was observed to be ambulatory without assistive devices.<br>An interview with resident #4 at 9:40 AM on 5/22/12 revealed the resident had a concern about the attitude of a Nursing Assistant (NA #2) during an incident which occurred on 5/17/12. The resident was visiting on another floor when the phone rang. NA #1 answered the phone call and informed the resident that NA #2 called and said the resident needed to return to his floor "now" to get his medications. When the resident returned to the unit he questioned NA #2 regarding his attitude. The resident stated that NA #2 stood up and started yelling at him. He felt the NA was rude and confrontational. He further stated that he spoke with the Administrator and | F 241 | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Winston-Salem Nursing & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."<br><br>Social Service met with Resident # 4 within 24 hours of notification of alleged occurrence as well as continued follow up with resident for several days to assure wellbeing.<br>See exhibit A.<br><br>Administrator met with Resident #4 to assure wellbeing and further investigate.<br>See exhibit B. | <br><br><br><br><br>5/22/12<br><br>5/21/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/18/12

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 | Continued From page 1<br>the director of nursing (DON) on 5/21/12 regarding the incident. He told them he did not appreciate being treated in that manner.<br><br>An interview with Nurse #1 on 5/22/12 at 3:05 PM revealed that she did not instruct NA #2 to call the 4th floor to inform the resident to return to the unit. She stated "He took it upon himself." She further stated that NA #1 told her that NA #2 called to tell him to come to the unit immediately. When the resident returned to the unit he was angry.<br><br>Nurse #2 was interviewed at 3:20 PM on 5/22/12 and stated that she observed the incident between resident #4 and NA #2. She observed resident #4 ambulate to the nurses ' station and approach NA #2. The resident told him that he thought telling him to return to the unit in that manner was inappropriate and he didn't appreciate being told to come down to the unit in that tone of voice. NA #2 proceeded to tell him that he did not feel it was inappropriate and stated "I don't care how you perceived what I said because I know what I said and I don't want to have a conversation with you about this." The resident informed the NA he was going to report the incident and the NA responded "Go ahead. I don't care." They were both loud and Nurse #2 stated that NA #2 was confrontational and she felt it was inappropriate on the part of the NA.<br><br>An interview with NA #2 on 5/22/12 at 4:34 PM revealed resident #4 "came at him very confrontational" and stated that Nurse #1 had called the 4th floor and told NA #1 to ask the resident to return to the unit for his medications. The resident didn't come down in 10 minutes so | F 241 | Facility implemented education to all departments by SDC regarding Residents Rights-inclusive of Respect & Dignity, as well as Abuse process. Inservicing initiated 5/22/12 through 6/5/12.<br>See exhibit C.<br><br>1:1 Education with Nursing Assistant #2 from SDC related to communication and dealing with challenging residents, post investigation. SDC to continue with this being part of orientation.<br>See exhibit D.<br><br>To assure wellbeing of other resident's random interviews completed by Nursing, Administrator & Social Service regarding care from nursing assistant #2 as well as continued follow up with resident #4.<br>See exhibit E. | 6/5/12<br><br><br><br><br>5/29/12<br><br><br><br>5/23/12 |

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| F 241 | Continued From page 2<br>NA #2 called and asked NA #1 to please tell the resident to come down and get his meds " now." NA #1 said "Do you want me to tell him like that and he asked to have the resident come to the phone." He did not talk to the resident but handed the phone to Nurse #1 who had asked him to call. Nurse #1 asked the resident " Would you please come down and get your meds now? " When resident #4 arrived on the unit he was irate. Nurse #1 took him to his room and gave him his medications about 10:40 PM. The resident came back out from his room and sat in a chair next to the elevator. At 11:00 PM the resident jumped up, stood and yelled I'm going to write this up to the DON. When asked what was wrong, he said "You violated my rights" pointing at the NA #2 stating "and your fat a.. is going down to the office in the morning." NA #2 stated "I put my hands together and said "The one thing I will not let you do is lie on me. I did not do anything to you. " NA #2 further revealed he was not yelling and didn't know what he was talking about. He told the resident "I will come in at 10:00 AM and talk to the DON too."<br><br>Review of a Concern/Comment Report written by Nurse #2 and received from the DON on 5/22/12 at 5:45 PM revealed she observed the verbal altercation between resident #4 and NA #2. She noted that NA #2 spoke in a demanding, disrespectful manner on the phone and said the resident was to return to the unit "right now." She further noted that NA#2 acted unprofessionally when the resident returned to the unit and the verbal altercation occurred.<br><br>A second interview with Nurse #1 was conducted on 5/23/12 at 9:45 AM. She revealed that she | F 241 | To assure ongoing compliance and ongoing interviews related to Dignity & overall care/quality, Administrator has implemented Guardian Angel Rounds for Department Heads and Managers as well as line staff-during these weekly rounds staff assigned are reviewing resident's quality of life as well as dignity. For non-interviewable residents staff will check on residents overall appearance, inquire with roommate and establish relationship with family in order to assure quality of life and dignity for residents. Angel rounds will be weekly and ongoing without end date-outcomes will be reported through QA/QI monthly and ongoing without end date. Administrator to oversee process. See exhibit E.1<br><br>Facility implemented for systemic change of discussing daily during stand up any resident concern/grievance. Administrator to assure appropriate follow up in collaboration with Social Service and Department Heads. .<br>See exhibit F.<br>Facility implemented for systemic change of discussing Guardian Angel Rounds weekly after rounding is completed to assure follow up for any areas identified. See exhibit E.1 | 6/7/12<br><br>6/5/12 |

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| F 241 | Continued From page 3<br>heard NA #2 on the phone but he wasn't loud and she didn't hear what he was saying. When the resident returned to the unit he stated that he would be reporting to the DON in the morning and started yelling and pointing at NA #2. NA #2 was loud and said he understood but he didn't know what he was talking about. Both NA #2 and resident #4 were loud and it was difficult to understand what was said. The resident started yelling and pointing down at her. She stated that she was afraid. NA #2 was trying to remain calm. Resident #4 went to his room. After the shift change the resident got on the elevator and went back to the 4th floor. About 11:20 PM resident #4 returned to the unit. She wrote a statement about the situation and placed it under the DON's door.<br><br>A subsequent interview with resident #4 on 5/23/12 at 1:30 PM indicated that he still felt he was not treated with respect and his resident rights had been violated.<br><br>Interview with NA #1 on 5/23/12 at 3:10 PM revealed that on 5/17/12 she was standing at the nurses' station talking with resident #4 when the phone rang. She answered the call and Nurse #1 asked her to request that resident #4 return to his unit for his medications. When she told the he shrugged and continued with the conversation. About 5 minutes later the phone rang again and when she answered it NA #2 yelled to have the resident return to the unit "now" for meds. The resident was standing very close to her and could hear the caller. Resident #4 left and returned to ask NA #1 who the male was on the other end of the phone. She provided the information to the resident as requested. | F 241 | To further ensure compliance Department Heads to continue with Grievance/Concern & Guardian Angel process and report and follow up on concerns daily and ongoing and report outcomes during QA/QI monthly during QA meeting. This will always be a part of monthly QA therefore it is indefinite. Outcomes will be reviewed to assure process is effective and that correction is maintained. Oversight by Social Service in collaboration with Administrator. See exhibit F. | 6/15/12 |