STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 01/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY MEDICAL CENTER	4130 US HWY 64 EAST MURPHY, NC 28906

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #P22111. Following IDR results of 03/03/17 to uphold F241, F278, and F281, the facility requested a State Survey Agency review of IDR decision regarding F278 and F281. The State Agency Review overturned the IDR panel's to uphold F278 and F281. The facility was notified of an ammended 2567. Event ID #P22111.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to maintain dignity for 1 of 1 (Resident #67) sampled resident when staff stood over the resident while feeding a meal. Findings included: Resident #67 was admitted to the facility on 08/18/14 with a diagnosis of Alzheimer's disease. Review of the most recent annual Minimum Data Set (MDS) dated 06/22/16 for Resident #67 revealed the resident had severe impaired cognition and needed extensive assistance with meals. A review of the care plan for Resident #67 dated 06/27/16 revealed staff was to provide extensive assistance with meals. The bed was kept in the lowest position with a floor mat beside the bed.	F 241	Tag 0241 - 483.14 (a) Dignity and Respect of Individuality Corrective action will be accomplished for resident # 67 by educating his caregivers about this requirement under the dignity tag by 2/1/17. Corrective action will be accomplished for those residents having potential to be affected by educating all caregivers about this requirement under the dignity tag by 2/1/17. This was accomplished by the Director of Nursing 2/1/17. The measures that will be put into place to	2/7/17

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

Electronically Signed | 02/02/2017

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F 241	Continued From page 1 On 01/11/17 at 8:20 AM, Nurse Aide (NA) #1 was observed feeding Resident #67 breakfast in bed. The resident's bed was in the lowest position with the head of the bed elevated. NA #1 was feeding the resident while standing. An empty chair was available. NA #1 was not engaging with or talking to the resident. She was asked to help a different resident and was replaced by NA #2. On 01/11/17 at 8:20 AM, NA #2 took over feeding Resident #67's breakfast. NA #2 continued to feed the resident the entire meal while standing. The bed remained in the lowest position with head of the bed elevated. NA #2 stood above eye level as the resident looked up at her. NA #2's demeanor was polite and engaging with the resident. She asked if he would like something to drink and offered multiple food items from his tray. An empty chair was available and close to the resident. During an interview on 01/11/17 at 9:18 AM, NA #2 revealed she had been trained to either sit or stand when feeding a resident. She also acknowledged standing over Resident #67 with the bed in the lowest position. During an interview on 01/11/17 at 10:11 AM, NA #1 revealed she always stood when feeding a resident. She also acknowledged standing over Resident #67 with the bed in the lowest position. During an interview on 01/11/17 at 11:14 AM, the Charge Nurse revealed it was her expectation staff be at eye level with the resident when feeding. During an interview on 01/11/17 at 11:29 AM, the Director of Nursing (DON) revealed staff was trained to be at eye level with the resident when feeding. She also revealed the Social Worker (SW) provided dignity training to the staff. During an interview on 01/11/17 at 11:29 AM, the	F 241	ensure the deficient practice will not occur will be to include this dignity requirement to the new hire orientation pack and will be taught by the social worker during each new hire orientation, beginning 2/7/17 Facility will monitor its performance by having the Director of Nursing or her designee audit staff performance and interaction on a sample of 2 residents who require assistance with meals, from each hall weekly. Results will be reported by the Director of Nursing at the monthly QAPI meeting for a minimum of 3 months or until substantial compliance is achieved.	

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F 241	Continued From page 2 Social Worker (SW) confirmed she was responsible for training staff. She also revealed being at eye level with the resident, or in a seated position was not discussed when feeding residents. During an interview on 01/13/17 at 7:00 PM, the Administrator revealed it was her expectation for the staff not to stand over residents when feeding. She expected staff be at eye level with the resident when feeding.	F 241		