

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2017
NAME OF PROVIDER OR SUPPLIER EMERALD HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 54 RED MULBERRY WAY LILLINGTON, NC 27546	
(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>DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1)</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: Based on observations, record review, family, resident and staff interviews, the facility failed to maintain residents' dignity by failing to meet the needs for toileting assistance when call bells were not answered for 2 of 3 residents which resulted in incontinent episodes for continent residents (Resident #1 and Resident #2).</p> <p>Findings included:</p> <p>1-Review of the medical record revealed Resident #1 was admitted to the facility on 7/2/0/2017 with diagnoses which included Hypertension and Cerebral Infarction (a stroke).</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 7/27/2017 indicated the resident was cognitively intact, required extensive assistance of one person for toileting, was impaired on one side and was occasionally incontinent.</p> <p>Review of the Care Area Assessment (CAA) dated 7/27/2107 revealed Resident #1 was admitted to the facility for short term rehabilitation for a stroke with left sided weakness. The CAA further indicated the resident required extensive assistance with bathing, grooming and dressing. The CAA reported the resident was continent of bladder and bowel with an occasional incontinent</p>	F 241	<p>Process that lead to deficiency cited: 1. Resident #1 and resident #2 did not receive adequate assistance due to all staff not answering call bells timely. Procedure for implementing acceptable POC: 1. All staff have been reeducated on customer service and call light policy by ADON and/or designee to be completed by 11/15/2017. Monitoring procedure to ensure the POC is effective: 1. Call bell audits will be conducted daily, at random times, for 2 weeks, 3x/week x 2 weeks, and weekly x 2 weeks by ADON and/or designee. 2. New hires will be educated on call bell policy by ADON during orientation. 3. 3-5 alert and oriented residents will be interviewed on call bell responsiveness a minimum of 5x/week for 6 weeks by designated staff. 4. Call bell audits and resident interviews will be brought to Risk Meetings to determine trends and further action if needed. 5. Call bell audits and resident interviews will be presented by DON at QAPI meeting for review for two months. If</p>	11/15/17

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

TITLE

(X6) DATE

Electronically Signed

11/09/2017

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.

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

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F 241	<p>Continued From page 1</p> <p>episode and was assisted with toilet transfers due to the ability to stand and pivot with one person assist.</p> <p>Review of the resident's care plan updated 8/7/2017 listed a problem of occasional incontinence related to decreased mobility with interventions which included to provide incontinence care after each incontinent episode and as needed and to assist for toileting when requested.</p> <p>Review of Nursing Progress Notes from admission to 10/17/2017 revealed daily assessments which included documentation of Resident #1 as being continent of bladder and bowel.</p> <p>A telephone interview was conducted with Resident #1's family member on 10/17/2017 at 9:05 AM. The family member indicated the resident got upset when the staff did not respond to his call light in time for him to get to the bathroom. The family member stated the call light response time was often over 40 minutes, and he could not hold his bladder or bowels that long. The responsible party reported the resident would call her at home and be very frustrated because he could not get assistance to the bathroom. The family member reported she called the nursing station at times and asked for assistance for the resident when he called her at home. The responsible party indicated the Nursing Assistants (NA) worked hard, and there was not enough to meet the needs of the residents timely. The family member stated the NAs were apologetic when the resident soiled himself, and she knew they just couldn't leave other residents in the middle of care. The family member indicated there were</p>	F 241	discrepancies are noted, further actions will be implemented.		

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F 241	<p>Continued From page 2</p> <p>several times when she visited, the call light would be on for 30 to 40 minutes before anyone responded.</p> <p>An observation and interview was conducted with Resident #1 on 10/17/2017 at 10:35 AM. The resident was in his room in his wheelchair, his left arm was in a splint and his left leg was on a foot pedal. The resident propelled himself in the wheelchair with his right foot. The resident was alert, oriented and well kempt. Resident #1 resided in a private room with a bathroom which was located approximately 8 feet from the resident's bed. The room was clean with no clutter observed. Resident #1 stated at times he waited over an hour for assistance after he used his call bell. Resident #1 indicated he felt very frustrated at times because he could not get assistance to the toilet when he was unable to physically get to the toilet himself. Resident #1 stated it was a terrible feeling when he soiled himself because no one would answer his call light. Resident #1 stated there were several times since admission to the facility he soiled himself due to staff not responding to his call light. Resident #1 indicated the staff were apologetic when he soiled himself and told him they were busy assisting other residents.</p> <p>An interview was conducted with the Nurse Unit Manager (UM) on 10/18/2017 at 10:55 AM. The UM indicated Resident #1 was alert, oriented and never complained about much. The UM indicated there were times the NAs were unable to answer call lights timely and the nursing staff tried to answer them. The UM indicated he thought the call lights were answered pretty quickly.</p> <p>An interview was conducted with NA #1 on</p>	F 241			

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F 241	<p>Continued From page 3</p> <p>10/18/2017 at 11:52 AM. NA #1 stated she worked on 1st shift with Resident #1 and was familiar with his care needs. NA #1 indicated there were times residents had to wait a long time for care due to the acuity of some of the residents and staff availability. NA #1 stated she recalled times when Resident #1 waited for assistance and soiled himself. NA #1 reported she apologized to the resident when it happened. NA #1 indicated the nurses usually did not answer the call lights.</p> <p>A telephone interview was conducted with NA #2 on 10/18/2017 at 2:24 PM. NA #2 reported she worked on 3rd shift and Resident #1 was on her regular assignment. NA #2 stated the amount of care the residents required on her assignment made it difficult to meet their needs. NA #2 indicated Resident #1 called for assistance during the night at times for assistance to the bathroom. NA #2 stated if she was with another resident and did not get to him in time to assist, the resident went in his brief. NA #2 indicated she tried very hard but there were times she could not get to Resident #1 in time. NA #2 reported the nurses did not help much because they were busy too.</p> <p>A telephone interview was conducted with NA #3 on 10/18/2017 at 2:50 PM. NA # 3 stated Resident #1 was on her regular assignment on the evening shift. NA #3 indicated there were times she was unable to get to Resident #1 when he called for assistance and the resident went in his brief. NA #3 indicated she apologized to the resident and explained she was busy. NA #3 further indicated she knew the resident felt bad when he soiled himself.</p> <p>An interview was conducted with the Director of</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>Nursing (DON) on 10/18/2017 at 4:57 PM. The DON indicated the facility knew there were issues with call light response time. The DON stated the expectation was for call lights to be answered in a timely manner to assure residents maintained their dignity.</p> <p>2-Record review revealed Resident #2 was admitted to the facility on 9/9/2017 with diagnoses which included Fracture of Right Tibia and Fibula (both bones in lower leg) and Abnormalities of Gait and Mobility.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 9/16/2017 revealed Resident #2 was cognitively intact and required limited to extensive assist with all Activity of Daily Living (ADLs). The MDS indicated the resident was occasionally incontinent.</p> <p>Review of the Care Area Assessment (CAA) dated 9/16/2017 indicated Resident #2 was admitted to the facility for short term rehabilitation with multiple fractures from a motor vehicle accident. The CAA indicated the resident required extensive assistance with bathing, grooming and dressing and required assistance of one person for transfers and ambulation. The CAA reported the resident utilized pads or briefs to assist with keeping dry from incontinent episodes.</p> <p>Review of the daily nursing notes for Resident #2 from admission date of 9/7/2017 to present revealed the resident was continent and required one person physical assist with toileting.</p> <p>Review of the Care Plan updated 9/7/2017 listed a problem of occasional incontinence related to decreased mobility. Interventions included to</p>	F 241			

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F 241	<p>Continued From page 5</p> <p>provide incontinence care after each incontinent episode and as needed, and to assist for toileting when requested.</p> <p>An interview was conducted with Resident #2 on 10/17/2017 at 2:30 PM. The resident was observed sitting in his wheelchair in his room. The resident was alert and oriented. The resident was observed to be well kempt. The resident reported the staff assisted with his ADL needs. The resident indicated the call bell response time caused him to soil himself often. The resident stated it felt terrible. The resident stated he was embarrassed at first but was accustomed to it now. The resident indicated sometimes he waited 30 to 45 minutes for staff to answer his call light and he could not hold his bowels or bladder that long. The resident stated the staff apologized when they were unable to get to him in time.</p> <p>An interview was conducted with the Nurse Unit Manager (UM) on 10/18/2017 at 10:55 AM. The UM indicated Resident #2 was alert and oriented. The UM indicated there were times the NAs were unable to answer call lights timely and the nursing staff tried to answer them. The UM indicated he thought the call lights were answered pretty quickly.</p> <p>An interview was conducted with NA #1 on 10/18/2017 at 11:52 AM. NA #1 stated she worked on 1st shift with Resident #2 and was familiar with his care needs. NA #1 indicated there were times residents had to wait a long time for care due to the acuity of some of the residents and staff availability. NA #1 stated she recalled times when Resident #1 waited for assistance and soiled himself. NA #1 reported she apologized to the resident when it happened. NA #1 indicated the nurses usually did not answer</p>	F 241			

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F 241	Continued From page 6 the call lights. A telephone interview was conducted with NA #2 on 10/18/2017 at 2:24 PM. NA #2 reported she worked 3rd shift and Resident #2 was on her regular assignment. NA #2 stated the amount of care the residents required on her assignment made it difficult to meet their needs. NA #2 indicated Resident #1 called for assistance during the night at times for assistance to the bathroom. NA #2 stated if she was with another resident and did not get to him in time to assist, the resident went in his brief. NA #2 indicated she tried very hard, but there were times she could not get to Resident #2 in time. NA #2 reported the nurses did not help much because they were busy too. A telephone interview was conducted with NA #3 on 10/18/2017 at 2:50 PM. NA # 3 stated Resident #2 was on her regular assignment on the evening shift. NA #3 indicated there were times she was unable to get to Resident #2 when he called for assistance and the resident went in his brief. NA #3 indicated she apologized to the resident and explained she was busy. NA #3 further indicated she knew the resident felt bad when he soiled himself. An interview was conducted with the Director of Nursing (DON) on 10/18/2017 at 4:57 PM. The DON indicated the facility knew there were issues with call light response time. The DON stated the expectation was for call lights to be answered in a timely manner to assure residents maintained their dignity.	F 241			
F 353 SS=D	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4)	F 353		11/15/17	

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F 353	Continued From page 7 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill	F 353			

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F 353	<p>Continued From page 8</p> <p>sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, resident and family interviews and observations, the facility failed to have adequate staffing to ensure continent residents were toileted when call lights were not answered for 2 of 3 residents (Resident #1 and Resident #2) which resulted in incontinent episodes for continent residents.</p> <p>Findings included:</p> <p>This citation is cross referenced to F241- Based on observations, record review, family, resident and staff interviews, the facility failed to maintain residents' dignity by failing to meet the needs for toileting assistance when call bells were not answered for 2 of 3 residents which resulted in incontinent episodes for continent residents (Resident #1 and Resident #2).</p> <p>A telephone interview was conducted with Resident #1's family member on 10/17/2017 at 9:05 AM. The family member stated the call light response time was often over 40 minutes. The responsible party reported the resident would call her at home and be very frustrated because he could not get assistance to the bathroom. The family member reported she called the nursing station at times and asked for assistance for the resident when he called her at home. The</p>	F 353	<p>Process that lead to deficiency cited:</p> <ol style="list-style-type: none"> 1. Resident #1 and resident #2 did not receive adequate assistance due to all staff not answering call bells timely. <p>Procedure for implementing acceptable POC:</p> <ol style="list-style-type: none"> 1. All staff have been reeducated on customer service and call light policy by ADON and/or designee to be completed by 11/15/2017. Monitoring procedure to ensure the POC is effective: <ol style="list-style-type: none"> 1. Call bell audits will be conducted daily, at random times, for 2 weeks, 3x/week x 2 weeks, and weekly x 2 weeks by ADON and/or designee. 2. New hires will be educated on call bell policy by ADON during orientation. 3. 3-5 alert and oriented residents will be interviewed on call bell responsiveness a minimum of 5x/week for 6 weeks by designated staff. 4. Call bell audits and resident interviews will be brought to Risk Meetings to determine trends and further action if needed. 5. Call bell audits and resident interviews will be presented by DON at QAPI meeting for review for two months. If 		

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F 353	<p>Continued From page 9</p> <p>responsible party indicated the Nursing Assistants (NA) worked hard, and there was not enough to meet the needs of the residents timely. The family member stated the NAs were apologetic when the resident soiled himself, and she knew they just couldn't leave other residents in the middle of care. The family member indicated there were several times when she visited, the call light would be on for at least 30 to 40 minutes before anyone responded.</p> <p>An observation and interview was conducted with Resident #1 on 10/17/2017 at 10:35 AM. The resident was in his room in his wheelchair, his left arm was in a splint and his left leg was on a foot pedal. The resident propelled himself in the wheelchair with his right foot. The resident was alert, oriented and well kempt. Resident #1 resided in a private room with a bathroom which was located approximately 8 feet from the resident's bed. Resident #1 stated at times he waited over an hour for assistance after he used his call bell. Resident #1 indicated he felt very frustrated at times because he could not get assistance to the toilet when he was unable to physically get to the toilet himself. Resident #1 stated there were several times since admission to the facility he soiled himself due to staff not responding to his call light. Resident #1 indicated the staff were apologetic when he soiled himself and told him they were busy assisting other residents.</p> <p>An interview was conducted with Resident #2 on 10/17/2017 at 2:30 PM. The resident was observed sitting in his wheelchair in his room. The resident was alert and oriented. The resident was observed to be well kempt. The resident reported the staff assisted with his ADL needs.</p>	F 353	discrepancies are noted, further actions will be implemented.		

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F 353	<p>Continued From page 10</p> <p>The resident indicated the call bell response time caused him to soil himself often. The resident indicated there were many instances in which he waited over 45 minutes for staff to answer his call light. The resident further indicated the staff told him they were unable to get to him due to the amount of residents they were responsible for. An interview was conducted with the Nurse Unit Manager (UM) on 10/18/2017 at 10:55 AM. The UM indicated Residents #1 and #2 were on his unit. The UM reported both of the residents were alert, oriented and never complained about much. The UM indicated there were times the NAs were unable to answer call lights timely and the nursing staff tried to answer them.</p> <p>An interview was conducted with NA #1 on 10/18/2017 at 11:52 AM. NA #1 stated she worked on 1st shift with Resident #1 and Resident #2 and was familiar with their care needs. NA #1 indicated there were times residents had to wait a long time for care due to the acuity of some of the residents and staff availability. NA #1 stated she recalled times when residents waited for assistance and soiled themselves. NA #1 reported she apologized to the residents when it happened. NA #1 stated there was not enough staff to meet the needs of the residents and oftentimes needed care was not provided. NA #1 indicated the nurses usually did not answer the call lights.</p> <p>A telephone interview was conducted with NA #2 on 10/18/2017 at 2:24 PM. NA #2 reported she worked on 3rd shift and Resident #1 and Resident #2 were on her regular assignment. NA #2 stated the amount of care the residents required on her assignment made it difficult to meet their needs. NA #2 indicated Resident #1</p>	F 353			

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NAME OF PROVIDER OR SUPPLIER EMERALD HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 54 RED MULBERRY WAY LILLINGTON, NC 27546		
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F 353	<p>Continued From page 11</p> <p>and Resident #2 called for assistance during the night at times for assistance to the bathroom. NA #2 stated if she was with another resident and did not get to them in time to assist, the residents went in their briefs. NA #2 indicated she tried very hard but there were times she could not get to the residents in time to provide the care they needed. NA #2 reported the nurses did not help much because they were busy too.</p> <p>A telephone interview was conducted with NA #3 on 10/18/2017 at 2:50 PM. NA # 3 stated Resident #1 and Resident #2 were on her regular assignment on the evening shift. NA #3 indicated there were times she was unable to get to the residents when they called for assistance and the residents went in their briefs. NA #3 indicated she apologized to the residents and explained she was busy. NA #3 further indicated there were not enough nursing assistants to provide care to the residents and there were many evenings the residents did not get the care they needed.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/18/2017 at 4:57 PM. The DON indicated the facility knew there were issues with call light response time. The DON stated the facility developed a plan and attempted to determine the root cause of the extended call light response time. The DON further indicated the plan was not fully implemented. The DON stated the expectation was for the facility to have adequate staffing to ensure call lights were answered in a timely manner to assure resident's needs were met.</p>	F 353			