STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING ______ B. WING ______	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		2/5/18

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

Electronically Signed — 02/02/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING ______ B. WING ______	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	**111 HARRILSON STREET CHERRYVILLE, NC 28021**

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to promote the dignity of a resident who was observed with staff standing while assisting the resident to eat a meal (Resident #4). Findings included: Resident #4 was re-admitted to the facility from a hospitalization on 10/27/17 with diagnoses that included Alzheimer's disease among others. The significant change Minimum Data Set (MDS) dated 11/10/17 indicated Resident #4 had short and long-term memory problems. The MDS also indicated Resident #4 required extensive assistance with eating. Record review indicated Resident #4 was on a puree diet with nectar thickened liquids. During an observation of the lunch meal at 12:27 PM on 01/24/18, Resident #4 was being assisted with eating while in her bed by a Nurse Aide (NA) who was standing beside her while assisting her eat. There was a folding chair noted in the room leaning against the wall. The observation of the lunch meal continued until the Assistant Director of Nursing (ADON) came into the room at 12:52PM and the NA exited the room. The ADON took the folding chair and sat down while assisting Resident #4 with eating her remaining lunch meal. During an interview at 12:52 PM on 01/24/18, the NA stated she wasn't sitting while assisting	F 550	Resident Rights/Exercise of Rights F550 CFR(s): 483.10(a)(1)(2)(b)(1)(2) CCHR continues to ensure residents have a right to a dignified existence, self-determination, and communication with an access to persons and services inside and outside the facility, including those specified in this section. On 1/24/17 the resident was provided appropriate assistance in eating to finish her meal by ADON. All residents requiring assistance with eating during meals were observed for appropriate assistance while eating. No further occurrences were observed. All nursing staff on duty re-educated on not standing over the resident during dining assistance and reasoning it is against a resident’s dignity. Instructed to sit with resident at eye level and encourage eating while assisting resident. Between 1/26/18 and 2/4/18 all staff in-serviced on resident rights of dignity and respect during all activities and interactions with the residents by staff. Audits at meal time for appropriate assistance during eating done one meal daily for one week to ensure appropriate assistance with eating.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING ______ B. WING ______	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	**111 HARRILSON STREET CHERRYVILLE, NC 28021**

(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 550	Continued From page 2 Resident #4 but she usually did. The NA also stated she was in a rush to get trays out and just didn't think about sitting. The NA further stated she had been trained to sit when assisting with meals but was not aware it was considered a dignity issue for the resident. During an interview at 12:59 PM on 01/24/18, the ADON stated the NA's knew they were supposed to sit while assisting residents with meals. The ADON also stated she wasn't sure why the NA was not seated when she came into the room of Resident #4. During an interview at 5:29 PM on 01/24/18 the Director of Nursing (DON) stated NA's know what needs to be done for each resident in the care guide that is kept in a folder at the nurse's desk. The DON also stated during orientation and at least once a year, information regarding assisting resident with meals is reviewed in training and they do quarterly in-services on Activities of Daily Living (ADL's). The DON further stated her expectations were for staff to be sitting down during a meal, talking and trying to encourage a resident to eat and not to be standing.	F 550	To ensure quality assurance audits will continue as follows: Unit Manager will audit meals in dining room and residents being assisted in their rooms weekly for eight weeks. Bi-monthly for one month. Monthly for three months. Audit results will be reviewed in QAPI meeting monthly for 6 months.	