STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR	**4230 NORTH ROXBORO STREET DURHAM, NC 27704**

(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		1/28/18

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

Electronically Signed | 01/25/2018

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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, resident and staff interviews and record review the facility failed to treat resident in a dignified manner by not responding to a call light for assistance for 1 of 3 residents (Resident #5). The findings included: Resident #5 was admitted on 1/05/17. The diagnoses included in part, Cerebral Palsy and paraplegia. Review of the activities of daily living care area assessment dated 12/12/17, indicated Resident # 5 required extensive 1-2 person assistance with activities of daily living. The annual Minimum Data Set (MDS) assessment, dated 12/12/17, revealed Resident #5 cognition was intact, she required extensive to total assistance with activities of daily living and assistance with meals. She had impaired range of motion and mobility with both side of her upper and lower body. Review of Resident #5 care plan, dated 12/18/2017, identified the problem of alteration in Self Care/ ADL deficit related to Cerebral Palsy and Paraplegia, and refusal of bathing at times. The goal was that Resident #5 received daily care/ADLs from staff without negative outcome, the intervention to totally assist with bathing and dressing. Also identified was the problem she was at risk for falling related to Paraplegia and Cerebral Palsy. The goal was that she was free	F 550	Based on observations, resident and staff interviews and record review the facility failed to treat resident in a dignified manner by not responding to a call light for assistance for 1 of 3 residents (Resident #5). Resident #5 needs were immediately met by CNA. An audit by nurse managers and the Executive Director was completed immediately to ensure that no other residents call lights were on. Residents needing assistance needs were met immediately. Education was provided via in-service by the Executive Director and the Director of Nursing to all staff on call light response expectation and provision of timely ADL care. The in-service was held in groups. The in-service included hands on employees as well as all other employees. It is the Executive Director expectations that all staff answer call lights. In addition the in-service included re-educating staff on knowing which light is assigned to which bed. An audit was completed of current resident in regards to answering of the call bell lights and services being provided timely. This audit will serve as measure of identifying noted improvement and/or ongoing re-education and disciplinary action as warranted with employees. The audit will continue to be part of the education process for staff current and newly hired upon orientation.	

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F 550	Continued From page 2 from falls. The intervention was for bed mobility to assist with 2 persons. Roll her with an Aide or Nurse on each side of the bed and transfer with max assist and lift device. When entering Resident #5 room on 1/12/18 at 9:08AM, it was observed that the meal tray was had been set up for Resident #5 in her room. The resident was observed with her head lying underneath tray table. Resident #5 had poor trunk control and difficulty repositioning herself. She was unable to feed herself due to her limited physical abilities. Nurse #1 was observed at the medication cart two rooms away. Resident #5 activated her call light at 9:10AM, She was observed watching out of her door and her face saddened as several staff from various departments walked past her room. The activity assistant entered the room at 9:18 AM and walked by Resident #5. She spoke with the Resident in bed B and then left the room without asking Resident #5 if she required assistance. Nurse #1 entered the room at 9:20 AM and asked Resident #5 what she wanted. Resident #5 indicated she needed to be straighten up in the bed and needed two straws. An Aide entered the room and picked up the pillow off the floor and stated she needed to get another pillow cover, and Nurse # 1 told the Aide what Resident #5 needed. During the observation, Resident #5 indicated she was unable to eat her breakfast. While waiting for assistance she indicated that staff took a long time to answer the call bell and stated she felt that the staff doesn't care and she wanted to leave the facility. During interview on 1/12/18 at 9:25AM the	F 550	The Interdisciplinary Team including the Executive Director, Director of Nursing, Nurse Managers, Social Worker, Activity Director, Admission Coordinator, and other department heads will perform audits - which includes feedback from residents and Resident #5 regarding timely provision of ADL care and call light response. The audits will be completed 3 days per week for four weeks, then 2 days per week for four weeks: then monitored weekly to ensure resident dignity maintained and call bell lights answered in a timely manner with care being provided in a timely manner. The ED/DNS will report the audit findings to the QA committee monthly for 3 months. The QA committee will review the audits and ensure compliance is on going and determine the need for further audits/re-education beyond the 3 month period. Also call lights will be discussed in Resident Council monthly.	

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F 550	Continued From page 3 Director of Nursing came by the room and indicated her expectation was for all staff to answer the call bell regardless of what department they work. It was unacceptable for staff to walk by the room without checking on a resident. During interview on 1/12/18 at 9:30 AM the activity assistant indicated she had entered Resident #5 room for the resident in bed B and saw that Resident #5 call bell was lit and she thought someone else had answered it. During interview on 1/12/18 at 10:00AM the Social Worker confirmed that Resident #5 had requested to be transferred out of the facility. During interview on 1/12/18 at 12:56 PM Nurse #1 indicated anyone can answer the call bell and notify the aide or the nurse. She indicated she saw the bell when she came out of a room.	F 550		