STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	C 02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE GREEN HEALTH AND REHABILITATION	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

(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 The surveyor entered the facility on 2/24/23 to conduct a complaint investigation survey and exited on 2/25/23. Additional information was obtained on 2/27/23. Therefore, the exit date was changed to 2/27/23. Event ID# 1WVN11. The following intake was investigated NC00198558 One of the four complaint allegations resulted in deficiency.	F 000		
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.	F 550		3/4/23

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

Electronically Signed | 03/10/2023

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F 550	Continued From page 1 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 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, staff, and Regional Ombudsman interviews the facility failed to assure a resident (Resident # 1) was treated respectfully during a meeting held with staff members to discuss her care and concerns. This was for one of one sampled resident who met with administrative staff during a formal meeting. The findings included: Resident # 1 was admitted to the facility on 1/10/23 for rehabilitation after being hospitalized for a respiratory illness. Resident # 1's admission Minimum Data set assessment, dated 1/16/23, coded Resident # 1 as cognitively intact. Resident # 1 was not coded as displaying any behaviors during the assessment period. Resident # 1's care plan, updated on 2/20/23, noted Resident # 1 suffered from chronic pain. The care plan also addressed that she also displayed manipulative behavior/ attention	F 550	Resident #1 continues to reside in the facility. The Administrator and DON met with Resident #1 on February 27th, 2023 to reassure her that the team cared and would ensure care and treatment was provided in a dignified respectful manner. The care plan was reviewed and updated as needed. The attendees at the meeting (Director of Nursing, Assisted Director of Nursing, Social Worker, Business Office Manager, Dietary Manager, Rehab Director, Discharge Planner, Minimum Data Set Nurse, and Activity Director) received education on February 24th, 2023 by the Administrator regarding compassionate care, appropriate body language, treating residents in a dignified manner and respect. 100% audit of all interviewable residents was initiated by Director of Nursing or Designee on 2/25/2023 to ensure staff are	

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F 550	Continued From page 2 seeking behaviors. Although not all inclusive, some of the interventions to address behaviors on the care plan were as follows. Staff were directed to determine the reason for any behaviors, approach her in a calm manner, praise for desired behavior, and provide support as needed. Resident # 1 was interviewed on 2/25/23 at 9:40 AM and reported the following. She and two of her family members had a meeting within the past week with administrative staff members to discuss her care and concerns that she and her family had. One of the resident ' s main concerns, which was discussed, was pain management and getting her pain medication timely. The resident also reported that she had concerns that she heard staff talking about her from her room while they were in the hallway, and she did not appreciate that. Prior to the meeting, Nurse # 1 had informed Resident # 1 that upon her initial admission, Resident # 1 acted as if staff should drop everything and attend to her. According to Resident # 1, Nurse # 1 was a direct care nurse and had not been at the meeting. Resident # 1 did not recall anything specifically she had done to give staff this impression, and acknowledged that when she first came, she may not have remembered everything as clearly as she did currently. During the meeting with administrative staff, she stated she spoke up and apologized for anything she had done to upset facility staff. She told the administrative staff that she wanted everyone to get along. During the meeting she recalled the business office manager rolling her eyes during the meeting. She also recalled the social worker sat "as if she had a chip on her shoulder" and would not look at her. The resident stated it made her feel as "if I was	F 550	treating residents in a dignified manner. This audit was completed on 2/27/2023. The Director of Nursing or designee initiated a 100% audit for all non-interview able residents, by contacting the Responsible Party regarding any concerns of staff not treating the resident in a dignified manner. This audit was completed on 2/28/2023. Any voiced concerns were addressed by Social Worker or designee by 2/28/2023. The Director of Nursing or designee completed an in-service on 3/2/2023 for all staff on compassionate care, resident rights and dignity to include appropriate body language, or facial expressions. Any staff who did not receive this in-service by 3/4/2023 will not be allowed to work until this education has been completed. This education was added to the new hire employee orientation on 2/28/2023 by the Administrator. The Director of Nursing or Designee will interview 10 random interview able residents or family members of non-interview able residents weekly X 4 weeks, then 5 random interview able residents or family members of non-interview able residents weekly X 4 weeks, then 5 random interview able residents or family members of non-interviewable residents monthly X 1 month. The Director of Nursing or Designee will bring these audits to the Quality Assurance Committee meeting x 3	

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F 550	Continued From page 3 beneath them" and "a nobody to them." Resident # 1's family member was interviewed on 2/24/23 at 10:40 AM and reported the following. Resident #1, another family member, and she had met with several administrative staff members within the past week to discuss Resident # 1's care and concerns they had. The Regional Ombudsman was also present for the meeting. The family member reported the staff members looked down rather than at the resident and rolled their eyes during the meeting. The Regional Ombudsman was interviewed on 2/24/23 at 12:53 PM AM and reported the following. He had been in attendance during the meeting with Resident #1, two family members, and several administrative staff members within the past week. The administrative staff members who were present were the Rehabilitation Director, the Director of Nursing, the Social Worker, and the business officer manager. The Administrator was not physically present and had called in on the speaker phone. The Physician Assistant (PA) came for the first few minutes of the meeting and stepped out after discussing pain management. After the PA left, they further discussed concerns that the resident felt she had waited for care and pain medications, that the resident felt staff were talking about the resident in the hallway when she was not present, discharge planning, and the amount of assistance the resident needed to walk to the bathroom. The Regional Ombudsman corroborated that during the meeting he witnessed the social worker rolling her eyes as Resident # 1 was speaking. He also corroborated some of the administrative staff members would not look at the resident and looked down. The Regional Ombudsman	F 550	consecutive meetings, at which time a determination will be made if further monitoring is necessary.	

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F 550	Continued From page 4	F 550		

reported Resident # 1 spoke up and said she was not asking for special treatment, but only to be treated the way they would treat their own family member. According to the Regional Ombudsman, none of the staff members spoke up when this was said by the resident. Following the meeting, the Regional Ombudsman stated he had spoken to the Administrator about how the staff had acted during the meeting.

The Regional Ombudsman was interviewed again on 2/27/23 at 10:35 AM. The Regional Ombudsman reported the meeting with Resident # 1 and the family lasted approximately one hour and 15 minutes. They had also discussed what the social worker's role was during the meeting. He did see the social worker go up to the resident after the meeting had been concluded and as people were leaving. According to the Regional Ombudsman, as people were leaving the SW told Resident # 1 she cared.

The Administrator was interviewed on 2/24/23 at 5:25 PM and again on 2/25/23 at 3:45 PM and reported the following. She had been out of town when the meeting was held. It would have been her preference to have been physically present during the meeting, but she had not wanted to delay the meeting for her return. This was because she wanted any concerns Resident # 1 and her family had to be resolved. Therefore, she had called in by speaker phone and she could not see how her staff were acting nor always hear every detail. Since the meeting, she had followed up with her staff who reported that after the meeting the social worker had tried to reinforce that they cared about Resident # 1.