STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

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F 000	INITIAL COMMENTS The survey team entered the facility on 10/03/23 to conduct a complaint investigation survey and exited on 10/03/23. Additional information was obtained off site on 10/04/23 and 10/05/23. Therefore, the exit date was changed to 10/05/23. Event ID# 5T8711. One (1) of 15 allegations resulted in a deficiency. NC00205846, NC00206528, NC00207147, NC00207286.	F 000		
F 550 SS=G	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	F 550		10/27/23

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

Electronically Signed | 10/27/2023

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F 550	Continued From page 1 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 and staff interviews the facility failed to treat a resident in a dignified manner by not providing assistance and care when requested. Resident #1 contacted law enforcement and the responding officer had to request assistance from staff twice before care was provided. This deficient practice occurred for 1 of 3 residents reviewed for dignity (Resident #1). Resident #1 stated he was asking for assistance to the bathroom and then was incontinent of bowel movement due to the long wait which made him feel angry, disrespected, and embarrassed. The Findings included: 1. Resident #1 was admitted to the facility on 11/25/19 with diagnoses of hemiplegia and seizure disorder. The quarterly Minimum Data Set (MDS) assessment dated 08/02/23 revealed that Resident #1 was cognitively intact, required extensive assistance with toileting and transfers,	F 550	1) Resident #1 was provided care by NA #1 and NA #2 on 8/5/2023. NA #1 was provided re-education and counseling regarding answering call lights regardless of assignments. 2) Interviews were conducted with alert and oriented residents and/or responsible parties of residents by hall ambassadors between 10/23-10/27/2023 asking if there are any concerns with residents receiving timely, appropriate care, and that the resident□s are being treated with dignity and respect when receiving care. The interviews revealed no additional concerns. 3) All Licensed Nurses, including contract staffing, were in-serviced by the Administrator and/or Director of Nursing (DON) on residents' rights, treating residents with dignity and ensuring all	

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and was always continent of bladder and bowel. Resident #1 was assessed as requiring wheelchair for mobility. No refusal of care and no skin breakdown was noted during the assessment reference period.

Resident #1 was interviewed in his room on 10/03/23 at 12:20 PM. During the interview he stated he often had to wait at least 30 minutes or longer on staff to answer his call light when he needed assistance with using the bathroom. Resident #1 revealed on 08/05/23 at 10:15 AM he had put on his call light for assistance with transferring out of his bed and using the bathroom. He stated at 10:30 AM staff still had not responded to his call light, so he used his sliding board to transfer himself out of the bed into his wheelchair and went to the nurse station to ask staff for assistance with using the bathroom. He revealed staff were at the nurse station talking to themselves and ignoring his request, so he went back to his room and then called his sister asking her to call the facility and have someone come to his room to assist him in the bathroom. Resident #1 stated after speaking with his sister around 10:35 AM and continuing to wait on staff to assist him with going to the bathroom he had a bowel movement on himself. He revealed his sister called him back at 10:45 AM and told him she was not able to speak with any staff about assisting him with care and told him to contact local law enforcement. He stated he contacted law enforcement around 10:50 AM about staff not assisting him with using the bathroom causing him to have a bowel movement on himself and then went to the front lobby to wait for law enforcement to arrive. Resident #1 revealed once law enforcement arrived around 11:00 AM, he informed them of

residents have access to quality care the education also included that call lights should be answered by any staff regardless of assignments on 10/24/2023 thru 10/27/2023. All new licensed nursing staff or contracted nursing staff will be educated on policy prior to starting their first shift by the Director of Nursing. No employee will be allowed to work without this education after 10/27/2023. Receptionists were provided with education by the Administrator on how to properly handle telephone calls from residents requesting assistance when the resident does not identify themselves on 10/24/2023 thru 10/27/2023. Receptionists were instructed to notify the nurses on duty that a resident had called requesting help but did not give their name so that the nurse could check their assigned residents. Upon the hire of a new receptionist, education will be provided regarding this procedure. Receptionists will not be allowed to work after 10/27/2023 without this education.

4). Beginning 10/27/2023, department managers will monitor call bells for being answered timely during rounds twice a week x 4 weeks then weekly x 4 weeks then twice a month x 4 weeks. This is completed as part of their ambassador rounds by visual monitoring during daytime hours and weekly interviews with residents or Responsible Party□s to ensure care is being provided timely, appropriate and residents are being treated with dignity and respect. Resident #1 hall ambassador will visit him

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F 550	Continued From page 3 what had happened with him trying to receive staff assistance with using the bathroom and that he had a bowel movement on himself while waiting. He stated law enforcement asked the receptionist to have staff come to the lobby to assist him with care and two staff members came and said he would need to be in his room to receive care. He revealed the law enforcement officer assisted him back to his room and after waiting for 45 minutes for staff to come and assist him with care the law enforcement officer had to ask one of the staff again to assist him with care and at 12:00 PM Nurse Aide (NA) #1 and NA #2 assisted him with his care. Resident #1 also revealed he was able to know the time frame and how long he had to wait for care due to being able to read the clock in his room and on his cell phone. Resident #1 stated he felt mad, embarrassed, and disrespected because of the incident. A telephone interview conducted on 10/03/23 at 1:22 PM with Nursing Assistant (NA) #1 revealed she was familiar with Resident #1 and the incident that occurred on 08/05/23. She stated Resident #1's call light had gone off earlier that morning and she did not respond to the call due to not knowing he had been assigned to her. She stated the previous schedule had Resident #1 assigned to another staff member and due to Resident #1 requesting that staff member not work with him, the schedule had been changed and she had not checked the schedule prior to her shift. She revealed after Resident #1's call light had been going off for at least 30 minutes he did come to the nurse station and was cursing at staff about needing assistance with using the bathroom, but she was still not aware that he had been assigned to her and she assumed someone	F 550	3 times a week x 4 weeks then resume their weekly interviews with Resident #1. Department manager round reports and interview documentation will be turned into the administrator weekly for review and any concerns will be reported and addressed and/or investigated immediately. " Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5) Completion date 10/27/2023	

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else would provide his care, so she continued not to respond to his call light. She also revealed that each staff person has an assigned group of residents they are responsible for providing care to and if a resident is not in their assigned group they do not provide for their care. NA #1 stated after law enforcement arrived at the facility, she was told by Nurse #1 that Resident #1 had been assigned to her and she and NA #2 went into Resident #1's room and provided him with personal care to include cleaning stool off his bottom and assisted with changing his pants due to him having a bowel movement on himself. She did not recall Resident #1 having dried stool on his bottom or having any signs of redness or skin breakdown. She stated after the incident, she did receive a write-up from administration due to not providing care to Resident #1 in a timely manner.

Attempted to contact NA #2 on 10/03/23 and she did not return telephone calls.

On 10/03/23 at 2:07 PM an interview was conducted with the Receptionist. She stated she was working on 08/05/23 and had received a call earlier that morning from a resident asking for staff assistance with care but the resident hung up before she had been able to get the resident name or room number. She revealed later that day, Resident #1 met with a law enforcement officer in the lobby about not receiving assistance with his care and the law enforcement officer requested for her to call staff to the lobby to assist Resident #1 with care and so she did and then the law enforcement officer assisted Resident #1 to his room. She stated she only worked weekends and was not familiar with all the staff or their names and could not recall which staff came to speak with Resident #1 and the law

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enforcement officer in the lobby and did not know why staff did not assist Resident #1 back to his room.

On 10/04/23 at 12:34 PM an interview was conducted with the Law Enforcement Officer. He stated he had received a telephone call on 08/05/23 from Resident #1 around 10:45 AM stating he had been requesting assistance with using the bathroom from facility staff since 10:15 AM and no one would assist him causing him to have a bowel movement on himself. He revealed he responded to the facility at 11:00 AM and Resident #1 met with him in the lobby to discuss his concerns with staff not assisting him with using the bathroom when asked and causing him to have a bowel movement on himself. He stated he asked the receptionist at the facility to contact staff to come and assist Resident #1 with personal care and when staff arrived in the lobby, they stated Resident #1 would need to be inside his room to receive assistance with care. The officer stated he assisted Resident #1 back to his room and continued to wait for staff to come into the room and assist Resident #1 with personal care and no staff came. He revealed he left Resident #1 room and spoke with Nurse #1 and informed her of how long Resident #1 had been requesting assistance with using the bathroom causing him to have a bowel movement on himself and she stated she would find staff to assist as soon as possible. He stated staff did not arrive at Resident #1 room to provide him with assistance with using the bathroom until 12:00 PM and Resident #1 had been requesting assistance for at least an hour and forty-five minutes and had been sitting in his own bowel movement for at least an hour and a half.

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An interview was conducted with Nurse #1 on 10/03/23 at 3:03 PM. She stated she had been working on 08/05/23 but had not been made of any issues with Resident #1 not receiving assistance with his care until she had spoken with the law enforcement officer who was requesting staff to assist Resident #1 with his care. She revealed she asked NA #1 to go into Resident #1's room to provide for his care and the Administrator was notified about the incident and she made sure Resident #1 received assistance with his care in a timely manner for the rest of her shift.

On 10/03/23 at 1:33 PM an interview was conducted with the Social Worker (SW). During the interview she stated she had received a telephone call on 08/05/23 from the Administrator informing her of the incident with Resident #1 and was asked to go to the facility and speak with Resident #1 about the incident. She revealed Resident #1 informed her that he had put on his call light early that morning for assistance with using the bathroom and no staff responded so he went to the nurse station and tried to ask for assistance but no would help so he called law enforcement, and they came to the facility and had to ask staff to assist him. She stated Resident #1 informed her that he did not receive assistance with using the bathroom for at least an hour and a half and during that time had soiled himself. SW revealed Resident #1 was very upset about the incident and she informed the Administrator of his concerns.

An interview was conducted with the Director of Nursing (DON) on 10/03/23 at 1:54 PM revealed she was not at the facility when the incident with Resident #1 occurred and was told of the incident

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by the Administrator. She stated she had spoken with NA #1 about the incident and provided her with a written disciplinary action for not providing Resident #1 toileting care in a timely manner. She revealed she expected nursing staff to answer call lights and provide care to all residents in a timely manner.

On 10/03/23 at 2:52 PM an interview was conducted with the Administrator. She revealed she had received a telephone call on 08/05/23 from Nurse #1 about the incident with Resident #1 and had asked the SW to take his statement about the incident. She stated NA #1 should have provided incontinence care for Resident #1 and answered call light within a timely manner. She also stated Resident #1 should not have had to call law enforcement or wait over an hour on incontinence care.