

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2017
NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330		
(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>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY</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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interviews and record review the facility failed to treat residents in a dignified manner by responding disrespectfully when the residents needed assistance with activities of daily living for 3 of 5 sampled residents (Resident # 2, Resident # 3, Resident #4).</p> <p>Finding included:</p> <p>1. Resident # 2 was admitted to the facility on 09/05/2016 with diagnoses that included but were not limited to left toe abnormalities, lack of coordination, hemiplegia following cerebral infarction, acute kidney disease failure, type II diabetes, hypertension and peripheral vascular disease.</p> <p>The review of the most recent Minimum Data Set (MDS) 04/26/2017 identified that resident # 2 was cognitively intact with no behaviors. The MDS indicated the resident was totally dependent for bathing and toileting, required extensive assistance for bed mobility and dressing and required assist of one with transfers and locomotion on and off the unit. The resident was independent with all meals and required supervision and encouragement.</p>	F 241	<p>F-241</p> <p>Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law.</p> <p>Resident #2 and Resident #4 were interviewed by the Administrator on 6/14/17 to ensure each of them was being treated in a manner that promotes the best quality of life. Both Resident #2 and Resident #4 offered no concern with staff. Resident #3 was successfully discharged home from the facility on 5/31/17.</p> <p>The nurse referenced by Resident #2 was no longer an employee of the facility at the time of the complaint investigation. The nurse referenced by Resident #4 received 1:1 education regarding dignity and respect from the Director of Nursing on 5/29/17.</p> <p>Between 6/13/17 and 6/23/17, all licensed and unlicensed staff completed a digital interactive in-service promoting resident quality of life through dignity and respect.</p>	6/23/17	

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

TITLE

(X6) DATE

Electronically Signed

06/16/2017

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.

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F 241	<p>Continued From page 1</p> <p>Resident # 2 was interviewed on 05/22/2017 at 8:55 a.m. The resident stated that a couple of weeks ago on the second shift a nurse was hateful to him when he rang the bell for assistance to the bathroom. He stated she raised her voice at him and that she told him he always rings the bell when she is busy. He stated that she was hateful to everyone. He stated that it did not make him feel good being treated like that and that he was happy that she was fired. Resident was not sure if she got fired for this incident or for something else.</p> <p>Resident # 2 was interviewed on 05/23/2017 at 3:30 p.m. The resident stated again that a nurse a few weeks ago was hateful to him and that he rang his bell for assistance to the bathroom. Resident stated that the nurse got real loud with him and did not treat him with respect. Resident stated that this nurse was hateful to everyone.</p> <p>A record review of the monthly nursing notes dated 05/17 stated that resident was alert and was able to verbalize his needs.</p> <p>An attempt to interview the named employee on 05/22/2017 at 9:00 a.m. did not occur due to phone number being changed since employment at the facility.</p> <p>Staff interview on 05/22/2017 at 9:20 a.m. revealed that resident # 2 was alert and oriented and that he knows what is going on and that he needs assistance with all activities of daily living (ADLs). She stated that he is continent of both bowel and bladder.</p> <p>Certified Nursing Assistant (CNA #1) was</p>	F 241	To ensure quality assurance, Staff will receive dignity and respect education at least quarterly for one year. A minimum of five alert and oriented residents will be interviewed monthly for at least 90-days to ensure staff is treating residents in a manner that promotes maintenance or enhancement of his or her quality of life. Findings and resolution to interviews will be reviewed in QAA for a minimum of three consecutive meetings.		

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F 241	<p>Continued From page 2</p> <p>interviewed on 05/22/2017 at 10:00 a.m. and stated that Resident # 2 was a one person assist for transfers and toileting. The nursing assistant stated that he is oriented and knows what is going on around him.</p> <p>Staff interview (CNA # 2) on 05/23/2017 at 10:30 a.m. stated that resident is dependent on staff for toileting and that he is oriented.</p> <p>Staff interview (CNA # 3) on 05/23/2017 at 2:20 p.m. stated that she witnessed the nurse talking loudly and disrespectfully to resident # 2. She stated that when resident # 2 rang his call light she came in and got loud and annoyed with resident needing help to the bathroom.</p> <p>On 05/23/2017 at 2:45 p.m. the administrator was interviewed. She stated that she is concerned with the culture and thinking of the staff. She also stated that the named employee had been fired not for this situation but due to the fact that she has had multiple issues with this employee. She also stated that she was aware of the situation.</p> <p>2. Resident # 4 was admitted to the facility on 08/11/2016 with diagnoses that included but were not limited to muscle weakness, heart failure, end stage renal disease, hypertension and anemia.</p> <p>The review of the most recent Minimum Data Set (MDS) 03/21/2017 identified that resident was cognitively intact with no behaviors. The MDS indicated the resident required limited assist for toileting, bed mobility, dressing and totally dependent for bathing. According to the MDS the resident was independent for all meals and required set up only.</p>	F 241			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 241	<p>Continued From page 3</p> <p>Resident # 4 was interviewed on 05/20/2017 at 5:30 p.m. The resident stated that she had a problem with a lady on the 11-7 shift about two weeks ago and had not seen her since. Resident stated that she was to have her Nepro that was ordered two times a day once at 6:00 a.m. and the other at 8:00 p.m. The time of asking for the Nepro was around 6:00 a.m. per resident. She stated that the medication nurse threw her hands up at resident and said, "can't you see I am busy and it is almost 6:00 a.m. and it is almost the end of my shift." Resident then stated, "you should not treat me like that" and became tearful.</p> <p>Resident # 4 was interviewed again on 05/22/2017 at 10:15 a.m. Resident stated that the nurse that would not get her the Nepro was blonde with long hair and that she threw her hands up at her when she asked for her Nepro. When asked how this made her feel she stated, "I cried when that happened. I did not do anything to her so why did she have to treat me like that."</p> <p>Record review of a nurse note dated 05/18/2017 revealed that resident was alert and oriented x 3 person, place, and time and able to make needs known.</p> <p>Staff interview on 05/22/2017 at 1:40 p.m. with a licensed practical nurse (LPN) revealed that resident # 4 was alert and oriented. The LPN stated that she gives resident her Nepro before her dialysis days in the early morning and that she gets it at least two times a day.</p> <p>Staff interview on 05/22/2017 at 1:56 p.m. with the housekeeper revealed the resident reported the incident to the housekeeper. The interview with the housekeeper revealed that resident # 4</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>did call him on his phone regarding the staff member that treated the resident "not so nice." The housekeeper stated that resident was crying when she called and that he did report this to the social worker. The housekeeper reported that it happened a few weeks ago and could not remember the exact date and time.</p> <p>Staff interview on 05/22/2017 at 2:20 p.m. with the social worker revealed that she was aware of the incident and that resident # 4 does get Nepro by nurse on second shift. The social worker stated that during her investigation of this that resident never did get the Nepro from the nurse and that a nurse aide brought some to her with ice.</p> <p>Staff interview on 05/23/2017 at 10:10 a.m. with the medication nurse that worked the 11-7 shift stated that resident does get Nepro during the 11-7 shift and denied getting loud and waving hands at resident. The nurse stated that she never did get her the Nepro and that she believed the resident got it herself out of her personal refrigerator and that a nurse aide got her ice.</p> <p>Staff interview on 05/23/2017 at 12:05 p.m. with a nurse aide (CNA # 1) stated that resident # 4 had no behaviors and was always very pleasant.</p> <p>Staff interview on 05/23/2017 at 12:30 p.m. with a nurse stated that resident # 4 is very pleasant and does not typically have behaviors.</p> <p>Staff interview on 05/23/2017 at 12:40 p.m. with a nurse aide (CNA # 2) stated that resident # 4 is pleasant and has no behaviors.</p> <p>Staff interview on 05/23/2017 at 1:00 p.m. with</p>	F 241			

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F 241	<p>Continued From page 5</p> <p>the Director of Nursing (DON) stated she was aware of the incident as it was reported to her by the social worker.</p> <p>On 05/23/2017 at 1:30 p.m., the nursing home administrator stated that the culture of this building is just not typical and the corporate way and that she had been doing a lot of work since becoming the interim nursing home administrator.</p> <p>Staff interview on 05/23/2017 at 3:45 p.m. with a nurse aide (CNA # 3) who was on shift during the incident with resident # 4 stated that the nurse brushed the resident off and that she did not treat resident with respect. The nurse aide stated that everyone knows that resident # 4 is a sweetheart.</p> <p>3. Resident # 3 was admitted to the facility on 05/19/2017 with diagnoses that included, but were not limited to, acute myocardial infarction, angioplasty, severe cardiogenic shock, intra-aortic balloon pump, recurrent arrhythmia, Diabetes Mellitus II, hypertension and leukocytosis.</p> <p>The review of interim care plan dated 05/19/2017 identified resident as alert with moderately impaired cognition. The interim careplan identified resident as requiring two person assist with transfers and toileting assist by staff.</p> <p>Resident # 3 was interviewed on 05/20/2017 during the initial tour at 5:30 p.m. The resident stated that the first night he was admitted to the facility (05/19/2017) he rang the bell for help in the bathroom and that a nurse aide stated, "you can clean your own white ass." Resident stated, "you got to respect me like I respect you."</p>	F 241			

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F 241	<p>Continued From page 6</p> <p>The review of the nurses notes dated 05/21/2017 identified resident as alert and oriented x 3 and able to make needs known.</p> <p>The review of therapy notes dated 05/22/2017 stated that resident # 3 was alert and oriented and required supervision with toileting and assist of one, used a wheelchair for mobility and can use walker to ambulate with assist of one short distances.</p> <p>Staff interview on 05/23/2017 at 4:00 p.m. with the nurse aide (CNA # 1) on shift during the incident stated that she did come into the bathroom to assist resident when he rang the bell. The nurse aide stated that she asked him if he could wipe his own butt when resident # 3 asked her to help wipe him. Nurse aide stated she was trying to get to know the resident as he was new and that he did need assistance with all activities of daily living and that he needed help with toileting.</p> <p>Resident # 3 was interviewed on 05/23/2017 at 4:10 p.m. and he stated that during the night shift on the first night he was admitted (05/19/2017) a nurse aide stuck her head in the bathroom door when he rang for assistance and stated, " you mean you can't wipe your own ass?" When asked how this made resident feel he stated, "how do you think I felt. Asking to have someone wipe you and they say that."</p> <p>Staff interview on 05/23/2017 at 4:15 p.m. with the nurse aide (CNA #2) stated that resident was alert and oriented and does require assistance with toileting and all activities of daily living with minimal assistance.</p>	F 241			