STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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		7/5/18

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

Electronically Signed | 06/21/2018

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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, staff and Responsible Party (RP) interviews and record review, the facility failed to dress a resident in regular clothes during waking hours. The resident was dependent on the staff for his activities of daily living (ADLs). This was for 1 (Resident #8) of 2 residents reviewed for dignity. The facility also failed to provide a dignified dining experience for 1 (Resident #63) of 2 residents reviewed for dignity. The findings included: 1. Resident #8 was admitted 9/11/15 with cumulative diagnoses of Alzheimer's Disease and Congestive Heart Failure. Review of Resident #8's annual Minimum Data Set (MDS) dated 5/16/18 indicated severe cognitive impairment and he was coded as exhibiting no behaviors. He was coded as requiring extensive staff assistance with dressing. The Care Area Assessment (CAA) read that staff were to encourage him to pick out his clothes and staff were to dress him appropriately daily and as needed. Review of Resident #8's care plan last revised 5/23/18 read he was to be up out of the bed daily and the staff were to dress him as needed. The care plan read the staff were to encourage him to choose his own clothes. There was no care plan for refusal or rejection of his ADLs. In an observation on 6/4/18 at 9:50 AM, Resident #8 was in the dining room with other residents	F 550	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of Federal and State Law. Process: 1)Teammate #2, #3, #4, #5 was instructed to encourage and assist resident on choosing own clothing attire by Director of Nursing June 7, 2018. 2)Teammate #1 was instructed to be at eye level when assisting resident #63 with meals and engage with resident during the meal experience. Teammate was educated on 6/7/2018 by Staff Development/ Quality Assurance RN Procedure for implementing the plan of correction is as follows: All nursing teammates for all on all shifts, weekends included, and prn will receive resident right in-service education by July 5, 2018 by Staff Development Coordinator/ Quality Assurance RN. In-services will include encouraging residents to make own daily clothing attire choices and ensuring a dignified meal experience by conversing at meals and being at eye level when assisting with meals. In-service will	

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F 550	Continued From page 2 participating in an activity. He was observed wearing a pull-over shirt and pajama pants with tennis shoes. During a telephone interview on 6/4/18 at 5:03 PM, Resident #8's RP stated when he had been at the facility to visit, Resident #8 would be wearing pajama pants during the day. He stated he has been wearing pajama pants during his visits at least for at least 6 months. The RP stated that was something Resident #8 would not like if he were cognitively intact. The RP also stated there have been occasions he would have liked to have taken Resident #8 out but the pajama pants were thin and he would be too cold especially in the winter months. The RP stated he had not addressed his concern with the facility. In an observation on 6/5/18 at 9:15 AM, Resident #8 was sitting up in his wheelchair eating his breakfast. He was wearing a pullover shirt, pajama pants and tennis shoes. In an observation on 6/5/18 at 12:35 PM, Resident #8 was eating lunch in the dining room wearing the same pajama pants, pullover shirt and tennis shoes. In an observation on 6/6/18 at 8:10 AM, Resident #8 was sitting up in his wheelchair eating his breakfast. He was wearing a pullover shirt, pajama pants and tennis shoes. In an interview on 6/6/18 at 10:50 AM, Nursing Assistant (NA) #3 stated she dressed Resident #8 this morning before breakfast. She stated he	F 550	include resident rights focusing on 483.10(a), 483.10(a)(1), 483.10 (a)(2), 483.10(b), 483.10 (b)(1), 483.10(b)(2). The monitoring procedure to ensure compliance with choice of attire is as follows: 1)An audit will be completed 3x week to ensure resident #8 was given the choice to choose own attire and is wearing appropriate clothing for 4 weeks. If resident chooses to wear lounging attire rather than daily street attire this will be documented in electronic health record. 5 additional residents will be observed once a week x 3 months to monitor for appropriate attire with documentation made in electronic health record if resident refuses assistance or desires to deviate from dress in care plan. The monitoring procedure to ensure compliance during the meal experience is as follows: 1)An audit will be completed 3x week to ensure resident #63 is being assisted by teammates during meals by being at eye level and engaging with resident during meal. 5 additional residents will be observed once a week x 3 months to monitor to ensure teammates are at eye level and engaging during the meal experience. The audit outcomes will be reported in QAPI Meeting (Quality Assurance Performance Improvement). The title of the person responsible for implementing the plan of action is as	

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had never refused any of his ADLs for her. She stated she was aware that Resident #8 had several pairs of khaki slacks in his closet but she usually just put pajama pants on him. NA #3 stated it was easier to put on and easier to provide Resident #8's incontinence care if he was wearing pajama pants. NA #3 stated she did not think if Resident #8 was given a choice of pajama pants or khaki slacks, he would be able to choose what he wanted to wear. Observation of Resident #8's closet with NA #3 revealed 5 pairs of khaki slacks in various colors on hangers. All the khaki slacks were size 42 waists and did not appear to be new.

In an interview on 6/6/18 at 3:20 PM, NA #4 stated she had observed Resident #8 wearing khaki slacks on the weekends but most of the time, he wore pajama pants.

In an interview on 6/6/18 at 3:30 PM, NA #2 stated when she comes in to work on second shift, Resident #8 is usually in the bed and he doesn't get up out of the bed for dinner. She stated he was always dressed in pajama pants and she did not bother to dress him in slacks since he was not getting up again on her shift. NA #2 stated Resident #8 should be dressed in slack during the day for dignity but it seemed like he was always wearing pajama pants. NA #2 stated based on Resident #8's cognitive status, she did not feel he could choose between slacks or pajama pants if given a choice.

In an observation on 6/7/18 at 8:30 AM, Resident #8 was lying in bed with NA #5 assisting him with his breakfast. NA #5 stated she provided Resident #8 his morning ADLs before breakfast.

follows: Facility Resident Liaison/ or Admission Coordinator.

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He was observed wearing tan colored Khaki slacks. NA #5 stated she did not think he could pick out his own clothes if he was asked. She stated the pants she put on Resident #8 fit properly over his brief and she did not have any difficulty dressing him this morning. Observation of the slacks revealed a loose fit and no evidence that the slacks were too small.

In an interview on 6/7/18 at 9:30 AM, the Director of Nursing (DON) stated Resident #8 had experienced weight gain in the past few months but there was no change in the size of the brief he wore. The DON stated the khaki slacks in Resident #8's closet may have been too small. She stated she thought the Resident Liaison contacted the RP a month ago or so ago about his slack getting too small and he needed to buy some larger slacks. The DON stated that could be the reason the staff were dressing him in pajama pants. A review of Resident #8's weights from January 2018 to present, revealed there had been a 3-pound weight gain over the last 6 months. The DON stated it was her expectation that Resident #8 be dressed in his slacks unless he or the RP requested him to wear the pajama pants during his waking hours.

In an interview on 6/7/18 at 9:45 AM, the Resident Liaison stated she thought she called Resident #8's RP a month or so ago and told him that Resident #8's slacks were getting too small but she did not document it. She stated she was not aware staff were dressing Resident #8 in pajama pants daily and she would not expect him to be wearing pajama pants unless requested by Resident #8 or his RP.

In an interview on 6/7/18 at 10:50 AM, the

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Administrator stated the RP had not expressed any concerns about Resident #8 wearing the pajama pants during the day but stated it was her expectation that Resident #8 was dressed in regular clothes unless otherwise requested by Resident #8 or the RP.

2. Resident #63 was admitted 5/22/15 with cumulative diagnoses of Congestive Heart Failure and depression.

Review of Resident #63's quarterly Minimum Data Set (MDS) indicated severe cognitive impairment and she was coded as exhibiting no behaviors. She was coded as requiring extensive staff assistance with eating.

Review of Resident #63's care plan last revised 5/21/18 indicated she required extensive to total assistance with all of her activities of daily living (ADLs). The staff were to feed her slowly and encourage her to participate in her meals.

In an observation on 6/5/18 at 9:10 AM, Nursing Assistant (NA) #1 was in Resident #63's room with the door open standing while feeding Resident #63's breakfast. Resident #63's bed was not raised to the height where NA #1 and Resident #63 were eye to eye. NA #1 was heard telling Resident #63 to open her mouth to eat. There was no other verbal engagement observed.

In an observation on 6/6/18 at 8:50 AM, NA #1 was observed standing to feed Resident #63's breakfast. Resident #63's bed was not raised to the height where NA #1 and Resident #63 were eye to eye. NA #1 was heard telling Resident #63 to open her mouth to eat. There was no other

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F 550	Continued From page 6 verbal engagement observed. In an interview on 6/6/18 at 11:50 AM, NA #1 stated she always stood to feed Resident #63 and was not aware of any reason she should not stand. In an interview on 6/7/18 at 9:30 AM, the Director of Nursing (DON) stated it was up to Resident #63 if the staff sits or stands while she is eating. The DON stated if Resident #63's bed was in the high position; the aide may need to stand while feeding. The DON further stated some staff did not want to sit in the chairs in the resident rooms so they may be standing to feed. In an interview on 6/7/18 at 10:20 AM, the Corporate Accreditation Coordinator stated it was the expectation that staff sit to feed or assist resident with their meals or be at eye level. She provided evidence that NA #1 was in-serviced 4/11/17 on dignity which included the staff not to stand while feeding the residents. In an interview on 6/7/18 at 10:50 AM, the Administrator stated it was her expectation that staff sit or be at eye level while feeding Resident #63.	F 550		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		7/5/18

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F 658	Continued From page 7 by: Based on record review and staff interview, the facility failed to accurately transcribe the hydrocortisone cream (used to treat redness, swelling and itching of various skin conditions) as ordered by the physician for 1 of 1 sampled resident reviewed for skin condition (Resident #74). Findings included: Resident #74 was admitted to the facility on 3/8/18 with multiple diagnoses including chronic kidney disease and hepatitis C. The significant change in status Minimum Data Set (MDS) assessment dated 5/9/18 indicated that Resident #74's cognition was intact. Resident #74 had a physician's order dated 5/11/18 for hydrocortisone 0.5 % cream, apply to areas of itching from neck down every 4 hours as needed (PRN). On 5/29/18, the order for hydrocortisone was changed. The order indicated to apply the hydrocortisone to areas of itching from neck down three times a day. Review of the Treatment Administration Records (TARs) revealed that hydrocortisone cream was transcribed and was administered every 4 hours (round the clock) instead of three times a day as ordered from May 29 - June 7, 2018. On 6/7/18 at 9:32 AM, Nurse #1 was interviewed. She reviewed the orders for Resident #74 and stated that it was a medication error, it was transcribed to the TAR incorrectly. On 6/7/18 at 10:20 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to accurately transcribe physicians orders to the TARs and to administer	F 658	Process: Teammate immediately discontinued order for hydrocortisone cream with transcription error for resident #74. Teammate entered correct order to reflect application of hydrocortisone cream 3 times a day and PRN (as needed) for itching. The procedure for implementing the plan of correction is as follows: The ordered was corrected immediately for resident number #74 to reflect the correct order of hydrocortisone cream application. All licensed teammates will be in-serviced by Staff Development/Quality Assurance RN by July 5, 2018 on entering orders into the electronic health record and rechecking the order once entered in to the electronic health record. All facility Treatment Administration Records will be audited to ensure accuracy of physician orders. The monitoring procedure to ensure compliance is as follows: All facility Treatment Administration Records will be audited to compare the physician orders to the Treatment Administration Records in the electronic health record monthly to ensure accuracy until compliance is sustained. The audit will be presented at QAPI meeting (Quality Assurance Performance Improvement). The title of the person responsible for implementing the plan of action is as follows: Staff Development RN and/ or the Assistant Director of Nursing.	

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F 658	Continued From page 8 medications/cream as ordered.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff and Responsible Party (RP) interviews and record review, the facility failed to provide showers as scheduled for an activities of daily living (ADLs) dependent resident for 1 (Resident #8) of 2 residents reviewed for ADLs. The findings included: Resident #8 was admitted 9/11/15 with cumulative diagnoses of Alzheimer's Disease and Congestive Heart Failure. Review of Resident #8's annual Minimum Data Set (MDS) dated 5/16/18 indicated severe cognitive impairment and he was coded as exhibiting no behaviors. He was coded as requiring total staff assistance with bathing. The Care Area Assessment (CAA) read bathing was assigned and he was given showers weekly with partial bath on his non-shower days per the resident or RP discretion. Review of Resident #8's care plan last revised 5/23/18 read he was assigned and given showers weekly and partial bath on his non-shower day per the resident or RP discretion. There was no care plan for refusal or rejection of his ADLs.	F 677	Process: The Director of Nursing on 6/7/2018 instructed nursing assistant #2 to report to charge nurse when shower for resident #8 was not completed as assigned so shower could be rescheduled for resident #8 at another appropriate shower time The procedure for implementing the plan of correction is as follows: All nursing assistants will be in-serviced on how to communicate to the charge nurse when shower assignment is not completed during the shift. Nursing assistants will also be in-serviced on how to document in the electronic healthcare system the delivery or refusal of showers. The in-service would also include reporting refusal behaviors of care to licensed nurse. All licensed nurses will be in-serviced on documenting on the 24hr report to on coming shift when a shower is not given and needs to be reassigned to next appropriate shower time. In-service will be provided by Staff Development/Quality Assurance RN by July 5, 2018. The facility shower scheduled was reviewed by the Director of	7/5/18

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F 677	Continued From page 9 Review of the Completed Care Task electronic record from 2/1/18 to 6/5/18 indicated Resident #8 refused a shower on 5/8/18 and 6/1/18 There was no nursing documentation regarding the 5/8/18 shower refusal but there was a nursing note dated 6/2/18 timed 12:04 AM entered as a late entry for 6/1/18. The note read Resident #8 refused to get out of bed for supper and refused his shower. There were no other nursing notes referencing refusal of his showers. Review of the Completed Care Task electronic record from 2/1/18 to 6/5/18 indicated Resident #8 did not receive his scheduled showers on the following days and no documentation that he received the missed shower the following day: February 13-Tuesday-no scheduled shower on this shift February 16-Friday-no scheduled shower on this shift March 2-Friday-complete bed bath March 9-Friday-no scheduled shower on this shift March 16-Friday-no scheduled shower on this shift March 23-Friday-no scheduled shower on this shift March 30-Friday-no scheduled shower on this shift April 10-Tuesday-no scheduled shower on this shift April 24-Tuesday-no scheduled shower on this shift May 1-Tuesday-no scheduled shower on this shift May 25-Friday-complete bed bath Review of the 3-11 Assignment Sheets read showers were assigned by Charge Nurse (CN) #1 or CN #2 on the following dates: February 13-Resident #8	F 677	Nursing and updated on 6/7/2018. The monitoring procedure to ensure compliance is as follows: Audits will be completed on resident #8 once a week to ensure showers are offered for four weeks. An additional audit will be completed on 5 random residents once a week for 3 months to ensure showers were offered as scheduled. Audits will be reviewed monthly at QAPI meeting (Quality Assurance Performance Improvement) to ensure compliance. The title of the person responsible for implementing the plan of action is as follows: The Director of Nursing and/or Assistant Director of Nursing	

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February 16-Resident #8
March 2-Resident #8
March 9-Reisdent #8
March 16-Missing documentation of 400 hall assignments
March 23-Resident #8
March 30-Resident #8
April 10-Resident #8
April 24-documented refused on assignment sheet
May 1-Resident #8
May 25-Resident #8

In an interview on 6/6/18 at 9:50 AM, CN #2 stated she referred daily to the shower schedule and wrote on the Assignment Sheet who was scheduled to receive a shower on first shift and CN #1 did the same for second shift.

In an interview on 6/6/18 at 3:10 PM, CN #1 stated he used shower schedule to document on the second shift Assignment Sheet what showers were due on each day. He stated he was not aware that there were concerns that Resident #8 was not getting his showers as scheduled. CN #1 stated it was his expectation that if Resident #8 refused or if his shower was not done, the aide was to notify the floor nurse and the floor nurse was to follow up with the aide to ensure it was done or there was a documented reason why.

In an interview on 6/6/18 at 3:30 PM, Nursing Assistant (NA) #2 stated she sometimes doesn't have time to do all her showers on Tuesdays because it was vital sign day. NA #2 stated if call lights were going off and the NA assigned the first end of the hall was in a resident room, she could

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F 677	Continued From page 11	F 677		

not take Resident #8 into shower room. NA #2 stated on occasion, the floor nurse would help answer call lights when she needed to be in the shower room. NA #2 stated if she was not able to give a shower on a scheduled day, she tried to do it the next day and tells the floor nurse or CN #1. She stated she has gone in to offer Resident #8 his shower and he has made verbal threats but she did not always return to room to try again because she gets busy. NA #2 stated if he refuses his shower, she tells the floor nurse or CN #1.

In an interview on 6/6/18 at 3:40 PM, Nurse #2 stated if Resident #8 refused his shower, the aide was to let her or CN #1 know but reattempt to shower Resident #8. She stated she was not aware that Resident #8 was not getting to his showers on his assigned days. Nurse #2 stated she tried to help answer call lights when the aides were in the shower room if she was aware.

In an interview on 6/7/18 at 9:30 AM, the Director of Nursing stated if Resident #8 refused his shower or the aide was not able to complete the shower, it was her expectation that the aide informs the floor nurse or CN #1 so the assignment could be adjusted. The DON stated one of the aides assigned to give Resident #8 his showers on 2 of the days he missed his scheduled shower was no longer employed and she had no way of contacting her.

In an interview on 6/7/18 at 10:50 AM, the Administrator stated one of the aides who did not complete Resident #8's assigned shower was no longer employed at the facility but was unsure why NA #2 did not tell management she was unable to complete her assignment. She stated it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 677	Continued From page 12 was her expectation that Resident #8 receive his showers as scheduled or adjusted timely to ensure he received his shower as soon as possible.	F 677		