Not Asking Why It Took Three Hours

The nursing home failed to provide incontinence care to four residents (resident 66, resident 5, resident 36, and resident 35). The residents expressed feelings of being upset, humiliated, being forgotten about and feeling like the staff members didn't care about them.

Resident 66 was cognitively intact and required extensive physical assistance with bed mobility, toilet use and personal hygiene. He was also occasionally incontinent of both urine and bowel. His Care Plan indicated, "Interventions included to assist with activities of daily living as needed and to assist with toileting/incontinence care routinely and as needed."

During an interview, resident 66 stated he had sat for three hours before he was provided with incontinence care. The resident stated this happened all the time on the evening shift. The resident said that one time, two nurse aides came into his room to turn his call lights off twice on the evening shift and told him that they would come back but they never did come back. The resident stated he ended up receiving incontinence care at 1:00 AM. He said that this incident upset him and that it made him feel like they didn't care about him. He added that he had given up on using the bed pan because it took them a while to get back to him to take him off and being on a bed pan for an extended period hurts his back. He stated he usually had to wait for two to three hours on the evening shift before his call light was answered.

During a second interview held three days later, resident 66 revealed he was very frustrated and confused about the continued lack of response from the staff especially on the evening shift. The resident reported that yesterday (Tuesday) he had turned his call light on before 7:00 PM because he needed incontinence care, but nobody came into his room until 10:15 PM when nurse aide 4 provided him incontinence care but he never asked her why it took her a long time to come because he feared being retaliated on. The resident knew they were short staffed but felt like they forgot him and didn't care about him.

During an interview, nurse aide 4 revealed she was usually assigned to resident 66 on the evening shift but had to work by herself on the hall at least three times a week. Nurse aide 4 confirmed that she worked by herself (on the same Tuesday) on the evening shift and didn't get to resident 66's call light until after 10:00 PM. The aide said that that evening was very busy. She added that she usually started at the beginning of the hall and worked her way to the end of the hall so she could get everyone done. She said that was why it took her so long to get to resident 66's call light because his room was located all the way at the end of the hall. The aide added that there was nobody to help her do her rounds.

During interviews held the next day, the Director of Nursing (DON) and the Administrator stated they were not aware of the instances when resident 66 was not provided incontinence care until the end of the evening shift. The DON said that providing incontinence care at least every two hours would be great but not possible with only one nurse aide assigned to the hall.

Name of Nursing Home	Lenoir Healthcare Center / Provider ID: 345138
Address	322 Nuway Care Circle, Lenoir, North Carolina
Date investigation completed	July 9, 2021
Type of deficiency issued	F550 – Resident Rights
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/345138/health/standard?date=2021-07-09