STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWER NURSING AND REHABILITATION CENTER	**3609 BOND STREET RALEIGH, NC 27604**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with staff and resident interviews and record reviews the facility failed to allow a resident to obtain and wear a face shield provided by a family member for 1 of 1 resident reviewed for self-determination. (Resident #1) Findings Included: Resident #1 was admitted to the facility on [DATE]. Review of Resident #1 ' s minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He had no behaviors and was independent with all activities of daily living. Review of Resident #1 ' s care plan dated 6/1/2020 revealed he was care planned to be at risk for infection. During a phone interview on 7/23/2020 at 11:11 AM, Resident #1 stated a family member brought him a face shield to put him at ease as there had been some residents who were positive for the [MEDICAL CONDITION] in the facility and he was immunocompromised. He stated he was told the administrator would not let him have the face shield. He concluded this made him very nervous and worried about his health. During an interview on 7/23/2020 at 9:02 AM the Receptionist stated one day during the week of 7/5/2020 a family member of Resident #1 came to the facility and met with her outside socially distanced with a face shield, some face masks, and gloves. She told him she would check and see if he could have the items. She took the items to the administrator and the administrator told her Resident #1 could have everything but the face shield. The administrator told her Resident #1 should be staying in his room and it would not be fair to other residents if he had the face shield. She stated she went to his room and told him this reasoning for why he could not have the face shield, but he could have the other items after they were quarantined for the required time. She stated she then called the resident ' s family member and informed him of the same. During an interview on 7/23/2020 at 6:45 AM the Administrator stated someone Resident #1 knew dropped off a face shield with gloves and surgical masks for him. She stated she allowed him to be given the gloves and surgical masks which the facility provided to residents already. She stated the face shield was not given to him due to the following concerns. There was no facility policy regarding resident use of face shields. To her knowledge there were no Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, or State guidelines for the use of face shields for residents. She stated she had the understanding the face shield was medical equipment which would need to be cleaned and maintained and ensured it was worn properly and there was no policy in place which gave guidance on that. She stated the facility did provide surgical masks to wear when receiving care. She stated she did not have any recollection of Resident #1 bringing this concern to her attention and she did not speak with the family member, only the receptionist. She concluded there was no documentation about this issue.

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

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.