STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHAB CTR	109 FOOTHILLS DRIVE MORGANTON, NC 28655

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review the facility failed to immediately report an injury of unknown origin for a resident with a bruise extending from the shoulder down to the elbow for 1 of 3 sampled residents (Resident #3). The findings included: A document titled "Abuse Prohibition" dated 06/01/02 read in part: "The facility shall simultaneously develop and operationalize policy and procedures for screening and training employees, protection of residents, and for the prevention, identification, investigation and reporting of abuse, neglect, mistreatment and misappropriation of property. The facility shall train employees through orientation and on-going sessions about: - How staff should report their knowledge related to allegations without fear or reprisal - What constitutes abuse, neglect and misappropriation of resident property This facility shall ensure that all alleged violations	F 226	-Nurse aide #1 was counseled by the DON 01/16/15 to report all injuries of unknown origin with extensive bruising to the licensed nurse before continuing with showers or other activities of daily living. -All residents with injuries have the potential to be affected. All residents with injuries were audited 01/15/15-01/31/15 for appropriate reporting of injuries. No other residents were identified to be affected by this isolated practice. -On-hire/annual 2015 employee education shall be amended to provide additional information regarding the notification process when injuries of unknown origin with extensive bruising are discovered. All direct care staff shall receive additional information, as follows, by 02/12/15: "all injuries should be reported to the licensed nurse as soon as possible. If the injury is causing the resident pain, or limiting the resident's ability to move their body or body parts, the nurse should be notified before continuing with any movement or activity of daily living. This will allow the nurse to check the resident and prevent	2/12/15

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

Electronically Signed | 01/30/2015

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F 226	Continued From page 1 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures." Resident #3 was admitted to the facility on 11/17/14 with diagnoses that included Alzheimer's disease, osteoporosis, osteopenia, history of falls and fractures among others. The most recent Minimum Data Set (MDS) dated 11/24/14 specified the resident had severely impaired cognition, did not reject care, and required physical help with bathing. The MDS also specified the resident did not receive anticoagulant therapy. A physician's progress note dated 01/05/15 at 4:15 PM specified Resident #3 was noted by the nurse to have a large, well demarcated bruise to left upper arm and it was unknown if the resident sustained trauma or fell due to the resident's chronic dementia. The physician documented that Resident #3 had painful range of motion but was unable to verbalize pain scale. The physician ordered an x-ray to the left humerus and left shoulder and placed a sling across the left arm on 01/05/15. The results of the x-ray dated 01/05/15 specified Resident #3 had a fractured humerus and dislocated shoulder. Orders were written to send Resident #3 to the Emergency Department for further evaluation. The Emergency Department report dated 01/06/15 specified that the injury was discovered while the resident was being showered. Resident #3 was discharged back to the nursing home with scheduled pain medication	F 226	further injury to the area" -The DON (or designee) shall audit all reports of accidents and injuries for timeliness of notification of injuries of unknown origin with extensive bruising. Audits shall be completed weekly X 4, then monthly X 3. The DON shall ensure corrective actions are implemented. The DON (or designee) shall present audit results and corrective actions taken at QAPI (Quality Assurance Performance Improvement) team monthly meeting. The QAPI team shall ensure corrective actions are achieved and maintained. Preparation and/or execution of this plan of correction does not constitute admissions or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of Correction is prepared in/or executed solely because the provision of the Federal and State Law require it.	

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and an immobilizer (sling) to the left arm. On 01/07/15 Resident #3 was sedated and had her left shoulder set in place at the hospital.

On 01/13/15 at 9:45 AM Resident #3 was observed in her room sitting in her wheelchair. The resident had a sling to her left arm.

On 01/13/15 at 10:15 AM Nurse #1 was interviewed and reported that she was assigned to Resident #3 on 01/05/15 from 7 AM to 3 PM. Nurse #1 explained that on 01/05/15 she was finishing her shift and Nurse #2 reported that a bruise was discovered on Resident #3. Nurse #1 stated that she was unaware of any bruise prior to the end of her shift.

On 01/13/15 at 10:28 AM and 11:20 AM Nurse #2 was interviewed and stated that around 3:30 PM Nurse Aide #1 reported to her that Resident #3 had a bruise. Nurse #2 stated that the bruise was large, appeared fresh, was dark purple and swollen. She explained that the bruise covered the resident's upper arm extending from her shoulder to elbow and was painful to touch. Nurse #2 stated that Nurse Aide #1 reported that she removed the resident's shirt to shower her, observed the bruise, gave the shower and then reported the bruise to her. Nurse #2 stated that Nurse Aide #1 should have notified the nurse of the bruise before she undressed, showered and then redressed the resident. Nurse #2 stated she explained that to Nurse Aide #1. Nurse #2 added that the physician was in the facility and she asked him to assess the bruise. The physician assessed the bruise and ordered an x-ray to rule out a fracture. The nurse reported that she administered pain medication to Resident #3 and it was effective. Nurse #2 added that she notified

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the nurse manager of Resident #3's bruise.

On 01/13/15 at 11:35 AM the Director of Nursing (DON) was interviewed about Resident #3's injury. The DON reported that through an investigation she had determined that the injury of unknown origin occurred on 01/05/15 between 1:45 PM and 3:30 PM. The DON added that Nurse Aide #1 discovered the bruise when she took the resident into the shower room, removed her clothes and observed the bruise. The DON stated that Nurse Aide #1 proceeded to shower Resident #3 before she notified the nurse of the injury. The DON stated that "ideally the nurse aide should have notified the nurse first."

On 01/13/15 at 1:15 PM Nurse Aide #1 was interviewed. She explained that she worked from 12:30 PM to 8:00 PM Monday through Friday assisting residents with lunch and their showers. She stated that prior to starting her shift on 01/05/15 she was not told that Resident #3 had a bruise on her left arm. She stated that she was familiar with Resident #3 and that the resident was non-verbal but nodded her head "yes" to questions and did not reject care. Nurse Aide #1 stated that on 01/05/15 at 2:45 PM she asked the resident if she was ready for a shower and the resident nodded, yes. Nurse aide #1 reported that she took the resident to the shower room and started undressing the resident by instructing the resident to grab onto the shower room bar and pull herself up. The nurse aide stated that the resident repeatedly let go of the bar with her left hand but did not appear in pain. While the resident was standing holding onto the bar, the nurse aide removed her pants and rolled the shower chair behind the resident, locked the brakes and had the resident sit down on the

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shower chair. The nurse aide stated that she proceeded to remove the resident's shirt by pulling the right arm from the shirt, lifted the shirt over the resident's head and then pulled the shirt away from the left arm. In doing so, the nurse aide stated she immediately noticed a large dark purple, slightly swollen bruise on the resident's left arm extending from her shoulder down to her elbow. The nurse aide asked the resident if her arm hurt and the resident nodded "yes." Nurse aide #1 stated she was alone in the shower room and went ahead and showered and redressed the resident before notifying the nurse of the injury. The nurse aide added that after the shower she had to re-dress the resident by putting a t-shirt back on the resident. She stated that she was careful with the resident's arm when getting the shirt on. The nurse aide stated that Resident #3 was in "a little pain not a whole lot." She explained that she was trained to notify the nurse immediately of an injury but felt that she should not have left the resident unattended in the shower room to call for help. The nurse aide stated she didn't think about using the emergency call system located inside the shower room but added that she could have stuck her head outside the shower room and hollered for help to notify the nurse of the injury. Nurse Aide #1 stated she notified Nurse #2 around 3:15 PM that same day. Nurse Aide #1 stated that she did not ask the resident questions about how the bruise occurred and offered no explanation if she thought the bruise could have resulted from mistreatment of the resident.

On 01/13/15 at 1:45 PM the physician was interviewed and reported he was in the facility on 01/05/15 and was asked by Nurse#2 to assess Resident #3's bruise. He stated that it was a

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significant contusion (bruise) and when he first saw the resident she had her left arm resting across her body. He stated that he ordered an x-ray to rule out fracture but the reason for the injury was unknown due to her dementia and no one had witnessed an incident.

On 01/15/15 at 10:00 AM the DON and Long Term Care Quality Manager (LTCQM) were interviewed together. The LTCQM reported that she provided training to newly hired employees in orientation on the policy and procedures for identifying and reporting abuse. She stated that she emphasized the importance of the topic so that staff were well aware of the expectations of reporting any suspicion of abuse. She added that she stressed to staff that if they were sure, unsure or suspected abuse they were to report it "as soon as possible" and under no circumstance were they to try to decide for themselves what was or was not abuse. She stated that she gave staff handouts with examples of what could be abuse. During the interview the DON reported that staff were specifically trained on how to indentify suspicion of abuse that included bruising. The DON stated that nurse aides were expected to report concerns to their nurse "as soon as possible." The DON stated that there were times in which a nurse aide would not be able to report a suspicion of abuse right away but staff were trained to report it as soon as possible.