STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 02/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

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F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		3/17/17

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

Electronically Signed | 03/08/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and family interviews, the facility failed to notify a resident's family member (responsible party) of an allegation of abuse made by the resident for 1 of 3 residents reviewed for allegations of abuse and injury, Resident #1. Findings included: Resident #1 was admitted to the facility on 1/18/17 with multiple diagnoses, some of which included atrial fibrillation, hypertension, and arthritis. A review of the admission minimum data set (MDS) assessment dated 1/25/17 revealed Resident #1 required total assistance with bathing and locomotion on and off the unit. Per the same assessment Resident #1 required extensive assistance with bed mobility and with transfers, and that she was unsteady with surface to surface transfers. Section C of the assessment indicated Resident #1 was severely cognitively impaired. A review of the facility's 24-Hour Initial Report for an allegation of abuse revealed Resident #1 reported on 1/27/17 that a staff member was too	F 157	Submission of this response to the statement of deficiencies does not constitute an admission the deficiencies exist and/or were correctly cited or required correction. F 157 The following was accomplished for resident #1 who was affected by the practice: Resident #1 is her own Responsible Party and made the allegation herself on Friday, 1-27-17. Her son was made aware of the allegation, the investigation and the results of the investigation on Monday, 1-30-17 by the Assistant Director of Nursing per the son's statement to the surveyor. The following was accomplished for other residents having the potential to be affected by the practice: An audit of all allegations of abuse for the prior year was conducted by the administrator on 3-7-17. No negative findings were noted. All families were	

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F 157	Continued From page 2 rough with her, tossed her, and that she hit her side on the wheelchair on 1/26/17. A review of all nurse's notes dated 1/27/17, 1/28/17, and 1/29/17 revealed there were no notes present to indicate a family member or responsible party was notified of Resident #1's allegation of abuse. Resident #1's nursing care plan last updated 1/30/17 revealed there were goals with interventions in place to address her risk of side effects related to anticoagulant therapy use and her verbally or physically aggressive behavior during her activities of daily living care. During an interview with Resident #1's family member on 2/17/17 at 12:53 PM, he stated he had not been notified that Resident #1 had made an allegation of abuse or rough handling until 3 days after the resident reported it to staff. He explained that Assistant Director of Nursing (ADON) notified him on 1/30/2017 and that he came to the facility to see her that day and saw bruising on her right side around her waist and ribs. The family member stated he would have wanted to know about the allegation of abuse because he cared about her, adding that he did not want any pain or injury to keep her from improving in therapy. The family member added that he was concerned that the facility was not providing full information about Resident #1's allegation of abuse. The family member also stated he was the first point of contact (responsible party) for Resident #1. On 2/17/17 at 2:45 PM, an interview was conducted with the Occupational Therapist (OT) who stated that Resident #1 complained about	F 157	notified immediately of allegations of abuse. The following systemic changes were made to ensure that the practice will not recur: A new process was initiated by the Administrator on 3-7-17 to ensure that timely notifications of allegations of abuse are made to a resident contact or Responsible Party even if the resident is the Responsible Party. As of 3-7-17 allegations of abuse will be recorded on the electronic Health Record template under the "Quality Assurance" module of the licensed system the facility uses by the Director of Nursing, the Assistant Director of Nursing, the Administrator or licensed staff, immediately upon notification of an allegation of abuse. The template has a field that indicates who was notified and when. This will ensure that notifications have been made. 100% of licensed staff will be educated on this new process by the Director of Nursing, Assistant Director of Nursing or the Staff Development Coordinator by March 17, 2017. Licensed staff who have not been educated by this date will not be allowed to work until they have been educated. This following monitoring process will be put in place to ensure that the corrective action is achieved and sustained:	

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F 157	Continued From page 3 pain and the allegation of abuse in her right side on 1/27/2017 during her therapy. The OT stated she checked Resident #1's right side around her waist and ribs and saw no evidence of an injury. The OT also stated she reported Resident #1's complaint to the ADON and Resident #1 was able to tolerate the entire session of occupational therapy, but she was unable to remember if the therapy had to be modified that day due to her complaint of pain. In an interview with the ADON on 2/17/17 at 3:17 PM, she explained that she was called to the therapy room on 1/27/17 during the early afternoon and that the OT reported Resident #1's allegation of rough handling and pain in her right side. The ADON stated Resident #1 was a little upset at the time, but not crying, and that she examined her and found no redness or tenderness upon palpation. She added that Resident #1 told her she had been injured by a nursing assistant the day before, on 1/26/17. In an interview with the Administrator, the Director of Nursing (DON), and the ADON on 2/17/17 at 5:08 PM, the administrator explained that when there was an allegation of abuse, the facility staff would first examine the resident to determine if there was an injury, then notify the MD, and then notify the family. In a follow up interview on 2/18/17 at 1:30 PM with the Administrator, the DON, and the ADON, the Administrator stated she did not contact the family regarding Resident #1's allegation because she felt it was wiser for the facility to investigate the allegation of abuse first so more complete information could be offered to the family upon notification. The Administrator added that	F 157	Effective 3-7-17, the Administrator, Director of Nursing or Assistant Director of Nursing who completes the 24 Hour Initial Report of alleged abuse will double check that notifications were made immediately to the Responsible Party or family member. This monitoring initiative effective 3-7-17 will continue for 90 days or until a pattern of compliance is maintained. This will be included in our Quality Assurance Program. Results will be reported by the Administrator to the Quality Assurance Program. If any negative findings are noted when double checking the notification section of the report, a root cause analysis will be conducted and the process will be revised as needed.	

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F 157	Continued From page 4 although Resident #1's allegation was fairly consistent, the staff was never able to see evidence of bruising or redness, so she felt there was no need for contacting the family until 1/30/17. The Administrator explained that if Resident #1 had been mistreated or abused, there would have been evidence of bruising due to her use long-time use of anticoagulants.	F 157		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		3/17/17

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F 226	Continued From page 5 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to fully develop its abuse policy to include immediate reporting by staff members to the designated supervisory staff after suspicion or observation of abuse. The facility also failed to follow its abuse policy to screen 2 of 5 new staff members for a criminal background check prior to the hire dates, Staff Member #1 and Staff Member #2. Findings included: 1. A review of the facility's Abuse and Neglect Prohibition Plan/Abuse Prevention Policy, revised August 2016, page 4, revealed the following: "Reporting, 1. The facility will report all allegations and sustained occurrences of abuse, neglect or misappropriation of resident property to the state agency and law enforcement officials as appropriate." On page 6, under Abuse Prevention/Procedure, the following was included: "5. All incidents will be reported to the appropriate staff, Charge Nurse, Supervisor, Director of Nursing, Assistant Director of Nursing, and Administrator. An incident report will be completed and the incident investigated ...." Review of the seven page written policy revealed there was no part of the policy that indicated reporting of abuse by staff members in the facility to the appropriate staff (Charge Nurse, Supervisor, Director of Nursing, Assistant	F 226	The following was accomplished for the practice cited: Criminal background checks were completed on Friday 2-17-17 for the employees #1 and #2. There were no criminal findings on either record The following was accomplished for those having the potential to be affected by the practice: An audit of all current employee files was completed by the Administrator on Sunday, February 19,2017 to ensure that all employees had a criminal background check on file with no criminal findings. Two other employee background checks could not be located and this was corrected on 3-7-17. There were no criminal findings on either record. The following systemic change was made to ensure that criminal record checks are completed on applicants prior to their hire date: Effective 3-7-17,the Administrator will view and approve all Criminal Background checks of applicants prior to their orientation. The Administrator will initial each record to indicate approval.	

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F 226	Continued From page 6 Director of Nursing, and Administrator) should be immediate. In an interview with the Administrator on 2/18/17 at 1:30 PM, she stated that the facility reported allegations of abuse to the state within 24 hours. She added that although immediate reporting was not included in writing on the policy, the staff understood they were to report any allegations of abuse immediately to their supervisors. 2. a. Review of the facility's Abuse and Neglect Prohibition Plan/Abuse Prevention Policy, revised August 2016, under "Screening," page 3, revealed the following: "1. The facility screens all prospective employees by conducting a criminal background check and OIG [Office of the Inspector General] exclusions screening." A review of the facility's records for screening of newly hired staff members revealed there was no document present to show a criminal background check had been completed for Staff Member #1 before the hire date on 10/18/2016. The date of the criminal background check for this staff member was 2/17/17. In an interview with the Administrator on 2/17/17 at 5:08 PM, she stated she thought a criminal background check had been completed on Staff Member #1, but could not find it. The Administrator added the criminal background check document should have been completed before the hire date and included in the employee file. She explained the Director of Nursing (DON) ordered a new criminal background check on 2/17/17. Review of the criminal background check dated	F 226	Department Directors will be educated on this process by the Administrator by March 17, 2017. Department Directors who have not been educated by this day will not be allowed to work until they are educated. Additionally, on March 7, 2017 the Licensed Nurses were educated to ensure that notifications of allegations of abuse are made immediately per Federal Regulations. Any nurse not educated prior to 3-17-17 will not be allowed to work until educated. The Abuse Policy had been updated to include that reporting must be immediate, based on Federal Regulation. The following monitoring initiative has been put in place to ensure that the corrective action has been achieved and sustained: Effective 3-7-17,a checklist indicating that the proper documents have been secured and/or completed will be checked off by the Staff Development Coordinator. The Administrator will review the checklist for each new employee to ensure that the criminal background check was completed. The monitoring initiative will continue for 90 days or until a pattern of compliance is established. This initiative will become part of our Quality Assurance Program. Reports of this audit will be presented to the Quality Assurance Committee by the	

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F 226	Continued From page 7 2/17/17 for Staff Member #1 revealed there was no history or evidence of criminal charges present. b. A review of the facility's records for screening of newly hired staff members revealed Staff Member #2, hired on 1/25/2017, had a criminal background check completed on 7/30/2016. There was no criminal background check completed for the dates between 7/30/16 and 1/25/2017. In an interview with the DON and the Administrator on 2/17/17 at 5:08 PM, the DON stated she had considered hiring Staff Member #2 during the summer months of 2016 so a background check was completed at that time. The Administrator stated she would have expected for another criminal background check to have been completed before hire on 1/25/16 in order to cover the time period between July 30, 2016, and 1/25/2016.	F 226	administrator for review. Negative findings will be investigated, a root cause analysis completed and the plan revised as needed.	