STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to implement their abuse policy in the area of reporting for 1 of 1 sampled resident who reported an allegation of abuse related to a bruise on her arm (Resident #35). The findings included: Review of the policy titled "North Carolina Resident Abuse Policy" revised October 2016, November 2016, read in part: Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. 6) Initial Reports. Timing-All allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON), and to the applicable state agency. 11) Reporting. Incidents of alleged	F 607	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. *The deficiency was cited due to Nursing Assistant (NA)#1 not following proper abuse protocol and not reporting an allegation made by a Resident on May 2, 2018. NA#1 was educated immediately by Nurse #1 on May 3, 2018 that she should have reported the allegation immediately to a nurse regardless of prior statements made by the Resident. Our plan to correct the deficiency was inservicing. From July 13-17, 2018 inservicing was completed by the Director of Nursing, Staff Development Coordinator and Weekend House Supervisor. All staff were inserviced on our abuse protocol to include immediate	7/17/18

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

Electronically Signed | 08/01/2018

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F 607	Continued From page 1 or suspected abuse, involving physical or sexual abuse by other than staff members, will be reported immediately to the police and facility security. Resident #35 was admitted to the facility on 3/6/17 with diagnoses which included: Dementia, depression, and diabetes. Review of Resident #35's most recent Minimum Data Set (MDS) revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 4/18/18. The resident was coded as having had severe cognitive impairment. The resident was coded as having required limited to total assistance of one person for bed mobility, transfer (such as from a bed to a chair), and toileting, and independent with set up help for eating. A review was completed of a Pressure/Non-Pressure Skin Assessment nurses' note dated 5/3/18 and timed 8:00 AM for Resident #35. The note documented the wound type was a bruise, the location was to the right forearm, the size was 13 centimeters (cm) long and 14 cm wide, and the bruise had occurred while the resident was at the facility. The note further documented the resident had been sitting up in her wheelchair in her room when the physical therapist assistant (PTA) student walked in and noted the resident crying and the resident stated her right arm hurt. The resident told the PTA student that a woman "slapped down" on her arm this morning. The note documented the color of the bruise was blue and purple and there was no noted swelling in the area. A review was completed of a Head to Toe	F 607	notification to a nurse, manager or Abuse Coordinator/Administrator when any allegation of potential abuse has been made by any resident at any time. NA #1 received a one on one inservice on this topic by the Director of Nursing and Administrator. *Our procedure for implementing the plan of correction was to utilize a roster of all current employees to ensure everyone received re-education. Shift to shift inservicing was done as each staff member reported for duty. We continued the education and those staff members who were not scheduled to work received the education via letter/mail. This process of re-education was done by the Director of Nursing, Staff Development Coordinator and Weekend Registered Nurse House Supervisor. All newly hired staff have and will receive initial abuse training and education on our abuse protocol. *The monitoring procedure to ensure that the plan of correction is effective will be auditing. Audits will be done by the Administrator and Director of Nursing weekly for four weeks then monthly for three months. The first week of auditing was completed on July 24, 2018. Audit results will be taken to the Quality Improvement Committee who, at the end of the auditing period, will determine if further auditing is needed. The tool audits knowledge of the employee regarding types of abuse, what to do if an allegation has been made, ways to prevent abuse, etc. *The Administrator and Director of	

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F 607	Continued From page 2 Evaluation nurses' note dated 5/3/18 and timed 8:00 AM for Resident #35 which was completed by Nurse #1. The note documented the resident told a staff member in the morning, a white woman came into her room this morning and slapped her on the right forearm and walked out of her room. The resident continued to explain the woman did not say anything just slapped her arm and walked out. The resident stated it was bright outside but could not explain what the woman looked like. The note further documented the abuse coordinator/Administrator, the Director of Nursing (DON), the resident's physician, and the resident's family were notified. The police department was called and came to the facility, received a statement and completed a report at 9:40 AM. The resident was documented as having had no pain or discomfort. The resident was documented as having been disoriented, but responsive, pleasant, and cooperative. A review was completed of a nursing note dated 5/3/18 and timed 8:56 AM, which was completed by Nurse #1, for Resident #35. During an interview documented by Nurse #1, Nursing Assistant (NA) #1 stated she had been assigned to Resident #35 for the 3:00 PM to 11:00 PM shift on 5/2/18. NA#1 stated Resident #35 showed her the bruise, referring to the bruise on her arm, around 9:45 PM on 5/2/18 and told the NA "An old lady came in here last night and hit me right on the arm." The nurse documented the NA was re-educated immediately regarding the importance of notifying the charge nurse/supervisor upon any allegation of abuse. A phone interview was conducted on 7/11/18 at 12:03 PM with Nurse #1. The nurse stated a PTA student had told her about Resident #35's	F 607	Nursing will be responsible for implementing the plan of correction. *Corrective action was completed on July 17, 2018	

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F 607	Continued From page 3	F 607		

allegation about abuse on 5/3/18. The nurse stated through the investigation it was discovered NA #1, who was working on the 3:00 PM to 11:00 PM on 5/2/18, had been informed by the resident she had been hit and shown. The nurse further stated NA #1 informed her she had not reported the allegation of abuse or the bruise.

A phone interview was conducted on 7/11/18 at 1:30 PM with NA #1. The NA stated she had been working at the facility since November, 2016. The NA stated she had been assigned to care for Resident #35 on 5/2/18 on the 3:00 PM to 11:00 PM shift. The NA stated when she went to wash the resident before the resident was going to bed she had observed a bruise on the resident's right forearm. NA #1 stated the resident told her someone had come in and hurt her arm the night before. NA #1 further explained the resident had ongoing allegations of abuse. The NA stated she did not remember reporting the allegation or the bruise to the nurse that evening. The NA further explained she had spoken with Nurse #1 and Nurse #1 had told her to report anything. The NA stated she should have reported the allegation of abuse and the bruise that evening promptly.

An interview was conducted with the Administrator on 7/12/18 at 1:35 PM. The Administrator stated the investigation revealed NA #1 had noticed the bruise on Resident #35's arm and Resident #35 had made an allegation of abuse to NA #1. The Administrator stated through interviews with NA #1, NA #1 stated the resident had often made false comments and the NA did not feel the resident had been abused. The Administrator stated NA #1 had not reported the allegation of abuse made by Resident #35 or

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F 607	Continued From page 4 reported the bruise she discovered on Resident #35. The Administrator stated NA #1 received educated about abuse and reporting. The Administrator stated it was her expectation for an employee to report an allegation of abuse or an injury of unknown origin, such as a bruise immediately to their supervisor or the Abuse Coordinator.	F 607		