STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 8/16/19. Event ID# 92CK11. 1 of the 1 complaint allegation was not substantiated.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		9/13/19

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

Electronically Signed | 09/06/2019

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F 609	Continued From page 1 Based on observation, staff interviews and record reviews, the facility failed to investigate and report abuse allegation within 2 hours of notification of the allegation. This was for 1 of 1 alleged abuse for a sampled resident with bruises of unknown origin (Resident #1). The findings included: Resident admitted to the facility on 6/18/19. The diagnoses included senile degeneration of the brain, hypertension and Alzheimer ' s dementia. The admission Minimum Data Set (MDS) dated 6/30/19, indicated Resident #1 was cognitively impaired and required total assistance with activities of daily living. Review of the care plan dated 6/21/19, identified the problem as the resident has an alteration in hematological status related to aspirin use and anticoagulant side effects. The goal included the resident will remain free of complications related to altered hematological status through the review date. Interventions included complete Fall Risk assessment and increase vigilance for falls. Give medications as ordered. Monitor for side effects, effectiveness. Monitor and document vital signs as order. Monitor/document/report to MD PRN following signs and symptoms of anemia: Pallor; Fatigue; Dizziness; Syncope; Headache; Palpitations; Weakness; Feeling of cold; Low hemoglobin/hemacrit; shortness of breath on exertion; Sore tongue; Chest pain; Tinnitus; Headache; Changes in mental status. Obtain and monitor lab/ diagnostic work as ordered. Report results to MD and follow up as indicated. 2. Resident has had an actual fall with no injury on 8/15/19. The goal included the resident would resume usual activities without further incident.	F 609	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. The State Survey Agency has conducted an investigation into the allegation of abuse and has concluded that the allegation was not substantiated. 2. All residents have the potential to be affected by the deficient practice. 3. A.) ECU staff members have been educated on the regulation to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working	

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F 609	Continued From page 2 The intervention included low bed and fall matt in place. Monitor/document /report PRN x 72h to MD for sign/symptom: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Provide activities that promote exercise and strength building where possible. Provide 1:1 activity if bedbound. room change -- moved closer to nursing station. 3. Resident can be combative/ resistant to care at times Bruising noted to back of both upper arms. The goal included resident would be free from injuries. The interventions included if resistive leave resident safely and attempt to perform care later. Monitor for injuries and report and treat if needed. Resident is receiving hospice services. Resident would remain comfortable through next review hospice care as ordered notify hospice of any change in condition. Observed on 8/15/19 at 9:50 AM with Nurse #1, Resident #1 was seated in her Geri-chair in room pleasantly confused, dressed nicely in grey long sleeve sweat shirt and slacks. She was very calm and reported no pain when asked by the nurse. Resident #1 was very cooperative and responsive when nurse asked if she could do a body check. Resident #1 pointed to several bruises all over both arms, stating she did not know how they got there. The bruising in several areas appeared old/fading yellowing in color, however others were very large, dark red, purplish and deep in color. Resident #1 did not report any pain during the examination. Observation as follows: Left upper portion of the top of arm near shoulder area had a large light red to yellowing fade area measuring 9cm x7cm 1 cm. 2. Elbow 4.8cm x 4.6(light pink faded area). 3. Left forearm 2.2cm x2.4cm x1 light pink/yellow	F 609	days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. B.) Administrator and Director of Nursing have been educated to report and investigate as a standard allegation of abuse any event in which an outside agency informs them of a current or pending abuse investigation. C.) Social Services Coordinator is to maintain a tracking form to record all reported abuse allegations. The form will record and track each reported allegation, and timeframes for notification made to administrator and state survey agency. The tracking form will be reviewed daily in morning stand up meeting. 4. Administrator/designee will audit the reported abuse allegation tracking form weekly for four weeks, then monthly for three months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	

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area fading. 4. 1.2cm x 2.4cm circular area right below the 1st area was faded yellow. 5. Inner forearm was red/purple in color in oval/circular area 5cm x 4cm x3cm.

Observation as follows: Right forearm 1. blue, purplish with yellow center small and large oval 11.2 cmx 13cmx8cm. 2. Right forearm 3.6 cm x3.2 cm was a faded pink circular area. 3. Old yellow skin tear on middle section of the forearm and a purple/bluish rectangle scar measured 4.2 cmx3.4cm. 4 Inner forearm 1.4cm x1.2 cm purple near crease of inner forearm. 5. Underneath right elbow to the top portion of the back of shoulder had an extremely large dark, blue, red purplish bruise that was oval in patching bruises combining from elbow to shoulder. 56.6cmx 14cm x 8cm. There was no visible appearance of fingers/hand prints or indentations of the bruised area. Resident #1 did not report any pain in any of the identified areas. Resident #1 continued to state she did not know what happened. Additional areas observed was bilateral legs that had several old bruises to the fronts/sides of legs and shin areas that were yellow and faded.

During an interview on 8/15/19 at 10:00 AM, Nurse #1 stated upon admission the family reported the resident had a long history of falls, resulting in bruising and small skin tears while resident was at home. Nurse #1 further stated at times the resident exhibited behaviors of combativeness, swinging of arms/legs, resistance to care and was currently receiving hospice care. Nurse #1 stated the family also reported that Resident #1 bruised easily, and often unknown bruising may occur/show up at different times. Nurse #1 indicated the bruising was reported to her on 8/4/19 around 7:00 AM by the 1st shift

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nurse. Nurse #1 and the director of nursing did a head to toe assessment and there was no visible bruising at the time. Nurse #1 acknowledged that she did not document or measure any of the bruising that had been present at the time prior to her initial report. Nurse #1 stated Resident #1 was combative and resistive to care, the bruising possibly occurred during Resident #1 episode of behaviors. Review of the record did not indicate Resident #1 had any longstanding behaviors or exhibit any aggressive behaviors or excessive physical movements that would cause her to hit arms against any objects or the side rails of the bed. Nurse #1 stated she did not speak with any of the aides or nursing staff regarding Resident #1 ' s behaviors or report any concerns of behaviors to the physician. Nurse #1 further stated Resident#1 was on aspirin and receiving psychotropic medications which she thought may be a contributing factor to the bruising. Nurse #1 stated "I did not feel or think that staff had abused the resident. The bruises were indicative of her history of fragile skin, easily bruising as reported by her family." "I assessed and treated the situation as the resident with skin tears and bruises. There were no identified falls prior to observation of the bruises.

During an interview on 8/15/19 at 10:15 AM, the Administrator stated that on 8/8/19 a person from the Department of Social Service (DSS) came to the facility and stated they were in the facility doing an investigation on an allegation of abuse against Resident #1. "I was thinking the DSS staff was just informing him of the allegation as a for your information (FYI) and was waiting for their report. I had the nursing staff pull resident reports of injuries in the last few days but did not do a full

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investigation of abuse. Had I been aware there was a suspicion of abuse I would have followed the protocol investigated and reported to the state agency per regulations was that all allegation of abuse be sent it within 2 hours of the allegation." "I called the facility consultant and was informed not to do an abuse investigation and to wait till DSS send their report back, it was looked as bruises due to resident history of anticoagulant usage and history of falls." There were no identified falls prior to observation of the bruises.

During an interview on 8/15/19 at 10:15 AM, the Interim Director of Nursing (IDON) stated on 8/8/19 the DSS worker stated he was in the facility to do an abuse investigation on Resident #1. The administrator was made aware, myself and nursing and began collecting the skin assessments and notes. The IDON stated once an allegation of abuse was reported the "expectation per regulations was that all allegation of abuse be sent it within 2 hours of the allegation." IDON further stated staff should observe/assess the affected area, document a description of the area with measurements if there were skin tears, bruising, ulcers etc, resident condition/pain, location of injury, report to physician, nurse practitioner and family and complete a full investigation any time there was an allegation of abuse or injuries of unknown origins. The IDON confirmed a complete investigation had not been completed. There were no identified falls prior to observation of the bruises.

During an interview on 8/15/19 at 3:10 PM, the Department of Social Service (DSS) staff stated he reported to the facility on 8/8/19 following a report to the DSS that a resident at the facility had

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F 609	Continued From page 6 alleged to have been abused by staff at the facility. The DSS staff stated the facility administrator was informed his department would be doing an abuse investigation on Resident #1.	F 609		