STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (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-	F 157		10/31/17

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

Electronically Signed | 10/28/2017

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F 157	Continued From page 1 (A) A change in room or roommate assignment 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 and staff interviews, the facility failed to notify the physician and the responsible party (RP) of an injury of unknown origin that was identified during evening hours for 1 of 3 sampled residents (Resident #1). Findings included: Resident #1 was admitted to the facility on 6/14/17 with a readmission date of 10/5/17. Diagnoses included, in part, dementia, osteoporosis, and a fracture to the upper end of the right humerus. The Minimum Data Set (MDS) quarterly assessment dated 9/21/17 revealed the resident was severely cognitively impaired. She was noted as having behaviors continuously with inattention and disorganized thinking, rejection of care 1-3 days, wandering 1-3 days, and other behaviors not directed toward others for 1-3 days. The resident required extensive assistance with two staff members with bed mobility and transfers, dressing, toileting and personal hygiene and extensive assistance with one staff member with ambulating, locomotion, and feeding. She had no impairment and used a wheelchair. She	F 157	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. ROOT CAUSE Licensed nurse #1, notified on-call physician and Responsible party about 12 hours from the time the alleged bruise of unknown origin was reported to her. This was caused by nurse #1 clinical judgement that notifying the responsible party and physician wasn□t the priority if and when a condition does not constitute life threatening condition. Nurse #1 was not aware of the regulatory requirement	

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F 157	Continued From page 2 was not steady and only able to stabilize with assistance with balance. A review of a nursing note written on 10/4/17 at 1:40 am by Nurse #1 revealed the resident had no signs or symptoms of distress or pain and was currently resting in bed with eyes closed. The note stated when the nursing assistants (NAs) were undressing Resident #1 for bed (on 10/03/17) they noticed a large bruise on the right upper arm. The note stated Nurse #1 was called to the room where she measured the bruise and performed range of motion and Resident #1 stated there was pain on the right lower arm. Nurse #1 noted there was a bruise which was red and purple and measured approximately 11 centimeters (cm) length and 9 cm wide. The note indicated Nurse #1 was not sure how the resident obtained the bruise, but prior to going to bed she was noted leaning in a chair on her right side. A review of a nursing note written on 10/4/17 at 8:13 am by Nurse #1 revealed a call was placed to the on-call physician to explain the situation about the large bruise on Resident #1. The note indicated the resident was ambulatory and it was not known what could have caused the bruise. The note reported the physician ordered an x-ray of the right humerus and shoulder and that a call was placed to the mobile x-ray company. The note indicated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were on site to examine the bruise and the RP was notified. A review of the resident incident report dated 10/4/17 at 8:15 am revealed the resident had a hematoma to the right upper arm measuring 11cm X 9cm. The description of the incident	F 157	that requires the facility to immediately inform the resident; consult with the residents physician; and notify, consistent with his or her authority, the resident representative(s) when there is- An accident involving the resident which results in injury and has the potential for requiring physician intervention, In this case resident had an injury of unknown source that require medical intervention. Nurse #1 was re-educated by the Director of nursing on 10/12/17 on the requirement specifically for notification of changes to residents, physician and resident□s responsible party. IMMEDIATE ACTION On 10/04/2017, at 8:13 AM, the on-call physician was notified by nurse#1 of a bruise noted on resident #1. X-ray of the right humerus and shoulder was ordered by the on-call physician and obtained by the licensed mobile X-ray Company at resident #1□s bedside. Resident #1 was sent to hospital for evaluation and treatment on 10/04/17. Nurse #1 notified Resident #1 responsible party of the bruise, x-ray orders and the hospital transfer on 10/04/2017 at 8:13AM. No further actions taken for this resident. IDENTIFICATION OF OTHERS 100% audit of all current residents□ clinical documentation within the last 30 days will be completed by the Director of	

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F 157	Continued From page 3 stated the NAs were undressing the resident for night time on 10/03/17 and they noticed a large bruise on the right upper arm. The nurse was called to the room where it was measured and range of motion was performed. The report indicated the resident stated she had pain on the lower arm and the bruise was red and purple in color. The note reported the nurse was not sure how the resident got the bruise, but she was leaning in a chair at the table on that side. The report indicated the DON was notified at 8:05 am, the on-call physician was notified at 8:16 am, and the family was notified at 8:25 am. An interview was conducted with Nurse #1 on 10/12/17 via telephone at 11:25 am. Nurse #1 reported the aides put her to bed around 9:00 pm and that was when they noticed the bruise on Resident #1 ' s right upper arm and notified her. Nurse #1 reported it was a large bruise, red and purple in color inside the arm over towards the breast and there was no skin breakdown or swelling at this time. Nurse #1 stated she did not call the on-call physician until 8:15 am the next morning (10/04/17) because she thought it was just a pressure bruise. Nurse #1 reported that the physician ordered an x-ray of the right humerus and shoulder at that time. The nurse stated she did not notify the RP when the bruise was observed on 10/3/17 and added the staff only notified the family during the night shift if there was a life threatening situation. Nurse #1 stated that calling the RP at 9:00 pm was not an unreasonable time, but she decided to wait until the morning since it was not life threatening. Nurse #1 stated she was aware that she was supposed to notify the DON, family and physician if there was a new concern or finding for a resident. Nurse #1 stated she was going to notify	F 157	Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine any identified need for notification of changes was completed in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 10/23/17 Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. On 10/11/2017, 100% audit was completed by the Director of Nursing of all incidents reports completed within the last 30 days to ensure notification was done in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 10/23/17. Findings of this audit is documented on incident reports audit tool located at the facility compliance binder. SYSTEMIC CHANGES Effective 10/30/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take	

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F 157	Continued From page 4 the DON in the morning. The nurse stated the resident had no complaints of pain through the night and when she checked on her every two hours or so, she was sleeping. An interview with the Nurse Practioner (NP) was conducted on 10/12/17 at 1:30 pm. The NP stated her expectation of the nurses was to notify her, the provider on-call or the facility physician as soon as possible if there was an identified injury of unknown origin. A phone interview was attempted with the on-call physician at 10/12/17 at 2:05 pm. A voice mail message was left with no return call received. An interview with the facility physician on 10/12/17 at 2:20 pm revealed her expectation of the nurses was to notify her or the on-call physician if it was after hours for an injury of unknown origin. An interview with the DON on 10/12/17 at 4:45 pm revealed her expectation of the nurses was to notify the physician after an incident occurred or was identified. The DON reported she did not feel that 9:00 pm was an unreasonable time to call the RP and expected staff to call the RP if there was a change in condition for the residents.	F 157	place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the daily checklist form and maintained in the daily clinical meeting binder. Effective 10/30/201, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the daily checklist form and maintained in the daily clinical meeting binder. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the emphasis of this education was on the importance of	

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F 157	Continued From page 5	F 157	notifying Physician and the responsible party in a timely manner for any incident/accidents, resident□s change of condition, change of treatment/intervention and/or an injury of unknown source. This education will be completed by 10/31/2017. Any licensed nurse not educated by 10/31/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses effective 10/31/2017. MONITORING PROCESS Effective 10/30/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician and/or responsible party by conducting clinical meeting daily (M-F), review the daily clinical meeting checklist to ensure completion and proper follow through, will review any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical report, and daily clinical checklist forms daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of	

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F 157	Continued From page 6	F 157	compliance is maintained. Effective 10/31/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 10/31/17, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or	F 225		10/31/17

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F 225	Continued From page 7	F 225		

misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(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.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect,

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F 225	Continued From page 8 exploitation, or mistreatment while the investigation is in progress. (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: Based on record review and staff interviews, the facility failed to submit a 24 hour report and a 5-day report to the state agency for 1 of 3 sampled residents (Resident #1) reviewed for an injury of unknown origin. Findings included: Resident #1 was admitted to the facility on 6/14/17. Diagnoses included, in part, dementia, osteoporosis, and fracture to upper end of right humerus. The Minimum Data Set (MDS) quarterly assessment dated 9/21/17 revealed the resident was severely cognitively impaired. She was noted as having behaviors continuously with inattention and disorganized thinking, rejection of care 1-3 days, wandering 1-3 days, and other behaviors not directed toward others for 1-3 days. The resident required extensive assistance with two staff members with bed mobility and transfers, dressing, toileting and personal hygiene and extensive assistance with one staff member with ambulating, locomotion, and feeding. She had no impairment and used a wheelchair. She was not steady and only able to stabilize with	F 225	F225D ROOT CAUSE This alleged noncompliance was resulted from the Center□s Director of Nursing misinterpretation of regulatory requirements related to reporting an injury of unknown source. The DON stated the way she understood for an injury of unknown origin to be reported, one of the criteria was that the resident was not ambulatory. The DON stated since Resident #1 was ambulatory then the criteria would not have been met, and therefore, it would not be necessary to complete the 24-hour and 5-day report nor report it to the State Survey Agency. Regional Nurse Consultant re-educated the Center Administrator and the Director of Nursing on 10/23/2017 on reporting expectation if there is an injury of unknown origin noted for any resident in the facility. IMMEDIATE ACTION On 10/12/2017, the 24 hour report and 5	

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F 225	Continued From page 9 assist with balance. A review of a nursing note written on 10/4/17 at 1:40 am by Nurse #1 revealed the resident had no signs or symptoms of distress or pain and was currently resting in bed with eyes closed. The note stated when the nursing assistants (NAs) were undressing Resident #1 for bed they noticed a large bruise on the right upper arm. The note stated Nurse #1 was called to the room where she measured the bruise and performed range of motion and Resident #1 stated there was pain on the right lower arm. Nurse #1 noted there was a bruise which was red and purple and measured approximately 11 centimeters (cm) length and 9 cm wide. The note indicated Nurse #1 was not sure how the resident obtained the bruise, but prior to going to bed she was noted leaning in a chair on her right side. A review of a nursing note written on 10/4/17 at 8:13 am by Nurse #1 revealed a call was placed to the on-call physician to explain the situation about the large bruise on Resident #1. The note indicated the resident was ambulatory and it was not known what could have caused the bruise. The note reported the physician ordered an x-ray of the right humerus and shoulder and that a call was placed to the mobile x-ray company. The note indicated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were on site to examine the bruise and the family was notified. A review of the resident incident report dated 10/4/17 at 8:15 am revealed the resident had a hematoma to the right upper arm measuring 11cm X 9cm. The description of the incident stated the NAs were undressing the resident for	F 225	day report were sent to the Department of Health and Human Services, for resident #1□s injury of unknown source identified in 10/03/2016. These reports were completed and submitted by the Administrator. No further actions taken for resident #1. IDENTIFICATION OF OTHERS 100% audit of all current residents□ clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any injuries of unknown source documented in any resident□s medical records, and if any determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other incident of injury of unknown source documented in resident□s medical records. This audit was completed on 10/23/17. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Director of Nursing of all incidents reports completed within the last 30 days to identify any injuries of unknown source and ensure that a proper investigation was completed and a 24 hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act. The	

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F 225	Continued From page 10 night time and they noticed a large bruise on the right upper arm. The nurse was called to the room where it was measured and range of motion was performed. The report indicated the resident stated she had pain on the lower arm and the bruise was red and purple in color. The note reported the nurse was not sure how the resident got the bruise, but she was leaning in a chair at the table on that side. The report indicated the on call physician, the family, and DON were notified. A review of a nursing note written by Nurse #2 on 10/4/17 at 1:29 pm revealed one of the resident ' s family member (FM) had arrived to visit during this shift. The note stated upon seeing the resident ' s bruise, the FM requested the resident be evaluated by the emergency department (ED). The note indicated Resident #1 was transported via Emergency Medical Service (EMS) to the hospital at 1:10 pm. A review of a nursing note written by Nurse #3 on 10/5/17 at 2:56 pm indicated Resident #1 returned to facility at 1:38 pm in stable condition with a sling intact to the right shoulder with blue bruising and swelling noted to shoulder. A review of the discharge summary from the ED on 10/5/17 revealed the resident had an x-ray of the right shoulder. The impression showed an impacted proximal right humeral fracture. The discharge plan indicated with the residents other comorbidities and severe osteoporosis, the fracture may be treated as closed fracture and a shoulder immobilizer would be appropriate. An interview was conducted with Nurse #1 on 10/12/17 at 11:25 am. Nurse #1 reported that at 9:00 pm on 10/3/17, the aides reported to her	F 225	audit revealed no other incident of injury of unknown source noted. This audit was completed on 10/11/2017. Findings of this audit is documented on incident reports audit tool located at the facility compliance binder. 100% audit of skin assessments completed within the last 30 days of all active residents completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to identify any other resident with a documented injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 10/23/2017. 100% skin assessments of all active residents completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to identify any other resident with an injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 10/23/2017. SYSTEMIC CHANGES Effective 10/30/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure any injuries identified is thoroughly investigated and if	

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F 225	Continued From page 11 Resident #1 had a large bruise on the right arm. The nurse stated when she assessed the resident she took measurements and performed range of motion and when she moved the resident ' s arm, the resident complained of pain in her wrist. The nurse reported the resident had been sitting in a stationary chair for a couple of hours in the dining area prior to going to bed on 10/3/17 and she was noted to be leaning to her right side. The note indicated Resident #1 was not observed having a fall or bumping her arm. An interview with the DON on 10/12/17 at 4:45 pm revealed on 10/4/17 at 7:30 am, Nurse #2 met her at the door and made her aware of the bruise to the right arm on Resident #1. The DON reported that she and the ADON went to the resident ' s room to evaluate the bruising. The DON observed a large bruise on the inside of the right arm that was blue in color with a red border. The DON reported the resident was somnolent and did not appear to be in any pain at this time. The DON reported she investigated the injury of unknown origin. The DON stated she interviewed the NAs who identified the bruise at 9:00 pm on 10/3/17, the nurse who assessed the bruise at 9:00 pm on 10/3/17, and the nurse who assessed the bruise on day shift, as well as the day shift nurses who worked on 10/3/17. The DON reported after the investigation was completed, they were unable to determine the cause of the bruising. The DON provided evidence that she obtained written statements, implemented audits and completed in-services regarding notification on all the staff involved. The DON reported she did not complete the 24-hour report or the 5-day report or report it to the state agency. The DON stated the way she understood for an injury of unknown origin to be reported, one of the criteria	F 225	the source of injury is unknown the Director of Nursing will report such to the Administrator to ensure a 24 hours and a five days reports are completed and submitted to the State agency as required by regulation. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the daily clinical checklist form and maintained in the daily clinical meeting binder. Effective 10/30/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure any injuries identified is thoroughly investigated and if the source of injury is unknown the supervisor will notify the Director of Nursing and the Administrator. The DON and/or the Administrator will ensure a 24 hours and a five days reports are completed and submitted to the State agency as required by regulation. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and maintained in the daily clinical meeting binder.	

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F 225	Continued From page 12 was that the resident was not ambulatory. The DON stated since Resident #1 was ambulatory then the criteria would not have been met, and therefore, it would not be necessary to complete the 24-hour and 5-day report nor report it to the State Survey Agency. An interview was conducted with the Administrator on 10/12/17 at 4:45 pm. The Administrator indicated that his expectation was if there was an injury of unknown origin that resulted in harm, the facility was responsible for completing the required forms and reporting the injury to the state agency.	F 225	Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% re-education on the facility□s abuse/neglect policy including notification protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 10/31/2017. Any employee not educated by 10/31/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 10/31/2017, and will also be provided annually. MONITORING PROCESS Effective 10/30/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with investigation and reporting of injuries of unknown sources by conducting clinical meeting daily (M-F). This meeting will allow the team to review the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurred from the prior clinical meeting to ensure any injury of unknown source was noted investigated and reported per abuse policy. The nursing administrative team in will also review completion of skin assessments from prior day and ensure any documented injury of unknown source was followed through per policy. Any issues identified during this monitoring process will be addressed promptly.	

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F 225	Continued From page 13	F 225	Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/31/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 10/31/17, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and	F 226		10/31/17

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F 226	Continued From page 14 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, 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 follow its abuse and neglect policy when staff identified an injury of unknown origin and did not report it to the State Survey Agency for 1 of 3 sampled residents (Resident #1). Findings included: A review of the Abuse Policy and Procedure dated March, 2017 (revised) in the investigation section #1, page 7, revealed, in part, "All alleged	F 226	F226D ROOT CAUSE This alleged noncompliance was resulted from the Center's Director of Nursing misinterpretation of regulatory requirements related to reporting an injury of unknown source. "The DON stated the way she understood for an injury of unknown origin to be reported, one of the criteria was that the resident was not	

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F 226	Continued From page 15 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 executive director of the center and to other officials including to the State Survey Agency." Resident #1 was admitted to the facility on 6/14/17 with a readmission date of 10/5/17. Diagnoses included, in part, dementia, osteoporosis, and fracture to upper end of right humorous. The Minimum Data Set (MDS) quarterly assessment dated 9/21/17 revealed the resident was severely cognitively impaired. She was noted as having behaviors continuously with inattention and disorganized thinking, rejection of care 1-3 days, wandering 1-3 days and other behaviors not directed toward others for 1-3 days. The resident required extensive assistance with two staff members with bed mobility and transfers, dressing, toileting and personal hygiene and extensive assistance with one staff member with ambulating, locomotion, and feeding. She had no impairment and used a wheelchair. She was not steady and only able to stabilize with assist with balance. A record review of a nursing note written on 10/4/17 at 1:40 am by Nurse #1 revealed the resident had no signs or symptoms of distress or pain and was currently resting in bed with eyes	F 226	ambulatory. The DON stated since Resident #1 was ambulatory then the criteria would not have been met, and therefore, it would not be necessary to complete the 24-hour and 5-day report nor report it to the State Survey Agency. Regional Nurse Consultant re-educated the Center Administrator and the Director of Nursing on 10/23/2017 on reporting expectation if there is an injury of unknown origin noted for any resident in the facility. IMMEDIATE ACTION On 10/12/2017, the 24 hour report and 5 day report were sent to the Department of Health and Human Services, for resident #1's injury of unknown source identified in 10/03/2016. These reports were completed and submitted by the Administrator. No further actions taken for resident #1. IDENTIFICATION OF OTHERS 100% audit was completed on new-hires over the last 30 days to ensure education of abuse policy and procedure and reporting requirements was completed upon hire. This audit was completed by the facility Administrator, Director of Nursing and/or Director of Human resources. The audit revealed that all new hires had been educated on abuse policy and reporting procedures upon hire. This audit was completed on 10/23/2017. Findings of this audit is documented on "new hires abuse education audit tool"	

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F 226	Continued From page 16 closed. The note stated when the nursing assistants (NAs) were undressing Resident #1 for bed on the evening of 10/3/17, they noticed a large bruise on the right upper arm. The note stated Nurse #1 was called to the room. Nurse #1 measured the bruise and performed range of motion and Resident #1 stated there was pain on the right lower arm. Nurse #1 noted there was a bruise located on her upper arm which was red and purple and approximately 11 centimeters (cm) length and 9 cm wide. The note indicated Nurse #1 was not sure how the resident obtained the bruise, but prior to going to bed she was noted leaning in a chair on her right side. A record review of a nursing note written on 10/4/17 at 8:13 am by Nurse #1 revealed a call was placed to the on-call physician to explain the situation about the large bruise on Resident #1. The note indicated the resident was ambulatory and it was not known what could have caused the bruise. The note reported the physician ordered an x-ray of the right humerus and shoulder and that a call was placed to the mobile x-ray company. The note indicated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were on site to examine the bruise and the family was notified. A record review of a nursing note written by Nurse #2 on 10/4/17 at 1:29 pm revealed one of the resident ' s family member (FM) had arrived to visit during this shift. The note stated upon seeing the resident ' s bruise, the FM requested the resident be evaluated by the emergency department (ED). The note indicated Resident #1 was transported via Emergency Medical Service (EMS) to the hospital at 1:10 pm.	F 226	located in the facility compliance binder. 100% audit of all current residents' clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any injuries of unknown source documented in any resident's medical records, and if any determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other incident of injury of unknown source documented in resident's medical records. This audit was completed on 10/23/17. Findings of this audit is documented on "clinical records audit tool" located at the facility compliance binder. 100% audit was completed by the Director of Nursing of all incidents reports completed within the last 30 days to identify any injuries of unknown source and ensure that a proper investigation was completed and a 24 hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act. The audit revealed no other incident of injury of unknown source noted. This audit was completed on 10/11/2017. Findings of this audit is documented on incident reports audit tool located at the facility compliance binder. 100% audit of skin assessments	

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F 226	Continued From page 17 A record review of a nursing note written by Nurse #3 on 10/5/17 at 2:56 pm indicated Resident #1 returned to facility at 1:38 pm in stable condition with a sling intact to the right shoulder with blue bruising and swelling noted to shoulder. A review of the discharge summary from the ED on 10/5/17 revealed the resident had an x-ray of the right shoulder. The impression showed an impacted proximal right humeral fracture. The discharge plan indicated with the residents other comorbidities and severe osteoporosis, the fracture may be treated as closed fracture and a shoulder immobilizer would be appropriate. A record review of a physician ' s progress note written on 10/6/17 for evaluation and management after readmission, revealed the resident was found to having bruising on the right upper extremity on 10/4/17 per nursing staff. An x-ray of the right humerus and shoulder was ordered, however this was canceled per the FM and requested the resident be sent for evaluation to the ED. Resident #1 was sent to the ED and found to have a closed fracture of the right proximal humerus. The resident was ordered to wear a shoulder immobilizer and was not recommended for surgical intervention. An interview was conducted with Nurse #1 on 10/12/17 at 11:25 am. Nurse #1 reported that at 9:00 pm on 10/3/17, the aides reported to her Resident #1 had a large bruise on the upper right arm. The nurse stated when she assessed the resident she took measurements and performed range of motion and when she moved the resident ' s arm, the resident complained of pain in her wrist. The nurse reported the resident had been sitting in a stationary chair for a couple of	F 226	completed within the last 30 days of all active residents completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to identify any other resident with a documented injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 10/23/2017. 100% skin assessments of all active residents completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to identify any other resident with an injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 10/23/2017. SYSTEMIC CHANGES Effective 10/30/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure any injuries identified is thoroughly investigated and if the source of injury is unknown the Director of Nursing will report such to the Administrator to ensure a 24 hours and a five days reports are completed and submitted to the State agency as required by regulation. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed	

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F 226	Continued From page 18 hours in the dining area prior to going to bed on 10/3/17 and she was noted to be leaning to her right side. The note indicated Resident #1 was not observed having a fall or bumping her arm. An interview with the DON on 10/12/17 at 4:45 pm revealed on 10/4/17 at 7:30 am, Nurse #2 met her at the door and made her aware of the bruise to the right upper arm on Resident #1. The DON reported that she and the ADON went to the resident ' s room to evaluate the bruising. The DON observed a large bruise on the inside of the right upper arm that was blue in color with a red border. The DON reported the resident was somnolent and did not appear to be in any pain at this time. The DON reported she investigated the injury of unknown origin. The DON stated she interviewed the NAs who identified the bruise at 9:00 pm on 10/3/17, the nurse who assessed the bruise at 9:00 pm on 10/3/17, and the nurse who assessed the bruise on day shift on 10/4/17, as well as the day shift nurses who worked on 10/3/17. The DON provided evidence that she obtained written statements, implemented audits and completed in-services regarding notification on all the staff involved. The DON reported she did not report the incident by completing the 24-hour report or the 5-day report and submit them to the state agency. The DON stated the way she understood for an injury of unknown origin to be reported, one of the criteria was that the resident was not ambulatory. The DON stated since Resident #1 was ambulatory then the criteria would not have been met, and therefore, it would not be necessary to complete the 24-hour and 5-day report nor report it to the State Survey Agency. The DON confirmed that she did not follow the abuse policy and procedures regarding reporting injuries of	F 226	promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the “daily clinical checklist form” and maintained in the daily clinical meeting binder. Effective 10/30/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure any injuries identified is thoroughly investigated and if the source of injury is unknown the supervisor will notify the Director of Nursing and the Administrator. The DON and/or the Administrator will ensure a 24 hours and a five days reports are completed and submitted to the State agency as required by regulation. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the “week end supervisor report form” and maintained in the daily clinical meeting binder. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% re-education on the facility’s abuse/neglect policy including notification protocols. This education will be provided for all employee, to include full time, part time and as needed staff.	

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F 226	Continued From page 19 unknown origin. An interview was conducted with the Administrator on 10/12/17 at 4:45 pm. The Administrator indicated that his expectation was if there was an injury of unknown origin that resulted in harm, the facility was responsible for following the facility ' s Abuse policy and procedures.	F 226	This education will be completed by 10/31/2017. Any employee not educated by 10/31/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 10/31/2017, and will also be provided annually. MONITORING PROCESS Effective 10/23/2017, the Administrator and/or DON will conduct random selected five staff interviews regarding the facilities abuse policy and procedure as well as reporting requirements. Random interviews will be conducted daily 5x times a week (M-F) x 2 weeks, then 2x times a week (M-F) x 3 more weeks or until the pattern of compliance is maintained. Effective 10/30/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with investigation and reporting of injuries of unknown sources by conducting clinical meeting daily (M-F). This meeting will allow the team to review the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurred from the prior clinical meeting to ensure any injury of unknown source was noted investigated and reported per abuse policy. The nursing administrative team in will also review completion of skin assessments from prior day and ensure any documented injury of unknown source was followed through per policy. Any	

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F 226	Continued From page 20	F 226	issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/31/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 10/31/17, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	