STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	**03/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE / OXFORD	**500 PROSPECT AVENUE OXFORD, NC 27565**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, staff, and family interview the facility failed to follow through on grievances lodged by family members for two (Resident #5 and Resident #6) of four residents reviewed for grievances. Findings included: 1. Resident #5 was readmitted to the facility on [DATE]. Documentation on the most recent quarterly minimum data set assessment dated [DATE] coded the resident as cognitively intact with no behaviors and requiring extensive assistance of two people for bed mobility. Documentation on the same assessment revealed Resident #5 did not do any walking or locomotion during the assessment period. Resident #3 was admitted to the facility on [DATE]. Documentation on a quarterly minimum data set assessment dated [DATE] coded the resident as severely cognitively impaired, with a wandering behavior that occurred 1 to 3 days during the assessment period. Resident #5 was interviewed on 3/6/20 at 10:15 AM. Resident #5 revealed that Resident #3 had come into his room three times on the prior evening (3/5/20). He indicated he was concerned for the safety of Resident #3 because at night there was usually one nurse aide for the hall. He recounted Resident #3 had pulled on his covers at night while he was sleeping. He declared he did not want wandering residents to come into his room. An interview was conducted on 3/7/20 at 6:59 AM with a nurse aide (NA #1) who was assigned to care for Resident #3 on the 11:00 PM to 7:00 AM shift beginning on 3/6/20. NA #1 revealed that Resident #3 does wander throughout the facility, but everyone watches out for her, including the other residents. NA #1 revealed that the staff on other halls would let her know if Resident #3 was where she shouldn't be, so Resident #3 could be returned to her hall but occasionally she could slip by the staff monitoring her. NA #1 offered that Resident #3 loved to go to the hall for which Resident #5 resided and we don't know she is up there. An interview was conducted with the facility social worker at 9:14 AM on 3/7/20. The social worker revealed she had received a phone call from a family member of Resident #5 a couple of weeks ago but could not recall the exact date. The social worker indicated the family member of Resident #5 brought to her attention that a wandering female was going into the room of Resident #5 at night and this needed to stop. The social worker related that she did not write the concern from the family member as a grievance but brought the information to the morning clinical meeting so, the issue could be addressed as a team. The social worker thought that the resolution that was decided on by the team was a mental health consult for Resident #5. The social worker stated that she had not gone to talk to Resident #5 about the wandering resident and she herself had not communicated with the family member to let him know a resolution was being attempted for the concern of a wandering resident. The social worker was unaware if any other staff members had responded to the family member of Resident #5 regarding his concern. An interview was conducted with the family member of Resident #5 on 3/7/20 at 10:24 AM. The family member confirmed that he had called the social worker a couple of weeks ago regarding a wandering female resident coming into the room of Resident #5. The family member stated he had not received any response from the facility on this issue. Documentation on a list of grievances for the month of February 2020 did not include any concerns regarding Resident #5 or Resident #3. An interview was conducted on 3/7/20 at 4:00 PM with the facility Administrator. The Administrator recalled hearing a concern regarding the wandering of Resident #3, but he could not recall on which day it was. The Administrator confirmed the concern was not written up as a grievance and indicated it was not presented to him as a grievance. The Administrator indicated the process for handling grievances could be improved. 2. Resident #6 was initially admitted to the facility on [DATE]. Documentation on the quarterly minimum data set assessment dated [DATE] coded the resident as cognitively intact with no behaviors. Documentation on the same assessment coded the resident as not walking during the assessment period. Resident #3 was admitted to the facility on [DATE]. Documentation on a quarterly minimum data set assessment dated [DATE] coded the resident as severely cognitively impaired, with a wandering behavior that occurred 1 to 3 days during the assessment period. An interview was conducted on 3/7/20 at 6:59 AM with a nurse aide (NA #1) who was assigned to care for Resident #3 on the 11:00 PM to 7:00 AM shift beginning on 3/6/20. NA #1 revealed that Resident #3 does wander through out the facility, but everyone watches out for her, including the other residents. NA #1 revealed that the staff on other halls would let her know if Resident #3 was where she shouldn't be, so Resident #3 could be returned to her hall but occasionally she could slip by the staff monitoring her. NA #1 offered that Resident #3 loved to go to the hall for which Resident #6 resided and we don't know she is up there. Resident #6 was interviewed on 3/6/20 at 10:02 AM. Resident #6 related that he never gets out of bed and Resident #3 came into his room at night and tried to crawl into bed with him. Resident #6 insisted Resident #3 continues to come into the room and if he told her to get out, she would pitch a fit. Resident #6 revealed he told the social worker about unwanted visits to his room by Resident #3, during a recent care plan meeting held in his room. Resident #6 indicated a family member called the business office manager to relay a concern about a wandering resident coming into the room of Resident #6. Resident #6 complained that nothing was being done to stop Resident #3 from coming in his room. An interview was conducted with the facility social worker at 9:14 AM on 3/7/20. The social worker confirmed that a care plan meeting for Resident #6 was held in his room on 1/28/20. The Social Worker denied discussing a concern regarding Resident #3 coming into the room in that care plan meeting. She indicated she would have written down and addressed the concerns of Resident #6 if he had any at that time. An interview was conducted with the business office manager on 3/7/20 at 10:34 AM. The business office manager confirmed that a family member for Resident #6 did call her a couple weeks ago regarding a concern for a wandering female resident coming into the room of Resident #6. The business office manager added that the concern was that the female resident was hard to redirect. The business office manager indicated she was not given a name, but she assumed the family member was referring to Resident #3. The business office manager stated that the phone call was after the morning staff meeting so she went to the Administrator to see if a Velcro stop sign could be purchased for the doorway of Resident #6 to impede Resident #3 from entering the room. The business office manager did not think that the family member wanted a formal response back regarding the concern she voiced. The business office manager stated, referring to the family member, I told her if I needed her I would call her back, but she didn't ask to be called back. The facility maintenance director stated on 3/7/20 at 11:35 AM, I need to put a stop sign on (Resident #6's) door. A stop sign was observed on the door of Resident #6 on 3/7/20 at 11:37 AM. Documentation on a list of grievances for the month of February 2020 did not include any concerns regarding Resident #6 or Resident #3. The facility Administrator was interviewed on 3/7/20 at 4:00 PM. The Administrator recalled hearing a concern regarding the wandering of Resident #3, but he could not recall on which day it was. He remembered the business office manager telling him of the concern for the wandering of Resident #3. He recalled asking central supply to order a Velcro stop sign to affix to a doorway. The Administrator stated he knew the staff were watching Resident #3 more but could not say if she had been in the room of Resident #6 lately. The Administrator indicated the process for handling grievances could be improved.

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