STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	**1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 10/09/14. Event ID# F5FI11.	F 000		
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to update the care plan for 1 of 4 sampled residents reviewed for supervision to prevent accidents (Resident # 32). Findings included: Resident # 32 was admitted to the facility with	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	10/29/14

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

Electronically Signed | 10/29/2014

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F 280	Continued From page 1 diagnoses of depression, hypertension, Allergies, hyperlipidemia, anxiety, diabetes and restless legs. A quarterly Minimum Data Set (MDS) dated 9/22/2014 specified Resident # 32's cognitive skills was severely impaired, required limited assistance of 1 person for bed mobility and transfer. The MDS also indicated the resident was independent with no set up help with locomotion on unit. The resident's care plan to prevent fall was dated 2/3/2014. The care plan goal was for the resident will have no injuries from falls through next review. Current interventions listed on the care plan included the following: a) Give resident verbal reminders not to transfer without assistance. b) Observe that resident has and wears properly fitting soled shoes c) Fall assessment routinely d) Call light within reach when in room/bed e) Chair Alarm as indicated f) Provide environment with adequate lighting, free of glare Review of Resident # 32's current care plan revealed it was not updated for the falls that occurred on 5/9/2014 and 6/9/2014. Further review of the care plan revealed the fall prevention care plan was not updated during the last quarterly review dated 9/22/2014. On 5/9/2014 at 10:36 PM, a nursing entry specified "called to resident's room, resident was on the floor, resident stated "I sat myself down on floor" Resident has small scrape on right elbow. Reminded resident the importance of using call bell and asking for assistance." On 6/9/2014 at 4:13 PM, a nursing entry noted "After medication given, heard front door alarm going off. Resident noted sitting in front of door.	F 280	it is required by the provisions of federal and state law. 1. Resident #32 was reassessed for fall risk by the Director of Nursing on 10/9/14 with care plan and care guide updated to reflect fall precautions and interventions. Nursing clinical team was retrained on interventions for this resident. 2. All residents have the potential to be affected by the alleged deficiency. A fall risk profile was completed for current residents to identify risk for falls with care plan and care guides updated. The MDS nurse was inserviced on 10/27/14 by the MDS consultant with regard to fall care plans and interventions for falls. MDS nurse will review all care plans with each quarterly assessment and with any change of condition to ensure care plan reflects appropriate interventions for falls. 3. Measures to ensure the alleged deficient practice does not recur: Medical records of residents who have experienced a fall with event report will be brought to morning meeting. The Interdisciplinary Team will review resident falls with updating of Individual Resident Fall QA&A Log, care plan and care guide. Weekly Standards of Care Meeting will be held to ensure that appropriate safety interventions were added to the fall care plan and care guide for residents identified as risk for fall on new admission, quarterly, and with change of condition. The Director of Nursing and	

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F 280	Continued From page 2 This writer assisted resident back to room." No intervention indicated after the fall. On 10/9/2014 at 2:00 PM, Resident # 32 was observed in the front entrance doorway trying to push the door. The door alarm went off and staff was observed assisting the resident back into the facility. Interview on 10/9/20142014 at 3: 00 PM, the Minimum Data Set (MDS) nurse when questioned regarding the resident's care plan stated that it was her responsibility to update the residents' care plans at the facility. The MDS nurse further reported that she receives information in the morning stand up meetings about the residents and updates the care plans. She also reported that Resident # 32's fall care plan was not updated by another MDS nurse who was no longer employed by the facility. Interview on 10/9/2014 at 4:00 PM, the Director of Nursing (DON) stated it was her expectation for the care plan to be updated to reflect the resident current status and condition. She added Resident # 32's care plan should have been updated to reflect each fall and interventions.	F 280	Administrative Nurse will audit daily for two weeks and then weekly for 30 days for compliance. Any discrepancy will be followed up with appropriate staff for further education or counseling. 4. The Director of Nursing/Assistant Director of Nursing will submit summary from audit to monthly Quality Assurance and Performance Improvement Meeting. Revisions to this plan will be discussed at this meeting.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		10/29/14

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F 323	Continued From page 3 by: Based on observation, medical record review, and staff interviews the facility failed to implement interventions to prevent repeated falls and injuries for 1 of 4 sampled residents reviewed for supervision to prevent accidents (Resident #32). Findings included: Resident # 32 was admitted to the facility with diagnoses of depression, hypertension, Allergies, hyperlipidemia, anxiety, diabetes and restless legs. A quarterly Minimum Data Set (MDS) dated 9/22/2014 specified Resident # 32's cognitive skills was severely impaired, required limited assistance of 1 person for bed mobility and transfer. The MDS also indicated the resident was independent with no set up help with locomotion on unit. The resident's care plan to prevent fall was dated 2/3/2014. The care plan had the goal that the resident "will not experience injuries from falls through next review." Current interventions listed on the care plan included the following: a) Give resident verbal reminders not to transfer without assistance. b) Observe that resident has and wears properly fitting soled shoes c) Fall assessment routinely d) Call light within reach when in room/bed e) Chair Alarm as indicated f) Provide environment with adequate lighting, free of glare Review of the resident's assessment of fall risk for months of March 2014, April 2014 and July 2014 revealed the resident scored 22 points each month, which was high risk for falls (Score of 20 or more denotes high risk for falling) The incident report dated 4/23/2014 was reviewed and revealed the resident was found sitting on the floor in her room. The document	F 323	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. 1. Resident #32 was reassessed for fall risk by the Director of Nursing on 10/9/14 with care plan and care guide updated to reflect fall precautions and interventions. Nursing clinical team was retrained on interventions for this resident. 2. All residents have the potential to be affected by the alleged deficient practice. A fall risk profile was completed for current residents to identify risk for falls with care plan and care guides updated. 3. Measures to ensure the alleged deficient practice does not recur: Medical records of residents who have experienced a fall with event will be brought to morning meeting. The Interdisciplinary Team will review resident falls with updating of Individual Resident fall QA&A Log, care plan and care guide. Weekly Standards of Care Meeting will be held to ensure that appropriate safety interventions were added to the fall care plan and care guide for residents identified at risk for fall on new admission, quarterly, and with change of condition. Inservicing of Licensed Nurses and	

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F 323	Continued From page 4 specified intervention as "obtain UA (Urinalysis)." On 4/24/2014 at 1:30PM, a nursing entry specified Resident # 32 fell on 4/23/2014. The resident had a bruise, left arm pain and a skin tear. On 4/26/2014 at 8:00 PM, a nursing entry noted "writer heard door alarm sounding and wheel chair alarm. Writer went down Hall to see what was happening. Another Nurse was already on there way down hall. She got to the door observe resident on ground and writer saw resident lying on ground." The nurse note further documented the resident had injury to right forearm and hand. The resident was send to Emergency room. The incident report dated 4/26/2014 was reviewed and revealed the resident was observed lying on pavement with injury to right forearm and hand. The document specified intervention as "Frequent observation upon return." Review of the medical imaging report dated 4/26/2014 indicated the resident had "a fall with right forearm injury." The report further noted "There is a soft tissue contusion and laceration of the mid-dorsal medial region. The document indicated the impression as " Soft tissue contusion and laceration without acute bony abnormality. On 5/9/2014 at 10:36PM, a nursing entry specified "called to resident's room, resident was on the floor, resident stated "I sat myself down on floor" Resident has small scrape on right elbow. Resident reminded the importance of using call bell and asking for assistance." On 6/9/2014 at 4:13 PM, a nursing entry documented "After medication given, heard front door alarm going off. Resident noted sitting in front of door. This writer assisted resident back to room." No intervention indicated after the fall. On 8/2/2014 at 7:01 PM, a nursing entry noted	F 323	Certified Nurse Assistants by the Assistant Director of Nursing as to the importance of appropriate falls intervention being in place. Nurses and Certified Nurse Assistants will not be able to work until they have received inservice. The Director of Nursing and Administrative Nurse will audit daily for two weeks and then weekly for 30 days for compliance. Any discrepancy will be followed up with appropriate staff for further education or counseling. 4. The Director of Nursing/Assistant Director of Nursing will submit summary from audit to monthly Quality Assurance and Performance Improvement Meeting. Revisions to this plan will be discussed at this meeting.	

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"Resident had a fall today getting up unassisted from bed to chair. Resident stated "she got herself up" Resident has a skin tear to right elbow, treatment in place per standing order."
The incident report dated 8/2/2014 was reviewed and revealed "Resident fell while getting up unassisted." The document specified intervention as "increase observation."
Review of the orthopedic report dated 8/6/2014 documented the resident "seen for right wrist pain. The resident is right hand dominant. The pain started after she fell on the floor after trying to proof that she could walk on 8/2/2014. She was seen by the attending Doctor and x- ray was done. X-ray was taken at the facility that showed distal radius fracture no displaced. Severity of pain: worse 10/10 and best 0/10. Radiation of pain present into the fingers. Quality of pain is dull and aching. Pain is constant unless she is asleep. No nocturnal or rest pain. Pain is aggravated with use of the hand and arm. Pain is better with rest and medication. Associated swelling present. Associated symptoms: she has a skin tear on the right forearm due to the fall."
On 10/4/2014 at 3:17 PM, a nursing entry noted "Told by License Clinical Nurse (LPN) that resident said she fell and hit her head. Pt (patient) said she was trying to reach her w/c (wheel chair) in the middle of the floor but missed the w/c."
The incident report dated 10/4/2014 was reviewed and revealed "patient fell and hit her head. The document specified interventions as "Physical therapy referral for possible follow up for strengthening."
On 10/8/2014 at 10:50 AM, Resident # 32 was observed lying in her bed. The call bell was lying on the bed next to the resident within reach.
On 10/9/2014 at 2:30 PM, Nursing Assistant (NA) #1 was interviewed. She stated she was unaware

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F 323	Continued From page 6	F 323		

of the resident's recent falls since she was not regularly assigned to the resident. The NA # 1 further stated she was unaware of fall precautions and fall interventions for Resident # 32. Review of the care guide with NA # 1 revealed there was no source of documentation for frequent visual checks for Resident # 32. Further review of the Nurse's Aide care guide revealed no noted instruction or interventions to prevent Resident # 32 from a fall.

On 10/9/2014 at 3:00 PM, The Assistant Director of Nursing (ADON) was interviewed. She explained the facility utilized a stand up meeting that met daily each morning to discuss any residents concerns that included falls. The ADON stated when Resident # 32 fell; it was the responsibility of the nurse to implement an immediate intervention. The ADON also added she was responsible in reviewing the incident reports and making sure the interventions were appropriate for the residents at the facility. Resident # 32's incident report was reviewed with ADON that specified the resident was to be observed frequently and ensure the resident ' s call bell was in reach. The ADON confirmed that the interventions already in place for resident # 32 were used repeatedly even though they were not effective in preventing the resident from falling. ADON also confirmed that there was no documentation or instructions given to staff as to when and how to observe the resident while she was not in her room. ADON also reported that no intervention had been put in place since the last fall on 10/4/2014. She added that they were waiting for Physical Therapist to evaluate the resident. She added that the physical therapist had not evaluated the resident as of 10/9/2014.

On 10/9/2014 at 4:00PM, the Director of Nursing (DON) confirmed that she was new at the facility

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F 323	Continued From page 7 but her expectation was for the facility to implement appropriate interventions for Resident # 32 who scored as a high risk for falls and was severely cognitively impaired. DON further stated that the current fall interventions for Resident # 32 were not effective in preventing the resident from falling and she was going to make changes.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		10/29/14

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F 431	Continued From page 8 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to discard an expired medication in 1 of 7 medication carts (the C Hall cart #2) inspected for proper medication labelling and storage. Findings included: An observation on 10/09/14 at 3:55 PM of the C Hall medication cart #2 revealed a bottle of Latanoprost 0.005% eye drops with a label indicating the bottle was opened on 8/11/14 and had an expiration date of 9/25/14. The Latanoprost bottle was labeled for Resident #70. Record review for Resident #70 revealed a current Physician's Order to "instill one drop into the left eye at bedtime for diagnosis of Glaucoma." The resident's most recent MDS dated 5/03/14 listed Glaucoma as a current diagnosis. Review of the resident's October, 2014 medication administration record (MAR) revealed the Latanoprost eye drops had been administered to the resident 13 times after the medication expiration date of 9/25/14. An interview was conducted on 10/09/14 at 4:00 PM with Nurse #1 who was responsible for the C Hall medication cart #2. During the interview Nurse #1 acknowledged the medication was past the manufacturer's expiration date and should have been discarded 6 weeks from the open date of 8/11/14. An interview was conducted on 10/09/14 at 4:15 PM with the Director of Nursing (DON) during which she indicated that it was her expectation	F 431	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Lantanoprost 0.005% eye drops was discarded by the Director of Nursing. All medication, treatment carts and medication room were checked by the Director of Nursing on 10/9/14. No expired medications were found. 2. Charge Nurses on 11-7 shifts to check medication carts, treatment carts and medication room daily to ensure expired medications are removed. Pharmacy consultant to audit monthly for any expired medications. Any discrepancy will be discussed with the Director of Nursing. Inservicing of Licensed Nurses by the Director of Nursing and Assistant Director of Nursing that any medication found to be expired on audit form will be discarded or sent back to pharmacy. Nurses will not be able to work until they have received inservice.	

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F 431	Continued From page 9 that the nursing staff discard expired medications. She further stated "the facility nursing staff should not administer an expired medication to a resident." The DON stated that it was the responsibility of the night shift nursing staff to examine the medication carts, identify expired medications, remove expired medications from the cart, and make sure any expired medications were reordered promptly.	F 431	3. The Director of Nursing and/or Administrative Nurse will audit daily for two weeks and then weekly for 30 days for compliance. Any discrepancies will be followed up with the appropriate nurse for further education or counseling. 4. The Director of Nursing or Assistant Director of Nursing will prepare a summary from audit information and bring to monthly Quality Assurance and Performance Improvement Meeting. Revisions to this plan will be discussed at this meeting.	