| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 02/11/2019-02/15/2019. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event D93O11.. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted from 01/22/2019 and ended 02/15/2019. Past-noncompliance was identified at CFR 483.25 at tag F689 at a scope and severity IJ. The tag F689 constituted Substandard Quality of Care.<br><br>An extended survey was conducted during the recertification and complaint survey of 02/15/2019, and the facility's credible allegation for F689 dated 08/27/2018 was validated on 02/15/2019.<br><br>No deficiencies cited as a result of complaint investigation of 02/15/2019 Event D93O11. | F 000 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced | F 607 | | 3/19/19 |

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

Electronically Signed | 03/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|---|---|
| F 607 | Continued From page 1<br>by:<br>Based on observation, record review, resident interviews, family interviews, staff interviews, and physician interviews, for two (Residents # 1 and # 2) of four sampled residents, the facility failed to implement their abuse/neglect policy and identify through their clinical records, family concerns, and incident reports that possible neglect or abuse may have occurred and needed to be investigated and a 24 hour and five day report filed with the state agency. The findings included:<br><br>Review of the facility's "Freedom From Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property" policy, revised June, 2017, revealed the facility would take a proactive response in identifying events that might constitute abuse or neglect through reviewing incident reports, reviewing grievances/concerns, and reviewing clinical records. Incidents which constituted possible abuse/neglect would be investigated and reported to the state agency.<br><br>1. Record review revealed Resident # 1 resided in the facility from 8/14/ 18 to 8/24/18.<br><br>Review of the resident's baseline care plan, initiated on 8/14/18, revealed the staff identified the resident had safety issues and a history of falls. Staff were directed to provide assistance with activities of daily living and keep commonly used items within the resident's reach. There was also a notation that the resident was not cooperative with care, was impulsive, and had poor safety awareness secondary to her dementia.<br><br>Record review revealed the resident had a five | F 607 | F-607<br><br>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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the 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.<br><br>Root cause:<br>The Executive Director and Director of Nursing discussed on 2/15/19 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from inadequate training/understanding of staff and as a result, the facility failed to properly implement the abuse/neglect policy (Residents #1 and 2).<br><br>For affected residents:<br>Resident #1 no longer resides in the facility. For resident #2, upon learning of the allegation on 1/23/19, the accused individual was suspended pending investigation and a 24 hour initial allegation report was initiated by the Administrator and the DON. A detailed investigation was conducted by the facility Administrator within five days of this | |

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|---|---|---|---|---|
| F 607 | Continued From page 2<br>day Minimum Data Set (MDS) assessment, completed on 8/21/18. The resident was assessed to be severely cognitively impaired, and needed extensive assistance with her activities of daily living. The resident was also coded as having sustained falls prior to admission and since admission.<br><br>Review of hospital records revealed Resident # 1 underwent a CT scan while in the emergency room after she was transferred to the hospital on 8/24/18. She was identified to have fractures of the 2nd, 3rd, 4th, 5th, and 6th ribs. The 2nd, 5th, and 6th ribs were documented to be displaced. The hospital records noted it was the resident's left wrist which had sustained injury, and not her right wrist as reflected in the facility record. An X-ray, completed while in the ER, revealed the resident had a left non-displaced ulnar styloid fracture. (left wrist fracture). The resident was also identified to have a hemopneumothorax (air and blood were in the chest cavity) and pulmonary contusion (lung bruising).<br><br>The resident's responsible party (RP) was interviewed on 1/22/19 at 2:30 PM and reported the following. The RP did not feel the resident sustained her injuries from a fall on 8/24/18, and she had communicated this to the facility and received no explanation. The RP stated after Resident # 1 passed away, she and other family members met with the administrator and informed him of all the injuries which were identified at the hospital. The RP stated, "We told them we wanted to know what happened because something was not right for her to have a punctured lung and broken ribs." The RP stated the administrator maintained that the injuries were due to the resident's fall without giving an | F 607 | alleged allegation. The result of the investigation unsubstantiated the allegation due to inconsistencies of resident #2's statements as well as like resident and staff interviews did not show any evidence of abuse/neglect. The accused employee was re-educated on customer service, abuse/neglect, and reporting abuse/neglect by the Administrator on 1/28/19.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance. Like resident interviews were initiated on 1/23/19 conducted by the Administrator to determine if any other residents had experienced the same treatment by the accused individual or any employee. No other residents were identified in the audit.<br><br>Facility plan to prevent re-occurrence:<br>All facility staff will be re-education regarding abuse/neglect and reporting abuse/neglect by the Administrator, Director of Nursing, or designee by 3/19/19. Any employee not educated by 3/19/19 will not be allowed to work until re-education has occurred.<br><br>In Addition, an abuse/neglect and reporting abuse/neglect audit tool will be completed by the Administrator, Director of Nursing, or designee to interview 10 residents weekly for 8 weeks to ensure the abuse and neglect policy is being followed by all staff. The audit will consist of new admissions along with long term | |

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|---|---|---|---|---|
| F 607 | Continued From page 3<br>explanation of how this could have occurred.<br><br>On 1/24/19 at 9:00 AM another relative, (Relative # 1), was also interviewed. Relative # 1 reported the following. Relative # 1 stated a letter was sent on October, 9.2018 requesting to meet with the administrator, and conveying to him they had concerns about the resident's care. On 11/14/18, she, the resident's RP, and another relative met with the administrator, Nurse # 2, and the former DON. Relative # 1 stated she told the administrator that she did not think that the resident could have sustained her injuries from falling off a bed onto a soft floor mat. Relative # 1 stated the bed was only about 12 to 18 inches off the ground. Relative # 1 stated they told the Administrator that they wanted to know more about an incident for which Resident # 1 was medicated on the AM of 8/24/18, and they were not given any more information. Relative # 1 stated she wanted to know if the staff had to hold the resident in order for her to receive the medication, and if she was combative and possibly could have gotten hurt at that time. Relative # 1 stated the administrator and his staff maintained that the resident had sustained the injuries from her fall, and the family received no further explanation or follow up.<br><br>The facility Administrator was interviewed on 1/23/19 at 8:10 AM and again at 1/25/19 at 4:45 PM. The Administrator stated he recalled talking to the family about concerns they had regarding Resident # 1's falls, and the family was wanting to know more information in regards to what had happened. Per the Administrator, he did not recall what the family had said in regards to the extent of Resident # 1's injuries. The Administrator stated he had not interpreted that there was a | F 607 | care residents.<br><br>Responsible Party:<br>The Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.<br><br>In addition, the Administrator and/or the Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>Compliance Date: 3/19/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

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|---|---|
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|---|---|---|---|---|
| F 607 | Continued From page 4 | F 607 | | |

question of neglect or abuse with the resident, and thus he had not conducted an investigation to determine if there had been any abuse or neglect.

Review of the facility's Investigation into the Resident's fall which occurred on 8/24/18 revealed documentation was located on a Resident Incident Report. Nurse # 3 had noted on the form the resident had "been seen on floor mattress at 4:03 PM." Nurse # 3 noted the resident was complaining of pain in her hip. Nurse # 3 noted, "did not see any injury and did not see any skin break down." Attached to the Resident Incident Report form was a page entitled, "Incident Investigation." It was signed by the former DON, and was not dated. Under "narrative of investigation" the narrative did not address what time the resident fell or if there had been two falls. It did not address where she fell, and what part of her body hit what object. It did not address if there were any witnesses to the fall. The "narrative investigation" included five sentences which read, "On 8/24/18 resident was observed on the floor. Resident complained of pain her hip area and x-ray was ordered. Investigation of this fall conducted by the Director of Nursing concluded that resident attempted to transfer self lost balance and fell. Due to the fall impact resident sustained a fracture of her ribs. Resident was sent to the ER for evaluation and treatment."

It was clarified with the Administrator on 1/25/19 at 4:45 PM that this was the only documentation that the facility had in regards to their investigation into the resident's injuries. According to the Administrator, he had never identified through the family's concerns, incident reports, and clinical records that there was a

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 607 | Continued From page 5 | F 607 | | |

need to implement the facility's neglect/abuse policy and conduct an investigation for neglect/abuse.

2. Record review revealed Resident # 2 was admitted to the facility on 5/13/14. The resident had diagnoses of osteoarthritis, muscle weakness, diabetes, atrial fibrillation, hypertension, gastroesophageal reflux disease, anxiety, and unspecified dementia without behavioral disturbance.

Review of the resident's Minimum Data Set assessment, dated 10/16/18, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated she was cognitively intact. The resident was assessed to have no behaviors and no range of motion problems. She was assessed to need extensive assistance from staff with her activities of daily living. A readmission MDS assessment, dated 1/2/19, coded the resident as also having a BIMS score of 15.

Record review revealed the resident had an initial psychiatric evaluation, conducted by a NP (Nurse Practitioner) and dated 11/5/18, because staff reported the resident could be irritable and agitated at times. The NP noted on 11/5/18 the resident was "pleasant, smiling, stated she was happy all the time and nice to everyone." The resident told the NP she did not have problems with anxiety, depression, mood, hallucinations, or delusions. The resident told the NP the staff were out to get her because she was a happy person all the time. The resident reported that the night staff had pulled her hair and sliced her cord on her bed controller. The NP noted the resident was alert, coherent, oriented to person; place; and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 607 | Continued From page 6 | F 607 | | |

time, appropriate in affect, had organized thinking, had good short and long term memory, and good concentration. The NP noted the resident was having questionable paranoid delusions.

Review of nursing notes revealed a nursing entry by Nurse # 5, dated 12/13/18 at 11:02 AM, noting that the resident complained of chest pain at 8:22 AM. At 8:37 AM the resident complained her left arm was numb and she still had chest pain. The resident informed the nurse that "maybe she should go to the hospital."

Interview with Nurse # 5 on 1/23/19 at 9:00 AM revealed the resident's onset of pain was sudden, and she had not been experiencing pain with her chest or arm prior to 12/13/18.

Record review revealed the resident was hospitalized from 12/13/18 until 12/19/18. Review of hospital records revealed the resident presented to the hospital with sudden and new left shoulder pain. An orthopedic physician was consulted. The resident underwent a CT of her shoulder while hospitalized. According to the hospital discharge summary, the resident's pain was due to crystal arthropathy (minerals deposited within joints) superimposed on severe glenohumeral arthritis. The CT scan had shown the resident had anterior subluxation (partial dislocation) of the humeral (arm bone) head along with some shoulder effusion (fluid accumulation) and possible chronic rotator cuff tear (a tear in the tissues connecting muscle and bone at the shoulder).

The resident was initially interviewed on 1/22/19 at 1:03 PM. During the interview, Resident # 2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

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|---|---|
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|---|---|---|---|---|
| F 607 | Continued From page 7 | F 607 | | |

stated before the Christmas holiday, NA # 2 had jerked her arm because the NA was mad. The NA also told her she was "tired of cleaning up her shit." Resident # 2 said it tore the ligaments in her arm, and it caused it to start hurting. Resident # 2 was observed to reach inside the bodice of her clothing and to pull out a small slip of paper she had hidden beneath her clothes. The word, "Corporate," was observed written on the piece of paper. Resident # 2 pointed to the paper and stated that "these people" were coming to talk to her about it, and she wanted to see what they would do. Resident # 2 asked for nothing to be said about it on the day of 1/22/19.

Resident # 2 was interviewed again on 1/23/19 at 8:30 AM. Resident # 2 stated she had given it some thought, and she wanted her comments shared and looked into. The resident again said that NA # 2 had pulled her arm out of spite, and she had told Nurse # 5 about it.

Nurse # 5 was interviewed on 1/23/19 at 9:00 AM. Nurse # 5 stated that about 2 weeks after Resident # 2 returned from the hospital, the resident had told her that someone had "been rough with her arm." Nurse # 5 was not aware the resident thought someone had been rough with her arm intentionally. Nurse # 5 stated Resident # 2 had not given the name of the person, but that she (Nurse # 5) thought it was NA # 2 because she had been told by Supervisor # 1 that NA # 2 could not work with the resident any longer. Nurse # 5 did not know why NA # 2 could not work with the resident, but stated she thought there was an investigation going on in regards to the resident's arm injury.

NA # 3 was interviewed on 1/23/19 at 9:10 AM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 607 | Continued From page 8 | F 607 | | |

and again on 1/23/19 at 1:20 PM. NA # 3 stated she routinely was assigned to care for Resident # 2 during the day shift. NA # 3 also stated the resident said every day that someone had hurt her arm. NA # 3 stated that the resident would say a name that started with the same letter that NA # 2's name did.

The facility social worker was interviewed on 1/23/19 at 2:55 PM. The SW reported the following. She had just become employed at the facility on 1/2/19, and visited with the resident about two days after she started work. On that day, she recalled the resident reported she was in pain, and the resident complained specifically about NA # 2 positioned her wrong in bed at some previous time. The SW asked if she had reported it to someone, and the resident replied to her to her that the NA was still working at the facility. The SW stated she brought it up in the morning administrative meeting, and was told by the DON and administrator that they took care of it.

Supervisor # 1 was interviewed on 1/23/19 at 2:35 PM. Supervisor # 1 reported the following. She did not recall the exact date, but sometime in the past she had been told by the former ADON that NA # 2 should not work with Resident # 2. The supervisor thought that the resident's daughter might have spoken to the Administrator, and did not know where or why a concern originated. It was the understanding of the supervisor that NA # 2 was to receive further training on transfers, and that NA # 2 herself did not want to be assigned to Resident # 2 because she was fearful of being blamed and getting in trouble for things. Supervisor # 1 stated she never heard that Resident # 2 accused NA # 2 of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 607 | Continued From page 9 | F 607 | | |

hurting her arm.

The resident's RP (responsible party) was interviewed on 1/23/19 at 10:20 AM. The RP reported the following. When Resident # 2 was hospitalized, the physician told her that the resident's current arm pain originated from a pull on her shoulder. She had spoken to Resident # 2, and Resident # 2 had told her that NA # 2 had hurt her arm. The RP said that Resident # 2 does not usually get up from bed, and that the staff have to turn her to change her. The RP stated that Resident # 2 had been "going on about (NA # 2) for months," and reporting that NA # 2 dug her nails in to her skin, and "was nasty." The RP stated she talked to the Administrator after the resident's hospitalization and shared all of this information with him. The RP stated the Administrator asked if she (the RP) thought the resident had been abused or the injury was intentional. The RP stated she replied to the Administrator, "How would I know?" The RP stated the Administrator told her he would have more training done with the staff.

On 1/23/19 at 9:50 AM, the Administrator was interviewed and reported the following. He recalled having a meeting with Resident # 2's RP around 12/19/18, and that the RP stated she thought there needed to be more staff training about transfers. The RP did not say that the resident had been abused or mistreated. He did not know there were instructions that NA # 2 was not to be assigned to Resident # 2, and did not know why there would be a stipulation such as this. The Administrator stated the facility conducted some transfer training.

On 1/23/19 NA # 2's personnel file was reviewed.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 607 | Continued From page 10 | F 607 | | |

Review of the personnel file revealed documentation that there had been two incidents since NA # 2 had been employed at the facility in which concerns had been brought to the facility's attention about how NA # 2 had cared for residents. According to the personnel file records, the care concerns originated in 2018.

Interview with the Administrator on 1/23/19 at 3:15 PM revealed he had not identified there had been concerns with NA # 2 providing care at the facility. The Administrator stated the care concerns were before his time and when another Administrator had been at the facility.

The orthopedic physician, who saw the resident in the hospital, was interviewed on 1/25/19 at 12:16 PM. The orthopedic physician reported the following. The resident's CT scan indicated the resident's subluxation and rotator cuff tear were considered to be chronic in nature. According to the orthopedic, it was reasonable that a staff member could have been providing care appropriately, and a movement could have caused the resident's sudden pain to flare up with the chronic condition. He also stated that the resident initially told him that there had been no trauma when she was initially hospitalized. The orthopedic physician stated that later the resident told him, "She did not want to get anyone in trouble," but that a staff member had "pulled her arm into a weird position" before she started having problems with her arm.

NA # 2 was interviewed on 1/23/19 at 2:50 PM. NA # 2 had been assigned to care for Resident # 2 on the evening before she was hospitalized on 12/13/18. NA # 2 stated nothing out of the normal happened with the resident. NA # 2 stated she no

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 607 | Continued From page 11<br>longer cared for Resident # 2 because the resident had said that she (NA #2) had hurt her shoulder, and she had not done so. The NA said she did not want to be assigned to the resident any longer.<br><br>An interview was held with the Administrator on 1/25/19 at 4:45 PM again. The Administrator confirmed he had never talked to Resident # 2 herself after she had developed new onset of pain and Resident # 2's RP brought concerns to him. He also had not identified through reviewing personnel files that NA # 2 had a history of concerns being voiced about her care while she was employed at the facility. The facility failed to show that they had implemented their policy to be proactive in identifying possible incidents of neglect by their failure to talk to a resident, who had complained about rough treatment by a nurse aide, who had a past history of documented grievances about her care. | F 607 | | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires | F 645 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 645 | Continued From page 12 | F 645 | | |

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 645 | Continued From page 13<br>facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) after the initial thirty day approval for nursing home placement expired for one of two residents reviewed for PASRR (Resident #38).<br><br>Findings included:<br><br>A review of records revealed Resident #38 was admitted 9/26/2018 with diagnoses of schizoaffective disorder - bipolar type and Diabetes Mellitus.<br><br>The Admission Minimum Data Set (MDS) dated 10/3/2018 noted Resident #38 to be cognitively intact and needed limited assistance for all Activities of Daily Living with the physical help of one person.<br><br>A review of records revealed no Preadmission Screening and Resident Review (PASRR) information.<br><br>On 2/14/2019 at 11:00 AM the Admissions | F 645 | F-645<br><br>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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the 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.<br><br>Root Cause:<br>The Administrator and the Regional Director of Operations discussed on 2/14/19 to identify the root cause of this alleged non-compliance. Root-cause analysis conducted revealed the alleged non-compliance resulted from inadequate training/understanding of Social Worker, Admissions Coordinator, Business Office | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 645 | Continued From page 14<br>director stated she would locate the PASRR.<br><br>The facility corporate nurse supplied the information on 2/14/2019 at 11:20 AM. A review of the documentation revealed nursing facility placement was appropriate for a limited stay of no more than 30 days. The notification further explained if the resident was expected to extend beyond that 30 day period (10/26/2018), further approval and screening must be obtained within 5 days of the PASRR expiration date. The corporate nurse stated the facility did not get further approval or screening for Resident #38.<br><br>On 2/14/2019 at 2:00 PM, the facility Administrator stated his expectation was the facility would have a system in place to prevent the PASRR from being overlooked. | F 645 | Manager, and Administrator. As a result, the facility failed to ensure that resident #38 had a current PASRR.<br><br>For affected resident:<br>For resident #38 along with two other residents identified, a PASRR was applied for on 2/14/19.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance. On 2/14/19 a complete PASRR audit was done by the Administrator and Regional Director of Operations. No other PASRR's were found to be expired.<br><br>Facility plan to prevent re-occurrence:<br>The Social Worker, Admissions Coordinator, Business Office Manager, and the Administrator were re-educated by the Regional Director of Operations on 2/14/19 on the process for verifying and maintaining documentation of all PASRR's in AHT.<br><br>In addition, a PASRR audit sheet will be done monthly by the Administrator or the Social Worker for 2 months to ensure all residents have a current PASRR.<br><br>Responsible Party:<br>The Administrator and the Social Worker will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 645 | Continued From page 15 | F 645 | In addition, the Administrator and/or the Social Worker will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>Compliance Date: 3/19/19 | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs | F 657 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 657 | Continued From page 16<br>or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to invite a resident to a care plan meeting for one of five residents reviewed for care plan meeting invitations (Resident #45).<br><br>Findings included:<br><br>A review of records revealed Resident #45 was admitted 4/25/2018 with diagnoses of Diabetes Mellitus, End Stage Renal Disease and Dialysis.<br><br>The Quarterly Minimum Data Set (MDS) dated 8/11/2018 noted Resident #45 to be cognitively intact and needed limited to extensive assistance for all Activities of Daily Living with the physical help of one person.<br><br>A review of the medical record revealed on 5/14/2018 a care plan was developed for Resident #45. However, further review of the medical record revealed there were no care plan meeting dates or notes.<br><br>On 2/11/2019 at 4:38 PM, in an interview, Resident #45 stated he did not remember being invited to a care plan meeting and was not sure what a care plan was.<br><br>On 2/13/2019 at 12:35 PM in an interview, the facility Social Worker (SW) stated she made copies of the invitations to care plan meetings, | F 657 | F-657<br><br>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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the 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.<br><br>Root Cause:<br>The Administrator, Director of Nursing, and Social Worker discussed on 2/15/19 to identify the root cause of this alleged non-compliance. Root-cause analysis conducted revealed the alleged non-compliance resulted from inadequate training/understanding of Social Worker. As a result, the facility failed to ensure that resident #45 was invited to a care plan meeting.<br><br>For affected resident:<br>On 2/15/19 the Administrator invited resident #45 (who is his own responsible party) to attend a care plan meeting with | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 657 | Continued From page 17<br>mails one to the resident responsible parties and takes a copy to the resident if they are alert and oriented. The SW stated she had been employed at the facility about 6 weeks and had not attended a care plan meeting since her employment. The SW indicated she had not seen any notes or documentation of care plan invitations to the residents.<br><br>In an interview with the facility corporate consultant on 2/13/2019 at 1:30 PM, the consultant stated there were no notes about Resident #45's care plan meetings.<br><br>On 2/13/2019 at 3:10 PM in an interview, the facility Administrator stated his expectation was the residents would be invited to their care plan meetings and be involved with their care. | F 657 | the interdisciplinary team. Resident #45 declined the invitation stating that he had no questions or concerns regarding his care at this time.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance. Care plan schedule reviewed with new Social Worker on 3/6/19. All letters of invitation to be sent out accordingly and monitored for compliance as stated below.<br><br>Facility plan to prevent re-occurrence:<br>The new Social Worker was educated on her start date of 3/6/19 by the Administrator on the process for inviting residents and their responsible party (if applicable) to attend their care plan meeting.<br><br>In addition, a care plan invitation audit sheet will be done monthly by the Administrator or the Social Worker for 2 months to ensure that all residents and their responsible party have been invited to attend their care plan meeting.<br><br>Responsible Party:<br>The Administrator and the Social Worker will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.<br><br>In addition, the Administrator and/or the Social Worker will report findings of the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 657 | Continued From page 18 | F 657 | monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>Compliance Date: 3/19/19 | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interviews, family interviews, staff interviews, and physician interviews, for one (Resident # 1) of two sampled residents with injuries, the facility failed to assure a resident did not sustain injuries which led to her death. Resident # 1 sustained three falls during her eleven day residency. Following an incident on the resident's last residency date, in which the resident was found on the floor, she was transferred to the hospital and identified to have multiple rib fractures, a hemopneumothorax, and a fracture in the wrist area. The resident expired on 9/4/18 from complications of her injuries. | F 689 | Past noncompliance: no plan of correction required. | 3/27/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 19 | F 689 | | |

The findings included:

1. Record review revealed Resident # 1 resided in the facility from 8/14/ 18 to 8/24/18. Prior to her facility residency the resident had been hospitalized following a fall at home. The hospital physician noted the resident had a "sudden significant decline in status" and "rapidly worsening dementia" during her hospitalization. Additionally, the resident had diagnoses of anxiety, depressive disorder, and osteopenia.

Review of the resident's baseline care plan, initiated on 8/14/18, revealed the staff identified the resident had safety issues and a history of falls. Staff were directed to provide assistance with activities of daily living and keep commonly used items within the resident's reach. There was also a notation that the resident was not cooperative with care, was impulsive, and had poor safety awareness secondary to her dementia.

Record review revealed the resident had a five day Minimum Data Set (MDS) assessment, completed on 8/21/18. The resident was assessed to be severely cognitively impaired, and needed extensive assistance with her activities of daily living. The resident was also coded as having sustained falls prior to admission and since admission.

Review of nursing notes revealed Resident # 1 sustained an unwitnessed fall on 8/18/18 at 3:39 PM. Nurse # 1 documented at this time that Resident # 1's family had stepped out from the resident's room to speak to him (the nurse), and as the family was speaking to the nurse they heard a scream for help. Resident # 1 was found

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 20 | F 689 | | |

on the floor on her left side, had a golf ball sized "node" to the back of her head, and complained of a headache and left hip pain.

According to facility documentation, NA # 5 had been assigned to care for Resident # 1 on the 3:00 PM to 11:00 PM shift on 8/18/18. NA # 5 was interviewed on 1/23/19 at 12:35 PM, and did not recall the resident or any events related to the resident.

According to the nursing notes, Resident # 1 was sent to the hospital for evaluation directly following the 8/18/18 incident and returned at 10:30 PM on 8/18/18 following the hospital's determination that all x-rays were negative for injury.

According to an interview with the DON (Director of Nursing) on 1/23/19 at 9:25 AM, Nurse # 1 was currently on an extended work leave and was not available for interview.

Review of the facility's "post incident actions" form, dated 8/18/18 revealed under "Immediate Post-Incident Action," it was noted the resident was assisted to the chair and the family and resident were re-educated to ask for assistance when there was a need for transfer."

Review of nursing notes revealed Nurse # 2 made an entry on 8/19/18 at 12:21 AM noting that the resident's bed was in the lowest position, and fall mats were in place.

On 8/20/18 at 6:59 AM, Nurse # 2 noted the resident was assessed again, found to have no injuries, and denied pain or discomfort.
On 8/22/18 at 3:27 PM the NP (Nurse

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 21 | F 689 | | |

Practitioner) entered a progress note. The NP documented within the note that she saw the resident due to intermittent episodes of agitation. The NP noted she consulted with a psychiatrist regarding behavior management, and a change was made to the resident's medication regimen. The NP noted the plan was discussed with the resident's family and included the psychotropic medications Zyprexa, Clonazepam, and Escitalopram.

On 8/22/18 at 7:29 PM, Nurse # 2 documented the following information in a nursing entry. Resident # 1 had sustained a second fall at 7:15 PM on 8/22/18. The resident had been sitting outside the nursing station while Nurse # 2 was at the medication cart, which was about five feet away from the resident. Nurse # 2 heard a noise and saw the resident laying on her right side on the floor. The wheelchair was turned upside down and positioned beside of the resident. The resident was found to have a 7 cm (centimeter) in length by 1.5 cm in width skin tear to her right leg below the knee, and stated her right leg was hurting her. The resident's range of motion was assessed, and the resident did not complain of pain with movement of her extremities. The skin tear was cleansed, dressed, and the resident was offered to be assisted to bed. The resident stated she wanted to remain in the chair. The resident was kept in the common area, and the physician and responsible party were notified.

Nurse # 2 was interviewed on 1/23/19 at 10:35 AM, and reported the following. She had been standing at the medication cart on 8/22/18 attending to her duties. The resident was close to her, but she did not see her fall. When she heard the noise, she turned to see the resident on the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 22 | F 689 | | |

floor. The nurse did not recall that the resident had any other injury than the skin tear noted in her nursing entry.

According to facility documentation, NA # 6 was assigned to care for Resident # 1 on the 3:00 to 11:00 PM shift of 8/22/18. NA # 6 was interviewed on 1/24/19 at 11:31 AM and reported she did not recall the resident or events related to the resident.

Review of the facility's "post incident actions" form, dated 8/22/18 revealed under "Immediate Post-Incident Action," it was noted the resident was reminded to wait for assistance before ambulating, and there would be a medical evaluation for aggressive behaviors.

Following Nurse # 2's entry of 8/22/18 at 7:29 PM, the next nursing entry was entered on 8/23/18 at 3:17 PM. At this time, a nurse noted the resident was confused, combative, and had multiple attempts to get out of her chair. The nurse noted the resident was placed at the nursing station for one on one monitoring.

On 8/23/18 at 12:58 PM, the NP entered a progress note with the following information. She was seeing the resident due to the resident's fall the previous evening. The NP noted the resident had small ecchymoses (bruising) on her extremities and a larger ecchymosis to the right lower extremity with a skin tear. The NP noted the resident was in no acute distress, and was considered stable.

On 8/23/18 at 4:37 PM, the NP made an addendum to her progress note. The NP documented the nurse reported the resident was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 23 | F 689 | | |

combative, aggressive, and restless the previous night. The NP noted she would order Ativan 1 mg (milligram) IM every day as needed for combative and agitated episodes for 14 days.

Resident # 1's NP was interviewed on 1/25/19 at 12:45 PM, and reported the following. She recalled talking to both Nurse # 2 and Nurse # 3 while the resident was residing at the facility, and they had informed her the resident would become more agitated in the evening times. She had talked to a psychiatrist about managing the resident's behaviors, but at times the resident would be agitated and would refuse to take her medication by mouth. Therefore, she ordered the Ativan IM for periods when the resident would not take her medication by mouth. According to the NP, she had not identified that the resident sustained any evident new injuries from her 8/22/18 fall other than the skin tear. The NP stated the resident always had some bruising on her extremities, and it was difficult to determine what was new and old.

According to facility documentation, NA # 7 had been assigned to care for Resident # 1 on the shift which began on 8/23/19 at 11:00 PM and ended at 7:00 AM on 8/24/19. NA # 7 was interviewed on 1/23/19 at 10:14 AM, and reported she did not recall the resident or events related to the resident.

Review of the record revealed no nursing entries between the time of 8/23/18 at 3:17 PM and 8/24/18 at 4:31 PM. During this interim, in which there were no nursing notes, there was documentation on the Resident's August, 2018 MAR (medication administration record), that the resident received Ativan 1 mg (milligram)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 24 | F 689 | | |

intramuscularly on 8/24/18 at 8:28 AM by Nurse # 2. The reason noted on the MAR was for "hitting, scratching, grabbing, screaming, disruptive behaviors."

Nurse # 2 was interviewed on 1/23/19 at 12:06 PM. According to Nurse # 2 the resident was "restless, anxious, didn't want anyone near her, and couldn't calm herself down."

According to facility documentation, NA # 1 had been assigned to care for Resident # 1 on the 7:00 AM to 3:00 PM shift of 8/24/18. NA # 1 was interviewed on 1/23/19 at 9:30 AM and reported the following. She recalled that Resident # 1 would punch, kick and be combative with care. She did not recall the specific events of the last day she cared for Resident # 1 on 8/24/18 or if she was exhibiting behaviors on that day.

On 8/24/18 at 3:47 PM, the NP documented in a progress note that she was seeing the resident for a fall, and the resident reported general pain. The NP noted the resident was alert, confused, restless, and agitated. The NP noted she ordered the resident to have an x-ray of her Lumbar spine, and x-ray of the hip. The NP also noted that she ordered the resident Morphine for her pain.

Following the nursing entry of 8/23/18 at 3:17 PM, the next nursing entry was entered on 8/24/18 at 4:31 PM by Nurse # 3. Nurse # 3 documented the following at this time. Resident # 1 had been found on the floor mattress at 4:03 PM on 8/24/18. The resident was complaining of hip pain. The PA (physician's assistant) and responsible party were notified. The resident's vital signs were taken, and she was assessed for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 25 | F 689 | | |

injury and none were seen. The resident was given an antianxiety medication. Also, although the nursing entry was made into the digital medical record by Nurse # 3 at 4:31 PM, Nurse # 3 documented within this entry that she gave Morphine at 5:00 PM on 8/24/18. Five o'clock had not transpired at the time of the digital entry. Nurse # 3 noted the resident was quiet after her pain medication.

Nurse # 3 was interviewed on 1/24/19 at 8:05 AM and could not recall the resident or any details regarding the incident or events which had happened with the resident.

According to facility documentation, NA # 4 had been assigned to care for Resident # 1 on 8/24/18 from 3:00 PM to 7:00 PM. NA # 4 was interviewed on 1/25/19 at 3:17 PM and could not recall the resident or any details or events which happened with the resident.

The NP was interviewed on 1/25/19 at 12:45 PM, and reported the following. She was called to Resident # 1's room on 8/24/18 at 3:47 PM by the staff because the resident had fallen. The resident was still on the floor mat by the bed and was lying on her back. She asked the resident if she hurt and the resident said she "hurt all over," but because of her confusion the resident could not describe if the pain was worse in any one area. When the NP checked the resident's back, it appeared tender, and she seemed to have limited range of motion in her left hip. She ordered the x-rays and some Morphine for the resident's pain. The NP stated the resident had no other evident injuries. She stated her chest was symmetrical, and she was not experiencing any breathing problems. The NP thought the fall,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 26 | F 689 | | |

which was documented by Nurse # 3 as occurring on 8/24/18 at 4:03 PM, was the fall that had actually occurred at 3:47 PM. It was her understanding that the resident only experienced one fall that day, and there had been no other incidents of which she was aware. The NP stated after the 3:47 PM fall, she thought the staff got the resident up to the wheelchair so they could watch her. The NP stated she left around 4:00 PM.

The current DON and Administrator were interviewed on 1/25/19 at 4:45 PM. The Administrator was interviewed regarding whether there had been a fall at 3:47 PM and again at 4:03 PM. The Administrator stated he was not sure. According to the DON he had talked to Nurse # 3 on 1/25/19, and pointed out to her that she could not have charted at 4:31 PM that she gave the resident Morphine at 5:00 PM since that reflected a time in the future. The DON stated Nurse # 3 had informed him that she charted at 4:31 PM what she intended to do at 5:00 PM. According to the DON, it was his expectation that the record should have reflected accurately what events had occurred after they had occurred, and nurses were not to chart what they planned to do.

Following the nursing entry of 8/24/18 at 4:31 PM, the next nursing entry was entered on 8/25/18 at 2:03 AM by Nurse # 2. Nurse # 2 documented the following at this time. The resident had been received by her "alert and awake, resting in bed asleep." At 9:00 PM the resident awakened and complained of back pain. The resident was given 5 mg (mg) of Morphine at 9:10 PM. She had a hematoma to her right hand from top of her fingers to her wrist. The resident's right hand was noted to have increased swelling. The physician

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 27 | F 689 | | |

was notified, and orders were given to send the resident to the emergency room for evaluation and treatment. The resident was transferred to the hospital on 8/24/18 at 9:30 PM.

Nurse # 2 was interviewed on 1/23/18 at 10:35 AM and reported the following. She had come into work on 8/24/18 at 8:00 PM. When she arrived, the previous nurse had told her that the resident had fallen. The x-ray technician did not arrive right away, and one of the resident's hands appeared to have increasing swelling. The resident was moaning and groaning when the nurse reported to work, and therefore because of the x-ray delay and the increased swelling she contacted the physician to have the resident sent out for evaluation. Nurse # 2 did not recall any other bruising or injury other than one of her hands.

Review of hospital records revealed Resident # 1 underwent a CT scan while in the emergency room. She was identified to have fractures of the 2nd, 3rd, 4th, 5th, and 6th ribs. The 2nd, 5th, and 6th ribs were documented to be displaced. The hospital records noted it was the resident's left wrist which had sustained injury, and not her right wrist as reflected in the facility record. An X-ray, completed while in the ER, revealed the resident had a left non-displaced ulnar styloid fracture. (left wrist fracture). The resident was also identified to have a hemopneumothorax (air and blood were in the chest cavity) and pulmonary contusion (lung bruising). A chest tube was placed in the resident to drain the blood. The resident remained hospitalized until 8/30/18, and then was transitioned to hospice care. The resident expired on 9/4/18. Review of her death certificate revealed cause of death was listed as

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 28 | F 689 | | |

"complications of blunt force chest and arm trauma."

The resident's responsible party (RP) was interviewed on 1/22/19 at 2:30 PM and reported the following. The RP stated she had visited with the resident during the morning of 8/24/18, and the resident seemed sleepy, but uncomfortable in her back. She was told by a nurse that was in charge that the resident had been combative, and they had given her medication. The RP stated she had left around lunch time that day. The RP stated after Resident # 1 passed away, she and other family members met with the administrator and informed him of all the injuries which were identified at the hospital. The RP stated the administrator maintained that the injuries were due to the resident's fall without giving an explanation of how this could have occurred.

On 1/24/19 at 9:00 AM the other relative (Relative # 1), who had been with Resident # 1 on 8/24/19, was also interviewed. Relative # 1 reported the following. Relative # 1 received a phone call in the afternoon of 8/24/18 from the resident's RP. The RP informed Relative # 1 that the facility had called to let her (the RP) know the resident had fallen. Relative # 1 stated the RP could not go at that time, and she went to the facility around 4:15 PM. When she arrived to the resident's hallway, she could hear Resident # 1's screams into the hallway. She found the resident in bed. She found a nurse and inquired what had happened. The nurse told her she didn't know, and that she was just filling in. Around 5:00 PM a nurse gave the resident some Morphine for pain, and told her they were going to do x-rays. The X-ray technician was delayed in getting to the facility, and the resident was sent out to the hospital for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 29 | F 689 | | |

evaluation. Initially she was seen at one hospital, and transferred to a larger hospital due to trauma. The family was notified of the injuries at the hospital, and could not understand how they had occurred from a fall to a mat on the floor. Following the resident's death, Relative # 1 stated she looked through some photographs she had taken on the AM of 8/24/18, and realized the resident's left wrist was showing signs of swelling. Relative # 1 stated the picture indicated to her that something had been wrong with the resident's wrist before the resident fell on the afternoon of 8/24/18. Relative # 1 stated a letter was sent on October, 9.2018 requesting to meet with the administrator, and conveying to him they had concerns about the resident's care. On 11/14/18, she, the resident's RP, and another relative met with the administrator, Nurse # 2, and the former DON. Relative # 1 stated she showed the administrator the picture of the resident's wrist which had been taken earlier in the day prior to the fall event the facility claimed caused her injury. Relative # 1 also said she had obtained copies of the resident's clinical record before the meeting and pointed out that there were discrepancies in the record to the administrator, such as when the resident had sustained her last fall. Relative # 1 stated she told the administrator that she did not think that the resident could have sustained her injuries from falling off a bed onto a soft floor mat. Relative # 1 stated the bed was only about 12 to 18 inches off the ground. Relative # 1 stated the administrator and his staff maintained that the resident had sustained the injuries from her fall, and the family received no further explanation or follow up regarding how this could have occurred.

The facility Administrator was interviewed on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 30 | F 689 | | |

1/23/19 at 8:10 AM and again at 1/25/19 at 4:45 PM. The Administrator stated he recalled talking to the family about concerns they had regarding Resident # 1's falls, and the family was wanting to know more information in regards to what had happened. Per the Administrator, he did not recall what the family had said in regards to the extent of Resident # 1's injuries. The Administrator stated he had to step out of the meeting for a period and none of his staff had informed him of pictures.

The Emergency Room physician, who saw Resident # 1 when she presented to the second hospital on 8/25/18, was interviewed on 1/28/19 at 2:35 PM. The physician stated the resident sustained a "bad injury but it was not an impossible injury from a fall." According to the physician, "the injury pattern could be consistent with a fall" and the resident had been on a small dose of Aspirin which could have contributed to some of the bleeding.

The resident's facility physician was interviewed on 1/23/19 at 2 PM. The physician stated he felt the resident's injuries had been sustained from her fall. According to the physician the resident was constantly trying to get up, and was confused.

Review of the facility's Investigation into the Resident's fall which occurred on 8/24/18 revealed documentation was located on a Resident Incident Report. Nurse # 3 had noted on the form the resident had "been seen on floor mattress at 4:03 PM." Nurse # 3 noted the resident was complaining of pain in her hip. Nurse # 3 noted, "did not see any injury and did not see any skin break down." Attached to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 31 | F 689 | | |

Resident Incident Report form was a page entitled, "Incident Investigation." It was signed by the former DON, and was not dated. Under "narrative of investigation" the narrative did not address what time the resident fell or if there had been two falls. It did not address where she fell, and what part of her body hit what object. It did not address if there were any witnesses to the fall. The "narrative investigation" included five sentences which read, "On 8/24/18 resident was observed on the floor. Resident complained of pain her hip area and x-ray was ordered. Investigation of this fall conducted by the Director of Nursing concluded that resident attempted to transfer self lost balance and fell. Due to the fall impact resident sustained a fracture of her ribs. Resident was sent to the ER for evaluation and treatment."

It was clarified with the Administrator on 1/25/19 at 4:45 PM that this was the only documentation that the facility had in regards to their investigation into the resident's injuries. There was no mention in the five sentence investigation narrative regarding the injury to the resident's wrist which was initially identified at the facility and later identified to be a fracture. There was no indication what events were reviewed and to whom the former DON had spoken in regards to the events of the resident's day on 8/24/18 to determine that the resident was trying to transfer when she sustained the rib fractures. There was no documentation to address the inconsistencies of the clinical record noting that the resident fell at 3:47 PM and at 4:03 PM. There was no documentation to show that the facility had identified that a nurse had documented future events into a digital record on the date and time the nurse recorded the resident's fall, and that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 32 | F 689 | | |

they investigated why a nurse was documenting future events in the resident's clinical record at the same time she documented the fall. There was no documentation to show the facility had assessed their previous documentation on the "Post Incident Actions Form," which noted staff reinforced to the resident that she needed to call and wait for assistance, and evaluated if this was a reasonable intervention for a cognitively impaired resident. There was no documentation so show the facility had evaluated the necessity of the resident's 8/24/18 morning administration of Ativan and if it had contributed to an incident on 8/24/18 which may have led to the injuries via way of making the resident more unsteady and/or if she could have sustained injuries while being combative during the administration of the intramuscular Ativan injection.

The former DON was interviewed on 2/5/19 at 4:45 PM and reported the following. There was no witness to the fall of 8/24/18 at 3:47 PM. Prior to the incident, the former DON had been on the unit until around 3:00 PM on 8/24/18, and the resident had been in bed sleeping. The resident was found by Nurse # 3 on the floor mat, and Nurse # 3 had called the former DON when the resident was found. According to the former DON, Nurse # 3 had found the resident at 3:47 PM and not 4:03 PM as documented in the investigation and in the nursing entry. The resident was facing the door on the mat, and therefore the former DON concluded the resident was trying to get out of bed when she sustained the injuries. The former DON could not recall with certainty, but thought that the staff were going to get the resident up to the chair following her fall at 3:47 PM on 8/24/18. The former DON left the unit after the 3:47 PM fall, and had not been told the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 33 | F 689 | | |

resident had fallen again. At some point following the incident of 3:47 PM on 8/24/18, she had asked Nurse # 3 and NA # 4 if the resident had fallen again after 3:47 PM, and they had reported to the former DON that the resident had not done so.

The facility submitted a credible allegation of compliance they had completed on 8/27/18.

Corrective action accomplished for those residents found to have been affected by the deficient practice.
Resident #1 was admitted to the facility on 08/14/2018 for long term care services. Review of facility most recent minimum data set, with Assessment reference date 8/21/2018 section G indicated resident #1 requires extensive assistance with bed mobility with one assist, transfer with one assistance, and toileting with one assistance. Resident #1 coded in section J. to have a falls in the last month prior to admission, and also coded having a fall in the last 2-6 months prior to admission/entry or reentry. Review of fall incident log from 8/14/2018 up to 8/25/2018 indicated resident #1 had three falls dated 8/18/2018, 8/22/2018 and 8/24/2018. Review of resident's fall risk assessment completed on 8/14/2018 indicated resident is at risk for fall due to resident's fall history, history of fracture, impaired vision, cognitive deficit, and being on 3-4 medications to include but not limited to, psychoactive medication such as Zyprexa and Clonazepam, Anti-hypertensive medication such as Metoprolol and Norvasc as well as thyroid medication- Synthroid. Facility developed resident's baseline care plan within 48 hours of admission with intervention to prevent accidents and hazards.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 34<br>On 8/18/2018 Resident was observed on the floor in her room, family had stepped out to speak to licensed nurse #1 and left the resident in the room unattended and that's when we heard the resident scream for help. Licensed nurse #1 walked in resident's room and observed resident #1 laying on floor on her left side. Licensed nurse #1 assessed the resident and noted a raised area on the back of resident #1 head. No other injuries noted. Resident family was re-educated not to leave a resident unattended in the room. On 8/22/2018 resident #1 was sitting outside the nurses station, positioned at the door way. Resident attempted to ambulate and lost balance and fell. Resident was assessed by licensed nurse #2 and was able to move all extremities Medical evaluation was requested due to residents' aggressive behaviors. On 8/24/2018 resident # was observed on the floor, no apparent injuries noted, however resident was complaining pain in her hip area. Resident Physician was notified, as well as resident's family (Daughter). Resident #1 received pain medication and antianxiety medication, medication was effective per documentation. X - Ray was ordered and scheduled for Left spine. Resident #1 was sent to the hospital on 8/24/2018. Resident #1 is no longer in the facility. No further actions warranted. Root cause analysis indicated resident #1 medical condition that resulted onto cognitive deficit, confusion and multiple falls were not identified and addressed after each fall. Facility failed to identify the relationship between resident's incidents/accidents and her overall medical condition, medication management specifically psychoactive medication.<br>Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 689 | Continued From page 35 | F 689 | | |

practice.
100% audits of all current residents fall risk assessments was completed on 8/27/2018 by the facility Director of nursing, and/or unit manager to ensure each resident medical risk factors are identified and addressed on each residents care plan. Three other residents identified with medical condition that was not addressed on the care plan. Facility Director of nursing updated the three residents' care plans identified on 8/27/2018.
Interventions pertaining to nursing assistance were added on each resident's care card. Nursing assistants were notified of interventions added on residents' care cards through an in-service education provided by the facility Director of Nursing on 8/27/2018.
Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur
Effective 8/27/2018 licensed nurses will conduct fall risk assessments on admission, readmission, quarterly and with significant changes for each resident in the facility. Fall risk assessment will identify all factors to include medical, medicinal and historical and then ensure appropriate interventions are added on each resident's care plan to ensure resident's safety while in the facility.

Effective 8/27/2018 A license nurse who completes resident's incident report will conduct root cause analysis after each incident to identify all factors to include medical, medicinal and environmental. A license nurse will accomplish this task through answering questions in the "incident report form" that guide a licensed nurse to answer questions such as "what, when, and how" the incident occurs. Through answering those questions a licensed nurse will be able to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 689 | Continued From page 36 | F 689 | | |

determine the appropriate root cause for each incident. The licensed nurse will then ensure appropriate interventions are added on each resident's care plan to ensure resident's safety and prevent reoccurrences of incident/accidents. Any identified root cause will be addressed promptly on each resident's care plan before after each incident and intervention added on resident's care plans and care cards.

Effective 8/27/2018 licensed nurses will review resident's care plan before implementing new intervention to ensure the appropriateness of the intervention put in place. Effective 8/27/2018 nursing assistance will review each resident's care card, maintained electronically and accessible to nursing assistants throughout the facility via the mounted kiosks, before providing care for any resident to ensure appropriate interventions are in place while on duty. Nursing assistants were notified of the requirement to review electronic care cards via in-service education conducted by the facility Director of Nursing on 8/27/2018. Any nursing aide who was not notified of this requirement not allowed to work until educated.

Facility Director of Nursing and/or Unit manager #1 conducted re-education for current licensed nurses' onsite on 8/27/2018. This education included, importance of ensuring resident has a fall risk assessment on admission, readmission and quarterly as well as with significant changes, ensuring that the root cause analysis is completed after each fall and ensure all factors to include medical, medicinal, environmental and historical are considered to derive the appropriate intervention. This education will be completed by

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 689 | Continued From page 37 | F 689 | | |

8/27/2018, any licensed nurse not educated by 8/27/2018 will not be allowed to work until educated on this requirement. Effective 8/27/2018 this education will be added on new hires orientation education for all new facility Licensed nurses. This education will also be provided annually for all facility licensed staff.

Facility Director of Nursing and/or Unit manager #1 conducted re-education for current nursing assistants' onsite on 8/27/2018. This education included importance of following resident's interventions as indicated on the care cards, importance of reviewing care card before providing care and reporting any discrepancies to the licensed nurse promptly. The in-service education also emphasized on the importance of ensuring the resident environment remains as free of accident hazards as is possible; and also emphasized on importance of providing adequate supervision and assistance for each residents in order to prevent accidents. This education will be completed by 8/27/2018, any nursing assistant not educated by 8/27/2018 will not be allowed to work until educated on this requirement. Effective 8/27/2018 this education will be added on new hires orientation education for all new facility nursing assistants. This education will also be provided annually for all facility nursing assistants.

The facility plans to monitor its performance to make sure that solutions are sustained. Effective 8/27/2018 the Director of Nursing, Assistant Director or Nursing, RN supervisors will review all new admits from prior day to ensure the fall risk assessment is complete, accurate, and ensure risk factors are identified and verify the appropriate interventions are added on each

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 38 | F 689 | | |

resident's plan of care and resident's care guide. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily clinical meeting report form and filed in the daily 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 8/27/2018 the Director of Nursing, Assistant Director or Nursing, RN supervisors will review incident reports, completed electronically by licensed nurses on duty and maintained in each residents records, to ensure root cause analysis is completed and appropriate intervention were implemented. Licensed nurses on duty complete incident report following any incident and accident as part of the required documentation following an accident. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily clinical meeting report form and filed in the daily 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.
On 8/27/2018 Quality Assurance Committee was made aware of this potential noncompliance and adapted this performance improvement plan.
Effective 8/27/2018, 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 for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 689 | Continued From page 39 | F 689 | | |

the facility remains in substantial compliance.
The title of the person responsible for implementing the acceptable plan of correction Effective 8/27/2018 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.

Compliance Date 8/27/2018

On 02/15/19 at 12:10 PM, the credible allegation was validated and Immediate Jeopardy was removed.

The facility's plan of correction dated 08/27/2018 was validated as evidenced by the following:
The affected resident was no longer a resident in the facility at the time of the validation.
For other residents who might be affected, audits of all residents fall risk assessments were reviewed and were completed by the date of 08/27/2018 by the facility Director of Nursing and unit managers to ensure each resident medical risk factors were identified and addressed on each resident's care plan. Interventions pertaining to nursing assistance were added on each resident's care card. Nursing assistants were notified of interventions added on residents' care cards through an in-service education provided by the facility Director of Nursing on 08/27/2018. The staff roster for the education was reviewed and completed by all staff.

Interviews with random nursing staff revealed awareness of adequate supervision and assistance to residents in order to prevent accidents. Staff who were interviewed verified training had been received on the importance of a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 689 | Continued From page 40<br>fall risk assessment on admission, readmission, quarterly and significant changes.<br>For systemic changes, random records were reviewed for falls risk assessment for new admissions, readmissions, quarterly and significant change residents. All records reviewed contained these assessments.<br><br>On 8/27/2018, mandatory staff education included importance of following resident's interventions as indicated on the care cards, importance of reviewing care card before providing care and reporting any discrepancies to the licensed nurse promptly. The in-service education also emphasized on the importance of ensuring the resident environment remains as free of accident hazards as is possible and also emphasized on importance of providing adequate supervision and assistance for each residents in order to prevent accidents. This education will be completed by 8/27/2018, any nursing assistant not educated by 8/27/2018 will not be allowed to work until educated on this requirement. Staff rosters were reviewed, and education was complete for all staff.<br><br>Effective 08/27/2018 this education will be added on new hires orientation education for all new facility nursing assistants. This education will also be provided annually for all facility nursing assistants. New hire records since 08/27/2018 were reviewed, and this education was noted in the employee record.<br><br>Monitoring forms and documents were reviewed with 100% compliance. | F 689 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) | F 812 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 812 | Continued From page 41<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, the facility failed to store food in sealed, labeled, and dated containers in 1 of 2 kitchen observations.<br><br>The findings included:<br>1. An observation of the facility kitchen on 2/11/2019 that began at 10:35AM with the Dietary Manager revealed the following:<br><br>A. The dry storage area was observed to have a 25 pound bag of long grain brown rice that had been opened and was sealed, but not dated. There was also an opened 25 pound bag of flour stored in a white plastic bin that was dated 6/8/2018. A 5 pound box of cornbread mix that was observed to be dated but not closed or secured. A 35 oz. clear plastic bag of Rice | F 812 | F-812<br><br>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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the 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.<br><br>Root Cause: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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|---|---|---|---|---|
| F 812 | Continued From page 42<br>Krispies was observed to be opened, but was not dated. Also in the dry storage area, there was 1 bag of egg noodles, 1 bag of pasta shells, and 1 bag of ziti pasta that each had been opened but were not dated.<br>B. In the walk-in refrigerator, a large blue plastic bag was observed to have thawed strawberries in it. The large plastic bag was open to air and there was no date on the bag.<br>C. In the walk-in freezer, one bag of sliced garlic bread was observed in a plastic bag that was inside a cardboard box. The box and the plastic bag was open to air in the freezer and was not dated. Also observed in the freezer was one 5 pound bag of tater tots that had been torn open and the tater tots were exposed to freezer air. A clear bag of frozen breaded flounder was observed in the freezer. The plastic bag was open to freezer air and was also undated.<br>In an interview with the dietary manager on 2/11/2019 at 11:10AM, he reported that his expectation is that the food items that have been opened should be closed securely, labeled and dated so that anyone would be able to know when the food item was originally opened. He reported his staff is aware of the expectation, but felt the staff had over looked these items. | F 812 | The Dietary Manager, Administrator, and the Director of Nursing discussed on 2/15/19 to identify the root cause of this alleged non-compliance. Root-cause analysis conducted revealed the alleged non-compliance resulted from inadequate training/understanding of dietary staff. As a result, the facility failed to store food in sealed, labeled, dated containers.<br><br>For affected resident:<br>There were no directly identified residents.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance. On 2/15/19 all items that were identified in the dry storage area, walk-in refrigerator, and the walk-in freezer were immediately sealed, labeled, and dated appropriately. On 2/15/19 a complete storage audit of the dry storage area, walk-in refrigerator, and walk-in freezer was done by the Dietary Manager to determine if any other items were out of compliance. No other items were identified during the audit.<br><br>Facility plan to prevent re-occurrence:<br>The dietary department will be re-educated by the dietary manager, dietician, or designee regarding the proper storing of opened food in a sealed, labeled, and in dated containers by 3/19/19. Any employee not educated by 3/19/19 will not be allowed to work until re-education has occurred.<br><br>In addition, a storage audit sheet will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 812 | Continued From page 43 | F 812 | completed by the dietary manager, dietician, or designee to audit the dry storage area, walk-in refrigerator, and the walk-in freezer to ensure that any opened food is properly stored in a sealed, labeled, and dated container. The audit will take place 5 days a week for 8 weeks.<br><br>Responsible Party:<br>The Executive Director and the Dietary Manager will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.<br><br>In addition, the Administrator and/or the Dietary Director will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>Compliance Date: 3/19/19 | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. | F 880 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

| (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 880 | Continued From page 44<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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| F 880 | Continued From page 45<br>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review the facility failed to ensure a resident on droplet precaution wore appropriate personal protective equipment prior to exiting his room for 1 of 2 residents reviewed on droplet precautions. (Resident #15)<br><br>Findings included:<br><br>Resident #15 was admitted to the facility on 1/26/17. His active diagnoses included diabetes mellitus, muscle weakness, and major depressive disorder.<br><br>Review of a nurse practitioner's note dated 2/11/19 revealed Resident #15 was seen due to his roommate being positive for influenza. Resident #15 was assessed to have influenza due to unidentified influenza virus with other | F 880 | F-880<br><br>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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the 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.<br><br>Root Cause:<br>The Administrator and the Director of Nursing discussed on 2/11/19 to identify | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345561 | A. BUILDING _____ B. WING _____ | C 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| UNIVERSAL HEALTH CARE/FUQUAY-VARINA | 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526 |

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| F 880 | Continued From page 46<br>respiratory manifestations and was placed on droplet precaution.<br><br>Review of a physician's order dated 2/11/19 revealed Resident #15 was ordered to be on droplet precautions for influenza.<br><br>During observation on 2/11/19 at 12:04 PM Resident #15's room was observed to have droplet precaution signage and appropriate personal protective equipment available at the door entrance.<br><br>During observation on 2/11/19 at 12:14 PM Resident #15 was observed to exit his droplet precaution room. Resident #15 did not don a mask prior to exiting his room and entered the dining area across the hall from his room. Four other residents and two staff members were in the dining area at that time. Nurse Aide #1 provided Resident #15 his lunch tray and spoke briefly with the resident. She did not request the resident return to his room or don a mask. Nurse Aide #1 then continued to provide meals to the rest of the residents.<br><br>During an interview on 2/11/19 at 12:21 PM Nurse Aide #1 stated Resident #15 was able to come outside of his room without a mask on. She further stated Resident #15 was on droplet precaution and staff and visitors had to wear a mask when they entered his room, but Resident #15 could be outside of his room without a mask. Nurse Aide #1 then continued to aide dependent residents with meals and did not request the resident return to his room or don a mask.<br><br>During an interview on 2/11/19 at 12:22 PM Nurse #1 stated Resident #15 should not be outside his | F 880 | the root cause of this alleged non-compliance. Root-cause analysis conducted revealed the alleged non-compliance resulted from inadequate training/understanding of nurse aide #1. As a result, the facility failed to ensure that resident #15 on droplet precautions wore personal protective equipment prior to exiting the room.<br><br>For affected resident:<br>Resident #38 was immediately brought back to his room.<br><br>For other residents with the potential to be affected:<br>All residents have the potential to be affected by this alleged non-compliance. On 2/11/19 the Director of Nursing did a complete building audit of all residents on droplet isolation precautions. No other non-compliance was observed.<br><br>Facility plan to prevent re-occurrence:<br>On 2/11/19 nurse aide #1 was re-educated by the Director of Nursing regarding droplet precaution isolation. By 3/19/19 all facility employees will be re-educated on droplet isolation precautions. Any employees not re-educated by this date will not be allowed to work until education is completed.<br><br>In addition, an isolation compliance audit sheet will be done 5 days a week x 8 weeks by the Administrator, Director of Nursing, or designee to ensure droplet isolation precautions are being followed. | |

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| F 880 | Continued From page 47<br>room without a mask due to his droplet precautions ordered that morning. She further stated staff knew Resident #15 was on droplet precaution and should know any resident on droplet precaution should not be outside of their room without a mask. Upon observing the dining area, she stated Resident #15 needed to return to his room to eat and should not have been allowed outside of his room without a mask. She concluded Nurse Aide #1 should have known he could not be in the dining room or any area outside of his room without a mask.<br><br>During an interview on 2/11/19 at 12:29 PM the Director of Nursing stated if a resident was on droplet precaution and left their room the resident needed to wear a mask. He continued to state Resident #15 was placed on droplet precaution because, although he did not have a confirmed case of influenza, he was being treated prophylactically by the nurse practitioner who had ordered droplet precaution for Resident #15 that morning. He concluded it was his expectation the nurse aide had known a resident on droplet precaution could not leave his room without a mask. | F 880 | Responsible Party:<br>The Administrator and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged non-compliance to ensure the facility remains in substantial compliance.<br><br>In addition, the Administrator and/or the Director of Nursing will report findings of the monitoring process to the facility monthly Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>Compliance Date: 3/19/19 | |