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	345213	A. BUILDING _____ B. WING _____	C 10/25/2018

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 000	INITIAL COMMENTS A complaint survey was conducted from 10/22/18 through 10/25/18. Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity (J) The tags F684 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and Medical Doctor interviews, the facility failed to evaluate a resident's condition by a licensed professional before moving a resident following a fall in the facility's transport van for 1 of 2 residents sampled for assessment after an accident (Resident #1). Resident #1 experienced a Cervical (C2-C3) fracture to the neck and expired at the hospital. The findings included:	F 684	Past noncompliance: no plan of correction required.	11/6/18

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

Electronically Signed | 11/06/2018

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 684	Continued From page 1	F 684		

A review of the facility's undated Falls Procedures for Nursing Staff revealed to: evaluate resident's condition before moving, do not stand resident upright; lift to bed or chair, notify physician, and notified family or responsible party (RP).

Resident #1 was admitted to the facility on 05/05/18 and readmitted to the facility on 10/12/18 with diagnoses that included unspecified altered mental status, difficulty walking, muscle weakness, unsteadiness on feet, lupus, discitis cervical region, end stage renal disease (ESRD), dialysis, schizophrenia, and heart failure (HF).

Review of the most recent Minimum Data Set (MDS) dated 09/21/18 revealed Resident #1 was mildly cognitively impaired and required extensive assistance of 1 staff member with bed mobility. The MDS further revealed that Resident #1 had received dialysis.

A nursing note dated 10/18/18 at 7:46 PM revealed Resident #1 was sent to the emergency room (ER) for evaluation related to an accident in the facility van during transport. The medical director (MD) and responsible party (RP) were notified.

Review of a facility document titled Resident Incident Report dated 10/18/18 at 5:45 PM read in part, Nursing Assistant (NA) #1 (Transportation Aide #1) was transporting Resident #1 from dialysis when another vehicle cut in front of him and he had to apply emergency braking and then observed the resident on the transportation van's floor. Emergency Medical Services (EMS) was notified and resident was transported to the Emergency Room (ER) for evaluation.

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F 684	Continued From page 2	F 684		

An Emergency Medical Services (EMS) record dated 10/18/18 at 5:48 PM revealed Resident #1 was sitting on the bench with blood coming from forehead, mouth area as well as lower left leg. Resident #1 was sitting on passenger side of transport van. The driver of the van advised a vehicle pulled out in front of him causing the van to stop suddenly throwing patient into passenger side floor board. Resident #1's initial physical findings included: laceration to left forehead, blood coming from patient's mouth, laceration to left lower leg, mental status normal baseline for patient, and neurological normal basline for patient.

An ER Report dated 10/18/18 revealed Resident #1 had a head/neck Computed Tomography (CT) scan which showed a Second Cervical vertebrae (C-2) neck fracture.

A Hospital History and Physical (H&P) dated 10/18/18 at 10:42 PM revealed per Emergency Medical Services (EMS), the driver of the van said the patient was acting appropriately immediately following the incident. He was taken to their local hospital and by the time of his arrival he could not move any of his extremities. A neck cervical collar was applied. Resident #1 underwent a chest x-ray, head CT, neck CT, which showed a cervical vertebra #2 (C-2) fracture, and left 1st and 2nd rib fractures. He was then transferred to larger regional hospital for further care.

A Hospital Course note dated 10/19/18 revealed Resident #1 had a very brief hospital course. "The patient with severe C-2 fracture. He was seen by a Neuro Surgeon with the intent to operate, but patient had a poor clinical prognosis

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F 684	Continued From page 3	F 684		

with pre-existing medical conditions, including dementia and ESRD, as well as being unable to transfuse secondary to his religious beliefs. The resident's family arrived to bedside and after explaining patient's poor prognosis as well as the likely hood that he would unlikely be able to be separated from the ventilator, family decided to make him a do not resuscitate (DNR) and do not intubate (DNI). The patient became acutely unresponsive and bradycardic while family discussion was happening, and patient expired quite quickly at 11:12 AM".

A Hospital Discharge Summary dated 10/19/18 at 2:28 PM revealed Resident #1 with dementia and ESRD who sustained C-2 fracture with resultant complete quadriplegia, extremely poor prognosis given underlying morbidities; family wished for patient to receive comfort care and he subsequently expired shortly thereafter.

An interview was conducted with Transportation Aide (TA) #1 on 10/23/18 at 10:57 AM revealed on 10/18/18 around 5:20 PM "The resident and I were on our way back from dialysis (the 4th time he transported the resident to dialysis) heading to the facility when a beige truck with trailer pulled right going into the gas station from the left lane, cutting us off". He said, "I had to hit the brake, and when I did, I heard a thump behind me, and I observed Resident #1 had fallen out of his wheelchair and onto the floor". "Earlier, when I picked the resident up from dialysis I had strapped his wheelchair with the floor straps on the van, and had secured the resident with the seatbelt, going across his chest and abdomen, hooking it in the seat buckle to his right." The TA said the resident's wheelchair was strapped closer to the back of the van above the last floor

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F 684	Continued From page 4	F 684		

strap. He said, "After the accident, I pulled into the gas station and called my supervisor, who instructed me to call 911, and to stay there". TA #1 said, "She told me, she was coming up there with the Director of Nursing (DON)". The TA said the resident told him he felt uncomfortable on the floor. TA then called 911, and stayed with the resident. TA #1 said the resident's wheelchair was still secured with the floor straps; but, that the seat belt was unbuckled and back to the left of the wheelchair. He said, "I secured him in his chair, with the 4 point straps, and I put the seatbelt around his abdomen/shoulder, and pulled on it to make sure it was secure." The TA said, "the resident with his left hand could have un-buckled the seat belt." The TA said he demonstrated to the DON at the scene on how he hooked up the resident's wheelchair and seatbelt. The TA said the resident fell on the floor of the van with his left arm under him, and the left side of his face on the floor. He said the resident had a scrape on the left side of his nose and forehead, and was bleeding from his mouth. The TA said the resident talked to him, and wanted to get up, and that his head hurt. The TA said he couldn't go against the resident's wishes; so, he helped the resident up to the nearest seat.

An interview conducted with Transportation Aide (TA) #1 on 10/24/18 at 11:15 AM revealed on 10/18/18 Resident #1 was observed laying on his left arm with the left side of his face to the ground in the transportation van. TA #1 said, "I didn't want to get the resident up; but, he wanted to get up, even when I said he should not get up. I helped him up to the passenger seat on the side of the van." The TA then said, Residents have a right to get up, even in emergencies, the resident has a right to get up, and I got him up. He said

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F 684	Continued From page 5	F 684		

the EMS showed up in 5 to 10 minutes. TA #1 said he was trained to keep residents to the floor; but, if they say they want to get up, you cannot force them not to get up.

An interview conducted with Transportation Aide (TA) #1 on 10/24/18 at 12:41 PM revealed on 10/18/18 around 5:20 PM after Resident #1 had fallen to the van floor, he was moving his left arm trying to get up, and was not able to get up on his knees. The resident was laying on his left arm, on his front. Resident #1 told him he didn't want to stay there, that he wanted to sit up. The TA said, if the resident wanted to get up, he couldn't leave him there. He said, to Resident #1, I am calling my manager, and the resident said, "I don ' t want to lay down there"; so, I rolled him onto his back, and he helped me sit him up. The TA #1 said the resident was then helped from a sitting position, onto a van seat, by pushing up with his legs and I helped by lifting him under his arms to the nearest van seat.

Review of a Witness Interview Form dated 10/18/18 and signed by TA #1's Supervisor (who was over medical records and transportation scheduling) revealed a call came to her on 10/18/18 at 5:24 PM from TA #1 who said Resident #1 had fallen out of his wheelchair. He said a vehicle had cut him off and he had to slam on the brakes causing Resident #1 to hit the van floor. TA #1 said, the resident was strapped in, but not sure how it came loose. He said Resident #1 was bleeding around the head area. I told him to call 911. I called the DON and told him what had happened. The DON said, we have to go get the van because TA #1 cannot drive the van. When we (DON and I) arrived at the station, the paramedics were already there assessing

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F 684	Continued From page 6	F 684		

Resident #1. The DON walked on the driver side of the van to see what was going on with Resident #1. I looked at Resident #1, knowing that he had just completed his dialysis treatment and saw that his eyes appeared weak/sleepy-like and blood covering his bottom teeth. He looked to me and was trying to say something, but his words were not clear. At approximately 6:00 PM, Resident #1 was transported to the local hospital.

An interview with facility Medical Director (MD) #1 on 10/24/18 at 11:30 AM revealed on 10/18/18 Transportation Aide (TA) #1 should have called 911 first thing, and not put Resident #1 in the van seat before an assessment by a professional was conducted. MD #1 said "TA #1 should have kept the resident still, until EMS stabilized his neck". "You do not disturb the neck". He said the van stopped from going 45 miles per hour and the resident's neck hit the floor from the sudden stop. MD #1 said you also cannot hold a person down, if they say they want to get up. After saying it is not a good idea for them to get up, and they still want to get up, they will get up anyway. You cannot hold a person down, it could increase injury.

An interview on 10/24/18 at 12:16 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed if a resident falls with an apparent head injury, she would not move the resident until an assessment was done on the resident. The ADON said she would encourage the resident to wait where they were, and wait for assistance. The DON said Resident #1 attempted to get himself up while in the van on 10/18/18, and to avoid possible further injury, TA #1 helped the resident up to the nearest van seat. She said the resident was already getting up (per

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F 684	Continued From page 7	F 684		

what TA #1 told her at the van scene). She said, TA #1 also told her the resident was uncomfortable on the floor of the van and wanted to get up. She said the resident was moving and trying to get up by himself. The ADON said if a resident fell at the facility with a suspected head injury, she would call code green, would not move the resident, assess the resident fully, call the MD, and start neuro checks. The ADON said all facility NAs were instructed to get help when a fall occurs, remain with the resident, and don't move the resident.

Review of a Certificate of Death with date of death of 10/19/18 revealed Resident #1's immediate cause of death was multiple blunt force injuries. Description of how injury occurred revealed motor vehicle stopped abruptly throwing unrestrained passenger forward.

During an interview with the Administrator and the Executive Director on 10/25/18 at 12:32 PM they confirmed TA #1 should not have moved Resident #1 following the incident on 10/18/18 prior to being assessed by a licensed staff member or EMS. The administrator and Executive Director provided the following plan of correction with a compliance date of 10/19/18.

On 10/18/2018 at 5:20 PM, Resident #1 fell from the wheel chair inside the facility van while transported from dialysis back to the facility. Facility Van Driver TA #1 indicated that he was travelling on the local road within the city speed limits. He was driving the facility's van, from dialysis center back to the facility. Resident #1 was on the wheel chair that was correctly secured. Both lap seat belt and main seat belts were both correctly secured. Resident #1

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F 684	Continued From page 8	F 684		

unbuckled the seat belt without the knowledge of the driver. While driving north on a beige colored vehicle cut off the path of TA #1 ' s way that necessitated driver (TA) #1 to apply the emergency breaking.

Resident #1 fell forward off the wheel chair face forward and hit the floor that resulted onto facial injuries. Resident was able to move all extremities while on the van floor. Resident requested TA #1 to help him back to the seat as he was uncomfortable on the van floor. TA #1 assisted resident back to the van seat, following resident's requests, as well as multiple attempts by the resident to get off the floor, and lack of obvious signs of neurological injuries such as changes of mental status at that time.

TA #1 contacted the facility and spoke to TA #1's Supervisor at 5:22 PM via her cell phone with no answer, then at 5:24 PM via the facility phone. TA #1's supervisor advised him to call 911. TA #1 called 911, who arrived at the scene of the accident and took over the care of the resident.

The two medics assisted Resident #1 from a van chair to his wheel chair. Resident #1 was then wheeled outside the van via a rear van mechanical lift. While outside, two medics assisted Resident #1 from wheel chair to the stretcher before transporting resident to the Emergency Room (ER). Resident remained alert and oriented at the time he left the scene of an accident Director of nursing who was at the scene of the accident added. No obvious signs of neurological injuries noted.

Driver (TA) # 1 went to Hospital for drug screening, toxicology results shows that

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F 684	Continued From page 9	F 684		

employee was negative for amphetamine, Barbiturates, Benzodiazepine, Cocaine, Methadone, Opiates, PCP as well as Marijuana. Driver #1 was suspended pending investigation and findings.

Driver (TA) #1 driving privileges of the facility van has been revoked effective 10/19/2018. Resident #1 was transferred to another hospital on 10/18/2018 for further evaluation and treatment. No other actions taken for Resident #1 as he is no longer in the facility.

Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
100% of all drivers' education records were audited on 10/19/18 by the facility Administrator and/or Director of Nursing, to ensure each driver receive necessary education to drive the van safely. All drivers noted to have necessary training and qualification to drive the facility Van to include what to do in-case of an emergency.

100% of residents who has an incident or accident for the last 30 days starting on 9/20/2018 through 10/19/2018 were audited by the facility Director of Nursing on 10/19/2018 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the facility compliance binder.

Measures will be put into place or what systematic changes will be made to ensure that

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F 684	Continued From page 10	F 684		

the deficient practice will not occur.

Effective 10/19/2018 all non-licensed employees will not move any resident involved in an incident or accident, to include the incidents happened in the facility van when a resident experience any fall until the resident is assessed by the trained personnel. The Facility staff will ensure patient safety is maintained while to awaiting for help to arrive effective 10/19/2018.

Executive Director, and/or Director of Nursing conducted re-education for current staff members on duty to include full time, part time and as needed employees on duty on 10/19/2018. This education included the importance of ensuring resident is not moved from the floor when resident incident or accident occurred until proper assessments are completed by the appropriate, trained personnel. This education will be completed by 10/19/2018, any staff member not educated by 10/19/18 will not be allowed to work until educated on this requirement. Effective 10/19/2018 this education will be added on new hires orientation education for all new facility staffs. This education will also be provided annually for all facility staff to include drivers. In-service form stated "The resident should be kept safe in the location observed until help arrived. If a resident fell in an area that put resident at further risk for injuries, extreme precautions must be taken to ensure resident's injuries are not exacerbated, should the resident be moved."

Executive Director, and/or Director of Nursing conducted re-education for current drivers and back up drivers' onsite on 10/19/2018. This education included the importance of ensuring

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F 684	Continued From page 11	F 684		

resident is not moved from the floor of the van until proper assessments are completed by the appropriate, trained personnel. This education was completed by 10/19/2018, any driver not educated by 10/19/18 will not be allowed to drive until educated on this requirement. Effective 10/19/2018 this education will be added on new hires orientation education for all new facility drivers. This education will also be provided annually for all facility staff to include drivers.

The facility plans to monitor its performance to make sure that solutions are sustained.

Effective 10/19/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance of staff not moving residents until a proper assessment is completed by a trained licensed employee by conducting clinical meeting daily (Monday through Friday). This meeting will allow the team to review all incidents or accidents that occurred from the prior clinical meeting to ensure that non licensed employee did not move a patient before a proper assessment is completed by the trained personnel. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done. This monitoring process will take place daily (Monday-Friday) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

This Effective 10/19/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI) for any

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F 684	Continued From page 12	F 684		

additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. QAPI committee members notified of this plan of action and its monitoring process on 10/19/2018 by the facility Administrator. QAPI Committee adopted the established plan and will be the responsible body to modify any part of this plan effective 10/19/2018.

The title of the person responsible for implementing the acceptable plan of correction.

Effective 10/19/2018 the facility Executive Director 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.

Validation of the above referenced plan of correction was completed on 10/25/18 during an extended survey.
Validation included staff interviews regarding residents Fall Procedures. In-services regarding Fall Procedures were reviewed. In-services regarding not moving any resident involved in an incident or accident were reviewed. Staff were interviewed regarding in-service for residents not to be moved from the floor when resident incident or accident occurred until proper assessments are completed by the appropriate, trained personnel. Drivers' education records, as well as residents who had an incident or accident for the last 30 days starting on 09/20/18 through 10/19/18 were audited 100%. Compliance of staff not moving residents after an incident or accident audit tool were reviewed that will be and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 10/25/2018

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

(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 684	Continued From page 13 are used on a daily clinical report. This auditing process will take place daily (Monday-Friday) for 2 weeks, weekly x 2 more weeks, then monthly x 3 months as stated in the plan of correction. The date of 10/19/2018 was validated as the facility's date of compliance.	F 684		