STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	C 10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(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 000	INITIAL COMMENTS A Complaint Investigation survey was conducted on 10/16/19. One of the 6 allegations was substantiated. Event ETTW11.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, family and nurse practitioner interviews, and record review, the facility failed to provide incontinent care in a safe manner to prevent a fall from the bed which resulted in a fractured leg for 1 of 3 sampled residents reviewed for falls (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/25/18 with diagnoses which included left sided hemiplegia related to a cerebral vascular accident. Review of Resident #1's annual Minimum Data Set (MDS) dated 07/16/19 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #1 required the extensive assistance of 2 persons with bed mobility and toilet use. The MDS documented Resident #1 had no falls since the prior	F 689	PruittHealth Union Pointe acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of finding is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the resident. The plan of correction is submitted as written allegation of compliance. PruittHealth Union Pointe□s response to the Statement of Deficiencies and the plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Pruitt Health Union Pointe reserves the right to submit documentation to refute any of the stated deficiencies on the statement of	11/15/19

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

Electronically Signed | 11/03/2019

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 689	Continued From page 1 assessment. Review of Resident #1's care plan dated 07/29/19 revealed interventions to prevent falls included use of a mechanical lift with two persons for transfer. The care plan included direction to provide incontinent checks and provision of personal care. Review of a nursing note dated 10/07/19 by Nurse #1 revealed Nurse Aide (NA) #1 reported Resident #1 rolled out of bed during incontinence care. Nurse #1 documented Resident #1 complained of left knee and left hip pain after she fell from her bed. An x-ray of the left knee and hip was ordered. Resident #1 received Tylenol (a medication used to treat pain). Review of Resident #1's x-ray dated 10/07/19 revealed an acute fracture of the left distal femur with no acute pathology. Resident #1 received an orthopedic consultation and placement of a leg immobilizer on 10/08/19. Review of Resident #1's fall safety event form dated 10/08/19 revealed Nurse #2 documented Resident #1 rolled off the bed during incontinence care with the result of a distal femur fracture. Resident #1 received a scoop mattress after the fall to prevent recurrence. The report documented interventions were effective and did not contain description of the interventions except for addition of a scoop mattress after the fall. Interview on 10/16/19 at 10:17 AM with NA #1 revealed she asked Resident #1 to roll on her left side for incontinence care. NA #1 explained she began incontinence care and needed Resident #1	F 689	Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings. For the resident affected, a scoop mattress was added to the bed for Resident #1 to minimize a reoccurrence of this event. Nursing staff caring for her will also be in-serviced on the need to be prepared for sudden, excessive movements during her care. Those residents with the potential to be affected includes any resident when positioning them on their sides would be required for effective incontinence care. For these residents, nursing staff will be in-serviced on or before November 18 (or before their next shift, whichever is sooner) on the possibility that residents could be subject to voluntary and involuntary movements which could be excessive and without purpose. During care of these residents, staff must anticipate, as much as possible, such movement that could lead to an incident. In extreme cases, of which none were identified, scoop mattresses would be recommended. Nursing staff would also be encouraged to have continuous, reassuring conversations with the resident being cared for in order to help comfort and prevent sudden movements. Clearly all cases, such as this case, may not be avoidable. This in-service training will be provided to all new hires and will be continued to be	

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F 689	Continued From page 2 to turn away from her to be more on the left side. NA #1 stated Resident #1 was on her left side in the middle of the bed. NA #1 reported Resident #1 lifted her right leg up and over which caused the fall. NA #1 did not remember if Resident #1 reached for the ¼ side rail. NA #1 added she lowered the bed as Resident #1 was falling in order to lessen the height of the fall and used the call light to summon assistance. NA #1 explained Resident #1 could use the right leg and not the left leg. NA #1 reported Resident #1 required one person for assistance with turning. NA #1 explained she had cared for Resident #1 since her admission to the facility. NA #1 noted Resident #1 had always required one person's assistance with incontinence care since Resident #1 could move her right leg. Interview with Nurse #1 on 10/16/19 at 10:27 AM revealed she responded to NA #1's request for assistance on 10/07/19. Nurse #1 reported she assessed Resident #1 who complained of left leg pain. The Nurse Practitioner and Resident #1's family member received notification and an x-ray was ordered. Nurse #1 reported Resident #1 required one to two persons for incontinence care, but one NA could safely reposition Resident #1. Interview with NA #2 on 10/16/19 at 10:37 AM revealed Resident #1 required two persons for incontinence care due to Resident #1's immobility. NA #2 explained Resident #1 could not move in bed independently and required two person assistance due to inability to use her left side prior to the fall. NA #2 reported she began employment approximately 6 weeks ago and occasionally cared for Resident #1.	F 689	provide for all nursing staff on a regular basis. This training will be to anticipate sudden and perhaps unexplained movements and the apparent risks associated with each. When such a movement occurs, the staff should quickly respond by attempting to prevent a fall and if possible, lower the bed to help lessen the fall from the bed. The results of the intervention for Residents #1, and training for all staff, will be monitored beginning 11/7/19 by the quality assurance nurse who monitors all falls and will bring that monitoring to the quality assurance committee for the next three months and the PRN. Every fall in the facility is evaluated for possible interventions to prevent further occurrences. This monitoring will also include any resident that falls from the bed to determine if the training could be modified and/or if other interventions could be recommended. Any suggestions for improvement will be implemented by the director of nursing or clinical care coordinator. The quality assurance nurse or clinical competency coordinator will also monitor various staff turning and repositioning 3 residents in bed , 3 xs weekly for one month (beginning 11/15/19-12/15/19). Then quality assurance nurse will monitor various staff turn and reposition 3 residents 2 xs weekly for 2 months (12/16/19-2/16/20). For continued monitoring, all data	

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F 689	Continued From page 3 Observation on 10/16/19 at 10:50 AM revealed NA #2 and NA #3 used a mechanical lift to transfer Resident #1 onto a scoop mattress with ¼ side rails. NA #3 turned Resident #1 toward her and NA #2 provided incontinence care. Interview with NA #3 on 10/16/19 at 10:55 AM revealed Resident #1 required two-person physical assistance with turning prior to the fall from bed. NA #3 reported she always asked for another NAs assistance when assigned to Resident #1 for safety. NA #3 explained Resident #1's confusion and inability to move her left side required 2 persons. NA #3 reported she seldom cared for Resident #1 but always asked for assistance of another NA. During an interview with Resident #1 and a family member on 10/16/19 at 8:48 AM, Resident #1 reported she broke her leg when she fell out of bed. Resident #1 did not remember the details of the fall from bed. Resident #1's family member explained Resident #1 could not remember the exact circumstances of the fall. The facility informed Resident #1's family member that the fall occurred during incontinence care. An interview was conducted on 10/16/19 at 12:13 PM with Nurse #2. Nurse #2 reported her job responsibilities included fall investigations. Upon receipt of report of Resident #1's fall from bed, Nurse #2 reported a scoop mattress was immediately implemented to prevent recurrence. Nurse #2 explained Resident #1's leg movement caused the fall so the number of persons required for bed mobility was not addressed. Nurse #2 reported a reenactment was not done but NA #1 reported Resident #1 turned away from her. Nurse #2 stated Resident #2's leg movement	F 689	captured for assessing each fall or other incident will be monitored by the quality assurance committee after it is discussed by the daily clinical meeting. Some of the members from the daily clinical meeting will form the incident subcommittee for the quality assurance committee. Nov 15, 2019	

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F 689	Continued From page 4 caused the fall. Interview with the Director of Nursing (DON) on 10/16/19 at 1:28 PM revealed NAs caring for Resident #1 determined the number of persons required for turning and repositioning. The DON explained Resident #1 usually required one person's assistance except for periods of illness. The DON stated Resident #1's fall was a result of Resident #1's right leg movement. The DON reported NA #1 requested Resident #1 to turn away from her which caused the fall. The DON reported NA #1 could safely request this of Resident #1 since Resident #1 had no history of sudden leg movement and falls. The DON considered the fall unavoidable. Telephone interview with Nurse Practitioner (NP) on 10/16/19 at 11:41 AM revealed Resident #1's fall from bed resulted in the leg fracture. The NP explained she relied on the facility to assess the number of persons required for turning and repositioning Resident #1. The NP reported best practice would be to turn a resident toward the staff member since Resident #1 had limited mobility.	F 689		