STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING ______ B. WING ______	C 04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK ROAD FAIRVIEW, NC 28730

(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 An unannounced complaint investigation was conducted on 4/14/21. The survey team was onsite 4/14/21 and 4/16/21. Additional information was obtained offsite on 4/19/21 through 4/21/21. Therefore, the exit date was 4/21/21. Event ID# GWJ511. Eight of the 8 complaint allegations were not substantiated.	F 000		
F 684 SS=D	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 review and staff interviews the facility failed to thoroughly assess a resident for injury after a fall for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/12/20 with diagnoses which included dementia, diabetes mellitus, and weakness of the lower extremities. Resident #1 was discharged to the community on 4/12/21. A review quarterly Minimum Data Set (MDS) dated 1/1/21 assessed Resident #1's cognition as being severely impaired. Resident #1 was	F 684	The nurse involved was unaware that an "intercepted fall" is still considered a fall and a full assessment was not performed. A fall/intercepted fall requires a thorough assessment, treatment, if needed, documentation in nurses notes, incident report, and notification to MD and family. The resident is then added to the acute book to notify staff of the incident and to be monitored for 72 hours. The nurse involved has been counseled regarding the incident and policies and procedures for fall/intercepted fall.	5/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/10/2021

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 independent with bed mobility and needed supervision with transfers and was not steady and only able to stabilize with human assistance between balance transitions and walking. No falls had occurred since the prior assessment. The care plan last updated 4/7/21 identified Resident #1 as being a fall risk due to an unsteady gait and the use of psychoactive medications with a recent onset of falls. The goal was for Resident #1 not to sustain a significant fall related injury more serious than a bruise, abrasion, or skin tear. Interventions included to give verbal reminders not to ambulate or transfer without assistance when feeling weak or unsteady. A review of the nurse note written on 4/11/21 at 9:47 PM revealed Nurse #1 documented in part Resident #1 was "observed to have a 2-centimeter area of healing skin on the right shin that had partially reopened." Nurse #1's note indicated the injury was acquired from a fall that occurred two weeks ago. A telephone interview was conducted on 4/19/21 at 8:24 AM with Nurse Aide (NA) #1. NA #1 revealed on 4/11/21 he was asked to assist Resident #1 off the floor. NA #1 described when he entered the room Resident #1 was sitting on the floor by the bed with Nurse #1 present. Resident #1 was assisted off the floor and back into the bed. NA #1 then provided incontinence care and noted an area above Resident #1's ankle but couldn't recall which leg. NA #1 described the area appeared circular in shape and was the size of a nickel or slightly bigger that bled a little and was open to air and notified Nurse #1.	F 684	The resident was discharged home the day following the incident, so an assessment could not be completed but an incident report was filled out and the MD notified. In-service training with all nurses reviewing the fall and incident reporting policies and procedures. DON,ADON, or Care Plan Coordinators will monitor all falls through incident reports and acute book notification weekly to ensure that all falls had assessment done, incident report done, nurses note completed, MD and family notification, and monitoring for 72 hours. Documentation of the monitoring will be maintained and presented by the ADON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes to corrective action made as needed. Monitoring will continue until compliance is maintained for a minimum of 3 months or longer if the QAPI committee recommends. Person responsible for monitoring compliance: DON and ADON Corrective action completed 5/14/2021	

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F 684	Continued From page 2 A telephone interview was conducted on 4/21/21 at 3:05 PM with Nurse #1. Nurse #1 explained after assisting Resident #1 to the floor on 4/11/21 she didn't consider the incident a fall. After Resident #1 was assisted back to the bed Nurse #1 did not complete a head to toe body assessment to ensure there were no injuries. Nurse #1 did see the areas of the skin that were exposed and explained the area on the right shin was an old injury that was not actively bleeding. Nurse #1 revealed a head to toe skin assessment should have been done to ensure Resident #1 didn't acquire an injury after being assisted off the floor. During an interview on 4/21/21 at 4:46 PM the Director of Nursing (DON) explained the facility's fall protocol was for the nurse to fill out an incident report to describe what happened and assess the resident's body for injury. The incident was added to the acute book used to notify other nurses a fall occurred and assess the resident for 72 hours for latent injuries. The DON explained Nurse #1 was present when Resident #1 was assisted to the floor, knew what happened and didn't think a head to toe body assessment for injury was needed at the time of the incident.	F 684		