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F 000	INITIAL COMMENTS The surveyor entered the facility on 4/19/22 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 4/21/22. Therefore, the exit date was 4/21/22. Past-noncompliance was identified at: CFR 483.25 at tag F 689 at a scope and severity G. One of one complaint allegation was substantiated. Event ID# 74J411. NC 00187962	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, record review, and staff interview, for one (Resident # 1) of three sampled residents who had experienced accidents, the facility failed to assure a Nurse Aide safely assisted a resident with personal care. While Nurse Aide #1 was turning Resident# 1 for incontinence care, Resident # 1 rolled out of bed and sustained fractures to two toes and a fracture to her left orbital area (the area around the eyeball.) She also sustained a dislocated finger with possible fracture and a laceration to her forehead. The findings included:	F 689	Past noncompliance: no plan of correction required.	4/27/22

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

Electronically Signed | 04/27/2022

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Resident # 1 was admitted to the facility on 5/17/19. Although not all inclusive, the resident had diagnoses of muscle weakness, chronic obstructive pulmonary disease, and congestive heart failure.

The resident's quarterly MDS (Minimum Data Set) assessment, dated 4/6/22, coded the resident as cognitively intact and as needing extensive assistance by one person for bed mobility and hygiene needs.

Nurse # 1 made the following nursing entry on 4/8/22 at 6:31 PM. "CNA (certified nursing assistant) notified me that she needed help because resident had fallen out/off of bed while she was being turned. Upon entering room resident was on floor bleeding from her forehead. I sent CNA to desk to call EMS and get cold compress while I assessed the resident. Resident was alert and oriented X 4. I applied her O2 (oxygen) mask, covered her and CNA and I turned her on her back. Told CNA to stay with resident and apply pressure (to) the wound while I got her paperwork ready for EMS (Emergency Medical Services) and called RP (Responsible Party)." Nurse # 1 further noted Resident # 1's family arrived and the resident was transported to the hospital.

Review of Resident # 1's discharge summary, orthopedic consults, progress notes, and diagnostic tests for the hospitalization dates of 4/8/22 to 4/12/22 revealed the following information. Resident # 1 had sustained a 2 ½ centimeter laceration above her eye, which was repaired in the emergency department. She had sustained a nondisplaced left orbital fracture and hairline fractures to her second and third left toes.

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She also had sustained a subluxation (dislocation) of the left middle finger. According to the radiologist readings of the left-hand x-ray, the radiologist noted there was a slight bone density at the level of the finger dislocation which might signify an accompanying fracture. Hospital notes reflected an attempt was made to treat the dislocated finger, but orthopedic treatment was not successful. The physician noted this was discussed with Resident # 1's family, and since the dislocated finger was on the nondominant hand, the decision was made to leave the injury without further treatment. According to orthopedic notes, since Resident # 1 was non-ambulatory, no long- term splint was needed for the hairline fractures of her toes. For pain control, the hospital records indicated upon arrival to the Emergency Department Resident # 1 was given Morphine; noting that she was in "significant pain" upon arrival to the emergency department. Review of the hospital discharge summary revealed Resident # 1 had been diagnosed with exacerbation of both her congestive heart failure and chronic obstructive pulmonary and these conditions were also treated while she was hospitalized.

On 4/12/22 she was discharged back to the facility in stable condition.

Resident # 1 was interviewed on 4/19/22 at 2:30 PM and reported the following. She recalled on the day of the fall that she had told NA # 1 that she was too close to the edge of the bed. The resident stated the next thing she remembered, the NA let go of her and she went head first and hit the floor. Resident # 1 pointed to the area of her forehead directly above her eyes and stated she hit the floor there. Resident # 1 was observed

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to still have extensive bruising to the left side of her face and a small area also under her right eye. Half of the resident's left cheek was purple in color. Four of Resident # 1's left toes were purplish in color and her middle left finger was observed swollen. Resident # 1 stated the nurses were now giving her Tylenol to relieve pain.

NA # 1 was interviewed on 4/19/22 12:30 PM and reported the following about the day of the incident. She was preparing to provide incontinence care to Resident #1 on 4/8/22. At the time of the incontinence care, the bed was at "naval level." NA # 1 stated she always pulled residents close to her before turning them. According to NA # 1 she had pulled Resident # 1 towards her before turning her in the opposite direction away from her for care on 4/8/22. According to NA # 1, Resident # 1 was "acting sleepy" that day and, when she turned her, Resident # 1 rolled out of the bed. NA # 1 stated the nurse was right outside the door and she immediately called for the nurse to help. The nurse came immediately and checked Resident # 1. The resident had a cut on her head. NA # 1 stated she was directed to go get a washcloth to apply pressure to the resident's head. This was done. NA # 1 reported multiple staff members came in to check on the resident and she remained with Resident # 1 until EMS arrived in the parking lot and the resident said she was okay. After EMS arrival, she had to attend to a wandering resident.

Nurse # 1 was interviewed on 4/21/22 at 10:40 AM via phone and reported the following. She was two doors down from Resident # 1's room on the evening of 4/6/22 when NA # 1 stepped to the door and alerted her Resident # 1 had fallen. She

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went to assess the resident. They rolled her over and found she had a cut to her head. She directed NA # 1 to obtain a washcloth. MA (Medication Aide) # 1 was also present, and MA # 1 was directed to call 911 for emergency services. By holding the washcloth to the resident's head, she was able to get the bleeding to stop. NA # 1 remained with Resident # 1 after Nurse # 1 assured the resident was no longer bleeding, and then Nurse # 1 went to prepare transfer paperwork for EMS. The resident was transferred to the hospital via EMS.

The Administrator was interviewed on 4/19/22 at 11:40 AM and again at 3:00 PM. According to the Administrator, Resident # 1 had just undergone a quarterly MDS assessment on 4/6/22 prior to the accident. At that time the MDS nurse had assessed that Resident # 1 had enough upper body strength to help with positioning and thereby was deemed to need only one person's assistance for bed mobility. Following the incident, they had investigated the circumstances and talked to Resident # 1. Resident # 1 had indicated to the facility staff that NA # 1 had not pulled her closer to her before turning her on the day of the incident. Therefore, the facility had initiated a complete plan of correction for the incident. They had also updated Resident # 1's care plan to reflect she needed two staff members for bed mobility in future. The Administrator provided their written plan of correction.

The facility provided the following corrective action plan with a compliance date of 4/15/22:

"Problem identified: Resident # 1 was admitted to the facility on 5/17/2019 and readmitted on

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4/12/22. Between the original admission and last readmission, she has multiple readmissions. The most recent readmission, she was readmitted with diagnoses that included (in parts) Acute respiratory failure, anxiety disorder, hypertension, heart failure, muscle weakness, needs assistance with personal care.

Review of discharge summary form from a local hospital transcribed on 4/12/2022 indicted that Resident # 1 was diagnosed with left toe fracture, finger fracture, and left orbital fracture resulted from a fall, Resident # 1 was discharged back to the facility on 4/12/2022 with medication including Acetaminophen 650 mg (milligrams) Q 6 hours (every 6 hours) for pain.

Review of incident report completed on 4/8/2022, indicated that Resident # 1 fell out of bed when Nursing Assistant # 1 was providing activity of daily living care at around 5 PM. The report detailed that (in parts) on 4/8/22, Nursing Assistant # 1 was providing care to Resident # 1 while in bed.

Review of Nursing Aide # 1 written stated dated April 14, 2022, indicated that; Nursing Assistant # 1 provided care to Resident # 1 roommate before proceeding to Resident # 1. When she approached Resident # 1, Resident # 1 was asleep. Nursing Aide # 1 woke up Resident # 1 to change her. Nursing Aide # 1 statement added that, Resident # 1 lowered her head of bed to allow her to proceed changing her. Nursing Aide # 1 indicated that she turned a resident away from her body, while Resident # 1 bed was in position appropriate for nursing aide to provide care. She indicated that the bed was around her "Navel" level (measured to be 40 inches from the floor).

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She added that when she rolled Resident # 1, Resident # 1 was close to her side of bed, however when she rolled her, resident moved slightly and rolled to the floor. Nurse aide # 1 proceeded to call for assistance of a licensed Nurse # 1 who provide first aide to Resident # 1.

Review of Resident # 1 quarterly Minimum Data Set (MDS) assessment with Assessment Reference date (ARD) of 4/6/22 indicated that Resident # 1 had a Brief Interview of Mental Status (BIMS) score of 14 with no short term no long-term memory loss. Review of Section G (functional status) of MDS assessment indicated Resident # 1 requires one person assistance with bed mobility, two-person assistance with transfers, and/or set up assistance with eating. Review of care plan for Resident # 1 for activities of daily living dated 1/27/22 indicated (in parts); assist with perineal cleansing as needed, encourage resident to participate on small tasks of hygiene.

Root Cause Analysis (RCA):
The Governing body led by the facility Executive Director and Director of Nursing in collaboration with the selected members of the facility Quality Assurance and Performance Improvement (QAPI) committee conducted the root cause analysis on April 14,2022, to identify the causative factor for this alleged noncompliance and implemented appropriate measure to correct and prevent the reoccurrences.

The root cause analysis identified that the alleged noncompliance resulted from the failure of an employee to pull the resident to the center of the bed before turning resident during ADL care on 4/8/22 that resulted onto a fall. The RCA further

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identified that facility staff remained with the resident in the room for most of the time until resident was settled and stabilized but departed briefly to redirect another resident who walked in Resident # 1's room before EMS arrived to pick up Resident # 1 following Resident # 1's fall with injuries on 4/8/22.

Immediate Action Implemented:
Resident # 1 first aid was provided by Nurse # 1 by applying pressure to an open area on Resident #1's forehead on 4/8/22. While resident was on the floor, 911 was contacted and arrived at the facility to transfer resident to ER on 4/8/2022.

On 4/14/2022, Director of Nursing completed a competence evaluation titled "providing incontinence care for resident in bed" for Nursing Aide # 1. The emphasis was on component # 5 that focus on ensuring resident is centered in bed when care is provided.

Resident # 1 was readmitted on 4/12/2022. Resident # 1 was reassessed by MDS coordinator # 1 and care plan was revised to include measures for pain management and two person's assistance with ADLs.

Identification of Other Residents who Might be Affected:
100% audit of current resident's care plans completed by MDS Coordinator # 1 and/or MDS Coordinator # 2 on April 13, 2022, to assure each resident has an ADL care plan that indicates the amount of assistance required during ADL care and ensure the care guide in kiosk is updated with such information. Findings of this audit is documented on a care plan ADL audit tool located in the facility compliance binder.

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100% audit of all incident reports written in the last 30 days completed on Aril 12, 2022, by Director of Nursing, Unit coordinator # 1 and/or Unit manager # 2 to identify any other incident of fall or assisted fall in which resident was left unattended. No other incidents/ accidents identified with resident being left unattended. Findings of this audit is documented on an incident report audit tool located in the facility compliance binder.

100% audit of all current resident's medical records documented for the last 30 days was completed on April 13, 2022, by Director of Nursing, MDS Coordinator # 1, MDS Coordinator #2, Unit Coordinator # 1, and/or Unit Manager # 2 to identify any other documentation of a resident with an incident or accident and was left unattended. No other documentation of an incident/accidents identified with resident being left unattended. Findings of this audit is documented on clinical documentation audit tool located in the facility compliance binder.

Systemic Changes and Modification:
Effective April 14, 2022, all new residents will have a bed mobility assessment completed on admission, quarterly, and with any changes in their bed mobility status, by the licensed nurse on duty. This will be reviewed in the daily clinical meeting and be documented on the facility medical records under ADL care guide intervention module. Moving forward, residents, ADL assistance needs will be added on the care guide located electronically in the kiosks.

Effective April 14, 2022, resident will be centered in bed before being turned from one side to side

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during care. Staff member will use appropriate number of staff based on resident's care plan.

Effective April 14, 2022, no residents will be left unattended after being observed on the floor. Any staff member who observes a resident on the floor will ensure the resident is safe and then call for assistance by activating the call bell light. If no one comes immediately, staff will step outside of location and call for assistance (Staff member will remain with the resident at all times until 911 arrived.
Effective April 14, 2022, the facility clinical team to include the Director of Nursing, Assistant Director of Nursing, Unit Manager # 1 and/or Unit Manager # 2 revised the process of reviewing all new admits/readmits in a daily clinical meeting and include the provision for bed mobility assessment to ensure it is completed and documented in electronic medical records. Any discrepancies identified is corrected promptly. Finding of this systemic change is documented on the daily clinical meeting report form located on the daily clinical meeting binder.

100% education of all current nursing staff to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (# 1, #2). The emphasis of this education includes but not limited to, the importance of completing bed mobility assessment on admission, quarterly and with changes of bed mobility status.
This education will be completed by April 15, 2022. Any nursing staff members (Registered nurses, Licensed practical nurses, Medication aides, Certified nurse aides and patient care aides) not educated by April 15, 2022, will not be

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allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new nursing employees effective April 15, 2022. Incident and accident process and safety of our residents.

100% education of all current nursing staff to include full time, part time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators. The emphasis of this education includes but not limited to the importance of ensuring resident is centered in bed during bed mobility. The education also emphasized the importance of ensuring resident is not left unattended while on the floor, until proper assessment and assistance arrived.

This education will be completed by April 15, 2022. Any nursing staff members not educated by April 15, 2022 will not be allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new nursing employees effective April 15, 2022 incident and accident process and safety of our residents.

Monitoring Process:
Effective April 14, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete incident/accident monitoring process. This monitoring process will be accomplished by observing residents to ensure employees are providing services in the facility that assure an environment that is free from accidents and hazards. The monitoring process will be accomplished by observing five randomly selected staff members and residents. The

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observer will focus on observing ADL care specifically pertaining to bed mobility and ensure staff members keep resident at the center of the bed before turning from one side to another. The observer will also ensure appropriate number of staff based on individual residents' care plan is adhered. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on an accommodation of needs monitoring tool located in the facility compliance binder.

Effective April 14, 2022, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure that a bed mobility assessment has been completed. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "bed mobility assessment tool for new residents" located on the facility compliance binder.

Effective April 14, 2022, the Director of Nursing, and/or Unit Coordinators (# 1, #2) will review all incidents and accidents on daily clinical meeting to ensure that all residents were assisted promptly and not left unattended. This monitoring process will be completed daily Monday through

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Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the incidents and Accidents monitoring tool located in the facility compliance binder.

Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.

Person responsible to implement Corrective Plan of Care:
Effective April 14, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.

The facility alleged compliance date: 4/15/22

The facility's credible allegation of compliance was validated on 4/19/22 by the following.
Multiple residents were interviewed and reported they felt facility staff provided care in a safe manner. No resident reported any accidents in which a staff member was involved or whose care contributed to the accident.

Review of Resident # 1's care plan revealed it had been updated to reflect two staff members were needed to provide bed mobility assistance for Resident # 1.

On 4/19/22 at 2:15 PM Resident # 1 was observed as staff members provided

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	345213	A. BUILDING _____ B. WING _____	C 04/21/2022

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 689	Continued From page 13	F 689		

incontinence care. There were two nurse aides present and they took appropriate measures to assure the resident was not near the edge of the bed before turning her to care for her. Resident # 1 was interviewed following the direct care and reported no further safety problems. Resident # 1 reported she was happy to be back at the facility.

Review of in-service records revealed the DON and ADON presented a 30 minute education course for their direct care staff per their plan of correction on the topic of incidents, accidents and quality of care. There were accompanying sign in sheets where the facility staff members signed they attended. According to an interview with the Administrator, the in-services were begun on 4/11/22 and completed on 4/15/22. The signatures on the sign in sheets reflected this also.

The facility provided documentation NA # 1 had undergone competency evaluation in providing incontinence care on 4/14/22 and was evaluated to meet current standards of practice by the DON.

The facility provided evidence they had performed their audits per the plan of correction and documentation that their monitoring tools were begun on 4/14/22 and continuing per the planned schedule in their plan of correction.

Nurses and Nurse Aides from different shifts were interviewed and verified they had attended the facility's in-service training on incidents, accidents and quality of care. Interviewed staff members reported they would assure a resident was safe in the middle of the bed before turning them. Nursing staff members also knew to check the

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F 689	Continued From page 14 kiosk care plan information to find the appropriate amount of needed assistance for each resident.	F 689		