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 09/20/2021

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/07/21 through 09/20/21. Event ID # REJX11. 1 of the 10 complaint allegations was substantiated resulting in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy for F689 began on 08/29/21 and was removed on 09/01/21. Immediate Jeopardy for F600 began on 08/29/21 and was removed on 09/16/21. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		9/21/21

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

Electronically Signed | 09/20/2021

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff, physician, and Medical Examiner interviews, and record review, the facility neglected to provide assistance from two or more people for activities of daily living according to the most recent assessment dated 7/22/2021 (Resident #7). This resulted in a fall from a raised bed onto the floor. Multiple administrations of Cardio-Pulmonary Resuscitation (CPR) were required to stabilize Resident #7 prior to being taken to the hospital. Resident #7 expired the following day. This was for one of one residents reviewed for neglect (Resident #7). The Immediate Jeopardy began on 8/29/2021 when Nursing Assistant (NA) #4 gave a dependent resident (Resident #7) daily care alone when the resident required two person's assistance for care which resulted in a fall from his raised bed onto the floor. Resident #7 required CPR multiple times to be stabilized to be taken to the hospital. Immediate Jeopardy was removed on 09/16/2021 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training.	F 600	PROCESSES THAT LEAD TO THE IDENTIFED ISSUE ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED BY THE IDENTIFIED ISSUE On 8/29/2021 Certified Nursing Assistant (CNA) #4 was providing activities of daily living (ADL) care alone to Resident #7 when Resident #7 required two-person assistance for that care. CNA #4 continued to provide care alone when the Resident #7 became combative. Resident #7 fell from his raised bed onto the floor. Resident #7 was transferred to the hospital where he expired the following day. Kardex and care plan reflected 1-2 person assist. Most recent Minimum Data Set (MDS) dated 7/22/21 is total dependence with two-person physical assist for bed mobility and bathing. Resident #7 was transferred to the hospital on 8/29/21. Healthcare Personal Registry notified of neglect allegation with CNA #4 via faxed Initial Allegation Report on 9/16/21. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) HAVING POTENTIAL TO	

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F 600	Continued From page 2 Findings included: The care plan dated 2/19/2020 stated Resident #7 needed total assistance for all care with 1-2 persons. This was the active care plan. Resident #7 was readmitted on 4/3/2021 with diagnoses including dementia, history of falls, Alzheimer ' s disease, and atrial fibrillation (irregular and often rapid heart rate). The care plan dated 4/8/2021 listed Behavior: Exhibits aggressive behavior at times. There were general interventions listed: talk in calm voice, refer to Social Services for evaluation, monitor and document target behaviors, place in area where frequent observation is possible. This care plan was reviewed 6/24/2021. On 9/16/2021 at 11:00 AM, the MDS Nurse was interviewed and stated she did not know why the care plan was so general, and she would have put the number of staff needed for each care need. The MDS Nurse found a fall care plan from 4/3/21 with an intervention for fall mat indicated. The care plan was resolved on 6/24/21. The MDS Nurse stated if a resident with a fall care plan does not have a fall for a period of time, the care plan for falls is sometimes resolved. The MDS Nurse stated the nurses fill out the Kardex. The Quarterly Minimum Data Set (MDS) dated 7/22/2021 noted Resident #7 was severely impaired for cognition and required total assistance for all care needs with the assistance of two or more persons. The exceptions were eating and locomotion on and off unit which required one person ' s assist. The quarterly MDS	F 600	BE AFFECTED BY THE SAME ISSUE All residents with behaviors and that are dependent with care have the potential to be affected by the alleged deficient practice. On 9/16/21, a list of residents with behaviors were obtained through reviewing the most recent MDS assessments, discussions with staff and observations and a list of assistance needed based on the MDS coding was obtained. The Nursing Consultant, Director of Operations & MDS Coordinators reviewed the MDS Assessments, Care Plans & Kardex. The Nursing Consultant, Director of Operations, MDS updated the residents Kardex & Care Plan to reflect the needed assistance for care of each resident. All residents were reviewed by 8/30/21 by Nursing Consultant, Director of Operations, MDS with collaboration of CNAs to ensure the following areas have been appropriately addressed: 1) Numbers of staff members needed to provide care 2) Bed surface to ensure sufficient room for turning and repositioning 3) Whether or not the resident has a physical impairment or behaviors that need to be considered 4) Any resident that cannot assist with turning or repositioning A Kardex will be completed by MDS or designee for each new admission, and they will be updated with the quarterly and	

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F 600	Continued From page 3 did not indicate any behaviors or rejection of care. The Kardex (a care guide for NAs) indicated Resident #7 was dependent on total care for all ADLs and mobility was marked non-ambulatory, wheelchair, and transfers was checked with 2 assists with mechanical lift. Special care instructions were: Resident has episodes of agitation and behaviors, history of hitting/kicking at staff. The Kardex was undated. NA #6 was interviewed on 9/15/2021 at 12:15 PM, and stated she was familiar with Resident #7 and his care needs required two staff. NA #6 stated Resident #7 was combative most days. NA #6 stated resident information for care was in the Kardex, which was in a binder in the nurse ' s station. On 9/15/2021 at 12:33 PM NA #2 stated he worked for the facility through an agency. NA #2 knew where the Kardex was and stated if the Kardex said two staff were needed for a resident ' s care, he would always use two staff. NA #7 was interviewed on 9/15/2021 at 3:15 PM and stated she was working at the facility through an agency. NA #7 stated she knew what the Kardex was and if she had any questions about care needs, she would ask the nurse in charge of the hall. On 9/15/2021 at 3:25 PM, NA #8 was interviewed and stated she was an agency NA. NA #8 stated she would look for information about resident ' s needs in the Kardex but would ask the nurse on the hall if she was unsure about resident care needs.	F 600	significant change MDS and as indicated by nursing management for change in condition. All resident's care plans and Kardex that require updating were completed on 9/1/2021 by MDS Coordinators. The Executive Director (ED) informed them of this responsibility. ADDRESS WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE IDENTIFIED ISSUE DOES NOT OCCUR IN THE FUTURE Effective 8/30/2021, all direct care staff (including agency) will be educated on the locations of the resident Kardex, where on the Kardex to find the information needed to ensure appropriate care is provided to the resident, by ED or designee. Effective 8/30/2021, all direct care staff (including agency) will be educated on handling resident with behaviors as well as halting care and/or seeking assistance when a resident becomes combative, by ED or designee. Effective 8/30/2021, all direct care staff (including agency) will be educated related to proper technique for turning and repositioning residents (+1/+2), by the ED or designee. Direct care staff (including agency) not in-serviced on above topics by 9/1/21 will be in-serviced prior to their next scheduled shift. Responsible person: ED or designee	

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F 600	Continued From page 4 Nurse #3 was interviewed on 9/16/2021 at 5:28 PM, and stated she reviewed the training packet with NA #4 on her first day of work in the facility. Nurse #3 stated she reviewed Kardex information and resident care needs for assistance information. NA #4 was interviewed on 9/15/2021 at 1:30 PM, and stated she was working with Resident #7 on 8/29/2021 at the time of his fall from the bed. NA #4 stated she had been in Resident #7 ' s room earlier to feed him breakfast, and the Resident was not combative, ate all his breakfast, and she began care with other residents. NA #4 said she had only been to the facility one or two times prior to 8/29/2021. NA #4 indicated she was providing care to Resident #7 without any other staff ' s assistance. The NA noted she raised Resident #7 ' s bed and began to wash him and he started to swing his arms around and was trying to grab the washcloth. NA #4 indicated she changed Resident #7 ' s shirt, then took off his brief and washed his private area in the front and dried him. NA #4 said when she rolled the Resident to his side and started to wash his bottom, he was kicking his legs and he fell off the bed and onto the floor. When asked if she thought about stopping to get help when the Resident first became combative, NA #4 said" No, I just thought I would go ahead and get it done". NA #4 stated she was not sure if she had worked with Resident #7 before or not. She explained that she was an agency NA and had worked with a lot of residents. When asked how she knew how much assistance Resident #7 required, NA #4 said she got information about feeding and patient care from someone on staff, she did not know if it was a nurse or another NA, but she was only told that Resident #7 was total care. NA #4 said she	F 600	Effective 8/30/2021, the DON or designee will conduct direct observation of care audits to ensure that care is being provided according to the resident care plan and Kardex. The audits will be conducted 3 residents 3 x per week x 4 weeks, then 3 residents weekly for 8 weeks. In addition, audits of the Kardex and care plan will be conducted to ensure they complement each other. Any opportunities identified will be corrected. Effective 9/15/21, education was provided to all staff (including agency) on abuse and neglect, to include the definition of neglect with the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress along with consequences for not following the plan of care including potential negative outcome by DON or designee. Staff (including agency) not in-serviced on 9/16/21 will be in-serviced prior to their next scheduled shift. Responsible person: ED or designee Effective 9/16/2021, the Assistant Director of Nursing (ADON) or designee will add to orientation specific education regarding what constitutes neglect and handling residents with behaviors, referring to and location of the Kardex & care plan in regards to the assistance needed for care of the residents. MONITORING PROCESS	

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F 600	Continued From page 5 wanted to be clear that Resident #7 went from 20 % combative when she started his bath, to 150% combative when she started to wash his bottom. NA #4 stated she was not familiar with Kardex or Patient Care Guide, but other staff would give her a rundown on the residents she was assigned to. A nursing progress note dated 8/29/21 noted at 12:30 PM, Nurse #1 was notified by NA #4, who was assigned to Resident #7, of the fall. The note indicated the Resident became combative during care, kicking his legs and swinging his arms. NA #4 turned Resident #7 during care and the Resident slipped off the bed and fell to the floor and landed on his stomach on the fall mat which was in place. The note stated at 12:30 PM vital signs were taken and were blood pressure 138/80, pulse 52, oxygen saturation 80%. Nurse #1 cleaned the mid-forehead laceration with normal saline and applied a dry dressing. Nurse #1 was unable to assess blood on face due to not being able to move Resident #7 until Emergency Medical Services (EMS) arrived. EMS arrived 12:45PM, turned resident to lie on back while stabilizing neck, and Resident #7 became unresponsive and had no pulse. EMS began CPR, Nurse #1 assisted with chest compressions. More EMS personnel arrived to assist. Resident #7 left the facility via stretcher non-verbal, but responsive and stabilized at 1:35 PM to the hospital. Nurse #1 was interviewed on 9/15/2021 at 10:45 AM and repeated the same facts written in the progress note dated 8/29/2021. Nurse #1 stated when Resident #7 became combative NA #4 should have gotten help. On 9/15/2021 at 11:15 AM, Nurse #2 was	F 600	Effective 9/1/2021, DON or designee will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement (QAPI) Committee for any 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. The results of the audits were reviewed during the QAPI committee meeting on 9/17/21 with no identified issues. The audits will continue to be brought through the QAPI process monthly x 3 months review for need of continued monitoring or modification due to noted issues. Compliance Date: 9/16/2021	

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interviewed and stated she was paged by Nurse #1 when Resident #7 fell. Nurse #2 stated she entered the room and saw Resident #7 face down on the floor, bleeding from his head. Nurse #2 indicated Resident #7 had good vital signs, and she left the room, called 911, called the front desk to anticipate EMS arrival, went back to the room and observed Resident #7 breathing. Nurse #2 noted she called the facility physician. Nurse #2 also stated Resident #7 quit breathing when EMS turned him over, CPR was performed three separate times and then was taken to the hospital.

Resident #7 expired at the hospital on 8/30/2021. The Death Certificate signed 8/31/2021 noted the cause of death as Multiple blunt force injuries.

In an interview on 9/15/2021 at 5:01 PM, the Medical Examiner (ME) stated there were neck fractures and facial fractures and some rib fractures. The ME confirmed the cause of death as multiple blunt force injuries that resulted from a fall from the bed.

In an interview on 9/16/2021 at 10:40 AM, the Director of Nursing (DON) stated when Resident #7 was combative, two staff were needed. The DON stated NA #4 should have lowered the bed and gone for help.

On 9/17/2021 at 9:32 AM, the facility Medical Director (MD) was interviewed and stated Resident #7 was totally dependent for his care. The MD was asked about a note he wrote on an 8/12/2021 visit with Resident #7 indicating in his plan "fall precautions" and what did he mean. The MD stated it would be bed in low position, fall mat, and could progress to medications or

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medication changes. Regarding Resident #7s fall, the MD stated he got a call saying Resident #7 fell and coded.

The facility Administrator was notified of the Immediate Jeopardy on 9/16/2021 at 6:52 PM.

The facility supplied the acceptable credible allegation on 9/18/2021 at 2:45 PM.

Identification of residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 8/29/2021 CNA #4 was providing ADL care alone to Resident #7 when Resident #7 required two-person assistance for that care. CNA #4 continued to provide care alone when the Resident #7 became combative. Resident #7 fell from his raised bed onto the floor. Resident #7 was transferred to the hospital where he expired the following day. Kardex and care plan reflected 1-2 person assist. Most recent MDS dated 7/22/2021 is total dependence with two-person physical assist for bed mobility and bathing. Resident #7 was transferred to the hospital on 8/29/22021.

Healthcare Personnel Registry notified of neglect allegation with CNA #4 via faxed initial Allegation Report on 9/16/2021.

All residents with behaviors and that are dependent with care have the potential to be affected by the alleged deficient practice.
Action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when

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F 600	Continued From page 8	F 600		

the action will be complete:

On 8/30/2021, a list of residents with behaviors were obtained through reviewing the most recent MDS assessments, discussions with staff and observations and a list of assistance needed based on the MDS coding was obtained. The Nursing Consultant, Director of Operations & MDS Coordinators reviewed the MDS Assessments, Care Plans & Kardex. The Nursing Consultant, Director of Operations, MDS updated the residents Kardex & Care Plan to reflect the needed assistance for care of each resident.
All residents were reviewed by 8/30/2021 by Nursing Consultant, Director of Operations, MDS with collaboration of CNAs to ensure the following areas have been appropriately addressed:

1) Numbers of staff members needed to provide care
2) Bed surface to ensure sufficient room for turning and repositioning
3) Whether or not the resident has a physical impairment of behaviors that need to be considered.
4) Any resident that cannot assist with turning or repositioning

A Kardex will be completed by MDS or designee for each new admission, and they will be updated with the quarterly and significant change MDS and as indicated by nursing management for change in condition. All resident ' s care plans and Kardex that require updating were completed on 9/1/2021 by MDS Coordinators. The Executive Director informed them of this responsibility.

Effective 8/30/2021, all direct care staff (including agency) will be educated on the locations of the

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resident Kardex, where on the Kardex to find the information needed to ensure appropriate care is provided to the resident, by ED or designee.

Effective 8/30/2021, all direct care staff (including agency) will be educated on handling residents with behaviors as well as halting care and /or seeking assistance when a resident becomes combative, by ED or designee.

Effective 8/30/2021, all direct care staff (including agency) will be educated on related to proper technique for turning and repositioning resident (+1/+2), by the ED or designee.

Direct care staff (including agency) not in-serviced on above topics by 9/1/21 will be in-serviced prior to their next scheduled shift. Responsible person: ED or designee.

Effective 8/30/2021, the DON or designee will conduct direct observation of care audits to ensure that care is being provided according to the resident care plan and Kardex. The audits will be conducted 3 residents 3 x per week x 4 weeks, then 3 residents weekly for 8 weeks. In addition, audits of the Kardex and care plan will be conducted to ensure they complement each other. Any opportunities identified will be corrected.

Effective 9/15/21, education was provided to all staff (including agency) on abuse and neglect, to include the definition of neglect with the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress along with consequences for not following the plan of care including potential

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F 600	Continued From page 10	F 600		

negative outcome by DON or designee. Staff (including agency) not in-serviced on 9/16/21 will be in-serviced prior to their next scheduled shift. Responsible person. ED or designee.

Effective 9/16/2021, the ADON or designee will add to orientation specific education regarding what constitutes neglect and handling residents with behaviors, referring to and location of the Kardex & care plan in regards to the assistance needed for care of the residents.

The facility alleges the removal of Immediate Jeopardy on 9/16/21.

On 9/20/21 beginning at 8:55 AM multiple staff members were interviewed. This included staff in multiple disciplines; including nursing, rehabilitation, maintenance, administration, and dietary. All interviewed staff members validated they had attended in-service training regarding abuse and neglect. Interviewed staff members were able to provide examples of what constituted abuse and neglect and to whom they were to report any incidents. Nursing staff members, who were interviewed, were able to report they would stop care if dealing with combative residents and obtain the assistance and direction of their supervisor. Nursing staff members were also able to locate or verbally report where they could locate residents ' kardexs. A random resident, who was identified by staff to be cognitively intact and in need of total care assistance by two staff members, was interviewed on 9/20/21 at 9:42 AM. This resident reported he felt safe and two staff members assisted in turning and repositioning him. A second random resident, who was identified by staff to be cognitively intact and in need of total

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F 600	Continued From page 11 care assistance by two staff members, was interviewed on 9/20/21 at 9:55 AM. This resident also reported he felt safe and that two staff members turned and repositioned him. On 9/20/21 at 10:15 AM facility documents were reviewed. The facility provided documented evidence of in-service training for their staff regarding abuse/ neglect. They also provided evidence of in-service training for their direct care staff for turning repositioning, location of the Kardex and where to find information, and dealing with residents with behaviors. They facility also had documented evidence of audits completed per their credible allegation of compliance. The facility ' s credible allegation of compliance is validated for the date of 9/16/21.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		9/21/21

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F 609	Continued From page 12 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to send an initial report to the State Agency within the required time frame for 1 of 3 residents reviewed for accidents (Resident #7). Findings included: Resident #7 was readmitted to the facility on 4/3/2021 with diagnoses including dementia, history of falls, Alzheimer ' s Disease and Atrial fibrillation (irregular and often rapid heart rate). The Quarterly Minimum Data Set (MDS) dated 7/22/2021 noted Resident #7 was severely impaired for cognition and needed total assistance for all daily care with the help of two or more persons. A review of records revealed on 8/29/2021 NA #4 was giving daily care to Resident #7 in his room, in his bed. NA #4 was alone, and the Resident ' s bed was raised to the NA ' s waist height. NA #4 had washed Resident #7 and changed his shirt and removed his brief and washed and dried his front private area. NA #4 indicated Resident #7 was grabbing at the washcloth and moving his arms around, but when NA #4 rolled Resident #7	F 609	PROCESSES THAT LEAD TO THE ALLEGED DEFFICIENCY CITED On 8/29/21 the facility failed to follow the facility abuse policy with the requirement to report neglect within appropriate time frame. The Certified Nursing Assistance (CNA) providing care independently to a resident that required two persons assist with resultant fall and injury to the resident. THE PROCEDURES FOR IMPLEMENTING THE ACCEPTABLE CREDIBLE ALLEGATION Healthcare Personal Registry notified of neglect allegation with CNA #4 via faxed Initial Allegation Report on 9/16/21. Effective 9/17/2021, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to Executive Director (ED) and the Regional Director of Operation□s,	

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F 609	Continued From page 13 to his side to wash his bottom, he began to kick his legs and swing his arms. Resident #7 fell off the bed onto the floor, landing on the fall mat. Emergency Medical Services (EMS) were called and eventually, Resident #7 was taken to the hospital, where he expired the following day. In an interview on 9/15/2021 at 12:15 PM, Nursing Assistant (NA) #6 stated she had been assigned to Resident #7 in the past and knew that he was supposed to have two persons for assistance for all care, and that he was combative most of the time. The Death Certificate dated 8/31/2021 indicated the cause of death as multiple blunt force injuries. On 9/16/2021 at 10:40 AM, the Director of Nursing (DON) was interviewed and stated when Resident #7 was combative, two staff were needed for daily care. The DON stated NA #4 should have lowered the bed and gotten help. On 9/15/2021 a search in the 24-hour and 5-day investigation reporting system revealed no facility self-report for this incident. On 9/16/2021 at 6:30 PM the facility Administrator inquired if an initial 24-hour report and a 5-day investigation report would be required. She was informed it would be required. The Administrator was interviewed 9/19/2021 at 12:10 PM, and stated she was not aware at the time of the accident that she should have sent a 24-hour report. The Administrator stated she did not recognize it as neglect. The Administrator stated she sent the 24-hour report on 9/16/2021.	F 609	but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Education with all staff (including dietary, housekeeping, laundry, therapy) on abuse and neglect education. Strong emphasis on timely reporting and to whom any allegations of abuse and/or injuries of unknow origin are reported to. Education completed by 9/17/2021. Any staff not educated will be educated before they return to work. Effective 9/17/2021, the Regional Nurse Consultant will review resident all electronic nursing notes for the last 30 days to identify any other negative interactions, injuries of unknown origin or indications of abuse. This will be complete by 9/17/2021. No concerns noted. Effective 9/17/2021, the Regional Nurse Consultant will review all nursing 24-hour logs for all current residents for the last 30 day to identify any other signs of abuse and will be completed by 9/17/2021. No concerns noted.	

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F 609	Continued From page 14	F 609	100% audit was completed by the Regional Nurse Consultant for all allegation of abuse, neglect and/or injury of unknown origin submitted in the last 30 days to determine if all 24- & 5-days reports were completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed all completed reportable in the last 30 days were noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 9/17/2021 with no other concerns. The Director of Operations will in-service the Executive Director and the Director of Nursing on the Abuse Policy and reporting and the importance of following up on concerns timely by 9/17/2021. They will also be in-serviced on Reporting to the Director of Operations for supervision with each reportable who will ensure that the allegation was completely investigated. Completion date with new hire. Management Team will be educated by Administrator on abuse reporting with emphasis on timely reporting and whom to report to. This was completed on 9/17/2021. A review of the last 30 days of the grievances by the Director of Operations was completed on 9/17/2021 to ensure all areas of concern that could be a possible reportable was done so in the appropriate time frames. No areas of concern were	

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F 609	Continued From page 15	F 609	identified. A Quality Assurance Performance Improvement (QAPI) meeting was held by facility Regional Clinical Consultant on 9/17/2021 to discuss QAPI for failure to timely report. THE MONITORING PROCEDURE TO ENSURE THAT THE CREDIBLE ALLEGATION IS EFFECTIVE AND REMOVE THE ALLEGED IMMEDIATE JEOPARDY Effective 9/17/2021, Executive Director and the Director of Operations will review all alleged violation to ensure a thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. The Executive Director or designee will review the incident log daily Monday through Friday for four weeks in morning clinical meeting and then monthly for 3 months to validate that all notifications are made to the management staff and to the State Survey Agency are timely. Findings will be reported to the QAPI Committee monthly for five months recommendations or modifications until a pattern of compliance is achieved. QAPI meeting held on 9/7/21 and this plan was reviewed.	

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F 609	Continued From page 16	F 609	Effective 9/7/2021, Executive Director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any 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. TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION Effective 9/17/2021, the Executive Director is responsible for implementation. Compliance Date: 9/17/2021	
F 689 SS=J	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 staff, physician, Medical Examiner interviews and record review, the facility failed to provide supervision needed for one of three residents reviewed for falls (Resident #7), when a Nursing Assistant (NA) gave a dependent Resident (Resident #7) daily care alone when the	F 689	Past noncompliance: no plan of correction required.	9/20/21

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Resident required two person ' s assistance for that care according to the most recent assessment dated 7/22/2021. This resulted in a fall from a raised bed onto the floor. Multiple administrations of Cardio-Pulmonary Resuscitation (CPR) were required to stabilize Resident #7 prior to being taken to the hospital. Resident #7 expired the following day.

Findings included:

The care plan dated 2/19/2020 stated Resident #7 needed total assistance for all care with 1 - 2 persons. This was the active care plan. Resident #7 was readmitted to the facility on 4/3/2021. Diagnoses included dementia, history of falls, Alzheimer ' s Disease and Atrial fibrillation (irregular and often rapid heart rate).

The care plan dated 4/8/2021 listed Behavior: Exhibits aggressive behavior at times. There were general interventions: talk in calm voice, refer to Social Services for evaluation, monitor and document target behaviors, place in area where frequent observation is possible. This was reviewed 6/24/2021.

The MDS Nurse was interviewed on 9/16/2021 at 11:00 AM and stated she did not know why the care plan was so general, and she would have included the number of staff needed for each care need. The MDS Nurse did find a falls care plan dated 4/3/2021 with interventions of fall mat, bed in low position, etc. that had been resolved on 6/24/2021. The MDS Nurse stated if a resident had not had a fall for a period of time, the care plans are sometimes resolved. The MDS Nurse stated the nurses fill out the Kardex.

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The Quarterly Minimum Data Set (MDS) assessment dated 7/22/2021 indicated Resident #7 was severely impaired for cognition and needed total assistance with all daily care, with two person ' s physical assistance. The exceptions were eating and locomotion on and off unit which required one person ' s assistance. The quarterly MDS did not indicate any behaviors or rejection of care.

The Kardex (a care guide for NAs) for Resident #7 indicated the Resident was dependent on total care for all Activities of Daily Living (ADLs). Mobility was marked non-ambulatory, wheelchair, and transfers was checked with 2 assists with mechanical lift. Special care instructions were: Resident has episodes of agitation and behaviors, history of hitting/kicking at staff. The Kardex was undated.

Nurse #3 stated, in an interview on 9/16/2021 at 5:28 PM, she had reviewed the training packet with NA #4 on her first day of work in the facility. Nurse #3 stated she had reviewed information on the Kardex and resident care needs for assistance information.

NA #4 was interviewed on 9/15/2021 at 1:30 PM and stated she was working with Resident #7 on 8/29/2021 at the time of his fall from bed. NA #4 stated she had only been to the facility one or two times prior to 8/29/2021. NA #4 indicated she was providing care to Resident #7 without any other staff ' s assistance. NA #4 stated she raised Resident #7 ' s bed and began to wash him, and he started to swing his arms around trying to grab the washcloth. NA #4 indicated she changed Resident #7 ' s shirt, then took off his brief and washed his private area in front and dried him. When she rolled him to his side and started to wash his bottom, he fell off the bed and onto the

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floor. When asked if she thought about stopping to get help when the Resident first became combative, NA #4 stated "No, I just thought I would go ahead and get it done." NA #4 stated she was not sure if she had worked with Resident #7 before or not. She explained that she was an agency NA and had worked with a lot of residents. When asked how she knew how much assistance Resident #7 required, NA #4 said she got information about feeding and patient care from someone on staff, she stated she did not remember if it was a nurse or another NA but was only told that Resident #7 was total care. NA #4 stated she was not familiar with Kardex or the Patient Care Guide, but another staff member gave her a rundown on the residents she was assigned to.

A nursing progress note dated 8/29/2021 documented at 12:30 PM, Nurse #1 was notified by NA #4, who was assigned to Resident #7, of the fall. The note indicated the Resident became combative during care, kicking his legs and swinging his arms and began to slip off the bed, fell to the floor and landed on his stomach on the fall mat which was in place. The note stated vital signs were taken and were blood pressure 130/80, pulse 52, oxygen saturation 80%. Nurse #1 cleaned the mid-forehead laceration with normal saline and applied a dry dressing. Emergency Medical Services (EMS) arrived, turned the Resident over while stabilizing his neck, and Resident #7 became unresponsive with no pulse. EMS began CPR and Nurse #1 assisted with chest compressions. More EMS personnel arrived to assist. Resident #7 left the facility via stretcher non-verbal, but responsive and stabilized at 1:35 PM to the hospital.

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Nurse #1 was interviewed 9/15/2021 at 10:45 AM and stated the same facts as she wrote in the 8/29/2021 nurse progress note. Nurse #1 stated when Resident #7 became combative, NA #4 should have gotten help.

Nurse #2 was interviewed on 9/15/2021 at 11:15 AM and indicated she was paged by Nurse #1 when Resident #7 fell. Nurse #2 stated she entered the room, saw Resident #7 laying on his stomach with his head turned to the side and bleeding from his forehead. Nurse #2 indicated his vital signs were good, she left the room, called 911, called the front desk to anticipate EMS arrival, and called the facility Medical Director. Nurse #2 stated when EMS turned Resident #7 over, he quit breathing and CPR was performed three times and the Resident was taken to the hospital.

Resident #7 expired at the hospital on 8/30/2021. The Death Certificate signed 8/31/2021 noted the cause of death as multiple blunt force injuries. The Medical Examiner indicated on the death certificate the injuries occurred from a fall off the bed.

The Medical Examiner (ME) was interviewed on 9/15/2021 at 5:01 PM, and stated there were neck fractures, facial fractures, and some rib fractures. The ME confirmed the cause of death as multiple blunt force injuries that resulted from a fall from the bed.

In an interview on 9/16/2021 at 10:40 AM, the Director of Nursing (DON) stated when Resident #7 became combative, two staff were needed. The DON stated NA #4 should have lowered the bed and gone for help.

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F 689	Continued From page 21 On 9/17/2021 at 9:32 AM, the Medical Director (MD) was interviewed and stated Resident #7 was totally dependent for his care. Regarding Resident #7 ' s fall, the MD stated he got a call saying Resident #7 fell and coded. Corrective Action Plan 8/30/2021 Received 9/18/2021 12:30 PM PROCESSES THAT LEAD TO THE IDENTIFIED ISSUE On 8/29/2021 CNA #4 was providing ADL-care to Resident #7 when Resident #7 became combative, swinging his arms and legs and when CNA #4 turned Resident #7 he rolled onto the floor, sustaining a laceration to his mid-forehead. Resident #7 was transferred to the hospital where he expired. Review of Resident #7 care plan states 1-2 person assist with ADL care and most recent MDS on 7/22/2021 is total dependence with two-person physical assist for bed mobility and bathing. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED BY THE IDENTIFIED ISSUE Resident #7 care plan, Kardex and MDS were reviewed on 8/30/21 regarding Resident #7 needs. Resident #7 was transferred to the Hospital. Unable to update due to resident d/c. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLIISHED FOR RESIDENT(S) HAVING POTENTIAL TO BE AFFECTIED BY THE SAME ISSUE. All residents were reviewed by 8/30/21 by Nursing Consultant, Director of Operations, MDS with	F 689		

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collaboration of CNAs to ensure the following areas have been appropriately addressed:
1) Numbers of staff members needed to provide care
2) Bed surface to ensure sufficient room for turning and repositioning
3) Whether or not the resident has a physical impairment or behaviors that need to be considered
4) Any resident that cannot assist with turning or repositioning
The updated Kardex ' s and care plans were communicated verbally through training with all staff, including agency on 8/30/21.

ADDRESS WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE IDENTIFIED ISSUE DOES NOT OCCUR IN THE FUTURE.
Effective 8/30/2021, all direct care staff (including agency) will be educated by Interdisciplinary Team on the locations of the resident Kardex, where on the Kardex to find the information needed to ensure appropriate care is provided to the resident, by ED/Nursing Consultant.
Effective 8/30/2021, all direct care staff (including agency) will be educated by Interdisciplinary Team on handling residents with behaviors by ED/Nursing Consultant.
Effective 8/30/2021, all direct care staff (including agency) will be educated by Interdisciplinary Team related to proper technique for turning and repositioning residents (+1/+2).
Direct care staff (including agency) not in-serviced by 8/30/21 will be in-serviced prior to their next scheduled shift. Responsible person: ADON or designee.
Effective 8/30/2021, the ADON or designee will add to orientation specific education regarding

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	345561	A. BUILDING _____ B. WING _____	C 09/20/2021

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
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the Kardex to include the purpose of the Kardex and a detailed review of the information on the Kardex. As well as education on dealing with combative resident.
Effective 8/30/2021, the DON/designee will conduct direct observation of care audits to ensure that care is being provided according to the resident care plan and Kardex. The audits will be conducted 3 residents 3 x per week x 4 weeks, then 3 residents weekly for 8 weeks. These audits will be conducted on all shifts. In addition, audits of the Kardex and care plan will be conducted to ensure they complement each other. Any opportunities identified will be corrected.
All resident ' s care plans and Kardex that require updating were completed on 9/1/2021 by MDS Coordinators. The Executive Director informed them of this responsibility.

MONITORING PROCESS
QAPI meeting held on 9/1/21 and this plan was reviewed.
Effective 9/1/2021, DON or designee will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any 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.

The facility alleged full compliance with this plan of correction effective date 9/1/21.

On 9/20/21 beginning at 8:55 AM multiple direct care staff members were interviewed. These

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nursing staff members validated they had attended in-service training regarding resident safety and where to find information regarding care needs for residents. Nursing staff members, who were interviewed, were able to report they would stop care if dealing with combative residents and obtain the assistance and direction of their supervisor. Nursing staff members were also able to locate or verbally report where they could locate residents ' kardexs. A random resident, who was identified by staff to be cognitively intact and in need of total care dependence by two staff members, was interviewed on 9/20/21 at 9:42 AM. This resident reported he felt safe and two staff members assisted in turning and repositioning him. A second random resident, who was identified by staff to be cognitively intact and in need of total care assistance by two staff members, was interviewed on 9/20/21 at 9:55 AM. This resident also reported he felt safe and that two staff members turned and repositioned him. Both of these residents were observed to be in a safe position within their beds. On 9/20/21 at 10:15 AM facility documents were reviewed. The facility had documented evidence of audits completed per their credible allegation of compliance. The facility provided evidence of inservice training per their credible allegation of compliance. This included in-service training for their direct care staff regarding turning repositioning, location of the Kardex and where to find information, and dealing with residents with behaviors. Residents, who were documented to have behaviors, were verified to have this information on the kardex with instructions on how to deal with the behaviors. The facility also provided documentation that their quality assurance members met on 9/1/21 to assure continued

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F 689	Continued From page 25 compliance with their plan of correction. The facility ' s credible allegation of compliance is validated for the date of 9/1/21.	F 689		