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 01/13/2016

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews and family interview the facility failed to assure one (Resident # 1) of three sampled residents received assessment before being moved following two falls. The findings included: Record review revealed Resident # 1 resided at the facility from 11/18/15 until her discharge on 12/24/15. The resident had diagnoses of vascular dementia, a history of a stroke with residual left sided weakness, Parkinson ' s disease, and recent surgery for a fractured left hip. Review of the resident ' s Minimum Data Set (MDS) assessment, dated 12/1/15, revealed the resident was cognitively impaired and needed extensive assistance with her activities of daily living. Review of the resident ' s admission care plan, dated 12/1/15, revealed the staff had identified the resident was at risk for falls. Review of nursing notes from 11/18/15 through 12/24/15 revealed the resident sustained falls. One of these falls was entered into the resident ' s record by Nurse # 1 on 12/20/15 as a late entry for the previous day (12/19/15). The entry read, " Late entry for 12/19/15-Resident found sitting on fall mat while in room by CNA (nursing assistant-	F 309	1. Resident was transferred to the hospital on 12/24/15 and has not returned. 2. A. A falls investigation tool will be implemented, which requires licensed nurse and CNA input for completion. The tool creates the format to document appropriate care for a resident immediately following ta fall. By the DON, 1/14/16. A. A falls tracker will be put in place to address falls on a daily basis, and to assure documentation of appropriate responsiveness by staff in resident care following the fall, and in developing interventions to prevent future falls. By the DON, 1/14/16. B. Resident falls (with injury) will be reviewed by the charge nurse with the DON or RN designee within 2 hours of the fall. Appropriateness of follow up care will be reviewed and guidance given as needed for any deficient practice. Resident falls (without injury)will be reviewed by the charge nurse with the	1/31/16

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

Electronically Signed | 01/29/2016

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F 309	Continued From page 1 NA). Resident had female visitor in room at the time of incident, ...no complaints of pain. Resident back in wheelchair and in nurse ' s station with nurse. Will continue to monitor. " The last notation in the resident ' s record on 12/24/15 was entered by Nurse # 2 at 6:52 PM. This entry documented the resident ' s fall on 12/24/15. The entry read, " Resident was sitting in dining room at table reading magazines, resident removed alarm and stood up unassisted, fell onto floor. Resident complained of pain to right hip, x-ray was ordered. RP (responsible party), MD (Medical Doctor) and supervisor was notified of fall. " Review of the computerized progress notes revealed no further nursing notation on the date of 12/24/15. Review of a mobile X-ray report, dated 12/24/15 at 6:54 PM, revealed the resident had an acute displaced fracture of the right leg located above the right knee. Review of the facility ' s investigative report revealed the 12/24/15 fall, which resulted in the fracture, occurred at 5:50 PM and NA # 1 (nurse aide) responded first to the resident. Interview with the Director of Nursing (DON) on 1/13/16 at 2:15 PM revealed the resident was transferred to the hospital on 12/24/15 at 9:36 PM. Resident # 1 ' s RP (responsible party) was interviewed on 1/12/16 at 11:04 AM. The RP stated, when Resident # 1 fell on 12/19/15, the resident was the one to tell her about the fall. The RP stated she then asked staff members about the fall and learned a nurse aide had picked the resident up from the floor on 12/19/15 without notifying the nurse the resident had fallen. The RP stated she had voiced a concern to the staff members that the resident should have been assessed before the resident was moved on	F 309	DON or RN designee within 12 hours of the fall. Appropriateness of follow up care will be reviewed and guidance given as needed for any deficient practice. Beginning 1/14/16 C. Staff responsible for improper follow up or documentation will receive immediate disciplinary action. By an RN Supervisor, beginning 1/14/16. 3. A. Nursing staff will be inserviced on falls incident reporting, documentation, and follow-up. Inservice will include the specific steps to be followed following a fall, including (but not limited to): -Do Not move resident -Licensed Nurse to check vitals, range of motion, for injury, etc. Nurse to determine need to send resident out to ER. -Completion of Falls Scene Investigation -MD notification -DON notification -Family notification -Completion of incident reporting -Entry on 24 hour report and information exchange with next shift LN -Completion of falls risk assessment -Update to care plans To be completed by DON by 1/31/16. will be reviewed by the charge nurse with the DON or RN designee within 2 hours of the fall. Appropriateness of follow up care will be reviewed and guidance given as needed for any deficient practice. Beginning 1/14/16. Any staff member not in attendance will not work until the inservice training has been completed.	

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F 309	Continued From page 2 12/19/15. The RP stated on 12/24/15 the resident was again picked up by a NA following the fall which had occurred in the dining room. The RP stated there were witnesses to the incident and she had later learned the resident was not assessed by a nurse before the resident was placed back into her chair. The RP stated she was concerned the staff did not know how to act in an emergency situation since they had responded twice by picking the resident up without an assessment to assure there was no injury, and in the second incident the resident had sustained a fracture. An interview was conducted on 1/12/16 at 1:45 PM with Resident # 3 who had been in the dining room on the evening of 12/24/15 when Resident # 1 had fallen. A review of Resident # 3 ' s MDS assessment, dated 12/4/15, revealed Resident # 3 had no memory or cognitive problems. During the interview Resident # 3 was asked about any observations she might have had in the past month of staff members ' response to accidents. Resident # 3 stated Resident # 1 had fallen on 12/24/15. Resident # 3 stated the NA came quickly when the resident fell and placed the resident back in her wheel chair. Resident # 3 stated the NA " reacted upon instinct. " Resident # 3 stated her family member had been visiting in the dining room and had witnessed the resident ' s fall also. Resident # 3 ' s family member was interviewed on 1/13/16 at 10:45 AM. The family member was asked about any observations she might have had in the past month of staff members ' response to accidents. The family member recalled the incident regarding Resident # 1 on the evening of 12/24/15. The family member stated she was close to where the resident fell and described the incident as happening	F 309	B. All-staff inservice for falls prevention will be completed. By NHA, by 1/31/16. Any staff member not in attendance will not work until the inservice training has been completed. 4. A. Audit will be completed of falls incident reporting, documentation, and team review; weekly x 3 months. BY DON, beginning 1/18/16. B. Results will be reported to the QA Committee monthly, and need for further audits will be determined at that time. BY DON, beginning with Feb. 2016 QA meeting.	

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suddenly. The family member stated because of the way in which the resident fell, her right side took the complete impact of the fall and her left side took none. The family member described a staff member who immediately came. The family member stated due to the furnishings and other residents in close proximity, the resident had fallen in a very enclosed space. The family member stated the staff member started to get the resident up from the floor and asked the family member to go get a nurse. The family member stated she left and went to the nursing station to obtain help and there was a nurse at the station she told.

NA # 1 was interviewed on 1/12/16 at 3:55 PM. NA # 1 stated on 12/24/15 he was assisting residents in the dining room as they prepared for the evening meal. NA # 1 stated he stepped across the hall from the dining room to speak to a resident and heard Resident # 1 fall. NA # 1 stated the resident was complaining her leg hurt some but wasn ' t screaming in pain and he went and got Nurse # 2 who helped him get Resident # 1 up from the floor.

Nurse # 2 was interviewed on 1/12/16 at 4:20 PM and on 1/13/16 at 1 PM. Nurse # 2 stated she had been Resident # 1 ' s assigned nurse for the evening of 12/24/15. Nurse # 2 stated she had been busy with another resident at the time of the incident and had not witnessed or assessed the resident immediately following the fall before she was moved. Nurse # 2 stated she was told by another facility nurse (Nurse #3) the resident had fallen. Nurse # 2 stated the resident was already in the wheelchair when she first saw her following the fall and she was complaining of discomfort in her right leg. Nurse # 2 stated the resident was transferred to her bed and she (Nurse # 2) placed a call to the physician who ordered a portable

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x-ray. Nurse # 2 stated she called the portable x-ray company and then called and spoke to the family.
NA # 2 was interviewed on 1/12/16 at 4:35 PM and stated she had been assigned to care for Resident # 1 on the evening of 12/24/15 but had not been in the dining room when the resident fell. Interview with NA # 2 revealed she was with the resident when the resident was x-rayed and the resident was complaining her right leg hurt.
The administrator was interviewed on 1/12/16 at 3:33 PM and stated she was not aware Resident # 1 had been picked up by NAs after either of her falls on 12/19/15 or 12/24/15.
A follow up interview was conducted with the administrator on 1/13/16 at 10:20 AM. The administrator stated, during new communication with involved staff, she had verified the resident was picked up by NAs on both of the incident dates prior to a nurse assessing the resident. The administrator stated two different NAs had been involved in the two different incidents.
Regarding the first unreported fall on 12/19/15, the administrator stated the nurse aide involved in the incident had been NA # 3 and Nurse # 1 had been on duty. The administrator stated she had again spoken to Nurse # 1. The administrator stated within this new communication, she had learned NA # 3 had picked up the resident from the floor without telling Nurse # 1, and Nurse # 1 had chosen to address it with the individual NA and the information was not relayed to the administrator during the facility investigation. The administrator stated she had learned this was why the 12/19/15 fall was documented in the resident ' s medical record as a late entry. The administrator stated when she had initially investigated the fall she had thought Nurse # 1 made the late entry because she had forgotten to

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F 309	Continued From page 5 document the incident, but with the new communication she had verified with the nurse NA # 3 had not reported the fall. The administrator provided written documentation by Nurse # 1 showing Nurse # 1 had not been informed on 12/19/15 when the resident fell. Regarding the incident of 12/24/15, the administrator stated Nurse # 3 was the nurse whose assistance was obtained by the visiting family member who had witnessed the fall on the evening of 12/24/15. The administrator stated Nurse # 3 had been at the desk that evening. The administrator stated she again had spoken to Nurse # 3 since the previous interview on 1/12/16. The administrator stated Nurse # 3 verified Resident # 1 was already in the wheelchair when she went to the dining room to check on the resident and she had not helped get the resident up from the floor. The administrator stated with this new communication she had learned NA # 1 had picked up Resident # 1 before the resident could be assessed by Nurse # 3 or Nurse # 2. The administrator stated NA # 1 had not been truthful in the accounting of the incident. The administrator stated she routinely investigated falls and accidents and in both incidents regarding Resident # 1, she had focused on the events which led to the falls. The administrator stated during her investigations, which were done prior to the survey, the staff members had not relayed to her the NAs had been the ones to pick up the resident.	F 309		