**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**FLESHERS FAIRVIEW HEALTH CARE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**3016 CANE CREEK ROAD**

**FAIRVIEW, NC  28730**

**ID PREFIX** | **TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** | **ID PREFIX** | **TAG** | **PROVIDER'S PLAN OF CORRECTION** | **COMPLETION DATE**
--- | --- | --- | --- | --- | --- | ---
F 000 | SS=D | **INITIAL COMMENTS** | F 000 |  |  |  

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 684 | SS=D | **Quality of Care** | F 684 |  |  |  

§ 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

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed  

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.
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.

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
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.