PRINTED: 10/20/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	.w.			С
		345561	B. WING				/20/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	,	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
IINIVEDS	AL HEALTH CARE/FUQU	IAY VADINA		4	410 S JUDD PARKWAY SE		
UNIVERSA	AL HEALTH CARE/FUQU	JAI-VARINA		ı	FUQUAY VARINA, NC 27526		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 000	INITIAL COMMENTS	3	F	000			
	Immediate Jeopardy CFR 483.12 at tag F6 (J)	was identified at: 600 at a scope and severity					
	Past non-compliance CFR 483.25 at tag F6 (J)	was identified at: 689 at a scope and severity					
	The tags F600 and F Quality of Care.	689 constituted Substandard					
	and was removed on	for F600 began on 08/29/21					
	A partial extended su	rvev was conducted					
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F	600			9/21/21
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					
LABORATORY	l DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
	cally Signed						09/20/2021

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345561	B. WING _				20/2021	
	ROVIDER OR SUPPLIER AL HEALTH CARE/FUQU	JAY-VARINA		41	REET ADDRESS, CITY, STATE, ZIP CODE 0 S JUDD PARKWAY SE JQUAY VARINA, NC 27526	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	§483.12(a) The facilities §483.12(a) (1) Not use physical abuse, corportivoluntary seclusion. This REQUIREMENT by: Based on staff, physinterviews, and recorneglected to provide people for activities of most recent assessm (Resident #7). This rebed onto the floor. Mr. Cardio-Pulmonary Rerequired to stabilize Faken to the hospital. following day. This wreviewed for neglect. The Immediate Jeopa when Nursing Assistate dependent resident (1) when the resident recassistance for care whis raised bed onto the required CPR multiple taken to the hospital. removed on 09/16/20 and implemented an allegation of Immediate facility will remain out scope and severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second severity lepotential for minimal jeopardy) to ensure mediate in the second second severity lepotential for minimal jeopardy) to ensure mediate in the second second severity lepotential for minimal jeopardy) to ensure mediate second sec	e verbal, mental, sexual, or oral punishment, or is not met as evidenced ician, and Medical Examiner d review, the facility assistance from two or more f daily living according to the tent dated 7/22/2021 esulted in a fall from a raised cultiple administrations of esuscitation (CPR) were Resident #7 prior to being Resident #7 expired the as for one of one residents (Resident #7). andy began on 8/29/2021 ent (NA) #4 gave a Resident #7) daily care alone quired two person's hich resulted in a fall from the floor. Resident #7 et times to be stabilized to be Immediate Jeopardy was 21 when the facility provided	F6	600	PROCESSES THAT LEAD TO THE IDENTIFED ISSUE ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED IS THE IDENTIFIED ISSUE On 8/29/2021 Certified Nursing Assista (CNA) #4 was providing activities of da 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 Discet (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 on eglect allegation with CNA #4 via faxed Initial Allegation Report on 9/16/21. ADDRESS HOW CORRECTIVE ACTION RESIDENT(S) HAVING POTENTIAL TOTAL TOT	nt ily he ent r. 2 ata		

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		345561	B. WING	-	09	0/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE		
				410 S JUDD PARKWAY SE			
UNIVERSA	AL HEALTH CARE/FU	JQUAY-VARINA		FUQUAY VARINA, NC 27526			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
F 600	Continued From p	page 2	F 60	200			
				BE AFFECTED BY THE SAM	ME ISSUE		
	Findings included			BE AFFECTED BY THE SAM	VIE ISSUE		
	Findings included	•		All residents with behaviors a	and that are		
	The care plan dat	ed 2/19/2020 stated Resident		dependent with care have the			
		ssistance for all care with 1-2		be affected by the alleged de			
		s the active care plan.		practice.	HOICH		
	persons. This was	stile delive dale plan.		On 9/16/21, a list of residents	s with		
	Resident #7 was i	readmitted on 4/3/2021 with		behaviors were obtained thro			
		ng dementia, history of falls,		reviewing the most recent M			
		ase, and atrial fibrillation		assessments, discussions w			
(irregular and often rapid heart rate).				observations and a list of ass			
	()	,		needed based on the MDS of			
	The care plan dat	ed 4/8/2021 listed Behavior:		obtained. The Nursing Cons	sultant,		
		e behavior at times. There		Director of Operations & MD			
	were general inter	rventions listed: talk in calm		Coordinators reviewed the M	IDS		
	voice, refer to Soc	cial Services for evaluation,		Assessments, Care Plans &	Kardex. The		
	monitor and docu	ment target behaviors, place in		Nursing Consultant, Director	of		
	area where freque	ent observation is possible. This		Operations, MDS updated th	e residents		
	care plan was rev	iewed 6/24/2021.		Kardex & Care Plan to reflect assistance for care of each reflect.			
	On 9/16/2021 at 1	1:00 AM, the MDS Nurse was					
	interviewed and s	tated she did not know why the		All residents were reviewed I	by 8/30/21 by		
	care plan was so	general, and she would have		Nursing Consultant, Director	of		
	put the number of	staff needed for each care		Operations, MDS with collab	oration of		
	need. The MDS N	lurse found a fall care plan from		CNAs to ensure the following	ງ areas have		
	4/3/21 with an inte	ervention for fall mat indicated.		been appropriately addresse	d:		
		s resolved on 6/24/21. The MDS		Numbers of staff member	s needed to		
		esident with a fall care plan		provide care			
		all for a period of time, the care		Bed surface to ensure sur	fficient room		
	1 -	metimes resolved. The MDS		for turning and repositioning			
	Nurse stated the r	nurses fill out the Kardex.		3) Whether or not the reside			
				physical impairment or beha	viors that		
		nimum Data Set (MDS) dated		need to be considered			
		Resident #7 was severely		4) Any resident that cannot a	assist with		
		ition and required total		turning or repositioning			
		care needs with the assistance		A IZ-ad-a-adul	··· MDO ·		
		rsons. The exceptions were		A Kardex will be completed by	•		
		otion on and off unit which		designee for each new admi-			
	requirea one pers	on ' s assist. The quarterly MDS		they will be updated with the	quarterly and		

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		345561	B. WING			1	20/2021
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	091.	20/2021
TO THE OT TH	COVIDER OF CONTRIEN				10 S JUDD PARKWAY SE		
UNIVERSA	AL HEALTH CARE/FUQU	AY-VARINA					
					UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	÷ 3	F (600			
F 600	did not indicate any b The Kardex (a care g Resident #7 was dependent #7 was assists with mechanic instructions were: Reagitation and behavior at staff. The Kardex w NA #6 was interviewed PM, and stated she wand his care needs restated Resident #7 was affected #7 was affected #7 was in station. On 9/15/2021 at 12:3 worked for the facility knew where the Kard Kardex said two staff	uide for NAs) indicated endent on total care for all as marked non-ambulatory, fers was checked with 2 cal lift. Special care sident has episodes of rs, history of hitting/kicking was undated. ed on 9/15/2021 at 12:15 was familiar with Resident #7 equired two staff. NA #6 as combative most days. NA formation for care was in the a binder in the nurse 's 3 PM NA #2 stated he through an agency. NA #2 ex was and stated if the were needed for a resident '	F	600	significant change MDS and as indicate 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 (I informed them of this responsibility. ADDRESS WHAT MEASURES WILL E 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 locations of the resident Kardex, where the Kardex to find the information need to ensure appropriate care is provided the resident, by ED or designee. Effective 8/30/2021, all direct care staff (including agency) will be educated on	ED) ED) the con ed to	
	and stated she was wan agency. NA #7 stated was and if she care needs, she would the hall. On 9/15/2021 at 3:25 and stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infine she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infineeds in the Kardex by the stated she was a she would look for infine she was a she was a she would look for infine she was a she wa	and on 9/15/2021 at 3:15 PM vorking at the facility through at the she knew what the e had any questions about d ask the nurse in charge of PM, NA #8 was interviewed in agency NA. NA #8 stated formation about resident 's put would ask the nurse on sure about resident care			handling resident with behaviors as we as halting care and/or seeking assistan when a resident becomes combative, be ED or designee. Effective 8/30/2021, all direct care staff (including agency) will be educated related to proper technique for turning a repositioning residents (+1/+2), by the lor designee. Direct care staff (including agency) not in-serviced on above topics by 9/1/21 where in-serviced prior to their next scheduled shift. Responsible person: E or designee	ece by and ED	

		(X3) DATE COMP	SURVEY LETED					
		345561	B. WING _				20/2021	
NAME OF PI	ROVIDER OR SUPPLIER		<u>'</u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	,		
				41	IO S JUDD PARKWAY SE			
UNIVERSA	AL HEALTH CARE/FUQU	AY-VARINA		Fl	UQUAY VARINA, NC 27526			
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F 600	Continued From page	÷ 4	F 6	600				
	PM, and stated she rewith NA #4 on her first Nurse #3 stated she and resident care need information.				Effective 8/30/2021, the DON or design 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 than 3 residents weekly for 9	•		
	and stated she was w 8/29/2021 at the time #4 stated she had be earlier to feed him browns not combative, a	interviewed on 9/15/2021 at 1:30 PM, she was working with Resident #7 on at the time of his fall from the bed. NA she had been in Resident #7 's room eed him breakfast, and the Resident imbative, ate all his breakfast, and she			weeks, then 3 residents weekly for 8 weeks. In addition, audits of the Karde and care plan will be conducted to ens they complement each other. Any opportunities identified will be corrected	ure d.		
	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				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 provided and services necessary to avoice physical harm, mental anguish, or emotional distress along with consequences for not following the plant.	s vide		
	washed his private ar him. NA #4 said wher his side and started to kicking his legs and hithe floor. When asked stopping to get help with became combative, Ni would go ahead and she was not sure if she was	then took off his brief and ea in the front and dried in she rolled the Resident to be wash his bottom, he was e fell off the bed and onto d if she thought about when the Resident first IA #4 said" No, I just thought get it done". NA #4 stated he had worked with Resident explained that she was an worked with a lot of d how she knew how much #7 required, NA #4 said she			care including potential negative outco by DON or designee. Staff (including agency) not in-serviced on 9/16/21 will in-serviced prior to their next scheduler shift. Responsible person: ED or designee of Nursing (ADON) or designee will advorted in the specific education regarding what constitutes neglect and handling residents with behaviors, referring to all location of the Kardex & care plan in regards to the assistance needed for control of the specific education	me be d nee ctor d to		
	got information about from someone on sta a nurse or another N	feeding and patient care ff, she did not know if it was A, but she was only told that care. NA #4 said she			of the residents. MONITORING PROCESS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345561	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE/FUQ	UAY-VARINA	•	STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	
F 600	% combative when see combative when she NA #4 stated she was Patient Care Guide, a rundown on the real A nursing progress of 12:30 PM, Nurse #1 was assigned to Resident Resident Resident Resident Resident slipped off and landed on his st was in place. The notice signs were taken and 138/80, pulse 52, ox #1 cleaned the midnormal saline and all #1 was unable to as being able to move I Medical Services (E 12:45PM, turned resistabilizing neck, and unresponsive and has CPR, Nurse #1 assist compressions. More assist. Resident #7 I non-verbal, but resp PM to the hospital. Nurse #1 was intervial. Nurse #1 was intervial. Nurse #1 was intervial. Nurse #1 was intervial. Nurse #1 was intervial.	anat Resident #7 went from 20 she started his bath, to 150% a started to wash his bottom. As not familiar with Kardex or but other staff would give her sidents she was assigned to. Anote dated 8/29/21 noted at was notified by NA #4, who sident #7, of the fall. The note ent became combative during and swinging his arms. NA #7 during care and the the bed and fell to the floor omach on the fall mat which bote stated at 12:30 PM vital divere blood pressure tygen saturation 80%. Nurse forehead laceration with oplied a dry dressing. Nurse seess blood on face due to not Resident #7 until Emergency MS) arrived. EMS arrived aident to lie on back while Resident #7 became and no pulse. EMS began sted with chest EMS personnel arrived to eff the facility via stretcher onsive and stabilized at 1:35 seewed on 9/15/2021 at 10:45 as same facts written in the 8/29/2021. Nurse #1 stated ecame combative NA #4	F6	Effective 9/1/2021, DON or report findings of this more to the facility Quality Assumer Performance Improvement Committee for any addition or modification of this plan months, or until the patternis maintained. The QAPI modify this plan to ensure remains in substantial continuing the QAPI committee 9/17/21 with no identified audits will continue to be the QAPI process monthly review for need of continuing modification due to noted Compliance Date: 9/16/20	nitoring procesurance and nt (QAPI) onal monitoring n monthly x 3 m of complian committee care the facility mpliance. were reviewed be meeting on issues. The brought through y x 3 months used monitoring issues.	g ce n

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		345561	B. WING		C 09/20/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE/FUQI	JAY-VARINA		STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526	1 00/20/2021
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F 600	#1 when Resident #7 entered the room and on the floor, bleeding indicated Resident # she left the room, ca to anticipate EMS ar and observed Residented she called the also stated Resident turned him over, CPI separate times and thospital. Resident #7 expired The Death Certificate cause of death as M In an interview on 9/ Medical Examiner (Noractures and facial fractures. The ME coas multiple blunt force a fall from the bed. In an interview on 9/ Director of Nursing (1/2) was combative, to DON stated NA #4 sond gone for help. On 9/17/2021 at 9:32 Director (MD) was in Resident #7 was total The MD was asked a 8/12/2021 visit with Figlan "fall precautions MD stated it would be	ed she was paged by Nurse 7 fell. Nurse #2 stated she d saw Resident #7 face down g from his head. Nurse #2 7 had good vital signs, and lled 911, called the front desk rival, went back to the room ent #7 breathing. Nurse #2 facility physician. Nurse #2 #7 quit breathing when EMS R was performed three	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY MPLETED
		345561	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526		33/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	the MD stated he got fell and coded. The facility Administr Immediate Jeopardy The facility supplied allegation on 9/18/20 Identification of resid are likely to suffer, a a result of the noncoden on 8/29/2021 CN alone to Resident #7 two-person assistant continued to provide Resident #7 became	Regarding Resident #7s fall, a call saying Resident #7 ator was notified of the on 9/16/2021 at 6:52 PM. the acceptable credible 21 at 2:45 PM. ents who have suffered, or serious adverse outcome as impliance: A #4 was providing ADL care when Resident #7 required the for that care. CNA #4 care alone when the combative. Resident #7 fell	F6			
	was transferred to the the following day. Ka 1-2 person assist. Mo 7/22/2021 is total dephysical assist for be Resident #7 was trans/29/22021. Healthcare Personne allegation with CNA Report on 9/16/2021 All residents with bed dependent with care affected by the allegal Action the entity will system failure to previous present assistance.	naviors and that are have the potential to be				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	the action will be com On 8/30/2021, a list of were obtained throug MDS assessments, dobservations and a list based on the MDS consultant, I MDS Coordinators reconsultant, Director of the residents Kardex needed assistance for All residents were revolved as in the consultant, I with collaboration of Collabo	of residents with behaviors he reviewing the most recent discussions with staff and set of assistance needed ording was obtained. The Director of Operations & Viewed the MDS Plans & Kardex. The Nursing of Operations, MDS updated & Care Plan to reflect the or care of each resident. Viewed by 8/30/2021 by Director of Operations, MDS CNAs to ensure the following ropriately addressed: Interpretation of the company of the comp	F 600		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345561	B. WING _			C 09/20/2021		
	ROVIDER OR SUPPLIER	QUAY-VARINA		STREET ADDRESS, CITY, STATE, ZIP COD 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526		90,20,202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 600	information needed provided to the residency provided to the residency) will be educe with behaviors as we seeking assistance combative, by ED of Effective 8/30/2021, agency) will be educe technique for turning (+1/+2), by the ED of Direct care staff (inclin-serviced on abovin-serviced prior to the Responsible personneed Effective 8/30/2021, conduct direct obseensure that care is the resident care plate be conducted 3 residenced addition, audits of the serviced prior to the resident care plate to conducted 3 residenced addition, audits of the serviced prior to the resident care plate to conducted 3 residenced addition, audits of the serviced prior to the resident care plate to conducted 3 residenced addition, audits of the serviced prior to the serviced prior	lere on the Kardex to find the to ensure appropriate care is dent, by ED or designee. all direct care staff (including cated on handling residents ell as halting care and /or when a resident becomes r designee. all direct care staff (including cated on related to proper g and repositioning resident or designee. cluding agency) not e topics by 9/1/21 will be heir next scheduled shift.	Fé	600				
	other. Any opportuncorrected. Effective 9/15/21, edited including ager include the definition the facility, its employerovide goods and sphysical harm, mendistress along with or corrected.	ducation was provided to all ncy) on abuse and neglect, to n of neglect with the failure of oyees, or service providers to services necessary to avoid tal anguish, or emotional consequences for not force including potential						

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		345561	B. WING _				C 20/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 007	LU/LUL I
				4	110 S JUDD PARKWAY SE		
UNIVERSA	AL HEALTH CARE/FUQU	IAY-VARINA		F	FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 10	F 6	300			
	(including agency) no be in-serviced prior to Responsible person.	DON or designee. Staff of tin-serviced on 9/16/21 will of their next scheduled shift. ED or designee. The ADON or designee will					
	add to orientation spe what constitutes negl with behaviors, referr	ecific education regarding ect and handling residents ing to and location of the regards to the assistance					
	The facility alleges th Jeopardy on 9/16/21.	e removal of Immediate					
	members were interv multiple disciplines; ir rehabilitation, maintel dietary. All interviewe they had attended in-	nance, administration, and d staff members validated service training regarding nterviewed staff members					
	were to report any inc	interviewed, were able to					
	combative residents a and direction of their members were also a report where they cou	and obtain the assistance supervisor. Nursing staff able to locate or verbally ald locate residents '					
	by staff to be cognitive care assistance by two interviewed on 9/20/2 reported he felt safe assisted in turning an second random residence.	esident, who was identified ely intact and in need of total to staff members, was and the staff members d repositioning him. A ent, who was identified by					
	staff to be cognitively	intact and in need of total					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		245504		_			С
NAME OF PI	ROVIDER OR SUPPLIER	345561	B. WING	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	20/2021
UNIVERSA	AL HEALTH CARE/FUQU	IAY-VARINA			10 S JUDD PARKWAY SE		
			1	Fl	UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609 SS=D	interviewed on 9/20/2 also reported he felt is members turned and 9/20/21 at 10:15 AM reviewed. The facility evidence of in-service regarding abuse/ neg evidence of in-service staff for turning repos Kardex and where to with residents with be had documented evid per their credible alleged. The facility 's credible validated for the date Reporting of Alleged. CFR(s): 483.12(c)(1)(1)(1)(1)(2)(1)(2)(2)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	to staff members, was at 1 at 9:55 AM. This resident safe and that two staff repositioned him. On facility documents were provided documented a training for their staff lect. They also provided a training for their direct care litioning, location of the find information, and dealing shaviors. They facility also lence of audits completed gation of compliance. Le allegation of compliance is of 9/16/21. Violations (4) See to allegations of abuse, or mistreatment, the facility		600			9/21/21

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3)) DATE SURVEY COMPLETED
		345561	B. WING			C 09/20/2021
NAME OF P	ROVIDER OR SUPPLIER	1 2.222		STREET ADDRESS, CITY, STATE, ZIP (I CODE	09/20/2021
				410 S JUDD PARKWAY SE		
UNIVERSA	AL HEALTH CARE/FUC	QUAY-VARINA		FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO TO THE PROVIDER OF THE PROVIDER O	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	procedures. §483.12(c)(4) Repo investigations to the	rt the results of all administrator or his or her	F 6	509		
	designated represed accordance with State Survey Agency, with incident, and if the appropriate correction This REQUIREMENT by: Based on record refacility failed to send Agency within the research such accordance within the research services.	ntative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified we action must be taken. IT is not met as evidenced view and staff interview, the d an initial report to the State equired time frame for 1 of 3 for accidents (Resident #7).		PROCESSES THAT LEAR ALLEGED DEFFICIENCY On 8/29/21 the facility faile facility abuse policy with the to report neglect within apprentice.	CITED ed to follow the ne requirement	
	Resident #7 was rea 4/3/2021 with diagn history of falls, Alzh	admitted to the facility on oses including dementia, eimer 's Disease and Atrial and often rapid heart rate).		frame. The Certified Nursin (CNA) providing care indep resident that required two with resultant fall and injur- resident.	ng Assistance pendently to a persons assist	
	7/22/2021 noted Re impaired for cognition	num Data Set (MDS) dated sident #7 was severely on and needed total illy care with the help of two or		THE PROCEDURES FOR IMPLEMENTING THE ACCOREDIBLE ALLEGATION Healthcare Personal Register allegation with CNA	CEPTABLE	
	was giving daily car in his bed. NA #4 was bed was raised to the had washed Reside and removed his bri front private area. Nowas grabbing at the	revealed on 8/29/2021 NA #4 e to Resident #7 in his room, as alone, and the Resident 's he NA 's waist height. NA #4 nt #7 and changed his shirt ef and washed and dried his lA #4 indicated Resident #7 washcloth and moving his hen NA #4 rolled Resident #7		Initial Allegation Report on Effective 9/17/2021, All alle involving abuse, neglect, e mistreatment, including injunknown source and misal resident property, are repoimmediately to Executive I and the Regional Director	9/16/21. eged violations exploitation or uries of ppropriation of orted Director (ED)	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(С
		345561	B. WING			09/	20/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
IINIVERSA	AL HEALTH CARE/FUQI	ΙΔΥ-VΔΡΙΝΔ		4	10 S JUDD PARKWAY SE		
ONIVERSA	AL IILALIII CANLII OQI	ZAI-VAIXINA		F	UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag	e 13	F	309			
		is bottom, he began to kick		500	but not later than 2 hours after the		
		s arms. Resident #7 fell off			allegation is made, if the events that		
		r, landing on the fall mat.			cause the allegation involve abuse or		
		Services (EMS) were called			result in serious bodily injury, or not late	or	
		dent #7 was taken to the			than 24 hours if the events that cause the		
	•	rpired the following day.			allegation do not involve abuse and do		
	nospital, where he ca	chied the following day.			result in serious bodily injury, to the	1101	
	In an interview on 9/	15/2021 at 12:15 PM,			administrator of the facility and to other		
		A) #6 stated she had been			officials (including to the State Survey		
		t #7 in the past and knew			Agency and adult protective services		
	_	d to have two persons for			where state law provides for jurisdiction	liction in ance	
	assistance for all car	•			long-term care facilities) in accordance		
	combative most of th	e time.			with State law through established		
					procedures.		
	The Death Certificate	e dated 8/31/2021 indicated					
	the cause of death as	s multiple blunt force injuries.			Education with all staff (including dietal housekeeping, laundry, therapy) on ab		
	On 9/16/2021 at 10:4	10 AM, the Director of			and neglect education. Strong emphas	sis	
	Nursing (DON) was i	nterviewed and stated when			on timely reporting and to whom any		
		nbative, two staff were			allegations of abuse and/or injuries of		
		e. The DON stated NA #4			unknow origin are reported to. Education	nc חכ	
	should have lowered	the bed and gotten help.			completed by 9/17/2021. Any staff not		
					educated will be educated before they		
		ch in the 24-hour and 5-day			return to work.		
		g system revealed no facility			Effective 0/47/2004 the Demicro 121	_	
	self-report for this inc	ciaeni.			Effective 9/17/2021, the Regional Nurs	е	
	0:- 0/40/0004 -+ 0:00	DAA da a fa cilita A daccimintanda a			Consultant will review resident all		
		PM the facility Administrator			electronic nursing notes for the last 30		
		4-hour report and a 5-day vould be required. She was			days to identify any other negative	or	
	informed it would be				interactions, injuries of unknown origin indications of abuse. This will be comp		
		·			by 9/17/2021. No concerns noted.	ele	
		as interviewed 9/19/2021 at			F##: 0/47/0004 # D : 111	_	
	•	d she was not aware at the			Effective 9/17/2021, the Regional Nurs	-	
		hat she should have sent a			Consultant will review all nursing 24-ho		
	'	Administrator stated she did			logs for all current residents for the last		
		eglect. The Administrator			day to identify any other signs of abuse		
	stated sne sent the 2	4-hour report on 9/16/2021.			and will be completed by 9/17/2021. N concerns noted.	U	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345561	B. WING		C 00/20	V2024
	ROVIDER OR SUPPLIER AL HEALTH CARE/FUQU			STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526	09/20	72021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	Continued From pag	e 14	F 60	100% audit was completed by the Regional Nurse Consultant for all allegation of abuse, neglect and/o of unknown origin submitted in the days to determine if all 24- & 5-da reports were completed and submithe state agency as required by reand Elder Justice Act in a timely in The audit revealed all completed reportable in the last 30 days were with detail investigation and the A Perpetrator(s) were suspended. The was completed on 9/17/2021 with concerns. The Director of Operations will inthe Executive Director and the Director and the Director of Operations for superviseach reportable who will ensure the allegation was completely investige Completion date with new hire. Management Team will be educated Administrator on abuse reporting emphasis on timely reporting and to report to. This was completed 9/17/2021. A review of the last 30 days of the grievances by the Director of Operation of	or injury e last 30 ays nitted to egulation manner. ee noted illeged This audit i no other eservice rector of reporting p on ey will to the sion with hat the gated. ted by with whom on erations nsure all possible propriate	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345561	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	343361	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/20/2021
	AL HEALTH CARE/FUQU	JAY-VARINA		410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 609	Continued From page	e 15	F 60	identified. A Quality Assurance Performance Improvement (QAPI) meeting was held 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 revie all alleged violation to ensure a thoroug investigation is completed and reported the state agency and other officials as required by regulation and/or Elder Jus 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 mornin clinical meeting and then monthly for 3 months to validate that all notifications made to the management staff and to the State Survey Agency are timely. Finding will be reported to the QAPI Committee monthly for five months recommendation or modifications until a pattern of compliance is achieved. QAPI meeting held on 9/7/21 and this passed in the pattern of compliance is achieved.	ew gh d to stice I are the ngs e ons

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345561	B. WING _			09/	20/2021
	ROVIDER OR SUPPLIER	AV VA BINA			REET ADDRESS, CITY, STATE, ZIP CODE 0 S JUDD PARKWAY SE		
UNIVERSA	AL HEALTH CARE/FUQU	AY-VARINA		Fl	JQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 SS=J	CFR(s): 483.25(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ards/Supervision/Devices (2)		609	Effective 9/7/2021, Executive Director of report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee 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 plate on ensure the facility remains in substantial compliance. TITLE OF THE PERSON RESPONSIB FOR IMPLEMENTING THE CREDIBLE ALLEGATION Effective 9/17/2021, the Executive Director is responsible for implementation. Compliance Date: 9/17/2021 Past noncompliance: no plan of correction required.	for on I I. Ian	9/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345561	B. WING _			C 09/20/2021	
	ROVIDER OR SUPPLIER	UAY-VARINA		STREET ADDRESS, CITY, STATE, ZIP COL 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526)E	0.20,202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	that care according assessment dated 7 fall from a raised be administrations of C Resuscitation (CPR Resident #7 prior to Resident #7 prior to Resident #7 expired Findings included: The care plan dated #7 needed total assipersons. This was the Resident #7 was read 4/3/2021. Diagnoses of falls, Alzheimer's (irregular and often the Care plan dated Exhibits aggressive were general interverser to Social Service and document target where frequent observiewed 6/24/2021 The MDS Nurse was 11:00 AM and stated care plan was so ge included the number care need. The MDS plan dated 4/3/2021 bed in low position, on 6/24/2021. The MDS had not had a fall for the fall fall for the fall fall for the fall fall fall fall fall fall fall fal	vo person 's assistance for to the most recent //22/2021. This resulted in a d onto the floor. Multiple ardio-Pulmonary were required to stabilize being taken to the hospital. The following day. 2/19/2020 stated Resident stance for all care with 1 - 2 me active care plan. Admitted to the facility on a included dementia, history is Disease and Atrial fibrillation rapid heart rate). 4/8/2021 listed Behavior: behavior at times. There entions: talk in calm voice, coes for evaluation, monitor to behaviors, place in area envation is possible. This was seen interviewed on 9/16/2021 at d she did not know why the meral, and she would have of staff needed for each is Nurse did find a falls care with interventions of fall mat, etc. that had been resolved MDS Nurse stated if a resident of a period of time, the care is resolved. The MDS Nurse	F	589			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345561	B. WING _			1	20/2021	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2021	
				410	0 S JUDD PARKWAY SE			
UNIVERSA	AL HEALTH CARE/FUQU	IAY-VARINA			JQUAY VARINA, NC 27526			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 689	Continued From page	e 18	F 6	589				
F 689	The Quarterly Minimulassessment dated 7/2 #7 was severely impared of total assistant two person 's physical exceptions were eating unit which required on the quarterly MDS disported on t	um Data Set (MDS) 22/2021 indicated Resident aired for cognition and ce with all daily care, with al assistance. The ng and locomotion on and off ne person 's assistance. d not indicate any behaviors uide for NAs) for Resident dent was dependent on total of Daily Living (ADLs). non-ambulatory, wheelchair, ecked with 2 assists with al care instructions were: es of agitation and nitting/kicking at staff. The in interview on 9/16/2021 at riewed the training packet at day of work in the facility. nad reviewed information on ent care needs for	F	589				
	8/29/2021 at the time stated she had only b	of his fall from bed. NA #4 been to the facility one or two 21. NA #4 indicated she was						
	providing care to Res staff's assistance. N Resident #7's bed a he started to swing hi the washcloth. NA #4 Resident #7's shirt, washed his private ar When she rolled him	ident #7 without any other A #4 stated she raised nd began to wash him, and s arms around trying to grab indicated she changed then took off his brief and rea in front and dried him. to his side and started to fell off the bed and onto the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345561	B. WING _				20/2021
	ROVIDER OR SUPPLIER	AY-VARINA		410	REET ADDRESS, CITY, STATE, ZIP CODE S JUDD PARKWAY SE QUAY VARINA, NC 27526	1 03/	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	to get help when the combative, NA #4 sta would go ahead and ghe was not sure if sh #7 before or not. She agency NA and had we residents. When aske assistance Resident # got information about from someone on staremember if it was a ronly told that Resider stated she was not fa Patient Care Guide, be gave her a rundown consigned to. A nursing progress not documented at 12:30 by NA #4, who was at the fall. The note indiccombative during care swinging his arms and fell to the floor and lar fall mat which was in signs were taken and 130/80, pulse 52, oxy #1 cleaned the mid-fonormal saline and app Emergency Medical Sturned the Resident on neck, and Resident # no pulse. EMS began assisted with chest copersonnel arrived to a series of the start of the sta	Resident first became ted "No, I just thought I get it done." NA #4 stated he had worked with Resident explained that she was an worked with a lot of ad how she knew how much at required, NA #4 said she feeding and patient care ff, she stated she did not hurse or another NA but was at #7 was total care. NA #4 miliar with Kardex or the but another staff member on the residents she was notified ssigned to Resident #7, of cated the Resident became the, kicking his legs and do began to slip off the bed, anded on his stomach on the place. The note stated vital were blood pressure gen saturation 80%. Nurse the place is a dry dressing. Services (EMS) arrived, over while stabilizing his 7 became unresponsive with CPR and Nurse #1 ompressions. More EMS assist. Resident #7 left the on-verbal, but responsive	F	689			

		COMF	(3) DATE SURVEY COMPLETED				
		345561	B. WING _				C 20/2021
	ROVIDER OR SUPPLIER	UAY-VARINA		410 S	T ADDRESS, CITY, STATE, ZIP CODE JUDD PARKWAY SE JAY VARINA, NC 27526	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pag	e 20	F	889			
	and stated the same 8/29/2021 nurse pro when Resident #7 be should have gotten h	ewed on 9/15/2021 at 11:15					
	when Resident #7 feentered the room, sa stomach with his head bleeding from his for his vital signs were go 911, called the front arrival, and called the Nurse #2 stated when over, he quit breathing	e was paged by Nurse #1 ill. Nurse #2 stated she aw Resident #7 laying on his ad turned to the side and behead. Nurse #2 indicated good, she left the room, called desk to anticipate EMS e facility Medical Director. In EMS turned Resident #7 Ing and CPR was performed Resident was taken to the					
	The Death Certificate cause of death as m The Medical Examin	at the hospital on 8/30/2021. e signed 8/31/2021 noted the ultiple blunt force injuries. er indicated on the death s occurred from a fall off the					
	9/15/2021 at 5:01 PN neck fractures, facia fractures. The ME co	er (ME) was interviewed on M, and stated there were I fractures, and some rib onfirmed the cause of death se injuries that resulted from					
	Director of Nursing (#7 became combative	16/2021 at 10:40 AM, the DON) stated when Resident ve, two staff were needed. #4 should have lowered the lp.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED
		345561	B. WING _			C 09/20/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE/FUQI	JAY-VARINA		STREET ADDRESS, CITY, S 410 S JUDD PARKWAY S FUQUAY VARINA, NC	E	33/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD		
F 689	Continued From pag	e 21	F	689		
	(MD) was interviewe was totally depender	2 AM, the Medical Director d and stated Resident #7 nt for his care. Regarding he MD stated he got a call ell and coded.				
	9/18/2021 12:30 PM PROCESSES THAT ISSUE On 8/29/2021 CNA # Resident #7 when R combative, swinging CNA #4 turned Resid floor, sustaining a lac Resident #7 was tran he expired. Review of states 1-2 person as recent MDS on 7/22/	LEAD TO THE IDENTIFIED 44 was providing ADL-care to				
	BE ACCOMPLISHED FOUND TO HAVE B IDENTIFIED ISSUE Resident #7 care pla reviewed on 8/30/21 needs. Resident #7 Hospital. Unable to UNADDRESS HOW COBE ACCOMPLIISHE HAVING POTENTIA THE SAME ISSUE.	DRRECTIVE ACTION WILL D FOR RESIDENT(S) EEN AFFECTED BY THE In, Kardex and MDS were regarding Resident #7 was transferred to the update due to resident d/c. DRRECTIVE ACTION WILL D FOR RESIDENT(S) L TO BE AFFECTIED BY viewed by 8/30/21 by Nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345561	B. WING			l '	20/2021
	ROVIDER OR SUPPLIER	AY-VARINA	1	4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 S JUDD PARKWAY SE UQUAY VARINA, NC 27526	0311	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	areas have been app 1) Numbers of staff mages 2) Bed surface to ensiturning and reposition 3) Whether or not the impairment or behavious considered 4) Any resident that or repositioning The updated Kardex communicated verbal staff, including agence ADDRESS WHAT MEPLACE OR SYSTEM ENSURE THAT THE NOT OCCUR IN THE Effective 8/30/2021, agency) will be educated to ensure app the resident, by ED/N Effective 8/30/2021, agency) will be educated to ensure app the resident, by ED/N Effective 8/30/2021, agency) will be educated to ensure app the resident of the r	s to ensure the following ropriately addressed: nembers needed to provide sure sufficient room for ning resident has a physical ors that need to be annot assist with turning or s and care plans were lly through training with all y on 8/30/21. EASURES WILL BE PUT IN IC CHANGES MADE TO IDENTIFIED ISSUE DOES FUTURE. all direct care staff (including ated by Interdisciplinary so of the resident Kardex, to find the information propriate care is provided to lursing Consultant. all direct care staff (including ated by Interdisciplinary sidents with behaviors by int. all direct care staff (including ated by Interdisciplinary er technique for turning and is (+1/+2).	F	689			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	` '	OATE SURVEY OMPLETED
		345561	B. WING			C 09/20/2021
	ROVIDER OR SUPPLIER AL HEALTH CARE/FUQU	JAY-VARINA		STREET ADDRESS, CITY, STATE, ZIP CODE 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526	,	33/23/2321
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	and a detailed review Kardex. As well as excombative resident. Effective 8/30/2021, conduct direct observensure that care is be the resident care plan be conducted 3 reside weeks, then 3 reside These audits will be addition, audits of the be conducted to ensiother. Any opportunit corrected. All resident 's care pupdating were compl Coordinators. The Exthem of this responsi MONITORING PROQUAPI meeting held or eviewed. Effective 9/1/2021, Dindings of this monitoring or modification of the parameter of the properties of the facility alleged for correction effective on 9/20/21 beginning	e the purpose of the Kardex of of the information on the ducation on dealing with the DON/designee will vation of care audits to being provided according to an and Kardex. The audits will ents 3 x per week x 4 ants weekly for 8 weeks. Conducted on all shifts. In a Kardex and care plan will the they complement each dies identified will be a lans and Kardex that require eted on 9/1/2021 by MDS accutive Director informed bility. CESS on 9/1/21 and this plan was a conducted on the facility and Performance the for any additional action of this plan monthly x 3 and the	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345561	B. WING _				20/2021
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	20/2021
LININ/EDO	AL LICALTU CARCICUOL	IAV VA DINIA		41	IO S JUDD PARKWAY SE		
UNIVERSAL HEALTH CARE/FUQUAY-VARINA				F	UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI 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 24		F	689			
	REGULATORY OR LSC IDENTIFYING INFORMATION)			009			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) D.	(X3) DATE SURVEY COMPLETED	
		345561	B. WING _			C 09/20/2021	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/FUQUAY-VARINA				STREET ADDRESS, CITY, STATE, ZIP COD 410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526		03/20/2021	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	compliance with their	plan of correction. e allegation of compliance is	F6	89			