

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 345449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2020
NAME OF PROVIDER OF SUPPLIER UNIVERSAL HEALTH CARE/KING		STREET ADDRESS, CITY, STATE, ZIP 115 WHITE ROAD KING, NC 27021	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0689 Level of harm - Immediate jeopardy Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on record reviews and staff interviews, the facility failed to ensure two staff members provided care for 2 of 3 residents reviewed for accidents (Resident #4 on 7/7/20 and Resident #2 on 8/2/20) reviewed for falls. Resident #4 sustained a fall from her bed that resulted in fractures to her left wrist and to the 8th and 9th ribs on her right-side. Resident #2 sustained a fall from her bed that caused a hematoma to the back of her head, an acute [MEDICAL CONDITION] femur with medial displacement, and an acute femoral neck fracture in her left leg. Resident #2 passed away at the hospital. Findings included: 1. Resident #2 was admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #2 was alert and oriented; required extensive assistance with two persons for bed mobility, hygiene, and transfers and was noted as totally incontinent of both bowel and bladder. Resident #2 had limitation in range of motion on her right and left lower extremities and her left upper extremity. Resident #2's care plan dated for 10/18/2019 revealed that she was at risk for injury from falls due to her [MEDICAL CONDITION] and limited mobility. Items were to be placed within reach and her bed was to be in the low position. She was to have two-person assist with bed mobility and transfers. Resident #2's 10/20/18 care guide revealed she required a two-person assist for all bed mobility and transfers. A note written by Nurse #1 dated for 8/3/2020 at 12:15 AM indicated that she was called to Resident #2's room around 8:45 p.m. on 8/2/2020. The note detailed Nurse #1 finding Resident #2 on the floor beside her bed with a small bump on the back of her head and complaining of pain on both sides of her groin. She and NA #1 used the lift to help her back in bed. Resident #2's vital signs were within normal range for her. The on-call physician was contacted, and orders were received for pain medication to be given and x-rays to be performed when the mobile x-ray group was available in the morning. Per facility standing orders, they began neurological checks (checks testing her mental alertness and pupil reactivity) due to a bump on the back of her head. Neuro checks were documented in chart and were all within the resident's normal limits. It also revealed that Nurse #1 entered Resident #2's room around 4:00 a.m. to find Resident #2 cool, clammy to touch and only grunting responses when asked questions. Nurse #1 stated she immediately took her vital signs and they were within her normal range except her oxygen level was 85%. Nurse #1 applied oxygen via nasal cannula and that level rose to 95%. Nurse #1 called the doctor with abnormal findings and obtained an order to send out. Emergency medical services (EMS) was called and an ambulance transported Resident #2 to the hospital for evaluation. Neuro checks were observed documented in the chart. Hospital records from 8/2/20 indicated that Resident #2 was found to have an acute [MEDICAL CONDITION] femur with medial displacement, and an acute femoral neck fracture in her left leg. Death Certificate received on 8/26/20 revealed Resident #2's cause of death was complications from [MEDICAL CONDITION]. The manner of death was accidental and the cause of death was listed as a fall from an unknown height. The incident report from 8/3/2020 stated that Resident #2 rolled off bed during incontinent care. It also indicated that neurological checks and vital sign assessment were immediately taken. X-rays were to be done and an order for [REDACTED]. #1 (NA #1) via phone revealed that on 8/2/2020 at approximately 8:30 p.m. she entered Resident #2's room and discovered she required incontinent care. She stated that she raised her bed, rolled Resident #2 on her left side, cleaned her, and then turned to get a new brief off the nearby chair. She turned back to see Resident #2 roll forward and off the side of the bed onto a floor mat landing on her back. NA #1 stated that she immediately assessed Resident #2 by asking her how many fingers she was holding up which Resident #2 was able to do. She then explained she told Resident #2 she was going to leave the room and find help and would be right back. NA #1 stated that Resident #2 was not complaining of any pain prior to the incident and had been able to roll onto her left side with her assistance. NA #1 further explained that she had known where the care guide was and should have had a second staff member assisting her with incontinent care. The NA explained she had been the only NA on the hall at that time and did not see anyone in the hall to assist her at that time and chose not to leave Resident #2 soiled. She did not think to use the call bell to find another staff member. NA #1 stated Resident #2 had been alert and oriented the entire time. On 8/11/2020 at 6:43 a.m. an interview with Nurse #1 revealed that she was on the adjoining hall when NA #1 came to get her to assist with Resident #2 on 8/2/20 around 9:00 p.m. She stated when she arrived at the room, she found Resident #2 lying on her back on the floor mat beside her bed. She stated that Resident #2 was alert, oriented and had a small bump on the back of her head. She also complained about both left and right groin pain and reported her pain was 7/10 on the pain scale (0 being no pain and 10 being severe pain). Nurse #1 stated that her vital signs were normal and she and NA #1, used the total body lift to help her back into bed. Nurse #1 then contacted the on-call provider MD and an order was received for a hip and pelvis x-ray. She stated that Resident #2 wanted to wait for the mobile x-rays first thing in the morning before going to the hospital. She then stated that neuro checks were performed every 15 minutes for the first hour, then every 30 minutes for the next 3 hours and then hourly after that. She stated that she entered Resident #2's room around 4:00 a.m. to perform another neurological check and found Resident #2 cool, clammy to touch and only grunting responses when asked questions. She stated that her oxygen level had dropped to 85% so she applied oxygen via nasal cannula and that level rose to 95%. She contacted the on-call provider again and obtained an order to send her out to the emergency department. She then called 911 at and an ambulance arrived to transport Resident #2 to the hospital for evaluation. Nurse #1 stated that she was available and would have helped NA #1 if she had asked for assistance. Nurse #1 added that the mobile x-rays were never performed. They were on their way to the facility, but the resident was sent out prior to their arrival. On 8/10/2020 at 2:13 p.m. an interview with Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed that they were aware of the events that occurred on 8/2/2020 with Resident #2. Both the DON, ADON, and the administrator had a conference call with the agency NA #1. They both stated that NA #1 stated she had not waited for help in assisting Resident #2 with incontinent care and had chosen to do it alone. The DON also stated that NA #1 admitted to her that she was aware that Resident #2 required two staff members for bed mobility and she still made the decision to provide incontinent care without assistance from another staff member. The DON stated that they told NA #1 that her services were no longer needed at that time. The facility Plan of Correction dated for 8/2/2020 with a completion date of 8/5/2020. These steps will be followed for all residents: 1) Ensure correct number of staff members needed to provide care 2) Address and ensure bed surface is sufficient for turning and repositioning 3) Whether or not the resident has a physical impairment or behaviors that need to be considered. 4) Identify any resident that cannot assist with turning or repositioning. 5) All Nurse Assistants will be re-educated on the locations of the resident Kardex and where the find the information needed to ensure appropriate care is provided. 6) All Nurse Assistants will be re-educated in proper techniques for turning and repositioning. In addition to the above, the facility Quality Assurance (QA) process will include a Resident Questionnaire Tool to ensure all NAs were reviewing the Kardex and a question and answer quiz to test their knowledge on the where to locate specific items on the Kardex. The QA process will</p>		

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

TITLE

(X6) DATE

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.

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F 0689 Level of harm - Immediate jeopardy Residents Affected - Few	<p>(continued... from page 1)</p> <p>also include a completed Nurse Aide Competency checklist that includes procedures that are to be used when moving residents up in bed and turning residents from side to side. The DON or ADON will interview at least 3 NAs per day for 8 weeks and then weekly for 4 weeks on all shifts, as well as, random audits to ensure staff members are following the Kardex as written. 2. Resident #4 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #4's Quarterly Minimum Data Set (MDS) dated [DATE] indicated she had severe cognitive impairment, required extensive assistance with two persons for bed mobility, hygiene and transfers and was noted as always incontinent of bowel and bladder. A care plan dated 4/22/2020 revealed that Resident #4 was at risk for injury from falls due to limited mobility and right lower leg amputation. She was to have mats on floor around her bed. Resident #4 was also care planed for two-person assist with all activities of daily living. Resident #4's care guide (a guide indicating resident needs and care to be provided) noted that she was to have two-person assist with bed mobility and transfers. A note written by Nurse #2 revealed on 7/7/2020 at 2:39 a.m. the NA had rolled Resident #4 on her right side to perform incontinent care and while she was trying to adjust her bed sheets, Resident #4 rolled off her bed and onto the floor. Resident #4 suffered a large skin tear to her left forearm and top of left hand. She also complained of her left rib cage area hurting. Mobile x-rays were ordered and completed at the facility and revealed she had left wrist and rib fractures. Resident #4 was sent to hospital for evaluation on 7/7/2020 at 6:41 a.m. On 8/11/2020 at 2:25 p.m. an interview with NA #2 revealed that she was an agency NA who had worked in the building once prior to 7/7/2020. She stated she was oriented to the building on her first day and then given her assignment. She stated that she wasn't aware where the care guide was located and did not ask. She came in for her shift and proceeded to provide care for the residents. On 7/7/2020 at approximately 2:30 a.m., she entered Resident #4's room to provide incontinent care and rolled her onto her right side. While she was adjusting her bed sheets, Resident #4 rolled forward, off the side of the bed and onto the floor. NA #2 stated that she thought she probably should have had another staff member assist her, but she wanted to go ahead and get the Resident #4 cleaned up. On 8/12/2020 at 8:35 a.m. an interview with Nurse #2 revealed that NA #2 came out of the room yelling for help. She went into Resident #4's room and found her lying beside her bed on the floor mat. Resident #4 had a large hematoma on her left wrist and a large skin tear on her left forearm. Nurse #2 stated that her vital signs were stable, but she was unable to determine her pain level due to her dementia. She stated that she and NA #2 used the lift to help her back into bed. She added there had been the usual number of staff for the third shift that day. On 8/10/2020 at 2:13 p.m. an interview with Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed that they were aware of the events that occurred on 7/7/2020 with Resident #4. Both the DON and the ADON, spoke with agency NA #2 on 7/7/2020. They both stated that NA #2 stated she had not waited for help in assisting Resident #4 with incontinent care and had chosen to do it alone. The DON stated that all agency staff are oriented to the building and are made aware of the location of resident care guide prior to their first day there by letting them shadow one of the other nurse aides currently on the floor. The DON stated that the facility put a plan of correction (POC) in place on 7/7/2020 after this incident with a completion date of 7/9/2020 that included NA education on locations of the resident care guides for all staff, including agency staff. This re-education included competency forms for each NA and documentation that no NA would be allowed to work until they had completed a demonstration of competency. This was monitored by the DON and ADON to ensure ongoing completion. This POC was reviewed and no issues were noted. The facility Plan of Correction dated for 8/2/2020 with a completion date of 8/5/2020. 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The QA process will also include the DON or ADON interviewing at least 3 NAs per day for 8 weeks and then weekly for 4 weeks on all shifts, as well as, random audits to ensure staff members are following the Kardex as written. The Corrective Action Plan was verified on 8/12/20 through audit review and staff interviews. Record reviews revealed staff has completed their individual competency demonstrations and signed and dated prior to their next shift. Log sheets reveal staff names with their upcoming random audit dates to be completed by the DON. Interviews with various staff members (nurses and nurse aides) revealed they were knowledgeable. Each staff member interviewed was able to verbalize the location of resident care guides and the importance of moving residents correctly in bed and while turning.</p>		