STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **345529**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/15/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**

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 0550 **Level of harm -** Actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews it was determined that facility staff failed to treat 1 of 1 sampled resident's with dignity while providing care; talking down to the resident and snatching pillow from under the residents head (Resident #16). Findings included: Resident # 16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that she had video evidence of Resident #16 being abused. She stated the resident told her that staff threw him in the bed, they talked down to him and that they treated him horrible at the facility. She reported installing a recording device because she thought the resident was exaggerating his treatment. She said that one night she came in and the resident's television was on full blast, his phone was across the room and his call bell was dropped over the night staff. Both items were out of the resident's reach. She stated that the resident is able to use the telephone and the call bell. She reported that there was no need for the television to be on full blast and she had spoken to staff about it. During interview with the resident at 1:54 PM on 4/14/17 he stated that the staff are mean all the time; mostly at night. He said, One girl picks me up and flips me around like I'm a rag doll. He reported staff used the lift to get him up sometimes. He said one girl told him he needed a longer leash. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a staff member enter the resident's room during 3rd shift and state aww you stink. Another staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Another staff member entered the room and the resident was placed on the bed by the 3 staff. One staff exited the room while two remained in the room. The NA (later identified); then dropped the resident's legs onto the bed. The same nursing assistant was then observed snatching the pillow from underneath the resident's head without informing the resident of what she was doing. Review of the recording revealed the NA stating, How old are you? U should be enjoying your retirement; pooping on yourself-shame on u. The nurse #4 was observed in the room at this time giving the resident a tube feeding. Per the video it appeared she Nurse #4 responded, 1 when the NA asked Resident #16 how old he was. Interview with NA at 1:31 PM on 4/15/18 revealed that she found Resident #16 on the floor and reported it to the nurse. She stated that she asked the resident if he was ok and told him to wait a minute. She stated the resident was lying on the mat. He had taken off his brief and had bowel movement all over. She said she asked him if he could stay in bed so he wouldn't fall again when she was in the room. The nursing assistant denied telling the resident that he should be ashamed of himself. She stated that maybe she asked him how old he was because he tried to touch her. The NA said that the resident did not ring his bell to go to the bathroom. She said she gave him the call bell but he tried to rip it from the wall. She did not want him to get hurt so she put it to the other side and moved the table because he kept reaching for the phone. She stated that she did not want him to get hurt reaching because them he goes to the floor. During interview on 04/15/18 at approximately 5:20 PM with Resident #16 he stated he felt like hell on the day when the Nursing assistant and nurses got him up off the floor and back into bed. Stated he did not like the way he was treated and talked to, that he felt very depressed about it. Stated he does not care what happens to him anymore. Interview via telephone on 4/15/18 at 2:45 PM with nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse #4 stated she went to the room but did not go inside immediately because she needed help to get him up. The nurse stated that she, another nurse and the NA went into the room where the resident was lying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She stated she thought they were gentle enough with him. NA stated, You keep falling and it is hurting our backs. She said she could not remember the details about the conversation. NA said you are breaking our backs. The nurse said she did remember NA saying shame on you for pooping on yourself. She said the resident would say some things. The nurse stated she talked to the nursing assistant and told her not to go overboard with what she was saying to him. Nurse #4 said she also remembered someone saying .aww you stink! During interview with the social worker at 4:25 PM on 4/14/18 she reported that she, the rehabilitation manager and the resident's family member had a care plan meeting in 4/12/18. She said that she asked about concerns at the end of the meeting. Resident #16's family member said that the resident complained about staff being rude on 3rd shift. The social worker wrote the concerns up on a grievance form. Per review of the grievance form dated 4/12/18; the concern was addressed in the interdisciplinary team meeting on 4/12/18. Social worker planned to follow up with the resident's family member on Monday 4/17/18.
F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff, family and resident interviews it was determined that facility staff failed to notify the physician and family of a fall for 1 of 2 sampled residents (#16) with falls. Findings included: Resident # 16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Review of the medical record 4/14/18 revealed a nursing note (Nurse #4)4/11/18 4:51 am which stated, 4/10/18 at 7:45 PM

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 0580

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
patient noted to be hanging almost off the bed. Patient assisted back to bed 8:10 PM. One of the (family) members alerted this nurse that he had observed patient using his bed control to high position and was almost sliding off the bed. Patient observed way up hanging the bed. Patient continue to hang off the bed, restless throughout the night. Unable to redirect. Will continue to monitor.
Therapy note 4/11/18 1:22 PM stated, Patient reports recent fall, but unclear about details and number of falls.
Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that the resident was telling her every time he had a fall. She stated that he had goose egg on his head. She said that she had not been notified by the facility that Resident #16 had any falls. She stated that the rehabilitation manager and the social worker admitted that the resident had 6 falls during a care plan meeting.
Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a shot of the resident's unoccupied bed. Staff was seen entering the room and talking to someone below the bed on the other side. A staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle.
Interview with the administrator at 3:53 PM on 4/14/18 revealed that if a resident has a fall the nurse will assess for injury, the MD and family are notified and the incident is available for review in clinical rounds. Falls are investigated as needed.
During interview with the social worker at 4:25 PM on 4/14/18 she reported that she, the rehabilitation manager and the resident's family member had a care plan meeting in 4/12/18. She said that she asked about concerns at the end of the meeting. Resident #16's family member said that the resident complained about staff being rude on 3rd shift. The social worker wrote the concerns up on a grievance form. Per review of the grievance form dated 4/12/18; the concern was addressed in the interdisciplinary team meeting on 4/12/18. The attachment to the grievance form stated 4/1/18 (fall). Social worker planned to follow up with the resident's family member on Monday 4/17/18.
During interview with the rehabilitation manager on 4/15/18 at 2:20 PM, he stated that he did not remember the family member saying anything about falls during the care plan meeting. He reported that the falls log indicated that the resident had 2 falls per the incident log, one fall occurred on (MONTH) 1st.
Interview with a nursing assistant on 4/15/18 at 1:31 PM revealed that she found the Resident #16 on the floor and reported it to the nurse. She stated they tried to transfer him to bed because the lift could not go down to the floor. They got a 3rd person to help because it was so hard and it was killing their back. The NA said she did not report the fall to the nurse because the nurse was there.
Interview via telephone on 4/15/18 at 2:45 PM with Nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported to her that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse#4 stated she went to the room but did not go inside immediately because she needed help to get him up. Nurse #4 stated that she, another nurse and the NA #1 went into the room the resident was laying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She further stated that the night he fell it was documented. Put in electronic chart under notes.
Review of facility records revealed no documentation of the incident. There was no indication that the family or the resident's physician had been notified of the fall.

F 0585

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review, and resident and staff interviews the facility failed to record a grievance and failed to provide a written grievance summary for 1 of 3 residents (Resident #8) reviewed for grievances.
Findings included:
Resident #8 was admitted on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], indicated
the resident was cognitively intact and had no behaviors. It also revealed a functional limitation of one lower limb.
Resident #8's clinical record was reviewed and revealed the following entries in the Departmental Notes:
A Therapy note dated 3/26/18 included, Pt (Patient) reported that his W/C (wheelchair) is too small The note was signed by Physical Therapy Assistant (PTA) #1.
A Therapy note dated 3/28/18 included, Pt continues to report that he is not happy at this facility, and that we did not have the equipment required for proper rehab - Pt declined participation - (Rehab Director) and supervising OTR (Occupational Therapist) notified. The note was signed by Certified Occupational Therapy Assistant (COTA) #1.
A Therapy note dated 3/31/18 included, Pt was seated to the R-side (right side) of WC leaving 3-4 inch gap on L-side (left side) making complaint that his WC was inappropriately sized, and declining position change. The note was signed by Occupational Therapist (OT) #1.
A Therapy note dated 4/5/18 included, Pt stated wc (wheelchair) is too small for him and that he has spoken with the (Rehab Director) and other therapist (regarding) this issue. (Rehab Director) is aware of complaints. The note was signed by COTA #1.
A Therapy note dated 4/5/18 included, Patient refused therapy stating his w/c wasn't big enough. Stated he requested a mobile w/c for home. The note was signed by PTA #2.
A Therapy note dated 4/6/18 included, Patient refused therapy claiming that wheelchair is too small and that is rubbing against his thighs. The note also indicated the writer had asked the wound nurse, who said the resident had never complained to her about any irritation to the thigh area. The note was signed by Occupational Therapist #2.
On 4/14/18 at 10:38 AM, the Administrator provided one grievance filed on behalf of Resident #8. The single grievance was dated 3/18/18 and indicated the resident had expressed concern regarding the portion sizes on his meal trays. The grievance was addressed by the dietary manager on 3/20/18 and the response was that the resident would receive double portions. There were no grievances regarding the size of Resident #8's wheelchair. The Administrator confirmed there were no other grievances from Resident #8.
On 4/14/18 at 11:11 AM, Occupational Therapist #1 was interviewed about why she had not filed a grievance on behalf of Resident #8 when he complained about the size of his wheelchair. OT #1 said the resident only complained to her about the chair on that one occasion.
On 4/14/18 at 3:03 PM, the Rehab Manager indicated he was aware that Resident #8 believed the wheelchair was too small and said, He (Resident #8) told at least 3 therapists about the chair. The Rehab Manager said he had also spoken to the resident about the size of the wheelchair, but at the time the Rehab Manager thought it was the correct size wheelchair for Resident #8. When asked if he or his staff had completed a grievance form on Resident #8's behalf, the Rehab Manager said, I did not think of doing one or suggesting my staff complete a grievance. Looking back, I should have. The Rehab Manager added that the resident had the largest chair available from the supplier but a custom wheelchair was in process and Resident #8 should have been made aware.
During an interview on 4/14/18 at 4:00 PM, Physical Therapy Assistant #1 stated she had never seen Resident #8 in the wheelchair but to her knowledge the resident had been measured and he fit the wheelchair. PTA #1 said she did not fill out a grievance form because the Physical Therapy Department was already aware Resident #8 was not happy with the wheelchair the facility was able to provide.
COTA #1 was interviewed on 4/14/18 at 5:30 PM. COTA #1 was aware of the Grievance Policy and indicated she knew the policy said staff could complete a Grievance form on a resident's behalf. COTA #1 said she had not completed a form for Resident #8 but, I certainly brought it to my supervisor's and Rehab Manager's attention and thought that was enough.
Occupational Therapist #2 and PTA #2 were not able to be interviewed.
An interview was conducted with the Administrator on 4/15/18 /18 at 4:19 PM. The Administrator stated she had not been aware the resident was unhappy about his wheelchair. She also stated it was her expectation that resident complaints would be documented by staff on the Grievance/Complaint form. Part of the facility's grievance process, would be to provide the complainant with information regarding resolution.

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F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews it was determined that facility staff spoke to 1 of 1 sampled resident's in a verbally abusive manner (Resident #16). Findings included: Resident # 16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that she had video evidence of Resident #16 being abused. She stated the resident told her that staff threw him in the bed, they talked down to him and that they treated him horrible at the facility. She reported installing a recording device because she thought the resident was exaggerating his treatment. The resident's family member stated that on her recording she saw a staff member enter the resident's room on 3rd shift; look at the resident then leave. She reported that no one returned to the room for 12-15 minutes. During interview with the resident at 1:54 PM on 4/14/17 he stated that the staff are mean all the time; mostly at night. He said, One girl picks me up and flips me around like I'm a rag doll. He reported staff used the lift to get him up sometimes. He said one girl told him he needed a longer leash. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a staff member enter the resident's room during 3rd shift and state aww you stink. Another staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Another staff member entered the room and the resident was placed on the bed by the 3 staff members. One staff exited the room while two remained in the room. The NA (later identified); then dropped the resident's legs onto the bed. The same nursing assistant was then observed snatching the pillow from underneath the resident's head without informing the resident of what she was doing. Review of the recording revealed the NA #1 stating, How old are you? You should be enjoying your retirement; pooping on yourself-shame on you. Nurse #4 was observed in the room at this time giving the resident a tube feeding. It appeared that she responded, 1 when the NA asked Resident #16 how old he was. During interview on 04/15/18 at approximately 5:20 PM with Resident #16 he stated he felt like hell on the day when the Nursing assistant and nurses got him up off the floor and back into bed. Stated he did not like the way he was treated and talked to, that he felt very depressed about it. Stated he does not care what happens to him anymore. Interview with a nursing assistant at 1:31 PM on 4/15/18 revealed that she found Resident #16 on the floor and reported it to the nurse #4. She stated that she asked the resident if he was ok and told him to wait a minute. She stated the resident was lying on the mat. He had taken off his brief and had bowel movement all over. She said she asked him if he could stay in bed so he wouldn't fall again. The nursing assistant denied telling the resident that he should be ashamed of himself. She stated that maybe she asked him how old he was because he tried to touch her. Interview with the Administrator at 2:26 PM on 4/15/18 revealed that she learned about the incident from the Resident's family member on 4/14/17. She reported that staff members involved in the incident were identified from the video. The staff was placed on leave pending investigation. She filed a 24hour with the Division of Health Service regulation and made a police report. Resident's on the hall were interviewed by the social worker regarding staff treatment. Interview via telephone on 4/15/18 at 2:45 PM with nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse #4 stated she went to the room but did not go inside immediately because she needed help to get him up. Nurse #4 stated that she, another nurse and the NA went into the room where the resident was lying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She stated she thought they were gentle enough with him. The resident kept talking about doctors made him stay at the facility. He always gives this story when you talk to him. NA stated, You keep falling and it is hurting our backs. She said she could not remember the details about the conversation. NA said you are breaking our backs. Nurse #4 said she did remember NA saying shame on you for pooping on yourself. She said the resident would say some things. The nurse stated she talked to the nursing assistant and told her not to go overboard with what she was saying to him. The nurse said she also remembered someone saying .aww you stink! Nurse #4 further stated, now that she thought about it, it was probably verbal abuse, but at the time, she did not think of it that way. She talked to NA later and told her she should avoid saying things like this to the resident. She did not have NA leave the room when she said them. She stated the NA continued to talk to resident while she him gave the tube feeding. During interview at 3:01 PM on 4/15/18 with 3rd staff member (nurse #2), she stated that she just went in to help get him off the floor. She stated that she had worked with the NA when she worked the 400 hall sometimes. She stated that she had seen the NA talk to residents in the am and she talked to them so well. She reported no complaints from residents regarding the nursing assistant. Interview with the Administrator on 4/15/18 at 3:30 PM - The administrator stated that the video spoke for itself and that verbal abuse was clear. The administrator stated that resident was not handled in a dignified manner when found on floor and transferred back to bed. She stated she was following steps to report the abuse and that she was following the facility abuse protocol.
F 0636 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete care area assessment (CAA) summaries for 5 of 6 residents reviewed for comprehensive minimum data set assessments (Resident # 2, Resident # 4, Resident # 16, Resident # 3, and Resident # 8.) Findings included: 1. Resident #2 was a long term care resident who was admitted to the facility with [DIAGNOSES REDACTED]. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #2 was severely cognitively impaired, was receiving a therapeutic diet, and had a weight loss of 5% over the past month or 10% over the past 6 months. On the same admission MDS of 10/30/17, cognitive loss/dementia and nutritional status were among the care areas that triggered for further review. There was no indication that any of these CAA summaries were completed for this MDS assessment. In an interview with the MDS Coordinator on 4/13/18 at 11:15 AM, she stated that the care areas for cognitive loss/dementia and for nutritional status were evidently missed but should have been completed in order to determine whether care planning should proceed. She also stated that she was the staff member who was ultimately responsible for seeing that CAA summaries were completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for specifically for nutrition, and she thought she had completed them for each resident who triggered for nutritional status. 2. Resident #4 was admitted to the facility with [DIAGNOSES REDACTED]. A review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #2 was moderately cognitively impaired and had complaints of difficulty or pain with swallowing. The same assessment indicated Resident #4 had a feeding tube through which he received 51% or more of his calories.

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F 0636 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) The care areas which triggered for further review on the admission MDS of 3/2/18 included cognitive loss/dementia, feeding tube, and dehydration/fluid maintenance. There was no check to indicate CAA summaries had been completed for these care areas. In an interview with the MDS Coordinator on 4/14/18 at 9:30 AM, she stated that CAA summaries had not been completed for the triggered care areas of cognitive loss/dementia, feeding tube, or dehydration/fluid maintenance. She also indicated she was the staff member who was ultimately responsible for seeing that CAA summaries were completed before signing the MDS assessment. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments and write care area summaries before signing them as complete. On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutritional status. 3. Resident #16 was admitted to the facility with multiple diagnoses, some of which included [MEDICAL CONDITION], hypertension, [MEDICAL CONDITION], and depression. The admission minimum data set (MDS) assessment dated [DATE] indicated that Resident #16 had a feeding tube and that he received 51% or more of calories via a feeding tube. On the admission MDS of 04/05/2018, one of the care areas which triggered for assessment was a feeding tube. There was no indication on the MDS that a CAA summary was completed. In an interview with the MDS Coordinator on 04/14/18 at 9:30 AM, she stated that the feeding tube CAA summary was not completed but should have been to determine whether care planning should proceed. She indicated she was the staff member who was ultimately responsible for seeing that CAA summaries were completed before signing the MDS assessment. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutritional status. 4. Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. A review of the admission minimum data set assessment ((MDS) dated [DATE] revealed Resident #3 was severely cognitively impaired, exhibited behaviors of wandering 1-3 days during the look back period, and was receiving a therapeutic diet. On the same admission MDS of 03/06/18, the care areas that triggered for further review included, in part, cognitive loss/dementia, behavioral symptoms, and nutritional status. There was no indication that any of these CAA summaries were completed for the assessment. In an interview with the MDS Coordinator on 4/13/18 at 11:15 AM, she indicated that CAAs were not completed for cognitive loss/dementia, behavioral symptoms, and nutritional status and that they should have been completed to determine whether care planning should proceed for those areas. She indicated she was the staff member who was ultimately responsible for seeing that CAA summaries were completed before signing the assessment. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments and CAA summaries before signing them as complete. On 04/14/18 at 11:34 AM, the Dietary Manager stated she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutrition. 5. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], indicated the resident was cognitively intact and had no behaviors. It also revealed the resident required a therapeutic diet and received insulin. Cognitive Loss/Dementia, Behavior Symptoms, and Nutritional status were among the care areas that triggered for further review. There was no indication that these Care Area Assessment (CAA) Summaries were completed for assessment. During an interview on 4/13/18 at 11:15 AM, the MDS Coordinator stated that the care areas for cognitive loss/dementia and for nutritional status were evidently missed but should have been completed in order to determine whether care planning should proceed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. On 4/14/18 at 11:34, the Dietary Manager (DM) stated that she was responsible for writing the Nutrition CAA Summary.
F 0642 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure a qualified health professional conducts resident assessments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to certify that the comprehensive minimum data set (MDS) assessments were complete before submitting the comprehensive MDS assessments to the national database for 6 of 6 residents (Resident # 2, Resident # 4, Resident # 11, Resident # 16, Resident # 3, and Resident # 8.) The findings included: 1. Resident #2 was a long term care resident who was admitted to the facility with [DIAGNOSES REDACTED]. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #2 was severely cognitively impaired, was receiving a therapeutic diet, and had a weight loss of 5% over the past month or 10% over the past 6 months. The care areas that triggered for completion of care area assessment (CAA) summaries were cognitive loss/dementia and nutritional status. There was no indication that any of these CAA summaries were completed on the MDS. The admission MDS of 10/30/17 was signed and certified as complete on 11/03/17 by the MDS Coordinator and was submitted on 11/09/17. In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries had not been completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. 2. Resident #4 was admitted to the facility with [DIAGNOSES REDACTED]. A review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #2 was moderately cognitively impaired, had complaints of difficulty or pain with swallowing, and that he had a feeding tube through which he received 51% or more of his calories. Three of the care areas which triggered for further review on the MDS of 03/02/18 were cognitive loss/dementia, a feeding tube, and dehydration/fluid maintenance. There was no indication that care area assessment (CAA) summaries were completed on these care areas. The admission MDS of 03/06/18 was signed by the MDS Coordinator as complete on 03/07/18 and was submitted on 03/07/18. In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries had not been completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. 3. Resident #11 was a long term resident admitted to the facility with a partial list of [DIAGNOSES REDACTED]. A review of the annual comprehensive minimum data set (MDS) assessment dated [DATE] indicated Resident #11 was always incontinent of urine. One of the care areas that triggered for further review on the annual MDS of 3/31/18 included urinary incontinence/indwelling catheter. There was no indication that a care area assessment (CAA) summary had been completed for incontinence/indwelling catheter. The CAA indicated Current Care Plan continued. The annual comprehensive MDS of 03/31/18 was signed by the MDS Coordinator as complete on 04/03/2018 and was transmitted on 04/03/18. In an interview with the MDS Coordinator on 4/13/18 at 11:15 AM, she stated she took full responsibility for signing to certify the admission MDS dated [DATE] was complete even though the CAA summary for urinary incontinence/indwelling catheter had not been completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. 4. Resident #16 was admitted to the facility with multiple diagnoses, some of which included [MEDICAL CONDITION], hypertension, [MEDICAL CONDITION], and depression. A review of the admission minimum data set (MDS) assessment dated [DATE] indicated that Resident #16 had a feeding tube and that he received 51% or more of calories via a feeding tube. One of the care areas which triggered for further review was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **345529**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/15/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**

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 0642

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 4)
feeding tube. There was no indication on the MDS that a care area assessment (CAA) summary was completed for the feeding tube.
The admission MDS of 04/05/18 was signed as complete on 04/05/18 and was submitted.
In an interview with the MDS Coordinator on 04/14/18 at 9:30 AM, she stated that she took full responsibility for signing to certify the admission MDS assessment dated [DATE] was complete even though the CAA Summary had not been completed.
The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.
On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutritional status.
5. Resident #3 was admitted to the facility with a partial list of [DIAGNOSES REDACTED].
A review of the admission minimum data set assessment ((MDS) dated [DATE] revealed Resident #3 was severely cognitively impaired, exhibited behaviors of wandering 1-3 days during the look back period, and was receiving a therapeutic diet. The care areas which triggered for further review included, in part, cognitive loss/dementia, behavioral symptoms, and nutritional status. There was no indication that these care area assessment (CAA) summaries had been completed for Resident #3.
The admission MDS of 03/06/18 was signed by the MDS Coordinator as complete on 03/07/18 and was submitted on 03/07/18.
In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries for cognitive loss/dementia, behavioral symptoms, and nutritional status had not been completed.
The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.
6. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
The admission Minimum Data Set (MDS), dated [DATE], indicated the resident was cognitively intact and had no behaviors. It also revealed the resident required a therapeutic diet and received insulin.
Cognitive Loss/Dementia, Behavior Symptoms, and Nutritional status were among the care areas that triggered for further review. There was no indication that these Care Area Assessment Summaries were completed for assessment.
The admission MDS of 03/27/18 was signed by the MDS Coordinator as complete on 04/05/18 and was submitted on 04/05/18.
In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries for cognitive loss/dementia, behavioral symptoms, and nutritional status had not been completed.
The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.

F 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review and staff interview, the facility failed to administer [MEDICATION NAME] for chest pain, document times for assessment, and to monitor the resident for acute changes in weight as ordered for 1 of 3 residents reviewed who had a decline in condition (Resident #3.) The facility also failed to clarify insulin orders and MEDICATION ORDERS FOR [REDACTED].) The findings included:
1. a. Resident #3 was admitted to the facility with multiple [DIAGNOSES REDACTED]. (Subacute [DIAGNOSES REDACTED] is an
infection of the inner lining of the heart and the heart valves.)
The signed physician orders [REDACTED].
A review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #3 was admitted from an acute hospital stay, was severely cognitively impaired, and there was no indication that he had a prognosis of a life expectancy of less than 6 months.
The (MONTH) (YEAR) Medication Administration Record [REDACTED].
Review of a progress note dated [DATE] which was written by the Occupational Therapist (OT #2) revealed the Resident #3 did not feel good and described a dull aching pain to his chest. The same note revealed that his vital signs were checked and that his blood pressure started at ,[DATE], and that it went down to ,[DATE] after a few minutes. The note continued, indicating that Resident #3 was transferred back to bed and instructed not to get out of bed until the nurse had seen him.
In an interview with Resident #3's family member on [DATE] at 2:45 PM, she stated OT #2 returned Resident #3 to his room because his blood pressure was low and he was complaining of chest pain. The family member was concerned so she went to get a nurse to check on him, but she was told the nurse would come after she finished her medication administration pass. Resident #3's family member stated she could not remember what time OT #2 brought him back to the room, although it was during the morning hours on [DATE].
In an interview with OT #2 on [DATE] at 10:42 AM, she stated on [DATE] she went to work with Resident #3 and she found him at the nurse's station and that he was complaining of a dull ache in his chest. OT #2 explained that she checked his blood pressure and immediately took him to his room and assisted him into the bed. She further stated she instructed Resident #3 not to get out of bed until he had been seen by his nurse, and then she left his room and reported to his nurse, Nurse #1, that he had chest pain, shortness of breath, and a low blood pressure. She added that she did not know whether Nurse #1 immediately went to Resident #3's room after she reported his condition to her. OT #2 stated this chest pain event occurred between 8:00 AM and 10:00 AM.
A review of the progress notes revealed a note dated [DATE] written by Nurse #1 which indicated Resident #3 complained of chest tightness and shortness of breath, looked weak, was afebrile, and his skin was warm and moist. The same note indicated Resident #3's temperature was 97.4, his pulse was 97, and his blood pressure was ,[DATE].
In a phone interview on [DATE] at 4:40 PM, Nurse #1 stated she could not remember many details about Resident #3's chest pain during her day shift on [DATE]. Nurse #1 stated that she did not administer [MEDICATION NAME] 0.4 mg sublingually as ordered for chest pain, however she did remember reporting the resident's condition to the Assistant Director of Nursing (ADON) who came to Resident #3's room to look at him. Nurse #1 also stated she could not remember who told her the resident was having the chest pain and shortness of breath, and she did not know if she went immediately to assess Resident #3.
In an interview with the ADON on [DATE] at 3:40 PM, she stated she was called to Resident #3's room by Nurse #1 on [DATE]. The ADON stated she and Nurse #1 both assessed Resident #3's vital signs, and that his family member was present in the room. The ADON explained Resident #3 was lying down and she did not think he appeared to be short of breath or in distress, but his family member told her he did not look right. The ADON stated she would have expected for the [MEDICATION NAME] to be administered as ordered for chest pain, and she thought Nurse #1 had administered it.
The Director of Nursing (DON) stated in an interview on [DATE] at 4:30 PM that he would expect the nurse to follow the physician's orders [REDACTED]. The DON added that Nurse #1 might have felt that Resident #3's issue was chest tightness instead of chest pain.
The physician stated in a phone interview on [DATE] at 9:55 AM that he would expect the nurse to follow the physician's orders [REDACTED].#3's chest tightness or chest pain, but it would not have improved his poor cardiac condition.
b. Review of Nurse #1's progress note dated [DATE] indicated that Resident #3 complained of chest tightness and shortness of breath, and that though he was weak, he was alert and verbal. The same note indicated Resident #3 was lethargic and that the physician was called and an order was received to send Resident #3 to the emergency room for further evaluation. The note indicated Resident #3 left the facility at 7:00 PM. There was no time of day included in the note to indicate the time of day when Resident #3 experienced the shortness of breath or chest tightness, when he was assessed, or when the physician was notified.
A review of the transfer form completed before Resident #3 was sent to the emergency department included the date of [DATE]; the time of day for the transfer was left blank beside the date.
A review of the hospital emergency department discharge triage note revealed Resident #3 was first assessed in the emergency department by a nurse at 1:29 PM on [DATE] and expired at 5:35 pm the same day.

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NAME OF PROVIDER OF SUPPLIER **UNIVERSAL HEALTH CARE/NORTH RALEIGH**		STREET ADDRESS, CITY, STATE, ZIP **5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**	

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) In an interview with OT #2 on [DATE] at 10:42 AM, she stated on [DATE] she went to work with Resident #3 and found him at the nurse's station and that he was complaining of a dull ache in his chest. OT #2 explained that she checked his blood pressure (,[DATE]), then immediately took him to his room and assisted him into the bed. She further stated she reported his condition to his nurse (Nurse #1) that Resident #3 had chest pain, shortness of breath, and a low blood pressure. OT #2 added she did not know whether Nurse #1 immediately went to Resident #3's room after she reported his condition to her. OT#2 stated this event occurred between 8:00 AM and 10:00 AM on [DATE]. In a phone interview with Nurse #1 on [DATE] at 3:40 PM, she stated she was unable to remember what time of day on [DATE] when Resident #3 started experiencing chest tightness and shortness of breath. Nurse #1 stated she was not certain who reported to her the resident was experiencing chest pain and a low blood pressure. She stated she was not sure what time of day when she assessed Resident #3 or when the physician was called about his condition. Nurse #1 added she thought the resident left the facility earlier than 7:00 PM to go to the emergency room . In an interview with the DON on [DATE] at 4:30 PM, he stated that the documentation regarding Resident #3's condition did not include the time when the physician was called and did not include the correct time when Resident #3 was transferred by the emergency medical technicians to the emergency department at the hospital. He stated the time of day when Resident #3 experienced his decline in condition should have been documented in the Nurse #1's progress note. The DON added he would expect the time of Resident #3's transfer to the hospital to be included on the transfer form and for the time of physician notification of the resident's condition to be included. c. A review of the physician's orders [REDACTED]. Notify MD if weight gain more than five pounds in one week. (According to the Mayo Clinic, rapid weight gain from fluid retention may indicate a change in treatment for [REDACTED].) A review of the (MONTH) (YEAR) Medication Administration Record [REDACTED]. There were no other checks present to indicate any weights were taken on any Monday, Wednesday, or Friday during the month of (MONTH) until the resident was discharged on [DATE]. There was N present on the MAR for the weights on the following dates: Monday [DATE], Friday [DATE], Monday [DATE], Wednesday [DATE], Friday [DATE], and Monday, [DATE]. In a phone interview with Nurse #2 who marked the N on the (MONTH) (YEAR) MAR for the weights on [DATE] at 3:58 PM, she stated the N marked in place of the weight on Resident #3's MAR indicated [REDACTED]. Nurse #2 stated she did not know if there was a way to check Resident #3's weight on another day if a weight had been missed on a Monday, Wednesday, or Friday. She added that she did not call the physician to report missed weights or to find out if the weights could be delayed to another weekday if one had been refused the day before. Nurse #2 further stated she would not know whether there was a weight gain or loss or five pounds if weights were not taken. The DON stated in an interview on [DATE] at 4:30 PM that he would expect the nurse to at least notify the physician if an order could not be carried out due to resident refusal. The physician stated in a phone interview on [DATE] at 9:55 AM that if Resident #3 was refusing to have his weights taken, he would expect the nurse to contact him to receive further direction. The physician also stated that if weights were not being taken as ordered three days per week, there would be no weight data to determine if Resident #3 had a five pound weight loss or gain in one week which could be a sign of heart failure. d. A review of the physician's orders [REDACTED]. The order did not indicate where to apply the [MEDICATION NAME] on Resident #3's body surface. The (MONTH) (YEAR) MAR indicated [REDACTED]. In an interview with Nurse #3 on [DATE] at 3:08 PM, she stated the order for [MEDICATION NAME] 0.1% ointment needed to be clarified in order to know where to apply it to the resident's skin. She stated she did not process the order for Resident #3 and did not process this order upon admission. Nurse #3 stated she did not take care of Resident #3, but if she did, she would not know where to apply it. On [DATE] at 4:40 PM, in a phone interview with Nurse #1, she stated she would need to clarify the order to know where to apply the [MEDICATION NAME] ointment on Resident #3's skin. Nurse #1 stated she could not remember who would have processed this order and said she did not contact the physician for clarification. Nurse #1 stated she was not certain where it was applied. The DON stated in an interview on [DATE] at 4:30 PM that the order for the [MEDICATION NAME] 0.1% ointment should have been clarified so that staff would know where to apply it on Resident #3's body. The physician stated in an interview on [DATE] at 9:55 AM that he would expect the nurse to contact the physician who ordered the [MEDICATION NAME] ointment to clarify where it was to be applied. 2. Resident # 2 was admitted to the facility with [DIAGNOSES REDACTED]. A review of the admission minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 received insulin seven of seven days per week. The physician's orders [REDACTED]. An additional insulin order dated [DATE] for Resident # 2 was present as follows: [MEDICATION NAME] 100 units per ml [MEDICATION NAME], give 8 units with or after meals. The order did not indicate which meals were to be included with the insulin administration, and there was no route of administration included in the order. Another physician's orders [REDACTED]. Further review of the physician's orders [REDACTED]. The sliding scale included with the order was as follows: 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 - 400 = 10 units. A review of the (MONTH) and (MONTH) (YEAR) Medication Administration Record [REDACTED]. The (MONTH) (YEAR) MAR indicated [REDACTED]. In an interview with Nurse # 3 on [DATE] at 3:08 PM, she reviewed the [MEDICATION NAME]order dated [DATE] and stated the order needed to be clarified to determine the number of meals (all 3 meals or just 2 meals) when the [MEDICATION NAME]8 units should be administered. Nurse #3 further stated that a route of administration (subcutaneously) should be included with the order. She also added that Resident #3 had several different orders for insulin, including another [MEDICATION NAME]order to be administered at lunch time, as well as [MEDICATION NAME] per sliding scale four times per day, and that each order needed to include frequency of administration to avoid confusion. Nurse #3 continued, saying that it was not clear whether the [MEDICATION NAME] should be administered per sliding scale in addition to the other meal time [MEDICATION NAME]orders. She explained she did not process the order for the [MEDICATION NAME] and she did not know who did. The Director of Nursing (DON) stated in an interview on [DATE] at 4:30 PM that he would clarify the [MEDICATION NAME] orders so that it would be clear when the 8 units should be administered (with breakfast and supper) and to determine if the sliding scale insulin should be included with each meal in addition to the separate insulin administration with breakfast, lunch, and supper. He stated the physician orders [REDACTED]. 3. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's Physician order [REDACTED]. a. An order dated [DATE] read, [MEDICATION NAME] Powder Packet mix ,[DATE] ounces of fluid and give for constipation There was no frequency included in the order. b. An order dated [DATE] read, [MEDICATION NAME] ,[DATE] Kwikpen, inject 20 units under the skin every evening. c. An order dated [DATE] read, [MEDICATION NAME] ,[DATE] Kwikpen, give 33 units under the skin every morning. The medication orders were shared with the Administrator on [DATE] at 1:20 PM. The Administrator indicated the [MEDICATION NAME] order should include the frequency of administration. At 2:42 PM on [DATE], the Director of Nursing specified the insulin orders should have been recorded with the medical term 'subcutaneous' instead of 'under the skin' as it had been written.

F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff, family and resident interviews it was determined that facility staff failed to report a fall for 1 of 2 sampled residents (#16) to administration for analysis and implementation of appropriate fall interventions. Findings included:

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	345529	A. BUILDING ______ B. WING _____	**04/15/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) Resident # 16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Review of the medical record 4/14/18 revealed a nursing note 4/11/18 4:51 am which stated, 4/10/18 at 7:45 PM patient noted to be hanging almost off the bed. Patient assisted back to bed 8:10 PM. One of the (family) members alerted this nurse that he had observed patient using his bed control to high position and was almost sliding off the bed. Patient observed way up hanging the bed. Patient continue to hang off the bed, restless throughout the night. Unable to redirect. Will continue to monitor. Therapy note 4/11/18 1:22 PM stated, Patient reports recent fall, but unclear about details and number of falls. Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that the resident was telling her every time he had a fall. She stated that he had goose egg on his head. She said that she had not been notified by the facility that Resident #16 had any falls. She stated that the rehabilitation manager and the social worker admitted that the resident had 6 falls during a care plan meeting. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a shot of the resident's unoccupied bed. Staff was seen entering the room and talking to someone below the bed on the other side. A staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Interview with the administrator at 3:53 PM on 4/14/18 revealed that if a resident has a fall the nurse will assess for injury, the MD and family are notified and the incident is available for review in clinical rounds. Falls are investigated as needed. During interview with the social worker at 4:25 PM on 4/14/18 she reported that she, the rehabilitation manager and the resident's family member had a care plan meeting in 4/12/18. She said that she asked about concerns at the end of the meeting. Resident #16's family member said that the resident complained about staff being rude on 3rd shift. The social worker wrote the concerns up on a grievance form. Per review of the grievance form dated 4/12/18; the concern was addressed in the interdisciplinary team meeting on 4/12/18. The attachment to the grievance form stated 4/1/18 (fall). Social worker planned to follow up with the resident's family member on Monday 4/17/18. During interview with the rehabilitation manager on 4/15/18 at 2:20 PM, he stated that he did not remember the family member saying anything about falls during the care plan meeting. He reported that the falls log indicated that the resident had 2 falls per the incident log, one fall occurred on (MONTH) 1st. Interview with a nursing assistant on 4/15/18 at 1:31 PM revealed that she found the Resident #16 on the floor and reported it to the nurse. She stated they tried to transfer him to bed because the lift could not go down to the floor. They got a 3rd person to help because it was so hard and it was killing their back. The NA said she did not report the fall to the nurse because the nurse was there. Interview via telephone on 4/15/18 at 2:45 PM with nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported to her that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse #4 stated she went to the room but did not go inside immediately because she needed help to get him up. The nurse stated that she, another nurse and the NA went into the room the resident was laying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She further stated that the night he fell it was documented, put in electronic chart under notes.