STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526**

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 0580 **Level of harm -** Minimal harm or potential for 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 record reviews, staff and family interviews, the facility failed to notify the resident ' s responsible party of a new skin condition and treatment for 1 of 3 resident reviewed for notification of changes. (Resident #6) Findings included: Resident #6 was admitted to the facility on [DATE] for rehabilitation. Resident #6 ' s [DIAGNOSES REDACTED]. The 5-day admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #6 was cognitively impaired and required extensive assistance with bed mobility, transfers and toileting. The MDS further noted no skin conditions were present on admission. The care plan dated 4/25/20 stated Resident #6 had actual alterations in skin integrity as evidenced by a right hip surgical wound, right forearm skin tear and sacrum/buttock excoriation. The resident was at risk for further breakdown/pressure ulcers due to impaired bed mobility, weakness and episodes of incontinence. Resident #6 ' s medical record revealed the responsible party (RP) was a family member. A physician order [REDACTED]. The physician telephone order was taken by Nurse #2. A review of the nurses notes did not indicate the RP was notified of Resident #6 ' s skin condition or treatment ordered by the physician. An interview was conducted with Nurse #1 on 8/10/20 at 1:30pm. Nurse #1 stated the nurse receiving the order from the physician for a new wound was responsible for calling and informing the RP. An interview was conducted on 8/10/20 at 3:10pm with Nurse #2. Nurse #2 stated she was unable to recall taking the order from the physician or calling the RP. Nurse #2 stated it is her practice to call and make the RP aware of a new order and document in the nurses notes the notification. Nurse #2 stated the reason the notification was not documented could be due to the facility being short staffed. An interview was conducted with Resident #6 ' s RP on 8/10/20 at 11:55am. The RP stated the facility did not notify her of a new skin condition or ordered treatment. On 8/5/20, the Director of Nursing stated if a new order was placed the staff were to notify the RP.

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.