STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/30/19 and 10/31/19.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 1 building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that residents' evacuation capabilities were different from the evacuation capability listed on the facility's license for 1 of 3 sampled residents (Resident #1) who had cognitive and physical impairments which could prevent the resident from independently evacuating the facility. The findings are: Review of the facility's license with an effective date of 01/01/19 revealed the facility was licensed for a capacity of 6 ambulatory residents. Observation of the facility on 10/30/19 between 9:30am and 10:00am revealed: -The front entrance had a ramp with rails. -The facility was not equipped with a sprinkler system. -The facility had a side door off the dining room that led to a wooden deck; there was a ramp with rails connected to the deck that led to the yard. -Resident #1 was seated in a chair, wearing a brace over her torso. Review of the facility's Fire Rehearsal Schedule dated 07/17/19 revealed: -There was a fire drill conducted at 12:05pm. -The Supervisor in Charge (SIC) assisted Resident #1 down the ramp. -The total time for all residents to evacuate the	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 2	C 007		

facility was 3 minutes.

Review of the facility's Fire Rehearsal Schedule dated 08/26/19 revealed:
-There was a fire drill conducted at 4:00pm.
-Resident #1 was napping and remained in her room until the SIC "went to Resident #1's room to see how Resident #1 responded".
-The SIC assisted Resident #1 with her shoes and Resident #1 exited the bedroom, went down the hall and out the front door.
-The total time for all residents to evacuate the facility was 3 minutes.

Interview with Resident #1 on 10/30/19 at 2:50pm revealed:
-She participated in a fire drill every month.
- "I need help, but I can get up on my own."
-Sometimes she needed help evacuating the facility during the fire drills, especially if she was in bed when the alarm sounded.

Telephone interview with the Executive Officer on 10/31/19 at 11:28am revealed:
-Staff made sure Resident #1 did not "topple over" during fire drills.
-He had not noticed a change or decline in Resident #1's condition.
-Resident #1 was always the first resident to respond to fire drills, but staff had to remind her to take her time because she was always in a hurry.
-He had not notified the construction section that Resident #1 may not be able to evacuate the facility without prompting.
-He had not notified the construction section that Resident #1 required a walker to assist with ambulation.
-He did not know he needed to notify the construction section, since construction had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 3 to the facility in the spring of 2019. Refer to Tag C022 10A NCAC 13G .0302(b) Design and Construction Tag 0022 (Type B Violation)	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure that residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's license for 1 of 3 sampled residents (#1) residing at the facility, who had cognitive and physical impairments which could prevent the resident from independently evacuating the facility. The findings are: Review of the facility's license with an effective date of 01/01/19 revealed the facility was licensed for a capacity of 6 ambulatory residents. Observation of the facility on 10/30/19 between 9:30am and 10:00am revealed:	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 4	C 022		

-The front entrance had a ramp with rails.
-The facility was not equipped with a sprinkler system.
-The facility had a side door off the dining room that led to a wooden deck; there was a ramp with rails connected to the deck that led to the yard.
-There were three residents sitting in the living room.
-Resident #1 was seated in a chair, wearing a brace over her torso.
-There was one staff working.

Review of the staff scheduled/calendar on 10/30/19 at 9:40am revealed there was one staff scheduled for each shift.

Interview with the Supervisor-In-Charge (SIC) on 10/30/19 at 12:20pm revealed:
-Staff workd 7:00am-7:00pm and 7:00pm-7:00am (12 hour shifts) every day during the week except Friday.
-On Fridays, one staff worked 7:00pm-11:00pm and another staff came in from 11:00pm-7:00am.
-Staff worked 12 hours shifts on Saturdays, and on Sunday, one staff worked 7:00am-3:00pm; another staff came in and worked from 3:00pm-7:00am.

Second interview with the SIC on 10/30/19 at 9:45am revealed:
-There census was four residents.
-There were currently three residents residing in the facility; one resident was in a rehabilitation facility.
-Resident #1's family member was taking Resident #1 to an appointment.

Review of Resident #1's current FL-2 dated 10/08/19 revealed:
-Diagnoses included seizure disorder,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 5	C 022		

hypertension, urinary incontinence, memory loss, osteoporosis, refractory epilepsy, and right rib fracture.
-Resident #1 required assistance with bathing and dressing.
-Resident #1 was ambulatory.
-There was no documentation regarding Resident #1's orientation.

Review of Resident #1's previous FL-2 dated 12/17/18 revealed diagnoses included generalized epilepsy, dementia, dysthymic disorder, hypertension and urinary incontinence.

Review of Resident #1's Resident Register dated 12/02/17 revealed:
-Resident #1 needed assistance with dressing, bathing, ambulation, and toileting.
-Resident #1 was forgetful and needed reminders.
-Resident #1 required a walker for ambulation.

Review of Resident #1's care plan dated 12/10/17 revealed:
-Resident #1 had a history of developmental disabilities.
-There was documentation Resident #1 was a "big" fall risk and needed constant supervision and assistance with mobility around the facility.
-Resident #1 was ambulatory with assistive devices.
-Resident #1 had very limited use of her left side.
-She was forgetful and needed reminders.

Review of the facility's Fire Rehearsal Schedule dated 07/17/19 revealed:
-There was a fire drill conducted at 12:05pm.
-The Supervisor in Charge (SIC) assisted Resident #1 down the ramp.
-The total time for all residents to evacuate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 6 facility was 3 minutes. Review of the facility's Fire Rehearsal Schedule dated 08/26/19 revealed: -There was a fire drill conducted at 4:00pm. -Resident #1 was napping and remained in her room until the SIC "went to Resident #1's room to see how Resident #1 responded". -The SIC assisted Resident #1 with her shoes and Resident #1 exited the bedroom, went down the hall and out the front door. -The total time for all residents to evacuate the facility was 3 minutes. Interview with Resident #1 on 10/30/19 at 2:50pm revealed: -She participated in a fire drill every month. - "I need help, but I can get up on my own." -She needed staff assistance to get into her wheelchair. -Sometimes she needed help evacuating the facility during the fire drills, especially if she was in bed when the alarm sounded. Interview with the medication aide/Supervisor-In-Charge (MA/SIC) on 10/31/19 at 9:00am revealed: -The lead MA/SIC conducted fire drills monthly. -She had never conducted a fire drill, but she observed one during orientation at the facility, so she would know how to conduct a fire drill. Second interview with the MA/SIC on 10/31/19 at 11:10 am revealed: -She did not know how to complete a fire drill. -In the event of a fire, she would get the residents out of the facility. -She would have to "go behind" Resident #1 because she needed stand-by assistance. -She would have to call the lead MA/SIC or the	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 7 Executive Officer in order to conduct a fire drill, because the lead MA/SIC always conducted fire drills, and she would need to ask the Co-Administrator how to activate the fire alarm. Telephone interview with the Executive Officer on 10/31/19 at 11:18am revealed: -The alarm system had the option to be set off remotely. -He scheduled remote activation of the fire alarm for fire drills at the facility. Observation of a fire drill conducted by the MA/SIC on 10/31/19 at 11:21am revealed: -The alarm sounded. -Resident #1 stood from the living room chair and walked with her walker toward the side door without prompting. -The MA/SIC came up behind Resident #1 and placed a hand on the resident's back and the other on her walker. -The MA/SIC told Resident #1 she was going to just help her get her walker over the door threshold. -The MA/SIC assisted Resident #1 with getting her walker over the threshold. -The other two residents exited through the side door independently without prompting. -All three residents and the MA/SIC were outside at the fence in 41 seconds. Telephone interview with Resident #1's guardian on 10/30/19 at 8:06pm revealed: -In the event of a fire or other emergency, Resident #1 would need staff assistance to evacuate. -Resident #1 was confused at times and forgetful. -Resident #1 tended to get in a hurry, and she would fall.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 8	C 022		

Telephone interview with the MA/SIC on 10/30/19 at 7:48pm revealed:
-Resident #1 needed assistance with getting out of bed.
-Resident #1 used a walker.
-Resident #1 wanted to be independent and do things herself.

Telephone interview with another MA/SIC on 10/31/19 at 9:49am revealed:
-Resident #1 needed help with activities of daily living, including showering and cleaning herself after toileting.
-Resident #1 had pain, but the pain was getting better, and she was able to get out of bed more independently.
-Fire drills were conducted during the day shift, and she only worked at night.
-Resident #1 would likely be able to evacuate the facility one day, but unable to the next day because she "forgets."

Interview with Resident #1's Occupational Therapist on 10/31/19 at 10:30am revealed:
-Today (10/31/19) was her third visit with Resident #1.
-Resident #1 was doing better but was never going to be independent.
-She needed assistance mainly because of her history of dementia and could not recall cues, but she currently had physical limitations that affected her ability.
-Resident #1 could not evacuate the facility without assistance from staff.

Interview with the Administrator on 10/30/19 at 4:00pm revealed:
-Resident #1 could not comprehend things.
-Staff were continuously talking to Resident #1 and reminding her to call for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 9 -Resident #1 always promised to ask for assistance; she was "very stubborn" which was why she continued to fall. Telephone interview with the Co-Administrator on 10/31/19 at 11:28am revealed: -Staff made sure Resident #1 did not "topple over" during fire drills. -He had not noticed a change or decline in Resident #1's condition. -Resident #1 was always the first resident to respond to fire drills, but staff had to remind her to take her time because she was always in a hurry. -If Resident #1 was told to wait for staff, she would, but staff would still have to remind her. -Resident #1 could evacuate, because he had seen the drills on camera; she could get up and go in the direction she was supposed to leave the facility. Telephone interview with the nurse from Resident #1's Primary Care Provider's (PCP) office on 10/31/19 at 8:21 am revealed: -The PCP was aware Resident #1 fell on 10/07/19 and was currently wearing a brace. -Given the resident's history of dementia, seizures and falls, Resident #1 would need assistance from staff to evacuate the facility in the event of a fire. _____ The facility failed to assure the evacuation capabilities of Resident #1 were consistent with the current license status of 6 ambulatory residents. The facility's failure to assure residents residing at the facility were able to evacuate in an emergency without physical or verbal prompting by staff was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 10 The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2019.	C 022		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision according to the resident's assessed needs and current symptoms for 1 of 3 sampled residents (#1), who had multiple falls resulting in injuries to the resident's shoulder, hand and neck, and a compression fracture of the spine and fractured ribs. The findings are: Review of Resident #1's current FL-2 dated 10/08/19 revealed: -Diagnoses included seizure disorder, hypertension, urinary incontinence, memory loss, osteoporosis, refractory epilepsy, and right rib fracture. -Resident #1 required assistance with bathing	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 11 and dressing. Review of Resident #1's previous FL-2 dated 12/17/18 revealed diagnoses included generalized epilepsy, dementia, dysthymic disorder, hypertension and urinary incontinence. Review of Resident #1's Resident Register dated 12/02/17 revealed: -Resident #1 needed assistance with dressing, bathing, ambulation, and toileting. -Resident #1 was forgetful and needed reminders. -Resident #1 required a walker for ambulation. Review of Resident #1's care plan dated 12/10/17 revealed: -Resident #1 had a history of developmental disabilities. -There was documentation Resident #1 was a "big" fall risk and needed constant supervision and assistance with mobility around the facility. -Resident #1 was ambulatory with assistive devices. -Resident #1 had very limited use of her left side. -She was forgetful and needed reminders. -She required extensive assistance with bathing. Review of an Accident/Incident Report for Resident #1 dated 02/10/19 revealed: -At 7:12am, the medication aide/Supervisor-In-Charge (MA/SIC) responded to Resident #1's call for help. -The MA/SIC found Resident #1 on her knees beside the bed. -The resident stated she went to the bathroom and when she came back, she slipped. -The MA/SIC assisted Resident #1 back to bed; the resident did not have any complaints. -There was no documentation for "plan of	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 12	C 243		

treatment" as indicated on the Accident/Incident Report.

Attempted telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 02/10/19, on 10/31/19 at 8:20pm was unsuccessful.

Review of Resident #1's record revealed there was no documentation the Primary Care Provider (PCP) had been notified of Resident #1's fall, there was no increase in supervision nor, and there were no interventions implemented.

Review of an Accident/Incident Report for Resident #1 dated 05/13/19 revealed:
-At 1:10pm, the resident fell out of the chair at the kitchen table.
-She hit the back of her head on the floor and her right cheek hit the cord adapter.
-Resident #1 was able to answer simple questions to determine if there was a head injury.
-Staff assisted the resident back into the chair and applied ice to Resident #1's right cheek, shoulder, hand, and the back of her neck.
-Ibuprofen (a nonsteroidal anti-inflammatory medication used to treat minor pain) was administered.

Interview with the lead MA/SIC, who completed the Accident/Incident Report dated 05/13/19, on 10/30/19 at 12:15pm revealed:
-On 05/13/19, the resident fell from the dining table chair.
-The lead MA/SIC was present but could not get to the resident in time to prevent the fall.
-Resident #1 was not injured from the fall.
-The facility's policy was to send a resident to the emergency room (ER) if the resident was injured from a fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 13	C 243		

-Staff had encouraged Resident #1 to call for help.
-She had a bell sitting on her night stand in her bedroom that staff gave her to use when she needed assistance.
-Staff checked on residents every two hours.
-There had not been any additional interventions or increased supervision for Resident #1.

Review of Resident #1's record revealed there was no documentation the Primary Care Provider (PCP) had been notified of Resident #1's fall, there was no increase in supervision nor, and there were no interventions implemented.

Review of an Accident/Incident Report for Resident #1 dated 09/05/19 revealed:
-At 1:15pm, staff was in the bathroom and heard a sound coming from the living room.
-When staff reached the living room, Resident #1 was found on the floor.
-The resident said she was trying to adjust her shoe.
-Resident #1 was helped back into the chair.
-There were no injuries documented.
-There was no documentation for "plan of treatment" as indicated on the Accident/Incident Report.

Telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 09/05/19, on 10/30/19 at 7:48pm revealed:
-When she was hired at the facility, she was told Resident #1 was a "frequent faller."
-On 09/05/19, Resident #1 fell while the MA/SIC was using the bathroom.
-The MA/SIC heard Resident #1 fall and went to see what happened.
-Resident #1 was on the floor and said she was trying to tie her shoes and slid out of the chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 14	C 243		

-Staff had told Resident #1 to call for assistance.
-Resident #1 had to have assistance with getting out of bed and pulling up/down her pants.
-Resident #1 used a walker and had a bell by her bed.
-The MA/SIC checked on Resident #1 every 15-20 minutes when the resident was napping.
-Resident #1 wanted to be independent and do things herself.
-Resident #1 would sometimes ring her bell or call the staff's name if she needed assistance.
-There had been no increase in supervision and no interventions implemented that she was aware of.

Review of Resident #1's record revealed there was no documentation the Primary Care Provider (PCP) had been notified of Resident #1's fall, there was no increase in supervision nor, and there were no interventions implemented.

Review of an Accident/Incident Report for Resident #1 dated 10/02/19 revealed:
-At 4:35am, Resident #1 fell while trying to use the bathroom.
-Resident #1 fell on the floor between the bedroom and door to the bathroom.
-The resident was supposed to call for assistance but failed to do so until she had fallen.
-Resident #1 was assisted from the floor and given Ibuprofen upon request.

Telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 10/02/19, on 10/31/19 at 9:49am revealed:
-Resident #1 needed assistance because she was a "fall risk."
-Resident #1 needed assistance with her shower and cleaning herself after toileting.
-On 10/02/19, Resident #1 got out of bed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 15	C 243		

herself and fell.
-When the MA/SIC found the resident, she was on the floor by the bathroom.
-Resident #1 "tended to be reckless."
-Resident #1 was checked on every 2-3 hours; that was what she had been trained to do.
-She had a bell to ring if she needed assistance, but the resident's voice was louder than the bell.
-The resident did not always remember to use the bell.

Review of Resident #1's record revealed there was no documentation the Primary Care Provider (PCP) had been notified of Resident #1's fall, there was no increase in supervision nor, and there were no interventions implemented.

Review of an Accident/Incident Report for Resident #1 dated 10/07/19 revealed:
-At 3:20am, the MA/SIC heard a sound from Resident #1's room, so he rushed to her room and found her on the floor.
-The resident told the MA/SIC she was trying to get off the bed when she slipped from the bed and fell.
-An addendum was added to the Accident/Incident Report that Ibuprofen was administered at 4:00am.

Telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 10/07/19, on 10/30/19 at 4:47pm revealed:
-On 10/07/19, Resident #1's roommate had been calling for assistance frequently.
-He had been out of Resident #1's room about 15-20 minutes when he heard a sound.
-He went to the room and Resident #1 was lying on the floor by the bed.
-Resident #1 told him she fell from her bed.
-The MA/SIC called another resident to help him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 16	C 243		

get Resident #1 off the floor.
- "A few minutes later," Resident #1 complained of back pain, so he gave her Ibuprofen.
-There were no visible injuries at that time.
-There had been no increase in supervision or interventions implemented other than reminding Resident #1 to call for assistance.

Second interview with the lead MA/SIC on 10/30/19 at 12:15pm revealed:
-The third shift staff checked Resident #1 after she fell on 10/07/19 to "the best of his knowledge" and Resident #1 was okay.
-The third shift staff helped Resident #1 back to bed after checking her.
-She came on shift at 7:00am after the resident fell at 3:20am.
-Resident #1 went to the emergency room (ER) that morning after the fall because she complained of pain.

Review of a hospital discharge summary for Resident #1 dated 10/08/19 revealed:
-Resident #1 was admitted to the hospital on 10/07/19 with a right rib fracture and T12 compression fracture, resulting from a fall.
-Resident #1 reported falling and hitting her head.
-There was mild bruising on the back of her head.
-She complained of low thoracic pain that was worse with movement; she rated her pain 9 out of 10.
-Resident #1 had a CT (computed tomography) scan that revealed an acute T12 compression fracture (fracture of her twelth thoraic vertebra), displaced posterior right ninth rib fracture and nondisplaced posterior right tenth rib fracture.
-Resident #1 was to wear a TSLO (thoracic lumbar sacral orthosis) brace for three months.
-Physical Therapy evaluated the resident while in the hospital and recommended 24-hour

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 17	C 243		

assistance and intensive rehabilitation.

Review of Resident #1's record revealed there was no documentation the Primary Care Provider (PCP) had been notified of Resident #1's fall, there was no increase in supervision nor, and there were no interventions implemented.

Review of an Accident/Incident Report for Resident #1 dated 10/11/19 revealed:
-At 1:20pm, Resident #1 called out for assistance from staff.
-When staff went to Resident #1's room, she was half off the bed; her legs were hanging off and she was holding onto the bed rail.
-The staff attempted to put Resident #1's legs back on the bed, but the resident "was too far."
-The staff assisted the resident to transition safely to the floor and enlisted additional assistance to pick her up from the floor and onto the chair.
-The resident stated she was "okay and did not sustain any further injury to her ribs."
-The staff readjusted the bed rails to prevent another incident.

Interview with the lead MA/SIC, who completed the Accident/Incident Report dated 10/11/19, on 10/30/19 at 12:15pm revealed:
-Resident #1's family member brought in the bed rails to help keep the resident in the bed.
-Resident #1 was able to move around and get out of bed with the bed rails in place.
-Resident #1 did not call for assistance on 10/11/19 which resulted in her falling from her bed.
-Resident #1 was currently wearing a brace from the 10/07/19 fall and was receiving physical therapy and occupational therapy.
-There had been no increase in supervision or further interventions implemented for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 18 #1. Observation of Resident #1's bedroom on 10/30/19 at 10:55am revealed there was a single bed rail on each side of Resident #1's bed. Interview with Resident #1 on 10/30/19 at 9:15am revealed: -She was wearing a back brace because she fell out of her bed three weeks ago. -She had bed rails on her bed; she leaned back while in bed, but the rail was not there, and she fell out of the bed onto the floor on her back. Observation of Resident #1's bedroom on 10/30/19 at 2:50pm revealed: -Resident #1 was lying in her bed. -There was a single bed rail on each side of her bed. -On the left side of the bed, Resident #1's walker was pushed up next to the mattress and beside the bed rail. -On the right side of the bed, there was a chair pushed up next to the mattress and beside the bed rail. Interview with Resident #1 on 10/30/19 at 2:50pm and 5:00pm revealed: -On the night she fell in early October 2019, the staff working did not know what to do. -She did not have pain at the time of the fall, but it soon started hurting bad. -She went to the hospital later that morning. -She was still having pain from the fall, but it was getting better. -She was getting physical therapy, but she did not think it was helping. -Her family member brought in the bed rails from home. - "I need help, but I can get out of bed on my	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 19	C 243		

own."
-The lead MA/SIC put the chair and walker at each end of her bed to keep her from falling off the bed.

Telephone interview with Resident #1's guardian on 10/30/19 at 3:15pm revealed:
-She was notified of Resident #1's last fall on 10/11/19 by the Administrator.
-Resident #1 had another fall prior to 10/11/19 (could not recall date) when she fell out of bed and sustained a compression fracture.
-Currently, Resident #1 was receiving therapy, had to wear a brace and was in a lot of pain.
-The POA brought in the bed rails for Resident #1 because Resident #1 was falling out of bed.
-When Resident #1 stayed at home, she had a double bed and could move around more; the bed at the facility was smaller, and the resident was sliding off the bed.
-Resident #1 was supposed to call for assistance.

Interview with the lead MA/SIC on 10/30/19 at 3:40pm revealed:
-She had been putting the walker and chair next to Resident #1's bed after the fall on 10/11/19 to keep the resident in bed.
-The staff had never tried using a fall mat, bed alarm or pushing Resident #1's bed against the wall.
-There had been no increase in supervision.

Interview with Resident #1's Occupational Therapist on 10/31/19 at 10:30am revealed:
-This was her third visit with Resident #1.
-Resident #1 was doing better, but she was never going to be independent.
-Resident #1 would always need assistance mainly because of her history of dementia and not being able to recall cues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 20 -Resident #1 also had physical capabilities that limited her from being independent. Telephone interview with the Administrator on 10/30/19 at 4:04pm revealed: -Resident #1 wanted to be independent and did not comprehend what staff told her such as not to get up unassisted. -Even though Resident #1 did not comprehend what staff told her, it did help for staff to tell her to use the hand bell and the resident promised to ask for assistance. -Resident #1 was able to get out of bed with the bed rails. -The walker and the bedside chair were not supposed to be pushed up against the bed; the chair was for Resident #1 to sit in. -She had not considered fall prevention interventions such as a floor mat, concave mattress, mattress wedge and bed alarm. -Staff were expected to check residents every two hours. -She did not usually keep policies in the facility and would have to check her office for policies related to falls and supervision. -Staff were expected to send a resident to the ER if a resident complained of pain following a fall. -She, the Executive Officer or SIC normally called the primary care provider (PCP) because staff might not know the proper procedure. Telephone interview with the Registered Nurse from Resident #1's PCP office on 10/31/19 at 8:21am revealed: -The PCP was not familiar with the frequency of Resident #1's falls. -The PCP knew about the fall on 10/07/19 because she had been for a follow-up visit from the hospital stay regarding that fall and was currently wearing a brace.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 21 -There had been no recommendations given to the staff on any interventions to implement since the PCP was not aware of the number of falls. -The PCP would prefer for Resident #1 to be checked on more often than every 2 hours, but the facility staff were "probably" not able to check on her more frequently. -The PCP would want to be notified about Resident #1's falls or any incident that resulted in injury to the resident. The facility's failure to provide supervision according to Resident #1's assessed needs and current symptoms resulted in the resident having multiple falls. Resident #1, who had a history of dementia and frequent falls, had a fall on 10/07/19 that resulted in a head injury, compression fracture, two fractured ribs and severe pain. No increase in supervision or other interventions were implemented as a result of these falls, and Resident #1 had another fall on 10/11/19. This failure resulted in significant physical harm and neglect to Resident #1, which constitutes a Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/31/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2019.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 22 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the primary care provider for 1 of 3 residents sampled (#1), who had multiple falls and a delay in receiving medical treatment after a fall. The findings are: Review of Resident #1's current FL-2 dated 10/08/19 revealed: -Diagnoses included seizure disorder, hypertension, urinary incontinence, memory loss, osteoporosis, refractory epilepsy, and right rib fracture. -Resident #1 required assistance with bathing and dressing. Review of Resident #1's previous FL-2 dated 12/17/18 revealed diagnoses included generalized epilepsy, dementia, dysthymic disorder, hypertension and urinary incontinence. Review of Resident #1's Resident Register dated 12/02/17 revealed: -Resident #1 needed assistance with dressing, bathing, ambulation, and toileting. -Resident #1 was forgetful and needed reminders. -Resident #1 required a walker for ambulation. Review of Resident #1's care plan dated 12/10/17 revealed: -Resident #1 had a history of developmental disabilities. -There was documentation Resident #1 was a "big" fall risk and needed constant supervision	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 23	C 246		

and assistance with mobility around the facility.
-Resident #1 was ambulatory with assistive devices.
-Resident #1 had very limited use of her left side.
-She was forgetful and needed reminders.

Observation of Resident #1's bedroom on 10/30/19 at 10:55am revealed there was a single bed rail on each side of Resident #1's bed.

Interview with Resident #1 on 10/30/19 at 9:15am revealed:
-She was wearing a back brace because she fell out of her bed three weeks ago.
-She had bed rails on her bed; she leaned back while in bed, but the rail was not there, and she fell out of the bed onto the floor on her back.
-She had a history of seizures, but it had been a while since she had a seizure.
-She had a vagus nerve stimulator (VNS) device with a magnet that prevented seizures.

Observation of Resident #1's bedroom on 10/30/19 at 2:50pm revealed:
-Resident #1 was lying in her bed.
-There was a single bed rail on each side of her bed.
-On the left side of the bed, Resident #1's walker was pushed up next to the mattress and beside the bed rail.
-On the right side of the bed, there was a chair pushed up next to the mattress and beside the bed rail.

1. Review of an Accident/Incident Report for Resident #1 dated 10/07/19 revealed:
-At 3:20am, the medication aide/Supervisor-In-Charge (MA/SIC) heard a sound from Resident #1's room, so he rushed to her room and found her on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 24 -The resident told the MA/SIC she was trying to get off the bed when she slipped from the bed and fell. -An addendum was added to the Accident/Incident Report that Ibuprofen was administered at 4:00am. Telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 10/07/19, on 10/30/19 at 4:47pm revealed: -On 10/07/19, Resident #1's roommate had been calling for assistance frequently. -He had been out of Resident #1's room about 15-20 minutes when he heard a sound. -He went to the room and Resident #1 was lying on the floor by the bed. -Resident #1 told him she fell from her bed. -The MA/SIC called another resident to help him get Resident #1 off the floor. - "A few minutes later," Resident #1 complained of back pain, so he gave her Ibuprofen. -There were no visible injuries at that time. Interview with the lead MA/SIC on 10/30/19 at 12:15pm revealed: -The facility's policy was to send a resident to the emergency room (ER) if the resident was injured from a fall. -Staff completed an Accident/Incident Report and notified the Administrator. -It would be the Administrator who called the primary care provider (PCP). -The third shift staff checked Resident #1 after she fell on 10/07/19 to "the best of his knowledge" and Resident #1 was okay. -The third shift staff helped Resident #1 back to bed after checking her. -She did not know why the resident was not sent to the ER when she fell; came on shift at 7:00am after the resident fell at 3:20am.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 25 -Resident #1 went to the ER that morning after the fall because she complained of pain. Interview with Resident #1 on 10/30/19 at 2:50pm and 5:00pm revealed: -On the night she fell in early October 2019, the staff working did not know what to do. -She did not have pain at the time of the fall, but it soon started hurting bad. -She could not recall how long it was from the time she was given Ibuporfen until she went to the hospital. -She always took Ibuprofen for pain. -She went to the hospital later that morning. -She was still having pain from the fall. Review of Resident #1's medication administration record for October 2019 revealed: -There was an entry for Ibuprofen 200mg three times a day as needed for pain. -There was documentation Resident #1 had been administered Ibuprofen on 11 occasions prior to the fall on 10/07/19 at various times. . -There was documentation Resident #1 had been administered Ibuprofen on 24 occasions from 10/08/19-10/30/19 at various times. -There was an entry for Acetaminophen (a mild pain reliever) 325mg as needed for mild pain. -There was documentation Resident #1 had been administered Acetaminophen on 15 occasions since the fall on 10/07/19, but was not documented as administered prior to the fall on 10/07/19. Review of Resident #1's Emergency Medical Services (EMS) report dated 10/07/19 revealed: -EMS was dispatched to the facility at 8:36am and arrived at the facility at 8:44am. -Upon assessment, Resident #1 stated she fell out of her bed (approximately 2 feet) at 3:30am	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 26	C 246		

and landed on her back, hitting her head.
-Resident #1's chief complaint was pain in her ribs and back.
-A small bump was found on the back of her head and extreme (10 of 10) pain was noted upon palpation to the right lateral side of her ribs.
-Resident #1 also noted difficulty breathing whenever she moved, stating she held her breath due to pain.
-Resident #1 was visibly holding her breath and described the pain as "spasms that come and go."
-The resident arrived at the local ER at 9:32am.

Review of a hospital discharge summary for Resident #1 dated 10/08/19 revealed:
-Resident #1 was admitted to the hospital on 10/07/19 with a right rib fracture and T12 compression fracture, resulting from a fall.
-Resident #1 reported falling and hitting her head.
-There was mild bruising to the occiput of her head.
-She complained of low thoracic pain that was worse with movement; she rated her pain 9 out of 10.
-Resident #1 had a CT (computed tomography) scan that revealed an acute T12 compression fracture, displaced posterior right ninth rib fracture and nondisplaced posterior right tenth rib fracture.
-Resident #1 was to wear a TSLO (thoracic lumbar sacral orthosis) brace for three months.

Telephone interview with the Administrator on 10/30/19 at 4:04pm revealed:
-Staff were expected to send a resident to the emergency room (ER) if a resident complained of pain following a fall.
-Staff were able to call EMS for residents if that was needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 27	C 246		

-Staff were expected to evaluate the situation, "if there was an emergency, they call 911 and then call us (Administrator and/or Co-Administrator)."
-She, the Co-Administrator or the lead SIC normally called the PCP because staff might not know the proper procedure.
-Usually, "we go there to evaluate them."
-She did not know why Resident #1 was sent to the ER so late after the fall on 10/07/19.

Telephone interview with the Co-Administrator on 10/31/19 at 11:28am revealed:
-Resident #1 had pain before the fall on 10/07/19, so staff did not know if the pain was new.
-She had fallen before and asked for Ibuprofen all the time.
-The assessment completed by staff at 3:00am on 10/07/19 was not the kind of assessment to determine if she had injuries.
-Later that morning (10/07/19), staff was able to determine Resident #1's complaints of pain were "new pain."
-The staff working at the time of the fall never saw her fall, so he helped her to the bathroom and back to bed; then, Resident #1 asked for pain medication.
- "We did what we could at the time; we did not know what kind of injury she had."
-Resident #1 was taken to the hospital when staff determined the fall was causing more pain.
-Resident #1 was able to talk to staff about her pain.
-He expected staff to complete an assessment after a fall.
-He would have to look for a policy related to falls.

Telephone interview with the Registered Nurse from Resident #1's PCP office on 10/31/19 at 8:21am revealed:
-The PCP knew about the fall on 10/07/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 28	C 246		

because she had been for a follow-up visit from the hospital stay regarding that fall and was currently wearing a brace.
-If Resident #1 had an injury from a fall or any other incident, or complained of pain from a fall, the PCP would expect her to receive medical treatment immediately.

2a. Review of an Accident/Incident Report for Resident #1 dated 02/10/19 revealed:
-On 02/10/19 at 7:12am, the medication aide/Supervisor-In-Charge (MA/SIC) responded to Resident #1's call for help and found Resident #1 on her knees beside the bed.
-The resident stated she went to the bathroom and when she came back, she slipped.
-The MA/SIC assisted Resident #1 back to bed; the resident did not have any complaints.

b. Review of an Accident/Incident Report for Resident #1 dated 05/13/19 revealed:
-On 05/13/19 at 1:10pm, the resident fell out of the chair at the kitchen table, hitting the back of her head on the floor and her right cheek hit the cord adapter.
-Resident #1 was able to answer simple questions to determine if there was a head injury.
-Staff assisted the resident back into the chair and applied ice to Resident #1's right cheek, shoulder, hand, and the back of her neck; Ibuprofen was administered.

c. Review of an Accident/Incident Report for Resident #1 dated 09/05/19 revealed:
-On 09/05/19 at 1:15pm, staff was in the bathroom and heard a sound coming from the living room.
-Resident #1 was found on the floor; the resident said she was trying to adjust her shoe.
-There were no injuries documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 29 d. Review of an Accident/Incident Report for Resident #1 dated 10/02/19 revealed: -On 10/02/19 at 4:35am, Resident #1 fell while trying to use the bathroom. -Resident #1 was assisted from the floor and given Ibuprofen upon request. e. Review of an Accident/Incident Report for Resident #1 dated 10/07/19 revealed: -On 10/07/19 at 3:20am, the MA/SIC heard a sound from Resident #1's room, so he rushed to her room and found her on the floor. - Ibuprofen was administered at 4:00am. f. Review of an Accident/Incident Report for Resident #1 dated 10/11/19 revealed: -On 10/11/19 at 1:20pm, Resident #1 called out for assistance from staff. -When staff went to Resident #1's room, she was half off the bed; her legs were hanging off and she was holding onto the bed rail. -The staff attempted to put Resident #1's legs back on the bed, but the resident "was too far." -The staff assisted the resident to transition safely to the floor and enlisted additional assistance to pick her up from the floor and onto the chair. -The resident stated she was "okay and did not sustain any further injury to her ribs." -The staff readjusted the bed rails to prevent another incident. Review of Resident #1's record revealed there was no documentation the Primary Care Provider (PCP) had been notified of any of Resident #1's falls from 02/10/19-10/11/19. Interview with the lead MA/SIC on 10/30/19 at 12:15pm revealed: -The facility's policy was to send a resident to the	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 30	C 246		

emergency room (ER) if the resident was injured from a fall.
-Staff completed an Accident/Incident Report and notified the Administrator.
-It would be the Administrator who called the primary care provider (PCP).

Telephone interview with another MA/SIC on 10/30/19 at 7:48pm revealed:
-She completed Accident/Incident Reports and gave them to the Administrator.
-The Administrator called the PCP; staff did not.

Telephone interview with a third MA/SIC on 10/31/19 at 9:49 am revealed:
-She completed Accident/Incident Reports for Resident #1's fall and gave the report to the lead MA/SIC.
-First of all, she would call the Administrator.
-She would check the resident for injuries.
-If the resident fell and complained of pain, she would administer Ibuprofen.
-If it was an emergency, she would call 911 immediately, which was what the Administrator had told staff to do.

Telephone interview with the Administrator on 10/30/19 at 4:04pm revealed:
-Staff were expected to send a resident to the emergency room (ER) if a resident complained of pain following a fall.
-She, the Executive Officer or the lead SIC normally called the PCP because staff might not know the proper procedure.
-Usually, "we go there to evaluate them."

Telephone interview with the Executive Officer on 10/31/19 at 11:28am revealed:
-He expected staff to complete an assessment after a fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 31 -He would have to look for a policy related to falls. -He took Resident #1 to appointments with her PCP most of the time. -He would discuss things of concern with the PCP, but he did not mention Resident #1's falls. -The last time he took Resident #1 to the PCP's office was right after she came back from the hospital. -He did not have documentation of communication with the PCP because the PCP wrote her own notes. Telephone interview with the Registered Nurse from Resident #1's PCP office on 10/31/19 at 8:21am revealed: -The PCP was not familiar with the frequency of Resident #1's falls. -Staff had not contacted the PCP about any of Resident #1's falls. -The PCP knew about the fall on 10/07/19 because she had been for a follow-up visit from the hospital stay regarding that fall and was currently wearing a brace. -The PCP would want to be notified about Resident #1's falls or any incident that resulted in injury to the resident. _____ The facility failed to notify Resident #1's primary care provider of six falls from 02/10/19-10/11/19 and delayed referring Resident #1 for medical treatment after a fall on 10/07/19; the resident verbalized complaints of severe pain to her ribs, shortness of breath and had visible bruising to her head after the fall on 10/07/19. The resident did not arrive to the hospital until 6 hours after the fall, where she was diagnosed with a compression fracture, two fractured ribs and mild bruising to her head. This failure resulted in substantial risk for physical harm, pain and neglect to Resident #1, which constitutes a Type	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 32 A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/31/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2019.	C 246		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure accident and incident reports were sent to the Department of Social Services (DSS) within 48 hours for 1 of 1 sampled resident (#1) who experienced a fall with an injury that required emergency medical treatment. The findings are: Review of Resident #1's current FL-2 dated 10/08/19 revealed: -Diagnoses included seizure disorder,	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 444	Continued From page 33	C 444		

hypertension, urinary incontinence, memory loss, osteoporosis, refractory epilepsy, and right rib fracture.
-Resident #1 required assistance with bathing and dressing.

1. Review of an Accident/Incident Report dated 07/17/19 for Resident #1 revealed:
-At 8:45pm, another resident was asking for the television remote; Resident #1 told the other resident she could not change the channel.
-The other resident grabbed Resident #1 and pinched Resident #1's neck.
-The police were notified and upon arrival to the facility, Resident #1 told the police officer her neck was hurting.
-Emergency Medical Services was contacted and Resident #1 was transported to the local emergency room (ER).
-There was a typed note at the bottom of the report that read, "to be completed within 24 hours following accident/incident and returned to the County Department of Social Services (DSS).

Review of a hospital discharge summary for Resident #1 dated 07/17/19 revealed:
-The resident was seen for evaluation after assault.
-Resident #1 did not have any life-threatening injuries, and staff were instructed to separate Resident #1 from the other resident as much as possible.

Telephone interview with the medication aide/Supervisor-In-Charge (MA/SIC), who completed the Accident/Incident Report dated 07/17/19, on 10/30/19 at 3:21pm revealed:
-There was an incident between Resident #1 and another resident about television remote.
-The other resident grabbed Resident #1 by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 444	Continued From page 34	C 444		

neck but did not leave a mark.
-Resident #1 was scared and went to the ER to be checked out.

Interview with Resident #1 on 10/30/19 at 5:00pmn revealed:
-About two months ago, another resident grabbed and choked her.
-There were marks on her neck.
- "I went to the ER because I was afraid."
-There had been no other incidents with the other resident.

Interview with the Adult Home Specialist with the local county DSS office on 10/30/19 at 11:00 am revealed she had not received an Accident/Incident Report for the altercation between Resident #1 and another resident that occurred on 07/17/19.

Refer to interview with the lead MA/SIC on 10/30/19 at 12:15pm.

Refer to telephone interview with the Administrator on 10/30/19 at 4:00pm.

2. Review of an Accident/Incident Report dated 10/07/19 for Resident #1 revealed:
-At 3:20am, Resident #1 was found on the floor in her bedroom.
-Resident #1 told the medication aide/Supervisor-In-Charge (MA/SIC) she was trying to get out of bed when she slipped from the bed and fell.
-There was a typed note at the bottom of the report that read, "to be completed within 24 hours following accident/incident and returned to the County Department of Social Services (DSS).

Review of a hospital discharge summary for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 444	Continued From page 35	C 444		

Resident #1 dated 10/08/19 revealed Resident #1 was admitted to the hospital for a T12 compression fracture following a fall at the assisted living facility.

Telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 10/07/19, on 10/30/19 at 4:47 pm revealed:
-He heard a sound coming from Resident #1's room the night on 10/07/19, so he went to check on her and found her lying on the floor by the bed.
-Resident #1 told him she fell from her bed.
-The MA/SIC asked another resident to assist him in getting Resident #1 off the floor.
-Resident #1 complained of back pain, so he gave her Ibuprofen (Ibuprofen is a non-steroidal anti-inflammatory medication used to treat mild pain).
-There were no visible injuries at that time.
-He contacted the Co-Administrator immediately, and the Co-Administrator asked him to complete an incident report.

Interview with Resident #1 on 10/30/19 at 5:00pm revealed:
-When she fell on 10/07/19, the MA/SIC did not know what to do.
-She did not have pain "right then" but it started "hurting bad" so she went to the hospital.

Interview with the Adult Home Specialist with the local county DSS office on 10/30/19 at 11:00 am revealed she had not received an Accident/Incident Report for Resident #1's fall on 10/07/19.

Refer to interview with the lead MA/SIC on 10/30/19 at 12:15pm.

Refer to telephone interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 444	Continued From page 36 Administrator on 10/30/19 at 4:00pm. Interview with the lead MA/SIC on 10/30/19 at 12:15pm revealed: -Staff completed the Accident/Incident Report after an incident and notified the Co-Administrator and/or the Administrator. -She did not know what happened to the report after the report was completed and given to the Administrator or Co-Administrator. -She had not been asked to send Accident/Incident Reports to the county DSS office. Telephone interview with the Administrator on 10/30/19 at 4:00pm revealed: -When an accident or incident happened, staff called her right away, unless staff thought it was an emergency, in which case they would call 911. -Staff completed the Accident/Incident Report and the Administrator or Co-Administrator reviewed the reports. -She was not aware Accident/Incident Reports that resulted in evaluation at the emergency room or required treatment other than first aid were to be sent to the local DSS office. -She had never known there was rule about reporting accidents or incidents to the local DSS. -If the AHS asked for an incident report, she would fax the report to the AHS.	C 444		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 37 body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 38	C 453		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure bed rails were used only after a written physician order, a team assessment and care planning process, and alternatives were tried prior to the restraint that would provide safety to the resident for 1 of 1 residents sampled (#1), who had bed rails to keep the resident from getting out of bed.

The findings are:

Review of Resident #1's current FL-2 dated 10/08/19 revealed:
-Diagnoses included seizure disorder, hypertension, urinary incontinence, memory loss, osteoporosis, refractory epilepsy, and right rib fracture.
-Resident #1 required assistance with bathing and dressing.
-There was no physician's order for bed rails.

Review of Resident #1's subsequent physician's orders and notes revealed no order for bed rails and documentation of an assessment and care plan regarding the use of bed rails.

Review of Resident #1's care plan dated 12/10/17 revealed:
-Resident #1 had a history of developmental disabilities.
-There was documentation Resident #1 was a "big" fall risk and needed constant supervision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 39	C 453		

and assistance with mobility around the facility.
-Resident #1 was ambulatory with assistive devices.
-Resident #1 had very limited use of her left side.
-She was forgetful and needed reminders.

Observation of Resident #1's bedroom on 10/30/19 at 10:55am revealed there was a single half bed rail on each side of Resident #1's bed.

Interview with Resident #1 on 10/30/19 at 9:15am revealed:
-Her family member brought in the bed rails from home.
-She was wearing a back brace because she fell out of her bed three weeks ago.
-She had bed rails on her bed; she leaned back while in bed, but the rail was there, and she fell out of the bed onto the floor on her back.
-She had a history of seizures, but it had been a while since she had a seizure.
-She had a vagus nerve stimulator (VNS) device with a magnet that prevented seizures.

Observation of Resident #1's bedroom on 10/30/19 at 2:50pm revealed:
-Resident #1 was lying in her bed.
-There was a single half bed rail on each side of her bed.
-On the left side of the bed, Resident #1's walker was pushed up next to the mattress and beside the bed rail.
-On the right side of the bed, there was a chair pushed up next to the mattress and beside the bed rail.

Review of an Accident/Incident Report for Resident #1 dated 10/07/19 revealed:
-At 3:20am, the MA/SIC heard a sound from Resident #1's room, so he rushed to her room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 40	C 453		

and found her on the floor.
-The resident told the MA/SIC she was trying to get off the bed when she slipped from the bed and fell.
-An addendum was added to the Accident/Incident Report that Ibuprofen was administered at 4:00am.

Telephone interview with the MA/SIC, who completed the Accident/Incident Report dated 10/07/19, on 10/30/19 at 4:47pm revealed:
-On 10/07/19, he heard a sound from Resident #1's bedroom.
-He went to the room and Resident #1 was lying on the floor by the bed.
-Resident #1 told him she fell from her bed.
-The MA/SIC called another resident to help him get Resident #1 off the floor.
- "A few minutes later," Resident #1 complained of back pain, so he gave her Ibuprofen.
-There were no visible injuries at that time.
-He was not sure if Resident #1 hit the bed rail trying to get off the bed, because he did not witness her fall, but it was possible; she had to get off the bed at the end of the bed because the bed rails were in the middle of the bed.

Review of a hospital discharge summary for Resident #1 dated 10/08/19 revealed:
-Resident #1 was admitted to the hospital on 10/07/19 with a right rib fracture and T12 compression fracture, resulting from a fall.
-Resident #1 reported falling and hitting her head.
-There was mild bruising to the occiput of her head.
-She complained of low thoracic pain that was worse with movement; she rated her pain 9 out of 10.
-Resident #1 had a CT (computed tomography) scan that revealed an acute T12 compression

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 41	C 453		

fracture, displaced posterior right ninth rib fracture and nondisplaced posterior right tenth rib fracture.
-Resident #1 was to wear a TSLO (thoracic lumbar sacral orthosis) brace for three months.

Review of an Accident/Incident Report for Resident #1 dated 10/11/19 revealed:
-At 1:20pm, Resident #1 called out for assistance from staff.
-When staff went to Resident #1's room, she was half off the bed; her legs were hanging off and she was holding onto the bed rail.
-The staff attempted to put Resident #1's legs back on the bed, but the resident "was too far."
-The staff assisted the resident to transition safely to the floor and enlisted additional assistance to pick her up from the floor and onto the chair.
-The resident stated she was "okay and did not sustain any further injury to her ribs."
-The staff readjusted the bed rails to prevent another incident.

Interviews with the lead MA/SIC on 10/30/19 at 12:15pm and 3:40pm revealed:
-Resident #1's family member brought in the bed rails to help keep the resident in the bed.
-Resident #1 was able to move around and get out of bed with the bed rails in place.
-Resident #1 did not call for assistance on 10/11/19 which resulted in her falling from her bed.
-Resident #1 was currently wearing a brace from the 10/07/19 fall and was receiving physical therapy and occupational therapy.
-She had been putting the walker and chair next to Resident #1's bed after the fall on 10/11/19 to keep the resident in bed.
-The staff had never tried using a fall mat, bed alarm or pushing Resident #1's bed against the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 42	C 453		

wall.
-There was no order for the bed rails and there had been no care plan meeting regarding the use of bed rails.

Interviews with Resident #1 on 10/30/19 at 2:50pm and 5:00pm revealed:
-Her family member brought in the bed rails from home.
-The lead medication aide/Supervisor-In-Charge (MA/SIC) put the chair and walker at each end of her bed to keep her from falling off the bed.
-On the night she fell in early October 2019, she did not have pain at the time of the fall, but it soon started hurting bad.
-She went to the hospital later that morning.
-She was still having pain from the fall.
- "I can't really remember if I hit the bed rail during the fall, but I must have since my rib was broken."
-The last fall Resident #1 had (10/11/19), she was trying to get out of bed; she slid off the foot of the bed trying to get around the bed rail and her body was lying against the bed rail.

Telephone interview with Resident #1's guardian on 10/30/19 at 3:15pm revealed:
-The POA brought in the bed rails for Resident #1 because Resident #1 was falling out of bed.
-The bed rails were not being used as a restraint.
-They bed rails were used so that Resident #1 did not fall out of bed.
-She had not been asked to attend a care plan meeting regarding the bed rails.
-When Resident #1 stayed at home, she had a double bed and could move around more; the bed at the facility was smaller, and the resident was sliding off the bed.
-Resident #1 was supposed to call for assistance.

Telephone interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 43 10/30/19 at 4:04pm revealed: -Resident #1 had bed rails on her bed and she was recently provided a hand bell to call staff for assistance. -Resident #1 wanted to be independent and did not comprehend what staff told her such as not to get up unassisted. -Even though Resident #1 did not comprehend what staff told her, it did help for staff to tell her to use the hand bell, and the resident promised to ask for assistance. -Resident #1 was able to get out of bed with the bed rails. -The walker and the bedside chair were not supposed to be pushed up against the bed; the chair was for Resident #1 to sit in. -She had not considered fall prevention interventions such as a floor mat, concave mattress, mattress wedge and bed alarm. Telephone interview with the Registered Nurse from Resident #1's physician's office on 10/31/19 at 8:21am revealed: -The PCP was not familiar with the frequency of Resident #1's falls. -The PCP knew about the fall on 10/07/19 because she had been for a follow-up visit from the hospital stay regarding that fall and was currently wearing a brace. -She was not sure if the PCP was aware of the bed rails or if the PCP would consider the bed rails a restraint. -There was no documentation in the PCP's notes about bed rails being used nor was there an order in the resident's record about the use of bed rails. -The PCP would be concerned if the resident was injured as a result for the bed rails being in place and hindering her from getting out of bed. The facility's failure to assure there was a	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 453	Continued From page 44 physician's order for bed rails, a team assessment and that other alternatives had been attempted resulted in Resident #1, who has a history of dementia and epilepsy, being unable to get out of bed and having two falls from the bed. Resident #1 was found lying against the bed rails after trying to get out of bed resulting in a fall. This failure was detrimental to the health, safety and welfare of Resident #1, which constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2019.	C 453		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to building and design, personal care and supervision, health care and use of physical restraints. The findings are:	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 45 1. Based on observations, interviews, and record reviews, the facility failed to assure that residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's license for 1 of 3 sampled residents (#1) residing at the facility, who had cognitive and physical impairments which could prevent the resident from independently evacuating the facility. [Refer to Tag 022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provide supervision according to the resident's assessed needs and current symptoms for 1 of 3 sampled residents (#1), who had multiple falls resulting in injuries to the resident's shoulder, hand and neck, and a compression fracture of the spine and fractured ribs. [Refer to Tag 243 10A NCAC 13G .0901(b) Personal & Supervision (Type A1 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to notify the primary care provider for 1 of 3 residents sampled (#1), who had multiple falls and a delay in receiving medical treatment after a fall. [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure bed rails were used only after a written physician order, a team assessment and care planning process, and alternatives were tried prior to the restraint that would provide safety to the resident for 1 of 1 residents sampled (#1), who had bed rails to keep the resident from getting out of bed. [Refer to Tag 453 10A NCAC 13G .1301(a) Use of Physical Restraints (Type B Violation)].	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092059	A. BUILDING: _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLCARE ASSISTED LIVING	202 BAINBRIDGE CIRCLE GARNER, NC 27529

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE