STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065014	A. BUILDING: _____ B. WING _____	11/01/2019

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SPRING ARBOR OF WILMINGTON	809 JOHN D BARRY DRIVE WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted an annual survey and complaint investigation on 10/30/19 - 11/01/19.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff C) had a criminal background check completed prior to hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a dietary aide on 12/17/15. -There was a consent to have a criminal background check completed on 12/14/15. -There was no documentation of a completed criminal background check for Staff C, prior to her hire date of 12/17/15. Telephone interview with Staff C on 10/31/19 at 2:50pm revealed: -She was originally hired at the facility in 1999 and had to leave employment for a year. -She was rehired 12/17/15 as a dietary aide. -She did not remember having a criminal background check completed when she was rehired. -She did not think she needed to get a new	D 139		

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D 139	Continued From page 1 criminal background check completed. Interview with the Business Office Manager (BOM) on 10/31/19 at 3:45pm revealed: -Staff C was a rehire and should have had a criminal background check completed. -The previous Administrator was responsible for ordering and ensuring the criminal background check was completed. -She was in the process of completing a personnel record audit and noticed that Staff C did not have a current criminal background check. Interview with the Administrator on 10/31/19 at 3:50pm revealed: -She and the BOM were responsible for ensuring criminal background checks were completed prior to hire for all staff. -Staff C had a consent for a criminal background, however it was not completed by the previous Administrator. -She did not know Staff C did not have a completed criminal background check. -She was not sure why the criminal background was not completed. -The criminal background should have been completed in placed in the personnel record.	D 139		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver,	D 167		

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D 167	Continued From page 2 provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) and Choking Management for 4 of 6 sampled employees (Staff A, B, C and F). The findings are: Review of Staff A's personnel record revealed: -Staff A's date of hire was 08/12/19. -His position was Resident Care Director. -There was no documentation Staff A had completed CPR and Choking Management training in the past 24 months. -There was no documentation Staff A had completed CPR and Choking Management training in his record. Interview with Staff A on 10/31/19 at 3:55 revealed: -He had completed the CPR and Choking Management training in the past, however his certification had lapsed.	D 167		

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D 167	Continued From page 3 -He was not sure when his certification had expired. -He had intended to register for a refresher course as soon as he could locate a course being held in the community. Review of Staff B's personnel record revealed: -Staff B's date of hire was 10/19/04. -Her position was a medication aide (MA). -There was no documentation Staff B had completed the CPR and Choking Management training in the past 24 months. -There was no documentation Staff B had completed CPR and Choking Management training in his record. Attempted telephone interview with Staff B on 10/31/19 at 3:10pm was unsuccessful. Review of Staff C's personnel record revealed: -Staff C's date of hire was 12/17/15. -Her position was a dietary aide. -There was no documentation Staff C had completed the CPR and Choking Management training in the past 24 months. -There was no documentation Staff C had completed CPR and Choking Management training in his record. Attempted telephone interview with Staff C on 10/31/19 at 3:25pm was unsuccessful. Review of Staff F's personnel record revealed: -Staff F's date of hire was 01/28/15. -Her position was a housekeeper. -There was no documentation Staff F had completed the CPR and Choking Management training in the past 24 months. -There was no documentation Staff F had completed CPR and Choking Management	D 167		

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D 167	Continued From page 4 training in his record. Attempted telephone interview with Staff C on 10/31/19 at 3:40pm was unsuccessful. Review of the master schedule and current CPR certification for all employees from 10/18/19 through 10/31/19 revealed: -The facility had 3 shifts: first shift was from 7:00am to 3:00pm, second shift was from 3:00pm to 11:00pm and third shift was from 11:00pm to 7:00am. -There were no staff on duty with CPR and Choking Management training from 11:00pm -7:00am on 10/19/19-10/20/19. -There were no staff on duty with CPR and Choking Management training from 11:00pm -7:00am on 10/20/19-10/21/19. -There were no staff on duty with CPR and Choking Management training from 11:00pm -7:00am on 10/25/19-10/26/19. -There were no staff on duty with CPR and Choking Management training from 11:00pm -7:00am on 10/29/19-10/30/19. -There were no staff on duty with CPR and Choking Management training for 4 of 13 shifts from 10/18/19 through 10/31/19. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 3:55pm revealed: -She had been hired in August of 2019 as the SpecialCare Coordinator of the Special Care unit. -It was her responsibility to complete the staff schedule for the facility. -She used a template to staff each shift based on the census. -She did not assure each shift had a staff person with a current CPR and Choking Management certification.	D 167		

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D 167	Continued From page 5 -She did not know who was CPR and Choking Management certified amongst the staff. -The Administrator kept an electronic spreadsheet with staff training credentials. -She had never been trained to assure at least one person on each shift was CPR and Choking Management certified. -She had not been trained to identify staff with current CPR and Choking Management certification on the staff schedule. Telephone interview with the third shift Supervisor in Charge (SIC) on 10/31/19 at 4:40pm revealed: -She worked as the SIC on third shift. -She had CPR and Choking Management training a few years ago and it had recently expired. -She could not produce her expired card at this time. -She did not think anyone on third shift had a current CPR and Choking Management certification. -There had been no recent incidents where a resident or staff needed CPR or had an incident with choking. -"I guess I would just perform what I remember from my CPR training until the Medics arrived." Telephone interview with a third shift personal care assistant (PCA) on 10/31/19 at 5:15pm revealed: -She worked third shift as a PCA. -She did not have any CPR or Choking Management training. -She did not know what she would do if someone needed CPR or was choking. -"I guess I would go to my supervisor and tell her." -No residents required CPR or had a choking incident during the shifts that she worked.	D 167		

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D 167	Continued From page 6 Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She was hired in September 2019 as the Executive Director/Administrator. -She was responsible for the day to day operations of the facility. -She kept an electronic spreadsheet with the training requirements for each staff. -She was in the process of auditing the personnel and resident's records. -It was the responsibility of the RCC to create the staffing schedule. -She did not know 4 of 13 shifts in the past 2 weeks did not have a staff person with a current CPR and Choking Management training. _____ The facility failed to assure there was one staff member on duty in the facility at all times who had completed a course on CPR and Choking Management within the last 24 months. The facility's failure was detrimental to the health and safety of the residents in the event of an emergency requiring CPR or choking management. This non-compliance constitutes a Type B Violation. _____ 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 16, 2019.	D 167		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with	D 259		

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the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to assure a care plan was developed for 1 of 5 sampled residents (Resident #3) within 30 days following admission.

The findings are:

Review of Resident #3's current FL2 dated 07/22/19 revealed:
-Diagnoses included Alzheimer, dementia, chronic kidney disease and hypertension.
-Disoriented status was intermittently.
-Ambulatory status was semi-ambulatory.
-Personal care required assistance with bathing.

Review of Resident #3's record revealed there was no assessment and care plan for Resident #3.

Review of Resident #'3 Resident Registry revealed an admission date of 07/29/19.

Review of a care plan dated 10/29/19 revealed the care plan for Resident #3 was incomplete without a physician's signature.

Interview with the Resident Care Director (RCD) on 10/30/19 at 3:40pm revealed:
-He was aware a care plans were to be completed upon admission and for any significant change in the resident's condition.
-He was responsible for tracking resident's care

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plans and completing assessments for the residents in the facility.
-He used an on-line tracking system but had not reviewed the system in a while because he was always pulled to pass medications.
-The resident's care plans were important because they reflect what assistance's staff provided for the residents.
-He did not know Resident #3's initial care plan was not completed until 10/29/19.
-The Executive Director had brought it to his attention on 10/29/19.
-He faxed the care plan over to the physician's office on 10/30/19 to be signed and reviewed by the physician.
-He had not obtained a fax confirmation on 10/30/19.
-He had not contacted Resident #3's physician office to inquire if they had received the care plan for Resident #3.
-The care plan for Resident #3 "just got over looked."

Telephone interview with Resident #3's physician office revealed they had not received a care plan dated 10/29/19 for Resident #3.

Interview with the Administrator on 10/31/19 at 4:15pm pm revealed:
-The RCD was responsible for completing the care plans.
-She was reviewing Resident #3's record on 10/29/19 and realized Resident #3 did not have a care plan upon admission.
-She knew resident care plans were to be completed on admission and if there were significant changes in condition.
-There was a tracking system in place on the computer for identifying residents whose care plan were due.

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D 259	Continued From page 9 -She was in-charge of overseeing the RCD and the tracking system in the computer for resident's care plans. -The care plan for Resident #3 was over-looked. -The Administrator would expect the care plans to be completed within 30 days of admission.	D 259		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .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, record reviews, and interviews, the facility failed to provide supervision for 2 of 6 sampled residents (Resident #3 and #9) related to falls. The findings are: Review of the facility's resident care Fall Risk Program "The ROSE Program" revealed: -Residents were to be screened upon admission and readmission and after every fall to the facility. -Residents were a to be screened a minimum of quarterly, or if they had a change in condition.	D 270		

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D 270	Continued From page 10 -Resident were to be identified and resident specific interventions were to be implemented. -Intervention included evaluate physical and medical issues, environmental factors, cognitive and sensory changes. -Interventions included physical therapy (PT) and occupational therapy (OT) to determine therapy treatments, communication with physician, staff, residents and family, and education of staff, family and residents. -In the facility a ROSE card will be placed at room door for identifying high risk residents. -A ROSE label will be placed on any assistance device for residents at high risk. -Resident specific interventions will be added to the resident personal care service log and the activity of daily living log. -Reminders will be discussed regarding residents at risk during the daily stand-up and by management/ supervisor in charge each shift. -Weekly fall management meeting included PT and OT staff, care staff, Resident Care Director (RCD), and the Administrator to review each resident identified at risk, effectiveness of current interventions, and any addition falls, recommended change of interventions. -Documentation by updating care plans, Personal Care Services (PCS) log and Activity of Daily Living (ADL) logs with changes in risk factors and interventions. Review of the facility Hot Box policy revealed: -The hot box system was to assure additional attention was given to the residents who may be experiencing a temporary change in condition. -The medication aides (MA)s and the Supervisor in Charge (SIC) were responsible for documenting in the resident record each shift when residents were placed in the hot box system.	D 270		

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D 270	Continued From page 11 -Conditions that warrant placement in the hot box system included falls and residents returning from the hospital or rehabilitation. -The documentation requirements for residents with falls or returning from the hospital were 3 days or longer, if directed. -The RCD or designee will remove the resident from the hot box system when the situation had been resolved. 1. Review of Resident #9's current FL2 dated 07/19/19 revealed: -Diagnoses included dementia, paroxysmal atrial fibrillation, diabetes, and hypertension -Recommended level of care was documented as Special Care Unit (SCU). -Disoriented was documented as constantly. -Ambulatory status was documented as ambulatory. -Personal care assistance required with bathing and dressing. -Bowel and bladder were documented as incontinent of bladder and occasionally incontinent of bowel. -An order for physical therapy and occupational therapy to evaluate and treat. -Medication orders included apixaban (an anticoagulant used to reduce the risk of a stroke) 5mg two times daily. Review of Resident #9's Resident Registry revealed an admission date of 04/18/19. Review of Resident #9's Care Plan dated 04/25/29 revealed: -The care plan documented Resident #9 used a rollator walker for ambulation. -The care plan documented Resident #9 memory was forgetful needs reminders. -The care plan documented orientation as	D 270		

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sometimes disoriented.
-The care plan documented Resident #9 was independent in eating, ambulation, and grooming personal hygiene.
-The care plan documented supervision with toileting, dependent with bathing three times weekly, extensive assistance with dressing and limited assistance with transfers.
-There were no updates to the original care plan dated 04/25/19.

Review of Resident #9's incident report dated 07/01/19 at 5:30pm revealed:
-Resident #9 was found sitting on the floor in front of her recliner beside her bed.
-Resident #9 hit her head.
-Resident #9 was alert and verbal, observed to be confused and had no complaint of pain.
-Emergency Medical Services (EMS) was called for transport to the Emergency Room (ER).
-Vital signs were obtained and blood pressure (B/P) was 128/62, pulse 68, respirations 16, and temperature 97.2.
-The family and the physician were notified.

Review of Resident #9's progress notes revealed:
-On 06/11/19 Resident #9 was "confused this shift, unaware of what is doing."
-On 06/24/19 Resident #9 was very confused, seeing "cats in her room and a little girl with one arm." Will check on often.
-On 06/29/19 Resident #9 was confused, "thought no one wanted anything to do with her."
-On 07/01/19 at 6:00pm Resident #9 was found on the floor. She was made comfortable. The physician and the family were notified.
-EMS were contacted for transfer to the emergency room (ER) for an evaluation. The family will meet Resident #9 at the hospital.
-There was documentation on 07/01/19 at

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D 270	Continued From page 13 12:00am Resident #9 returned to the facility with no new orders. Review of Resident #9's hospital discharge dated 07/01/19 revealed: -Reason for visit was documented as fall, possible UTI and chest pain. -Resident #9 presented in the ER with dizziness and chest pain hurting since "earlier today". -Resident #9 was walking with her walker and lost her balance falling on her right side. The fall was unwitnessed. Resident #9 had a skin tear on her right forearm. Resident #9 said she scratched her am on the walker and fell straight on her butt. -Resident #9 had a history of UTI's. -Resident #9 had an X-ray ordered for the right hip and the findings suspected an impacted femoral neck fracture. -Resident #9 had a CT scan of the right hip without contract and the findings no displaced fracture seen. -Resident #9 was taking apixaban 5mg two times daily. Review of Resident #9's incident report dated 07/02/19 at 1:00pm revealed: -Staff observed a large bruise on Resident #9's right hip from the fall on 07/01/19. -Resident #9 complained of pain to her right hip. -EMS was called for transport to the ER because of increased pain -Vital signs were obtained B/P 140/70, pulse 66, respirations 16, and temperature 99.0 and the family and the physician were notified. Review of Resident #9's progress notes revealed: -On 07/02/19 at 10:55am the staff contacted Resident #9's physician office requesting a mobile X-ray of right hip due to the increase of swelling and pain from a status post fall on	D 270		

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D 270	Continued From page 14 07/01/19. Waiting on call back from physician's office. -On 07/02/19 at 2:45pm Resident had fallen on 07/01/19 and sent to ER. The staff noticed a bruise to the right hip. Resident #9 was in "a lot of pain" and the bruise was "very painful and hot to touch". The physician's office ordered Resident #9 to return to the ER for evaluation. Review of Resident #9's hospital discharge dated 07/02/19 revealed: -Upon physical exam Resident #9 had a "large hematoma on right hip" and is tender to palpate. -Resident #9 was seen in the ER on 07/01/19 and was diagnosed with a right hip fracture. "The story is quite confusing actually." -There were imaging performed on 07/01/19 which was inconclusive due to an X-ray finding an impacted femoral neck fracture, and a CT scan of the right hip that read with no fracture. -Resident #9 was taking apixaban 5mg two times daily. -Resident #9 was admitted to the hospital on 07/02/19 diagnosed with right hip pain, contusion of right hip and thigh. -Resident #9 was discharged from the hospital on 07/06/19 to a skilled nursing facility for rehabilitation. Review of Resident #9's progress notes revealed she was readmitted on 07/23/19 to the facility. Review of Resident #9's incident report dated 08/14/19 at 11:30pm revealed: -Resident #9 was found lying on the floor beside her bed. -Staff assisted Resident #3 up and back to her bed. -Resident #9 had no injury or skin tears were obtained.	D 270		

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D 270	Continued From page 15 -Tylenol 325mg two tablets were administered for pain. -Vital signs were B/P 147/97, pulse 84, respirations and temperature were not completed. -The family and the physician were notified. Review of Resident #9's progress note dated 08/14/19 revealed. -Resident #9 was found on the floor lying beside her bed. -Staff assisted her up and back to bed. -Resident #9 had no injury and Tylenol 325mg two tablets were given for pain. Review of Resident #9's incident report dated 08/18/19 at 7:20am revealed: -Resident #9 lost her balance falling, hitting her head on the floor. -Resident #9's head was hurting. -EMS was called. -Resident #9's temperature was obtained 97.8 no other vitals were documented. -The family and the physician were notified. Review of Resident #9's progress notes revealed there was no documentation for the fall dated 08/18/19 at 7:20am. Review of Resident #9's progress notes dated 08/19/19 at 1:20am revealed. -Resident #9 was found on the floor in her room in front of her recliner. -Resident #9 did not hit her head. -Staff assisted up and checked and vital signs were obtained B/P 134/88, Pulse 82, Respirations 20. -Resident #9 was assisted to the bathroom and placed back in the bed. Family and the physician were notified.	D 270		

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D 270	Continued From page 16 -At 10:30am Resident #9 had an unwitnessed fall in her room. She hit her head and was sent to the ER. All parties were notified. -Resident #9 returned from the ER on 08/19/19 at 12:10am diagnosed with a UTI with orders for an antibiotic. Review of the facility incident reports revealed there was no incident report dated 08/19/19 at 10:30am for Resident #9. Review of Resident #9's hospital discharge dated 08/19/19 revealed: -Resident #9's chief complaint was fall and rib pain. -Resident #9 had fallen and injured her left elbow and rib cage. -Resident #9 rated her chest pain as a 6 on the scale of 1-10 for pain. -Resident #9 did not think she hit her head. -Resident #9 was on blood thinner apixaban. -Resident #9 was diagnosed with a UTI and was returned to the facility. Review of Resident #9's incident report dated 09/06/19 revealed: -On 09/06/19 at 8:45pm Resident was back for the ER with no injuries or negative reports, nothing was found from head injury. -There was no other documentation on the incident report. -The incident report was signed by the Administrator and the staff completing the report. Review of Resident #9's progress note dated 09/06/19 at 2:30pm revealed: -Resident #9 had an unwitnessed fall in her room. -Resident #9 hit her head on the floor and had a "raised spot in the center of her head". -EMS was called for transport to the ER.	D 270		

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D 270	Continued From page 17 -The family and the physician were notified. Review of Resident #9's progress note dated 09/06/19 at 8:45pm revealed: -Resident #9 returned to the facility via EMS, no injuries noted at this time, CT scan and X-ray negative. -The Resident Care Director (RCD) was aware Resident #9 returned to the facility. Review of Resident #9's hospital discharge dated 09/06/19 revealed: -Resident #9's chief complaint was a fall. -Resident #9's baseline was dementia. -Resident #9 complained of right shoulder pain, back pain, and pain to the back of the head with a hematoma noted to the back of Resident #9's head. -Resident #9 was on apixaban an anticoagulant. -Resident #9 EMS administered 50microgram of fentanyl (an opioid pain medication used for severe pain) and Zofran (used for nausea) 4mg. -EMS had applied a sling to Resident #9's right arm, but she was moving her right arm in the ER. -A CT cervical spine was completed, and the findings were compared to the CT scan completed on 08/19/19, subacute fractures of the C7, T1 and T2. -The ER physician did have concerns of the anticoagulation therapy and the multiple falls. He thought the discussion of risks and benefits of anticoagulation was reasonable with her primary care provider concerning fall risk and head bleed versus stroke prevention. -Resident #9 was safe for discharge back to the facility with precautions and follow up information provided. Review of Resident #9's incident report dated 09/11/19 at 5:00pm revealed:	D 270		

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-Resident #9 was in the bathroom, staff heard a loud sound coming from her room.
-Resident #9 fell forward into the shower.
-Vital signs were obtained B/P 149/100, Pulse 94, respirations 18, temperature 98.0.
-EMS was called for transport to the ER.
-The physician and the family were notified.

Review of Resident #9's progress note dated 09/11/19 on the 3:00-11:00 shift revealed:
-Resident #9 had an unwitnessed fall in her bathroom.
-Resident #9 had a "raised area was spotted on the top of her head". -There was documentation EMS was called for transport to the ER.
-Resident #9 returned from the ER around 10:00pm with no apparent injuries.
-There was documentation all parties were notified.

Review of Resident #9's hospital discharge dated 09/11/19 revealed:
-Resident #9 chief complaint was a fall and head injury without loss of conscious.
-Resident #9 fell while going to the bathroom she hit her left side and hit her head.
-Resident #9 was on a blood thinner apixaban.
-Resident #9's baseline was dementia.
-Resident #9 had an X-ray and a CT scan completed with no acute findings.
-Final impression diagnoses closed head injury, dementia and chronic fractures of the spine.
-Resident #9 returned on 09/11/19 to the facility with fall precautions.

Review of Resident #9's incident report dated 09/21/19 at 10:30pm revealed:
-Resident #9 was found on the floor beside her bed.
-Resident #9 was assisted off the floor without

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complaints.
-Vital signs were obtained B/P 124/68, pulse 60, respirations 20, temperature 97.8 and the family and physician were notified.

Review of Resident #9's progress note dated 09/21/19 at 10:30pm revealed:
-Resident #9 was found on the floor beside her bed.
-Resident #9 "rolled off bed".
-Vital signs were taken.
-The family and physician were contacted.

Review of Resident #9's incident report dated 09/27/19 at 2:00am revealed:
-Resident #9 was found on the floor beside her bed.
-Resident #9 was assisted off the floor and back to bed.
-Resident #9 "slipped off the bed."
-Vital signs were obtained B/P 152/89, pulse 89, respirations and temperature were not documented, and the family and physician were notified.

Review of Resident #9's progress note dated 09/27/19 at 10:30pm revealed:
-Resident #9 was found on the floor beside her bed.
-Resident #9 "slid off the bed."
-Vital signs were taken.

Review of Resident #9's progress note dated 10/05/19 at 9:20pm revealed:
-Resident #9 was found on the floor in her bedroom.
-Resident #9 was assisted off the floor without complaints.
-Vital signs were obtained B/P 140/90, pulse 84, respirations 18 temperature 97.6.

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D 270	Continued From page 20 -The family and the physician were notified. Review of Resident #9's incident report revealed there was no incident report for Resident #9 on 10/05/19 at 9:20pm. Review of Resident #9's incident report dated 10/12/19 at 8:30pm revealed: -Resident #9 was found by staff on the floor in her room on her right side. -Resident #9 was assisted off the floor without complaint. -Vital signs were obtained B/P 140/62, pulse 76, respirations 20, temperature 97.4. -The family and the physician were notified. Review of Resident #9's progress note dated 10/12/19 at 8:30pm revealed: -Staff found Resident #9 on the floor in her room on her right side. -There was documentation Resident #9 was assisted off the floor without complaint. -The physician and the family were notified. -An incident report was completed. Review of Resident #9's incident report dated 10/14/19 at 3:10am revealed: -The staff were conducting rounds and observed Resident #9 on the floor by her couch. -Range of motion was conducted, vitals were obtained, blood sugar take. -Tylenol was administered due to Resident #9 complained of pain. -Vital signs were B/P 141/88, pulse 99, respirations 20, temperature 96.6 and blood sugar 250. -The family and the physician were notified. Review of Resident #9's progress note dated 10/14/19 at 3:45am revealed:	D 270		

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D 270	Continued From page 21 -The staff were conducting rounds, entered Resident #9's room and found Resident #9 on the floor. -Vitals were taken and range of motion was performed. -Resident #9 was assessed for bumps and swelling. -Resident #9 did not hit her head and was not sent to the ER. -Resident #9 did have scratches on her back to the left side. -Tylenol was given to Resident #9 for a complaint of pain. Review of Resident #9's incident report dated 10/14/19 at 5:30pm revealed: -Resident #9 was sent out to the ER for evaluation of neck, mouth and arm hurting. -The on-call physician was called, and orders obtained to send Resident #9 to the ER for evaluation. -Vital signs were obtained B/P 140/84, pulse 86, respirations 18, temperature 99.4. -The family and the physician were notified. Review of Resident #9's progress notes dated 10/15/19 at 5:30 pm revealed: -Resident #9 was sent to the ER for evaluation for neck hurting and mouth sore. -The physician and the family were notified. Review of Resident #9's hospital report dated 10/15/19 revealed: -Resident #9 chief complaint was altered mental status and multiple falls. -Resident #9 presented in the ER with complaints of multiple falls and generalized weakness. -Resident #9 complained of her neck hurting from a fall on Saturday. -Resident #9 said her urine was "smelling foul".	D 270		

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D 270	Continued From page 22 -Resident #9 would be admitted to the hospital for a urinary tract infection (UTI), altered mental status, multiple falls, cervical strain and closed head injury. Review of the ROSE fall program book for Resident #9 on 10/30/19 revealed: -There was documentation a fall assessment was completed for Resident #9 on 04/19/19 upon admission to the facility. -There were documented additional fall assessments were completed for Resident #9 on 07/23/19, 08/19/19, 09/11/19, 09/27/19, 10/12/19 and on 10/14/19. -There were no other falls assessments documented for Resident #9's falls which occurred on 07/01/19, 08/14/19, 08/18/19, 09/06/19, 09/21/19 or on 10/05/19. -On 07/01/19 there was documented interventions for Resident #9 which consisted of: a halo grab bar to bed; follow up with the physician due to Resident #9's increase in confusion; urine analysis, and medication review; speech and occupational therapy referral; utilize call light and ask for assistance with transfers and all activities of daily living (ADs);. remind the resident to utilize the walker at all times and place the call light within reach. On 08/14/19 there were documented interventions: Resident #9 will be monitored for safety awareness and a fall risk and Resident #9 should ambulate with a walker. -On 09/18/19 there was documented interventions to remind Resident #9 to utilize walker at all times for ambulation. A bedside commode was placed in Resident #9's room for night use and a referral for OT was pending. -There were no documented interventions for Resident #9's falls which occurred on 08/18/19, 08/19/19, 09/06/19, 09/11/19, 09/27/19, 10/05/19,	D 270		

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D 270	Continued From page 23 10/12/19 and 10/14/19. -There was no documentation of a weekly meeting to discuss Resident #9's falls utilizing the facility fall Rose program from 07/01/19 to 10/15/19. -There were documentation PT and OT were treating Resident #9 from 07/01/19 to 10/14/19. -There was no other documentation of family meetings to discuss options or interventions for Resident #9's multiple falls. Review of Resident #9's record revealed there was no documentation Resident #9's care plan was updated after falls that occurred. Review of the facility fall tracking report for Resident #9 from 07/01/19 to 10/14/19 revealed: -On 07/01/19 at 5:30pm Resident #9 fell in her room and was sent out to the ER. -On 07/02/19 at 1:00pm Resident #9 had not fallen but had an incident report completed. -On 08/14/19 at 11:30pm Resident #9 fell in her bedroom. -On 08/18/19 at 7:20am Resident #9 fell in her room walking to the bathroom. -On 09/11/19 at 5:00pm Resident #9 fell while walking in her room. -On 09/21/19 at 10:30pm Resident #9 fell while sitting on her bed in her room. -On 09/27/19 at 2:00am Resident #9 fell while sitting on her bed in her room. -On 10/03/19 at 9:20pm Resident #9 fell in her room. -On 10/12/19 at 8:30pm Resident #9 fell walking in her room. -On 10/14/19 at 9:20pm Resident #9 fell in her room. -There was no other documentation addressing Resident #9's falls on 08/19/19, 09/06/19, or on 10/05/19.	D 270		

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D 270	Continued From page 24 Interview with a medication aide (MA) on 10/30/19 at 11:42am revealed: -Resident #9 was on the ROSE fall program for her falls. -The MA was unsure how many times Resident #9 had fallen. -The interventions put into place after Resident #9's falls were PT and OT, she could not recall any other interventions. -She could recall documenting in Resident #9's progress notes per the Hot Box policy for 3 days after each fall. -She reminded Resident #9 to use her call bell for assistance with toileting and ambulating. -Resident #9 was forgetful and would forget to use her walker. -Resident #9 fell mostly in her room. Telephone interview with a personal care aide (PCA) on 10/30/19 at 7:00pm revealed: -She completed checks on the residents she was assigned to every 2 hours. -Resident #9 would forget to use her walker and that was why she had fallen most of the time. -Resident #9 fell in her room a lot. -She was never told to monitor Resident #9 more than every 2 hours. -In August 2019 staff started documenting every 2-hour check. -When Resident #9 fell the MAs were responsible "for making sure she was OK." -She did not know of any interventions the facility used to prevent Resident #9 from falling. Telephone interview with another MA on 10/30/19 at 8:20pm revealed: -She knew Resident #9 was in the facility ROSE fall program. -Resident #9 had "a lot of falls".	D 270		

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D 270	Continued From page 25 -She had documented in Resident #9's progress notes per the Hot Box policy for 3 days after some of the falls. -Sometimes it was hard to remember to document even if you did check on the residents. Interview with the Resident Care Director (RCD) on 10/30/19 at 3:40pm revealed: -He was a nurse and responsible for overseeing the assisted living clinical staff. -Resident #9 was not in the facility, she was currently in a rehabilitation facility. -He did not know why Resident #9 was in rehabilitation. -Resident #9 fell often and required ER visits several times monthly. -He was aware of some of the falls for Resident #9, but not all the falls. -He did not know Resident #9 had fallen 11 times from 07/01/19 to 10/15/19, with 8 of those 11 times requiring ER visits. -Resident #9 was on the ROSE fall program. -Resident #9 was to have a fall assessment after every fall whether she was sent to the ER or not. -He did not know fall assessments were not completed after each time Resident #9 had fallen per the ROSE program policy. -He thought PT was responsible for completing the fall assessments for Resident #9 after each fall. -He never informed the staff of any additional interventions for Resident #9 after any of the falls. -PT was in the facility daily and the RCD thought it was their responsibility to complete the fall assessment and put all interventions in place for Resident #9. -The RCD never evaluated the room environment, shoes, medical equipment, vital signs, blood sugars, or medications for Resident #9 after each fall.	D 270		

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-He had never conducted a meeting with the family to discuss options or interventions to reduce falls for Resident #9.
-The facility was not conducting weekly fall management meetings according to the ROSE program to discuss Resident #9's falls.
-Resident #9 should be in the hot box system after every fall for 3 or more days.

Interview with the Physical Therapy Director on 11/01/19 at 10:25am revealed:
-Resident #9 was on the ROSE fall program due to her falls.
-She did know some of the falls that occurred for Resident #9 but was not made aware of all the falls.
-She did not know Resident #9 had fallen 11 times from 07/01/19 to 10/15/19, with 8 of those 11 times requiring ER visits.
-When Resident #9 had fallen there should be fall assessment completed for each fall.
-PT or the RCD should complete the fall assessment for Resident #9 and document intervention on the fall risk assessment sheet.
-She was unsure why the fall assessments were not completed for Resident #9 after each time she fell.
-She was not sure why PT was not made aware of all the falls for Resident #9.

Telephone interview with Resident #9's Power of Attorney (POA) on 10/3/19 at 4:40pm revealed:
-He was aware Resident #9 had fallen several times at the facility.
-Resident #9 was currently at rehabilitation for strengthen and to improve ambulation.
-Resident #9 was forgetful and often did not remember to use her walker.
-The facility staff called him when Resident #9 fell- he could not say if they called every time.

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D 270	Continued From page 27 -Resident #9 had "soft falls" when she was found on the floor. -The facility never contacted him regarding any interventions to reduce falls for Resident #9. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She knew Resident #9 had several falls and was on the ROSE fall program. -She did know Resident #9 was currently in rehabilitation but was unsure why. -According to the ROSE fall program Resident #9 should had a fall risk assessment after each fall that occurred. -She considered finding a resident on the floor as a fall. -The RCD and PT were to work together to complete the fall assessments for Resident #9. -She did not know Resident #9 had fallen 11 times from 07/01/19 to 10/15/19, with 8 of those 11 times requiring ER visits. -She was not sure why the fall assessments were not completed each time Resident #9 had fallen. -The RCD and PT were responsible for ensuring interventions were put into place to assist Resident #9 from falling. -She knew Resident #9 had fallen in the facility 07/01/19 and required several weeks of rehabilitation before returning to the facility on 07/23/19. -She expected staff to check on Resident #9 more often due to the number of falls the resident had. Resident #9 was not interviewable due to being currently out of the facility in rehabilitation. Refer to telephone interview with another MA on 10/30/19 at 8:20pm.	D 270		

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D 270	Continued From page 28 Refer to interview with the Physical Therapist Director on 11/01/19 at 10:25am. Refer to interview with the RCD on 10/30/19 at 3:40pm. Refer to interview with the Administrator on 10/31/19 at 4:15pm. 2. Review of Resident #3's current FL2 dated 07/22/19 revealed: -Diagnoses included Alzheimer, dementia, chronic kidney disease and hypertension. -Disoriented status was intermittently. -Ambulatory status was semi-ambulatory. -Personal care required assistance with bathing. Review of Resident #3's Resident Registry revealed an admission date of 07/29/19. Review of Resident #3's progress note dated 08/04/19 at 4:15am revealed: -Resident #3 was found on the floor in her room. -Resident #3 "flopped down" while trying to go the bathroom. -Vital signs were obtained with blood pressure (B/P) 134/80, pulse 68, respirations 18. -Staff assisted Resident #3 to the bathroom. -The family and the physician were notified. -On 08/04/19 after Resident #3 was found on the floor at 4:15am, Resident #3 was checked by staff on 08/04/19 at 12:00am, 2:00am, 4:00am, 6:00am and at 6:45am. Review of the facility incident report for Resident #3 dated 08/04/19 at 4:00am revealed: -Resident #3's roommate called for assistance since Resident #3 could not reach the call bell because she was on the floor. -Staff answered the call-light and found Resident	D 270		

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#3 on the floor in a sitting position.
-Resident #3 was going to the bathroom and just "flopped down on the floor, legs gave out."
-Resident #3 did not hit her head.
-Resident #3 had a scrape on her left knee.
-Vital signs were obtained B/P 134/80, pulse 68. Respirations 18, temperature 97.5.
-Emergency Medical Services (EMS) was not called.
-The family and the physician were notified.

Review of Resident #3's progress note dated 08/25/29 at 7:00am-3:00pm revealed:
-Resident #3 approached the staff and told them she had fallen on the carpet in her room.
-Staff completed first aide for the abrasion.
-The staff called the family and the physician.

Review of the facility incident report for Resident #3 dated 08/25/19 at 10:00am revealed:
-Staff was approached by Resident #3 because she had fallen in her room on the carpet.
-Resident #3 was observed with a skin tear.
-Staff put ointment and a dressing on the abrasion.
-Vital signs were obtained. B/P was 135/60, pulse 72, respirations 18, temperature 98.1.
-EMS was not called.
-The family and the physician were notified.

Review of Resident #3's progress note dated 08/30/19 at 10:30am revealed:
-Resident #3 was found on the floor.
-Resident #3 said she had slipped and fell on the floor and had re-opened a right lower knee skin tear.

Review of the facility incident report dated 08/30/19 at 7:04am for Resident #3 revealed:
-Resident #3 was found on the floor.

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-Resident #3 had slipped, fell to the floor and had re-opened a skin tear to the right lower knee.
-The skin tear was not bleeding and needed no dressing.
-Vital signs were obtained. B/P was 169/90, pulse 94, and respirations 18.
-EMS was not called.

Review of Resident #3's progress note dated 09/05/19 at 12:10am revealed:
-Resident #3 was found sitting on the floor.
-Resident #3 was going to the bathroom and slipped on the floor.
-The family and the physician were notified.

Review of the facility incident report for Resident #3 dated 09/05/19 at 12:10am revealed:
-Resident #3 was found sitting on the floor and staff assisted Resident #3 up and back to bed.
-Resident #3 slipped on the floor going to the bathroom.
-Vital signs were obtained. B/P was 164/84 and pulse 102.
-EMS was not called.
-The family and the physician were notified.

Review of Resident #3's progress note dated 09/08/19 at 7:00am revealed:
-Resident #3 said her floor was slippery.
-Resident #3 had fallen each time she went to the bathroom.
-No injury was noted at that time.
-The family was called.

Review of the facility incident report for Resident #3 dated 09/08/19 at 6:00pm revealed:
-On 09/08/19 at 6:00pm Resident #3 was found sitting on the floor by her bed and staff assisted Resident #3 up and back to bed.
-Resident #3 said her floor was slippery when she

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tried to go the bathroom.
-Vital signs were obtained. B/P was 166/96, pulse 107.
-The family and the physician were notified.

Review of Resident #3's progress note dated 09/09/19 at 8:20pm revealed:
-Resident had an unwitnessed fall in her room.
-The family called the facility to report Resident #3 was on the floor.
-The family had seen Resident #3 fall on the security camera in her room.
-Resident #3 had 2 skin tears on her right and left lower legs and the staff applied first aide to the skin tears.
-Vital signs were obtained B/P 121/56, pulse 76, temperature 98.7.
-The physician was notified, and the family was already aware of the situation.

Review of the facility incident reports for Resident #3 dated 10/09/19 at 8:15pm revealed:
-Resident #3's family member called the facility to let them know Resident #3 was on the floor.
-Resident #3 family member said she slide on the floor trying to move her walker.
-The staff assessed Resident #3 and applied first aide to the right and left lower extremities due to skin tears.
-The staff assisted Resident #3 off the floor and put her in bed.
-Vital signs were obtained. B/P was 121/56, pulse 76, respirations 16, temperature 98.7.
-EMS was not called.
-The physician was called, and the family was aware.

Review of Resident #3's record revealed a facility physician's communication form dated 10/23/19 regarding Resident #3 who had an unwitnessed

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fall in her room resulting in skin tears. The facility was requesting physical therapy orders for Resident #3.

Review of the ROSE fall program book for Resident #3 on 10/30/19 revealed:
-There was no documentation a fall assessment was completed for Resident #3 upon admission to the facility.
-There were documented additional fall assessments completedfor Resident #3 on 08/31/19, 09/05/19, 09/17/19, 09/18/19 and on 10/13/19.
-There were no other falls assessments documented for Resident #3's falls which occurred on 08/04/19, 08/25/19, 09/08/19, 10/09/19.
-There were no documented interventions for Resident #3 except for physical therapy (PT) and occupational therapy (OT).
-There was no documentation weekly fall prevention meeting were conducted to discuss Resident #3's falls utilizing the facility's Rose program.
-There was documentation PT was treating Resident #3 on 07/23/19.
-There was no documentation of family meetings to discuss options or interventions for Resident #3's multiple falls.

Review of the facility fall tracking report for Resident #3 revealed:
-On 08/04/19 at 4:00am Resident #3 had fallen in her room.
-On 08/30/19 at 7:04am Resident #3 had fallen in her room.
-On 09/05/19 at 12:10am Resident #3 had fallen in her bathroom.
-On 09/18/19 at 6:00am Resident #3 had fallen in her bedroom.

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D 270	Continued From page 33 -On 10/09/19 at 8:15pm Resident #3 had fallen in her room. Interview with Resident #3 on 10/30/19 at 11:08am revealed: -She had skin tears to her arm due to fragile skin and she had fallen. -She had fallen several times in the past few weeks. -She said the carpet was slippery. -Her family placed a security camera on the wall in her room in August 2019. -The security camera was used because she had fallen, and staff did not come and help her. -About 2 months ago she had fallen and laid on the floor for 7 hours. -She could not reach her call bell and was laying on the floor in her room. -Her roommate had gotten up during the night to use the bathroom and found Resident #3 lying on the floor in her room. -The roommate used her call bell to call the staff for help. -After that incident her family placed the security camera on the wall. -The security camera was used by her family to watch and listen how staff assisted her in her room. Telephone interview with a family member of Resident #3 on 10/30/19 at 11:52am revealed: -Resident #3 had fallen in August 2019 and laid on the floor in her room for 7 hours. -Staff on third shift had not checked on Resident #3 during those 7 hours. -The security camera was placed in Resident #3's room after Resident #3 had fallen and laid on the floor for 7 hours. -The staff knew the camera was installed in Resident #3's room but still chose not complete 2	D 270		

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hour checks or provide extra supervision for Resident #3.
-The facility staff were not completing every 2-hour checks on Resident #3.
-Until August 2019 the staff were not held accountable by documenting the 2-hour checks for the residents.
-She sent the Administrator pictures from the security camera verifying staff were not completing 2-hour checks for Resident #3.
-She had spoken to the Administrator by phone and text message multiple times with concerns the staff were not providing supervision for Resident #3.
-The Administrator was aware staff were not doing their jobs.
-In October 2019 the family saw a picture on the camera of Resident #3 laying on the floor in her room yelling for help. The family member waited 5 minutes to see if staff would come and assist Resident #3 off the floor. No staff came to assist Resident #3 off the floor. The family member called the facility and informed them Resident #3 was on the floor in her room yelling for help. The staff told the family member the facility had an activity "a band" and had not heard Resident #3 calling for help due to increase in noise.
-Resident #3 had fallen 5 or 6 times that she was aware of since her admission in July 2019.
-The facility never contacted her concerning a plan of care meeting to discuss falls or interventions to reduce falls for Resident #3.
-She was unsure of any intervention used by the facility staff to reduce falls for Resident #3.

Interview with a medication aide (MA) on 10/30/19 at 11:42am revealed.
-All residents were to be checked every 2 hours.
-Resident #3 was on the ROSE fall program because of frequent falls.

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D 270	Continued From page 35 -She knew Resident #3's family had placed a security camera in Resident #3's room about 2 months ago. -The camera was placed in Resident #3's room after Resident #3 said she had fallen and laid on the floor for 7 hours. -The MA thought Resident #3's was getting PT, but she could not recall any other interventions. -She did know Resident #3's was placed in the Hot Box system a few times and she charted in the progress notes when Resident #3 was in the hot box. -She reminded Resident #3 to use her call bell for assistance with toileting and ambulating. -Resident #3 was forgetful and fell mostly in her room. -The MA was never told by management to check Resident #3's room for fall hazards. -The MA was never told by management to look at Resident #3's shoes to determine if they fit properly or if they were slippery. -The MA was never told by management to monitor Resident #3 more often due to Resident #3's frequent falls. Telephone interview with a personal care aide (PCA) on 10/30/19 at 7:00pm revealed: -She completed checks on the residents every 2 hours. -Resident #3 would forget to use her walker and fell mostly in her room on the carpet. -She was never told to monitor Resident #3 more than every 2 hours. -In August 2019 staff started documenting every 2-hour check. -She was aware Resident #3's family had placed a security camera in her room after a fall occurred about 2 months ago. -She had worked the night when Resident #3's roommate had called out for assistance due to	D 270		

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Resident #3 being on the floor.
-When she checked Resident #3, she was not wet or had no injury.
-She did not know of any interventions the facility used to prevent Resident #3 from falling.

Interview with the Physical Therapist Director on 11/01/19 at 10:25am revealed:
-PT was in the facility Monday through Friday and weekends if needed.
-Resident #3 was on the ROSE fall program due to falls.
-When Resident #3 had fallen there should have been a fall assessment completed for each fall.
-PT or the Resident Care Director (RCD) should complete the fall assessment for Resident #3 and document intervention on the fall risk assessment sheet.
-She was unsure why fall assessments were not completed for Resident #3 after each time she fell.

Interview with the RCD on 10/30/19 at 3:40pm revealed:
-He was a nurse and responsible for overseeing the assisted living clinical staff.
-He knew Resident #3 had fallen several times including August 2019 when Resident #3 said she laid on the floor for 7 hours.
-He knew the family had placed the security camera in Resident #3's room after that fall to monitor Resident #3 and the staff.
-He expected the staff to provide supervision for Resident #3 and to assist her with ambulation and personal care.
-Resident #3 was on the ROSE fall program.
-Resident #3 was to have a fall assessment after every fall.
-He did not know fall assessments were not completed after each fall Resident #3 had per the

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D 270	Continued From page 37 Rose program policy. -He never informed the staff of any additional interventions for Resident #3 after any of the falls. -The RCD never evaluated the room environment, shoes, medical equipment, vital signs, blood sugars, or medications for Resident #3 after each fall. -He never conducted a meeting with the family to discuss options or interventions to reduce falls for Resident #3. -The facility used a hot box system for residents who had falls. -When a resident fell, they were to be placed in the hot box system for 3 or more days. -Resident #3 should be in the hot box system after every fall for 3 or more days. Telephone interview with Resident #3's Medical Provider on 10/31/19 at 11:08am revealed: -If any of her residents fall, she wanted to be made aware of the incident. -She was not aware Resident #3 had multiple falls in the facility. -She expected the facility to provide supervision for Resident #3 and to follow their policy on fall preventions. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She knew Resident #3 had several falls and was on the facility fall program - ROSE program. -According to the Rose fall program Resident #3 should had a fall risk assessment after each fall that occurred. -Resident #3 fell mostly in her room on the carpet. -She was not sure why the fall assessments were not completed each time Resident #3 had fallen. -She knew Resident #3 had fallen in August 2019 and said she laid on the floor for 7 hours.	D 270		

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SPRING ARBOR OF WILMINGTON	809 JOHN D BARRY DRIVE WILMINGTON, NC 28412

(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
D 270	Continued From page 38 -The family of Resident #3 placed the security camera on the wall in Resident #3's room to monitor Resident #3's falls and the staff. -She knew staff were not completing every 2-hour checks on Resident #3 at night because she had been in communication with the family of Resident #3 who monitored the staff at night by the security camera to see how often they were completing checks for Resident #3. -She expected the staff to do their job and keep the residents safe by perform frequent checks and promoting interventions to reduce falls. Refer to telephone interview with another medication aide (MA) on 10/30/19 at 8:20pm. Refer to interview with the Physical Therapist Director on 11/01/19 at 10:25am. Refer to interview with the RCD on 10/30/19 at 3:40pm. Refer to interview with the Administrator on 10/31/19 at 4:15pm. _____ Telephone interview with another medication aide (MA) on 10/30/19 at 8:20pm revealed: -When a resident falls the MAs were responsible for "checking the resident out", obtaining vital signs and calling the physician and family. -The MAs filled out the incident reports and gave them to the Resident Care Director (RCD) for reviewing. -When a resident fell, they were placed into the "hot box" system for 3 days and the MAs were to assess them every shift for changes in behavior or skin tears. -We were to record the vital signs and document	D 270		

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in the progress notes every shift.
-"Sometimes it was hard to remember to document."
-The MAs were now documenting every 2-hour checks for all the residents.
-On night shift, the staff were to go into the room and lay eyes on the resident to make sure they were breathing.
-The staff started documenting on the 2-hour check sheet in August 2019.

Interview with the Physical Therapy Director on 11/01/19 at 10:25am revealed:
-Physical therapy (PT) was in the facility Monday through Friday and weekends if needed.
-When a resident fell there should be a fall assessment completed for each fall.
-PT or the Resident Care Director (RCD) should complete the fall assessment for residents and document interventions on the fall risk assessment sheet.
-She was unsure why the fall assessments were not completed for residents after each time they fell.
-Management or PT had not conducted weekly fall meetings per the ROSE program to discuss residents that had fallen in the facility or discuss any interventions that could be utilized.
-"We are communicating in the halls and in the office, but we did not have a formal weekly meeting."

Interview with the Resident Care Director (RCD) on 10/30/19 at 3:40pm revealed:
-He was a nurse and responsible for overseeing the assisted living clinical staff.-He thought PT was responsible for completing the fall assessments for the residents after each fall.
-He never informed the staff of any additional interventions for residents after any of the falls.

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D 270	Continued From page 40 -PT was in the facility daily, the RCD thought it was their responsibility to complete the fall assessment and all put all interventions in place for the resident. -The RCD never evaluated the room environment, shoes, medical equipment, vital signs, blood sugars, or medications for residents after a fall. -He had never conducted a meeting with the family to discuss options or interventions to reduce falls for residents. -The facility was not conducting weekly fall management meetings according to the ROSE program to discuss residents falls or intervention to be utilized. -"Maybe I got behind on some to the things I should be doing as the RCD." -He was responsible for reporting to the Administrator. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -According to the ROSE fall program residents should had a fall risk assessment after each fall that occurred. -She was not sure why the fall assessments were not completed for each fall in the facility. -The RCD and PT were responsible for ensuring interventions were put into place to assist residents from falling. -Staff were expected to remind residents to use their call bells. -PT should get involved, as well as the families. -She expected staff to check on residents more often due to the number of falls the resident had. -She had initiated in August 2019 a 2-hour check rounding log for the staff to use while making rounds. -She expected the staff to do their job and provide supervision to the residents by	D 270		

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D 270	Continued From page 41 performing frequent checks and promoting interventions to reduce falls. -She expected the RCD and PT to track the falls and initiate interventions to reduce the falls utilizing the facility ROSE fall program. _____ The facility failed to provide supervision for 2 of 6 sampled residents, Resident #9 who had a diagnosis of dementia, used a walker to assist with ambulation, was on a blood thinner, had 11 falls from 07/01/19 to 10/15/19, with 8 of those requiring emergency room (ER) visits, required rehabilitation for several weeks, and suffered a cervical spine subacute fracture and Resident #3 who had fallen multiple times without any interventions as required by the facility policy. This failure to provide supervision to residents resulted in serious physical harm and 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 DECEMBER 1, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 42 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed physicians for 3 of 6 residents (Resident #3, #9 and #5) related to documented falls (Resident #3 and Resident #9), and Resident #5 with labs ordered by her Rheumatologist. The findings are: 1. Review of Resident #3's current FL2 dated 07/22/19 revealed: -Diagnoses included Alzheimer, dementia, chronic kidney disease and hypertension. -The level of consciousness was documented as intermittently disoriented. -Ambulatory status was semi-ambulatory. -Personal care required assistance with bathing. Review of Resident #3's progress notes revealed: -On 08/04/19 at 4:15am Resident #3 was found on the floor in her room. Resident #3 said she "flopped down" while trying to go the bathroom. Vital signs were obtained, the family and the physician were notified. -On 08/25/19 on the 7:00am-3:00pm shift, Resident #3 approached the staff and told them she had fallen on the carpet in her room. Staff completed first aide for the abrasion. The staff called the family and the physician. -On 08/30/19 at 10:30am Resident #3 was found on the floor. Resident #3 said she had slipped. First aide was administered because Resident #3's wounds were re-opened.	D 273		

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D 273	Continued From page 43 -On 09/05/19 at 12:10am resident was found on the floor. Resident said she was going to the bathroom and slipped on the floor. The family and the physician were notified. -On 09/08/19 at 7:00am Resident #3 said her floor was slippery. Resident #3 had fallen each time she went to the bathroom. No injury was noted at that time. -On 10/09/19 at 8:20pm Resident #3 had an unwitnessed fall in her room. The family had contacted the facility and informed them Resident #3 was on the floor in her room. Resident #3 had 2 skin tears on her right and left lower legs. First aide was administered. Vital signs were obtained. The physician and the family were notified. Review of Resident #3's facility physician's communication form dated 10/23/19 revealed Resident #3 had an unwitnessed fall in her room resulting in skin tears. The facility was requesting physical therapy orders for Resident #3. Review of the facility incident reports for Resident #3 revealed: -On 08/04/19 at 4:00am Resident #3 was found by her roommate on the floor in her room. Vital signs were obtained. The family and the physician were both notified. -On 08/25/19 at 10:00am Resident #3 was observed with a skin tear due to falling on carpet in her room. Vital signs were obtained. The family and the physician were both notified. -On 08/30/19 at 7:04am Resident #3 was found on the floor with reopened skin tears to right lower knee. -On 09/05/19 at 12:10am Resident #3 was found on the floor in her room. Vital signs were obtained. The family and the physician were both notified. -On 09/08/19 at 6:00pm Resident #3 was found	D 273		

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D 273	Continued From page 44 on the floor in her room. Vital signs were obtained. The family and the physician were both notified. -On 10/09/19 at 8:15pm Resident #3 was on the floor in her room and was treated for skin tears. Vital signs were obtained. The family was notified. Telephone interview with Resident #3's physician's office Registered Nurse (RN) on 10/31/19 at 10:48am revealed: -The facility contacted the office on 08/05/19 because Resident #3 fell. -The office made an appointment for Resident #3 for 08/05/19 to be seen by the physician in the office. -On 08/12/19 the family of Resident #3 called the office with concern of a fall. -On 10/24/19 the facility faxed over to the office a request for PT due to Resident #3 had unwitnessed fall in her room. -The RN did not know Resident #3 had fallen on 08/25/19, on 08/30/19, on 09/05/19, on 09/08/19, or on 10/09/19. -The physician office was open 6 days a week and offered on an on-call service 24/7. -If the facility contacted the office after hours the call would be documented in the computer system. Telephone interview with Resident #3's Medical Provider on 10/31/19 at 11:08am revealed: -The office RN had informed her of all the falls for Resident #3. -She was not aware of Resident #3's falls until today 10/31/19. -If any of her residents fell, she wanted to be made aware. -The facility had a responsibly to inform her if a resident falls and what they had done to assess the resident after the fall.	D 273		

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D 273	Continued From page 45 -She expected the facility call her with any falls or if the resident was found on the floor. Interview with the Resident Care Director (RCD) on 10/30/19 at 3:40pm revealed: -The MAs were responsible for completing incident reports and contacting the family and the physicians after a resident fell. -The RCD reviewed the incident reports and signed off, then the Executive Director reviewed and filed the reports. -He contacted the family and physician sometimes if the MAs were busy or if they ask him too. -The policy was if a resident falls the facility staff were to contact the resident's physician even if the resident had an unwitnessed fall and was found on the floor. -He told the MAs if a resident fell on 3rd shift or late at night and was not injured not to contact the physician's office until the next morning. -First shift MAs were to contact the physician office if 3rd shift had not called. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -The facility incident policy was the MAs were to contact the physician's office after every fall witnessed or unwitnessed. -The MAs were to document on an incident report the time and date they called the physician's office. -She did not know the MAs were not contacting the resident's physician each time Resident #3 had fallen. -The MAs were to contact Resident #3's physician when Resident #3 was found on the floor. 2. Review of Resident #9's current FL2 dated	D 273		

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D 273	Continued From page 46 07/19/19 revealed: -Diagnoses included Dementia. -Current level of care was documented as skilled nursing facility. -Recommended level of care was documented as the Special Care Unit (SCU). -Resident #9 was documented as constantly disoriented. Review of Resident #9's progress notes revealed: -On 07/01/19 at 6:00pm Resident #9 was found on the floor. She was made comfortable. The physician and the family were notified. Emergency medical services (EMS) were contacted for transfer to the emergency room (ER) for an evaluation. Resident returned that afternoon to the facility. -There was documentation on 08/14/19 at 11:30pm Resident #9 was found lying on the floor beside her bed. No injury at this time. Tylenol was given for pain. -On 08/18/19 at 1:20am Resident #9 was found on the floor in her room in front of her recliner. Resident said she did not hit head. Vital signs were obtained. The physician and the family were notified. -On 08/19/19 at 10:30am Resident #9 had an unwitnessed fall in her room. She hit her head on the floor and EMS was called. All parties were notified. -On 09/06/19 at 2:30pm Resident #9 had an unwitnessed fall in her room and hit her head. Resident #9 had a "raised spot" in the center of her head. Resident #9's family and physician were notified. -On 09/11/19 on the 3:00pm to 11:00pm shift Resident #9 had an unwitnessed fall in her bathroom. Resident #9 hit her head on the rail in the bathroom. There was a raised spot on the top of her head. Resident family and the physician	D 273		

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were notified. EMS was contacted for transportation to the ER.
-On 09/21/19 at 10:30pm Resident #9 was found on the floor in her room. Resident #9 said she "rolled off her bed." The family and physician were notified.
-On 09/27/19 at 2:00am Resident #9 was found on the floor in her room. Resident #9 said she "slipped off the bed." The family and the physician were notified.
-On 10/05/19 at 9:20pm Resident #9 was found on the floor in her room. Vital signs were obtained. The family and the physician were notified.
-On 10/12/19 at 8:30pm Resident #9 was found on the floor. The family and the physician were notified.
-On 10/14/19 at 3:45am Resident #9 was found on the floor in her room. Vital signs were obtained. Resident had scratched her back on the left side. Tylenol was given due to Resident complained of right arm pain. The family and the physician were notified.
-On 10/15/19 at 5:30pm Resident #9 was sent out to the ER for because of "neck hurting and mouth sore". Physician and family aware of transfer to the ER.
-On 10/16/19 at 1:45am Resident #9 was admitted to the hospital.
-On 10/16/19 at 6:00pm Resident #9 was admitted to the hospital with a diagnosis of a severe urinary tract infection (UTI).

Review of the facility incident reports for Resident #9 revealed:
-On 07/01/19 at 5:30pm Resident was found on the floor in her room. Resident said she hit her head. EMS was called for transport to the ER. Vital signs were obtained. The family and the physician were notified.

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D 273	Continued From page 48 -On 07/02/19 at 12:00am there was documentation of a follow up after the fall on 07/01/19. No new orders, an X-ray was done, and a CT of the spine and the head were negative. -On 07/02/19 at 1:00pm staff observed bruising on Resident #9's hip from the fall on 07/01/19. Resident #9 complained of pain to the site. EMS called for transportation to the ER for an evaluation. Physician and the family were notified. -On 08/14/19 at 11:30pm Resident #9 was found lying on the floor beside her bed. Resident #9 had no injury. Tylenol was administered for pain. Vital signs were obtained. The family and the physician were notified. -On 08/18/19 at 7:20am Resident #9 lost her balance fell on the floor hitting her head. EMS was called for transportation to the ER. The family and the physician were called. -On 09/06/19 at 8:45pm Resident #9 had fallen early that day requiring an ER visit. Resident returned back to the facility "no injuries, no negative reports or nothing was found from the head injury." -On 09/11/19 at 5:00pm Resident #9 was found in the bathroom and had fallen toward the shower. Vital signs were obtained. EMS was called. The family and the physician were called. -On 09/21/19 at 10:30pm Resident #9 was found on the floor beside her bed. Resident #9 was assisted off the floor without complications. Vital signs were obtained. The family and the physical were notified. -On 09/27/19 at 2:00am resident was found on the floor beside her bed. Resident #9 said she slipped off the bed. Vital signs were obtained. The family and the physician were notified. -On 10/12/19 at 8:30pm Resident #9 was found on the floor in her room laying on her right side. Resident #9 was assisted off the floor without complications. Vital signs were obtained. The	D 273		

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family and the physician were notified.
-On 10/14/19 at 3:10am Resident #9 was found on the floor in her room. Vital signs were obtained, a finger stick blood sugar obtained, and range of motion was performed. Tylenol was given due to Resident #9 complained of pain. The physician was notified.
-On 10/15/19 at 5:30pm Resident #9 was sent out to the ER for an evaluation due to Resident #9 complained of neck, mouth, and arm hurt. Vital signs were obtained. The family and the physician were notified.

Telephone interview with Resident #9's Medical Provider's Registered Nurse on 11/01/19 at 9:00am revealed:
-The facility contacted the office on 07/02/19 requesting Resident #9 return to the ER for an evaluation from a status post fall on 07/01/19.
-The physician's office did not know on 08/14/19 Resident #9 had fallen.
-The physician's office did not know on 09/21/19, 09/27/19, 10/05/19, 10/12/19 or on 10/14/19 Resident #9 had fallen.
-It was very important they were made aware of Resident #9's falls.
-The physician can not treat the falls or the underlining reason if she is not made aware of all the falls.
-Resident #9 was taken apixaban (a blood thinner used to prevent stroke) for several months during some of the those falls. That would have been one of the first questions they would have asked when they received a call regarding Resident #9 falling.
-The apixaban was discontinued on 09/13/19 due to the increase of falls.
-The complications associated with falling and apixaban would be internal bleeding or a stroke.
-It was the facility responsibility to reach out to the

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physician after each fall so the physician could assess the resident or have them seen in the office.
-The physician's office was open 6 days a week and offered on an on-call service 24/7.
-If the facility contacted the office after hours the call would be documented in our computer system.

Interview with the RCD on 10/30/19 at 3:40pm revealed:
-The MAs were responsible for completing incident reports and contacting the family and the physicians after a resident fall.
-The RCD reviewed the incident reports and signed off on the reports, then the Executive Director reviewed and filed the reports.
-He contacted the family and physician "sometimes" if the MAs were busy or if they asked him to.
-The policy was if a resident fell the staff were to contact the resident's physician even if the resident had an unwitnessed fall and was found on the floor.
-He told the MAs if a resident fell on 3rd shift or late at night and was not injured not to contact the physician's office until the next morning.
-First shift MAs were to contact the physician office if 3rd shift had not called.

Interview with the Administrator on 10/31/19 at 4:15pm revealed:
-The policy was the MAs were to contact the physician's office after every fall witnessed or unwitnessed.
-The MAs were to document on an incident report the time and date they called the physician's office.
-She did not know the MAs were not contacting the resident's physician each time Resident #9

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SPRING ARBOR OF WILMINGTON	809 JOHN D BARRY DRIVE WILMINGTON, NC 28412

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had fallen.
-The MAs were to contact the physician when a resident fell or if they were found on the floor.
-The RCD was responsible for reviewing the incident report for completion prior to the Executive Director reviewing and signing the incident report.

3. Review of Resident #5's current FL2 dated 12/12/18 revealed diagnosis included seizure disorder, hypothyroidism, and neuropathy.

Review of a signed physician's order for Resident #5 dated 09/13/19 revealed:
-There was an order indicating a Thiopurine methyltransferase (TPMT) lab (a test used to determine whether there is a risk of developing severe side effects from medication treatment for rheumatoid arthritis).
-The order also indicated, if the results were "normal", the resident was to start Imuran (used to treat rheumatoid arthritis).

Review of Resident #5's record revealed there was no documentation of results for the TPMT lab and there were no orders/instructions for Imuran (used to treat rheumatoid arthritis).

Review of the September and October 2019 electronic Medication Administration Record (eMAR) for Resident #5 revealed she had not been administered Imuran.

Review of Resident #5's pharmaceutical review recommendations dated 10/22/19 revealed there was note indicating "09/13 Imuran order? not on MAR [sic], please follow-up regarding rheumatology evaluation. Please follow-up".

Telephone interview with Resident #5's primary

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D 273	Continued From page 52 care provider (PCP) on 10/31/19 at 9:55am revealed: -Resident #5 was seen by a Rheumatologist for rheumatoid arthritis. -She had no knowledge of a TPMT test ordered by the Rheumatologist. -She expected Resident #5 to receive care and treatment for rheumatoid arthritis as ordered by the Rheumatologist. Interview with a medication aide (MA)/Supervisor on 10/31/19 at 3:45pm revealed: -MA/Supervisors were responsible for placing new lab orders into the new order binder and the communication book so that the order can be followed up on the next shift until results are received. -MA/Supervisors were also responsible for placing a copy of lab orders under the Resident Care Director's (RCD) door. -Once a new order was received the MA/Supervisors were responsible for following up on the status of the order until results/further instructions was received. -She received the order dated 09/13/19 for Resident #5's TPMT lab and medication. -She informed the Administrator that that order was received and instructed her to place the order in the communication book to ensure follow-up. -She did not know what happened with the results of Resident #5's lab, she thought the results were still pending. -She had not contacted the Rheumatologist for an update. -She thought another MA/Supervisor or the RCD followed-up of the lab results. Interview with the Resident Care Director (RCD) on 10/31/19 at 11:40am revealed:	D 273		

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-MA/Supervisors were responsible for receiving orders and calling to get lab work scheduled.
-MA/Supervisors were responsible for contacting the PCP for results of lab work.
-Any results for lab work should be placed in the residents' record once received.
-His job was to oversee the MA's, "not do the work for them".
-He did not know the status of Resident #5's lab work or if she needed to be taking Imuran.
-He tried to call Resident #5's PCP on 10/30/19, however realized on 10/31/19 that he had been contacting the wrong physician.
-He had not seen the order in the new order book for Resident #5 dated 09/13/19.
-He did not know the Rheumatologist that was treating Resident #5.
-He was responsible for reviewing quarterly pharmaceutical review recommendations.
-He reviewed the recommendations for October 2019, however had not had a chance to correct all items because he had been working the cart as a MA.

Interview with Resident #5 on 10/30/19 at 9:20am revealed she did not know about a lab ordered by her Rheumatologist on 09/13/19.

Interview with the Administrator on 10/08/19 at 11:19am revealed:
-MA/Supervisor's were responsible for placing new orders in the new order binder, communication folder, and placing a copy of the new order in the RCD door once received.
-MA/Supervisor's were responsible for going through the communication folder daily to check for anything outstanding and refax the PCP or call for results.
-She knew about the order for the TPMT lab and Imuran dated 09/13/19, but she did not know the

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D 273	Continued From page 54 current status. -The MA/Supervisors and the RCD should have followed up on the lab results and subsequent medication order. _____ The facility failed to assure referral and follow up to the primary care provider for Resident #3 had who had fallen 5 times and for Resident #9 who was on a blood thinner and had fallen 6 times and there was also no follow up for an ordered laboratory test for Resident #5 to determine whether there was a risk of developing severe side effects from a medication treatment for rheumatoid arthritis. The facility's failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 16, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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This Rule is not met as evidenced by:
Based on interview and record review the facility failed to implement orders for an admission to the Special Care Unit (SCU) for 1 of 3 residents (Resident # 9).

The findings are:

Review of Resident #9's current FL2 dated 07/19/19 revealed:
-Diagnoses included Dementia.
-Current level of care was documented as skilled nursing facility.
-Recommended level of care was documented as the Special Care Unit (SCU)Resident #9 .
-Resident #9 was documented as constantly disoriented.

Observation during the initial tour on 10/30/19 between 10:05am and 11:45am revealed Resident #9's room was located on the Assisted Living side.

Interview on 10/30/19 at 11:45am with a personal care aide (PCA) revealed:
-Resident #9 was currently in the hospital.
-She was unsure why Resident #9 was in the hospital.

Interview on 10/30/19 at 12:10pm with a medication aide (MA) revealed:
-Resident #9 was currently in the hospital.
-Resident #9 fell one day and was sent out to the emergency room (ER) for an evaluation.

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D 276	Continued From page 56 -Resident #9 returned that afternoon. -The following day Resident #9 started getting bad and returned to the hospital. -She was admitted to the hospital. Review of Resident #9's care plan dated 04/25/19 revealed: -Resident #9 used a rollator walker for ambulation. -Resident #9 was incontinent at times of bowel and bladder. -Resident #9 was sometimes disoriented. -Resident #9's was forgetful needed reminders. -Resident #9 required supervision with toileting, independent with ambulation, dependent with bathing, extensive assistance with dressing, and limited assistance with transfers. -There was no documentation of an updated care plan from the current FL2 dated 07/19/19 for Resident #9's care plan or the order for admission to the SCU. Telephone interview on 11/01/19 at 9:45am with Resident #9's physician office's Registered Nurse (RN) revealed: -The FL2 was considered an order. -She did not know Resident #9 had an order on the FL2 for admission to the SCU. -Resident #9 had fallen in July 2019 and was in a rehabilitation facilit for about 3 weeks. -The new FL2 date 07/19/19 was from the rehabilitation facility. -The SCU was a smaller unit and was staffed to meet the needs of dementia residents. -The facility never contacted the office for implementation of the FL2 order for admission to the SCU. Telephone interview on 11/01/19 at 10:35am with Director of Nursing from the rehabilitation facility	D 276		

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D 276	Continued From page 57 revealed: -Resident #9 was discharged from the facility on 07/23/19. -Resident #9 fell on 07/01/19 and required rehabilitation from the fall. -The Social Worker completed Resident #9's FL2 dated 07/19/19 and the physician signed the FL2. -Resident #9 had a diagnosis of dementia. -The social worker thought Resident #9 had previously been in the SCU prior to her stay at the Skilled Nursing Facility (SNF). -The current facility never contacted them for implementation of the FL2 order for Resident #9's admission to the SCU. Interview on 11/01/19 at 11:15am with Resident #9's Physical Therapist revealed: -Resident #9 resided on the assisted living side of the facility. -She was seeing Resident #9 for PT for falls. -The FL2 were considered orders for the residents. -She did not know Resident #9 had a current order on the FL2 dated 07/19/19 for admission to the SCU. -The SCU was a small secured unit for the dementia residents and had 14 beds. Interview with the Administrator on 11/01/19 at 11:50am revealed: -When a resident was admitted to the facility or returned from a hospital stay or rehabilitation, an FL2 would accompany them. -The FL2 should be faxed to the facility before the resident arrived. -Normally, she did not admit or re-admit a resident to the community before an FL2 had been sent to the facility. -The Resident Care Director (RCD) or the Special Care Director (SCD) reviewed the FL2.	D 276		

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D 276	Continued From page 58 -In the absence of the Clinical managers, or if they are busy, the MAs reviewed the FL2. -If an assisted living resident left the facility for the hospital or rehabilitation and returned with a level of care indicating the need for a special care unit, they could not take them back if we did not have a bed available in the SCU. -The SIC's should be able to review an FL2 and process with the correct procedure. -She did not know Resident #9 returned from rehabilitation with the level of care designated as "special care unit." -She did not know who processed Resident #9 FL2 when they returned from rehabilitation. -She thought the MAs probably focused on the medications listed on the FL2 and not the level of care. -Her expectations were the clinical staff should be reviewing the FL2's after the MAs to verify all the information on the FL2 was correct.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 residents (Resident #8 and #3) were treated with dignity and respect in regard to Resident #8 being monitored by a roommate's security camera without knowledge of being videotaped and Resident #3 being left unattended in her room	D 338		

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D 338	Continued From page 59 waiting for staff to assist with her shower. The findings are: Review of the facility policy Electronic Monitoring of Residents' Room or Community Common Areas revealed: -The facility supports the resident's right to live in a safe environment and in privacy. -The facility does not permit any electronic monitoring or recording of residents in their rooms or common areas. -A resident cannot install or authorize an individual to install, operate, or maintain any form of electronic monitoring in a resident's room or the common areas. -The facility will remove from a resident's room any devicee for recording from a resident room after it was discovered or reported to the staff. -Electronic monitoring included visual and audio recordings and or monitor of individuals which include residents, staff, or visitors. Observation during the initial tour on 10/30/19 between 10:15am and 11:45am revealed a personal security camera located in a resident's room which was in direct view of a common area shared by another resident. 1. Review of Resident #8's current FL2 dated 05/20/19 revealed diagnoses included pain, depressive disorders, anxiety, and macular degeneration. Review of Resident #8's Resident Registry revealed an admission date of 07/30/14. Interview with Resident #8 on 10/30/19 at 11:15am revealed: -Resident was alert but appeared forgetful of time	D 338		

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D 338	Continued From page 60 and surroundings. -She shared a common area with her roommate. -The common area led into a shared bathroom and there was a sink she used daily. -She did not know a security camera was in her roommates' room and was in direct view of the common sink area. Interview with the Resident Care Director (RCD) on 10/30/19 at 3:40pm revealed: -He was aware the security camera was in the resident's room. -The facility had a policy no cameras allowed in the facility especially in a resident's room. -"I don't think it is right." -The Administrator agreed to the security camera after the resident had fallen on the floor in her room. -The Administrator, the Ombudsmen, RCD and the family met to discuss the falls. -The family requested placing a security camera in the resident's room for monitoring the resident and the staff. -The family of the roommate was notified, and they were aware of the security camera. -He was unsure if the roommate's family agreed to the security camera. -There was no documentation the family had been contacted by the RCD. -The roommate was not told due to her dementia and forgetfulness. -He knew the camera was located on a wall which exposed the common area shared by both residents. -The RCD never requested the camera be moved or relocated to another area to prevent exposure of the roommate. -The family had placed the camera up and chose the location of the security camera. -The camera had been placed in the resident's	D 338		

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D 338	Continued From page 61 room about 3 months ago. Telephone interview with the Power of Attorney (POA) for Resident #8 on 10/30/19 at 7:30pm revealed: -She and her family visited Resident #8 two or three times weekly. -Resident #8 had resided in the assisted living for 5 years. -She was not aware of the security camera in Resident #8's roommates' room. -She had not noticed the security camera in the roommate's room located on the wall facing the common area. -Resident #8 had dementia and would forget to dress appropriately at times. -On days Resident #8 did not take a shower she would give herself "a bird bath" at the common sink area. -Resident #8 would come out of the common bathroom "half dressed" at times. -"It's an invasion of her privacy." -Resident #8 considered her room as her home and she did not expect "to be spied on." -The facility never contacted her about the security camera. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She was aware of the security camera placed in a resident's room by the family. -The security camera was placed about 2 months ago. -The facility conducted a meeting with the family because the resident had fallen in her room. -The family mounted the camera to the wall facing outside the room and in direct view of the shared common area. -She thought the roommate was told about the camera but was not sure if the roommates POA	D 338		

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was notified.
-There was no documentation the Administrator had informed the roommate or notified the POA of the security camera.
-The facility policy on the use of security cameras in the facility, was that they were not allowed.
-The Administrator had contacted corporate regarding the security camera.
-The Administrator had informed corporate she was not sure staff were completing their jobs and would like the camera to stay up until she felt good about the staff.

A second interview with Resident #8's POA on 11/01/19 at 9:36am revealed:
-She had spoken to the other family members and no one was informed of the security camera located in the roommate's room.
-She had reviewed the admission package and saw the facility policy that no cameras were allowed in the facility.
-She was upset Resident #8 was not treated with respect and wanted the security camera to be taken down as soon as possible.
-She expected the facility to keep Resident #8 safe in her home and to respect her dignity.

2. Review of Resident #3's current FL2 dated 07/22/19 revealed:
-Diagnoses included Alzheimer, dementia, chronic kidney disease and hypertension.
-Resident #3 was intermittently disoriented.
-Ambulatory status was semi-ambulatory.
-Personal care required assistance with bathing.

a. Review of Resident #'3 Resident Registry revealed an admission date of 07/29/19.

Interview with Resident #3 on 10/30/19 at 11:08am revealed:

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D 338	Continued From page 63 -She said she had skin tears to her arm due to fragile skin and she had fallen. -She said she had fallen several times in the past few weeks. -She said her family had placed a security camera in her room. -The camera was used because she had fallen, and staff did not come and help her. -Once she had fallen and laid on the floor for 7 hours. -After that incident her family placed the camera on the wall. -The camera was used by her family to watch and listen how staff assisted her in her room. Telephone interview with Resident #3's family member on 10/30/19 at 11:52am revealed: -She had met with the Administrator, RCD and the Ombudsman to discuss options because Resident #3 had several falls in her room. -The security camera was placed in Resident #3's room after Resident #3 had fallen and laid on the floor for 7 hours. -The family had chosen the location of the security camera to monitor staff go in and out of Resident #3's room. -Family members could video, watch and listen to staff caring for Resident #3 in her room. -The family had never informed Resident #3's roommate or the roommate's family the camera was in direct view of a common area shared by both residents. -Neither the Administrator or the RCD told her the facility had a policy that security cameras were not to be used in a resident's room. Interview with the Resident Care Director (RCD) on 10/30/19 at 3:40pm revealed: -The facility had a policy camera were not allowed in the facility especially in a resident's room.	D 338		

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D 338	Continued From page 64 -The Administrator, the Ombudsmen and the RCD with the family met to discuss Resident #3's falls. -The family requested placing a security camera in the resident's room for monitoring the resident and the staff. -There was no documentation the roommate's family (POA) had been contacted by the RCD. -He knew the camera was located on a wall which exposed the common area shared by both residents. -The family had placed the camera up and chose the location of the security camera. -The camera had been placed in the resident's room about 3 months ago. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She was aware the security camera was placed about 2 months ago in Resident #3's room by the family. -The facility conducted a meeting with the family because Resident #3 had fallen several times in her room. -The family mounted the camera to the wall facing outside the room and in direct view of the shared common area. -The facility policy on the use of security cameras in the facility, they were not allowed. Review of the facility policy Electronic Monitoring of Residents' Room or Community Common Areas revealed: -The facility does not permit any electronic monitoring or recording of residents in their rooms or common areas. -A resident cannot install or authorize and individual to install, operate, or maintain any form of electronic monitoring in a resident's room or the common areas.	D 338		

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D 338	Continued From page 65 -The facility will remove from a resident's room any deceive for recording from a resident room after it is discovered or reported to the staff. b. Telephone interview with Resident #3's family member on 10/30/19 at 11:52am revealed: -Resident #3 was left unattended for over an hour waiting in her room for assistance with her shower. -Staff came into the room and told Resident #3 it was time for her shower. -Resident #3 was undressed except for a brief and her bra. -The staff gave Resident #3 a towel to cover herself up. -The family member said Resident #3 was a private person and was embarrassed about being left without clothes on. -Another staff person came into the room and offered a snack to Resident #3 while she was undressed with a towel draped over her, leaving Resident #3's door open. -Another staff administered medications to Resident #3 while she was undressed with a towel draped over her. -When the staff returned to assist Resident #3 with her shower, she informed Resident #3 she was busy with other residents. -The family member called the Administrator regarding the incident, but the Administrator did nothing. -Resident #3 sat in the chair in her room undressed for over an hour waiting for staff to return to provide personal care while she was probably cold. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She knew about Resident #3 left unattended in her room for over an hour waiting on staff to	D 338		

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D 338	Continued From page 66 return and provide personal care. -The family of Resident #3 had contacted her regarding the incident. -She had spoken to the staff and was told Resident #3 undressed herself after the staff approached her about getting a shower. -Resident #3 should not wait over an hour undressed to get a shower. -The family of Resident #3 had called her several times with incidents of staff not doing their jobs. _____ Based on observations, interviews and record reviews, the facility failed to assure residents were treated with dignity and respect in regard to Resident #8 being monitored by a security camera without knowledge. The camera was placed in a location that exposed Resident #8 while she was provided personal care at a common area sink while being partially dressed. Resident #3 was left unattended in her room waiting for staff to assist with her shower for over an hour while exposed undergarments with a towel covering her. These failures of the facility to assure residents rights was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation. _____ A plan of protection was provided from the facility in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 18, 2019.	D 338		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 67 (a) An adult 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 medical 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 notification to the county department of social services of any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 2 of 6 sampled residents (Resident #4 and #9). The findings are: Review of the facility's "Policy for Incident and Accident Report" dated December 2017 revealed: -An incident and accident report must be completed in the event that a resident experienced an occurrence that is unusual, improper or harmful while at the community or while participating in a community outing. Incidents may include but are not limited to, injuries, falls, sudden illness, unexplained absence, disruptive behavior, or allegations of abuse or theft. The individual's physician, family and responsible party and regulatory agency, if applicable, should be notified. 1. Review of Resident #4's most recent FL2	D 451		

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D 451	Continued From page 68 dated 04/02/19 revealed: -Diagnoses included anxiety disorder, chronic obstructive pulmonary disease, essential primary hypertension, paroxysmal atrial fibrillation, and type 2 diabetes. -Resident #4 was semi-ambulatory. -Resident #4 was intermittently disoriented. -Resident #4 had wandering tendencies. -Resident #4 required assistance with bathing and dressing. Review of Resident #4's progress note dated 07/27/19 revealed: -Resident #4 was found on the floor in hallway with large skin tear on upper right arm. -Resident #4 had two small lumps on the back of head on right side. -Resident #4 was transported to a local hospital by a family member for further evaluation. -The resident's progress note was completed and signed by a medication aide at 9:45am. Review of local hospital report dated 07/27/19 revealed: -Resident #4 went to the emergency room for an unwitnessed fall. -Resident #4 struck her head on the floor. -Resident #4 had two hematomas, right hip and right should pain. -The final impression was documented as a mechanical fall and a distal clavicle fracture. Review of facility incident report dated 07/27/19 at 9:15am for Resident #4 revealed: - "Resident found on floor in hallway with large skin tear on upper right arm. Resident also has two small lumps on back of head on right side." -Resident #4 was sent out to the local hospital for evaluation. -There was not an area on the form for staff to	D 451		

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document notification to the local department of social services.
-There was no documentation of notification via fax or phone call to DDS.

Review of the progress note for Resident #4 dated 09/23/19 revealed:
-The resident went to the bathroom and fell hitting her head on the wall.
-Resident #4 was transported to a local hospital by a family member for further evaluation.
-The resident's progress note was completed and signed by a medication aide at 6:30am.

Review of the local hospital report dated 09/23/19 revealed:
-Resident #4 went to the emergency room for an unwitnessed fall, hitting her head.
-Resident #4 had left shoulder and left hip pain.
-Resident #4 had two hematomas, right hip and right should pain.
-The conclusion impression was a distal left clavicle fracture.

Review of facility incident report for Resident #4 revealed:
-The date of the incident was 09/23/19 at 6:30am.
-Resident #4 was observed on the floor.
-Resident #4 was trying to go to the bathroom and fell on the floor.
-Resident #4 was sent out to local hospital for evaluation.
-There was not an area on the form for staff to document notification to the local department of social services.
-There was no documentation of notification via fax or phone call to DDS.

Interview with the local DSS Social Worker on 11/01/19 at 10:00am revealed:

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-The facility was responsible for faxing incident reports to DSS for any incident that happened which required more than first aide.
-She monitored the facility multiple times and the staff or management never informed her of the incidents for Resident #4.
-She had not received any of the above incident reports for Resident #4.

Refer to interview with the local DSS on 11/01/19 at 10:00am.

Refer to interview with the Resident Care Director (RCD) on 10/30/19 at 3:00pm.

Refer to interview with the Administrator on 10/31/19 at 3:30pm.

2. Review of Resident 9's most recent FL2 dated 07/19/19 revealed:
-Diagnoses included dementia, paroxysmal atrial fibrillation, dysphagia, type 2 diabetes, and hypertension.
-Resident #9 was ambulatory.
-Resident #9 was constantly disoriented.
-Resident #9 required assistance with bathing and dressing.

Review of Resident #9 progress note dated 07/01/19 revealed:
-The resident was found on the floor.
-Resident #4 was transported to a local hospital by emergency medical services (EMS).
-The resident note was completed and signed by a medication aide at 6:00pm.

Review of facility incident report for Resident #9 revealed:
-The date of the incident was 07/01/19 at 5:30pm.
-Resident #9 was observed sitting on the floor in

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D 451	Continued From page 71 front of recliner and beside bed. -Resident #9 reported heating head and was observed to be confused. -Resident #9 was sent out to local hospital for evaluation by emergency medical services per policy for head injury. -There was not an area on the form for staff to document notification to the local department of social services. -There was no documentation of notification via fax or phone call to DDS. Review of Resident #9's hospital discharge dated 07/01/19 revealed: -Reason for visit was documented as a fall, possible urinary tract infection and chest pain. -Resident #9 presented in the emergency room (ER) with dizziness and chest pain since "earlier today". -Resident #9 was walking with her walker and lost her balance falling on her right side. The fall was unwitnessed. -Resident #9 had a skin tear on her right forearm. -Resident #9 had scratched her am on the walker and fell straight on her butt. Review of "Resident Notes" for Resident #9 dated 07/02/19 revealed: -Resident #9 was sent out to the hospital on 07/01/19 for a fall. -The medication aide noticed the resident had a bruise on her right hip. -Resident #9 was in "a lot of pain" and the bruise was extreme and very painful. -Resident #9's primary care provider (PCP) was called and ordered for the resident to be sent back to the hospital via emergency medical services (EMS). -The resident note was completed and signed by a medication aide at 2:45pm.	D 451		

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D 451	Continued From page 72 Review of facility incident report for Resident #9 revealed: -The date of the incident was 07/02/19 at 1:00pm. -The incident type was documented as bruise with pain. -Staff observed large bruise on Resident #9's hip from a fall that occurred the day before. -Resident #9 complained of pain to the site. -Resident #9 was sent out to the local hospital for evaluation by EMS due to increased pain. -Resident #9 was admitted to the local hospital for observation. -There was not an area on the form for staff to document notification to the local department of social services. -There was no documentation of notification via fax or phone call to DDS. Review of Resident #9's hospital discharge dated 07/02/19 revealed: -Upon physical exam Resident #9 had a "large hematoma on right hip" and was tender to palpate. -Resident #9 was seen in the ER on 07/01/19 and was diagnosed with a right hip fracture. "The story is quite confusing actually." -There was documentation there were images performed on 07/01/19 which was inconclusive due to an X-ray finding an impacted femoral neck fracture, and a CT scan of the right hip that read with no fracture. -There was documentation Resident #9 was taking apixaban 5mg two times daily. -There was documentation the case was discussed with another medical provider and Resident #9 would be admitted to the hospital for placement at a Skilled Nursing Facility (SNF) for rehabilitation. -There was documentation Resident #9 was	D 451		

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D 451	Continued From page 73 admitted to the hospital on 07/02/19 contusion of right hip and thigh. Review of "Resident Notes" for Resident #9 dated 08/18/19 revealed: -The resident was found on the floor in front of a recliner. -Resident #4 stated she did not hit her head. -The resident note was completed and signed by a medication aide at 1:20am. Review of facility incident report for Resident #9 revealed: -The date of the incident was 08/18/19 at 7:20am. -Resident #9 was observed on the floor. -Resident #9 lost her balance and fell, hitting her head on floor. -Resident #9 stated "her head was hurting." -Resident #9 was sent out to the local hospital for evaluation by emergency medical services. -There was not an area on the form for staff to document notification to the local department of social services. -There was no documentation of notification via fax or phone call to DDS. Review of Resident #9's hospital discharge dated 08/19/19 revealed: -Resident #9's chief complaint was a fall and rib pain. -Resident #9 had fallen and injured her left elbow and rib cage. -Resident #9 was diagnosed with a urinary tract infection (UTI) and was returned to the facility. Review of Resident #9's progress note dated 09/06/19 at 2:30pm revealed: -There was documentation Resident #9 had an unwitnessed fall in her room. -There was documentation Resident #9 hit her	D 451		

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head on the floor and had a "raised spot in the center of her head".
-There was documentation EMS was called for transport to the ER.

Review of Resident #9's hospital discharge dated 09/06/19 revealed:
-There was documentation Resident #9's chief complaint was a fall.
-There was documentation Resident #9 complained of right shoulder pain, back pain, and pain to the back of the head with a hematoma noted to the back of Resident #9's head.
-There was documentation EMS had applied a sling to Resident #9's right arm, but she was moving her right arm in the ER.
-There was documentation a CT cervical spine was completed, and the findings were compared to the CT scan completed on 08/19/19, subacute fractures of the C7, T1 and T2.

Review of Resident #9's incident report dated 09/06/19 revealed:
-There was documentation on 09/06/19 at 8:45pm Resident #9 was back from the ER with no injuries or negative reports, nothing was found from head injury.
-There was no other documentation on the incident report.
-The incident report was signed by the ED and the staff completing the report.

Review of Resident #9 progress note dated 09/11/19 revealed:
-Resident #9 had an unwitnessed fall in bathroom hitting head on rail.
-Resident #9 was transported to a local hospital by emergency medical services (EMS).

Review of facility incident report for Resident #9

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revealed:
-The date of the incident was 09/11/19 at 5:00pm.
-Resident #9 had an unwitnessed fall.
-The resident assistant heard a loud sound that came from Resident #9's room.
-Resident #9 was in the bathroom and fell forward into the shower.
-Resident #9 was sent out to local hospital for evaluation by emergency medical services.
-There was not an area on the form for staff to document notification to the local department of social services.
-There was no documentation of notification via fax or phone call to DDS.

Review of Resident #9's hospital discharge dated 09/11/19 revealed:
-There was documentation Resident #9 chief complaint was a fall and head injury without loss of conscious.
-There was documentation Resident #9 had an X-ray and a CT scan completed with no acute findings.
-There were documented final impression diagnoses included a closed head injury, dementia and chronic fractures of the spine.
-There was documentation Resident #9 returned on 09/11/19 to the facility with fall precautions.

Review of "Resident Notes" for Resident #9 dated 10/15/19 revealed:
-Resident #9 was sent to the emergency room for evaluation due to neck pain and mouth sore.
-Resident #9' primary care physician (PCP) instructed staff to send the resident to the emergency room for evaluation.
-The Resident Note was completed and signed by a medication aide at 5:30pm.

Review of facility incident report for Resident #9

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D 451	Continued From page 76 revealed: -The date of the incident was 10/15/19 at 5:30pm. -Resident #9 was sent out to local hospital for evaluation by emergency medical services due to neck, mouth, and arm pain. -There was not an area on the form for staff to document notification to the local department of social services. -There was no documentation of notification via fax or phone call to DDS. Review of Resident #9's hospital report dated 10/15/19 revealed: -Resident #9's chief complaint was altered mental status and multiple falls. -Resident #9 presented in the ER with complaints of multiple fall and generalized weakness. -There was documentation Resident #9 complained of her neck hurting from a fall on Saturday. -There was documentation Resident #9 would be admitted to the hospital for a UTI, altered mental status, multiple falls, cervical strain and closed head injury. Interview with the local Department of Social Services (DSS) Social Worker on 11/01/19 at 10:00am revealed: -The facility was responsible for faxing incident reports to DSS for any incident that happened which required more than first aide. -She monitored the facility multiple times and the staff or management never informed her of the incidents for Resident #9. -She had not received any of the above incident reports for Resident #9. Refer to interview with the local DSS on 11/01/19 at 10:00am.	D 451		

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D 451	Continued From page 77 Refer to interview with the Resident Care Director (RCD) on 10/30/19 at 3:00pm. Refer to interview with the Administrator on 10/31/19 at 3:30pm. _____ Interview with the Resident Care Director (RCD) on 10/30/19 at 3:00pm revealed: -The MAs were responsible for completing the incident report. -The RCD was responsible for sending the reportable incident (when a resident is sent out for medical evaluation) to the county department of social services. The RCD thought he had sent the incident reports to the county DSS for Resident #4 and Resident #9. -The RCD did not have fax confirmations of incident reports sent to the county department of social services. Interview with the Administrator on 10/31/19 at 3:30pm revealed: -The MAs were responsible for completing incident reports. -The RCD or the Special Care Director (SCD) were responsible for sending the incident report to the county department of social services if the incident was a reportable. -The RCD and/or SCD should have a confirmation report showing the incident report was sent to the county department of social services. -The Administrator was not aware the facility incident report did not have an area on the incident report form to document notification to the local department of social services. -The Administrator indicated an area would be added to the incident report to document	D 451		

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D 451	Continued From page 78 notification to the county department of social services.	D 451		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled residents (Resident #4 and #11) admitted to the Special Care Unit (SCU) had a pre-admission screening for appropriate placement (Resident #4) and disclosure information regarding policies and procedures in	D 463		

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D 463	Continued From page 79 the SCU (Residents #4 and #11). The findings are: 1. Review of Resident #4's current FL2 dated 04/02/19 revealed: -Diagnoses included vascular dementia without behaviors. -The Special Care Unit (SCU) was documented as the recommended level of care. -Resident #4 was intermittently disoriented and a risk for wandering. Review of Resident #4's record revealed: -There was no documentation of a pre-admission screening prior to admission to the SCU. -There was no documentation that a disclosure regarding policies and procedures in the SCU was provided to and signed by the family members or the guardian. Telephone interview with the responsible family member on 11/01/19 at 9:40am revealed she was not sure if a Disclosure form was presented to them. Refer to the interview with the Business Office Manager on 11/01/19 at 10:30am. Refer to the interview with the Special Care Director (SCD) of the SCU on 10/31/19 at 3:40pm revealed: Refer to the interview with the Marketing Director on 11/01/19 at 10:55am. Refer to the interview with the Administrator on 11/01/19 at 11:30am. 2. Review of Resident #11's current FL2 dated	D 463		

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D 463	Continued From page 80 04/24/19 revealed: -Diagnoses included dementia. -Special Care Unit (SCU) was documented as the recommended level of care. -There was documentation that Resident #11 was constantly disoriented. Review of Resident #11's Resident Register revealed an admission date to the SCU of 03/22/19. Review of Resident #11's record revealed there was no documentation that a disclosure regarding policies and procedures in the SCU was provided by the facility to family members or the guardian. Refer to the interview with the Special Care Director (SCD) of the SCU on 10/31/19 at 3:40pm. Refer to the interview with the Business Office Manager on 11/01/19 at 10:30am. Refer to the interview with the Marketing Director on 11/01/19 at 10:55am. Refer to the interview with the Administrator on 11/01/19 at 11:30am. _____ Interview with the Special Care Director of the Special Care Unit (SCU) on 10/31/19 at 3:40pm revealed: -She was responsible for the resident records on the SCU. -She thought the Disclosure forms were kept in the Business Office Manager (BOM)'s office. -She did not know who gave the Disclosure form to the families to review and sign. -There was a section in the resident's record under the tab "Lifestyle Preferences", where	D 463		

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D 463	Continued From page 81	D 463		

according to the index of tabs in the front of the record, the resident's disclosure form should be filed there.
-She filed the resident's personal care logs in that section.
-She was not informed the Disclosure forms should be filed in the resident's record.

Interview with the Business Office Manager on 11/01/19 at 10:30am revealed:
-The Special Care Disclosure form was included in the Admission packet for new residents given to the responsible family member or guardian by the Marketing Director.
-Once the Disclosure form is reviewed and signed, the Marketing Director presented the form to the BOM who files it in the resident's business file, kept in her office.
-The Administrator had been auditing the files and had requested the Disclosures be placed in the resident's record.
-Some of the Disclosures may already be in the resident's record.

Interview with the Marketing Director on 11/01/19 at 10:55am revealed:
-She included the Special Care Disclosure form in the New Admission packet she presented to family members.
-She had not admitted a Special Care resident since she was hired, so she had not processed any disclosure forms.
-She thought the person to receive the completed Disclosure form for a new Special Care resident was the BOM.

Interview with the Administrator on 11/01/19 at 11:30am revealed:
-She had been auditing the resident's records since September, 2019.

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D 463	Continued From page 82 -Some of the Disclosure forms for the Special Care residents were in the BOM files, and some were in the resident's clinical record. -She was in the process of moving all the Disclosure forms to the resident's clinical record. -The Disclosure form was included in the New Admission packet given to the families by the Marketing Director. -When the family returned the signed Disclosure form, it should be filed in the resident's clinical record.	D 463		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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 review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Health Care referral and follow up, staff training in Cardio-Pulmonary Resuscitation and Resident Rights. The findings are: Based on observations, interviews, and record	D912		

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D912	Continued From page 83 reviews, the facility failed to assure referral and follow up with the licensed physicians for 3 of 6 residents (Resident #3, #9 and #5) related to documented falls (Resident #3 and Resident #9), and Resident #5 with labs ordered by her Rheumatologist. [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) and Choking Management for 4 of 6 sampled employees (Staff A, B, C and F). [Refer to Tag 0167 10A NCAC 13F .0507 Cardio-Pulmonary Resuscitation (Type B Violation)]. Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 (Resident #8 and #3) were treated with dignity and respect in regard to Resident #8 being monitored by a roommate's security camera without knowledge of being videotaped and Resident #3 being left unattended in her room waiting for staff to assist with her shower. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless	D935		

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D935	Continued From page 84 that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935		

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D935	Continued From page 85 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 4 sampled medication aides (Staff G and H) completed the 5, 10 or 15-hour state approved medication aide training. The findings are: 1. Review of Staff G's, a medication aide (MA)/Supervisor personnel record revealed: -Staff G was hired on 08/08/19. -Staff G completed the clinical skills checklist on 08/30/19. -Staff G passed the written medication examination on 08/22/02. -There was a medication aide employment verification completed 09/26/19, which provided verification Staff G worked as a MA 12/31/18-08/21/19. -There was no documentation Staff G had completed the 5, 10, or 15-hour state approved MA training. Review of facility electronic Medication Administration Records (eMARs) for September 2019-October 2019 revealed Staff G had documented the administration of medications. Interview with Staff G on 11/01/19 at 10:15am revealed: -She had been employed as a MA at the facility since August 2019. -Prior to her employment at this facility, she had worked as a MA at another facility where she had completed the 15-hour state approved MA training. -She had the employment verification form completed by her previous employed per the	D935		

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D935	Continued From page 86	D935		

request of the Administrator.
-She had not been asked to provide documentation of completion of the 15-hour training when she began employment at this facility.

Refer to interview with the Business Office Manager (BOM) on 10/31/19 at 3:00pm.

Refer to interview with the Resident Care Director (RCD) on 10/31/19 at 3:30pm.

Refer to interview with the Administrator on 10/31/19 at 3:50pm.

2. Review of Staff H's, a medication (MA)/Supervisor personnel record revealed:
-Staff H was hired on 12/04/17.
-Staff H completed the clinical skills checklist on 12/04/17.
-Staff H passed the written medication examination on 10/13/03.
-There was no documentation Staff H had completed the 5, 10, or 15-hour state approved MA training.
-There was no documentation of a MA employment verification form.

Review of facility electronic Medication Administration Records (eMARs) for September 2019-October 2019 revealed Staff H had documented the administration of medications.

Attempted telephone interview with Staff H on 11/01/19 at 10:08am was unsuccessful.

Refer to interview with the Business Office Manager (BOM) on 10/31/19 at 3:00pm.

Refer to interview with the Resident Care Director

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D935	Continued From page 87 (RCD) on 10/31/19 at 3:30pm. Refer to interview with the Administrator on 10/31/19 at 3:50pm Interview with the Business Office Manager (BOM) on 10/31/19 at 3:00pm revealed: -She was responsible for maintaining staff personnel records. -She was not sure what MA/Supervisors needed prior to administering medications to residents. -The Resident Care Coordinator (RCD) was responsible for ensuring the MAs completed all MA training when hired. Interview with the Resident Care Coordinator (RCD) on 10/31/19 at 3:30pm revealed: -He was responsible for ensuring staff had required MA training prior to administering medications. -He relied on the Administrator to notify him of staff who required training prior to administering medications once hired. -The Administrator had not told him Staff G and Staff H needed any required training or employment verification. Interview with the Administrator on 10/31/19 at 3:50pm revealed: -She was responsible for keeping a spreadsheet of required trainings for all staff. -She was currently working on making sure all staff had required trainings in their personnel record. -She did not realize that she needed to show consistent employment for 10/01/11-09/30/13 and every subsequent 24 months period for Staff G on the employment verification form. -She did not realize Staff H did not have proof of the 15-hour state approved training in her	D935		

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D935	Continued From page 88 personnel record. -The RCD was responsible for ensuring staff met all MA qualification requirements prior to administering medications.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for other staff Qualifications, training on cardio-pulmonary resuscitation, resident care plans, supervision, referral and follow-up, health care implementation, resident rights, reporting of accidents and incidents and admission to the special care unit. The findings are: Telephone interview with a medication aide (MA) on 10/30/19 at 8:20pm revealed: -The current management team was new. The previous management team helped them with all the paper work, but they were expected to do everything now. -Management was not present on the floor to	D980		

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D980	Continued From page 89 assist the staff or to assist with all the paper work they had been assigned. -The facility's policy was no security cameras were to be placed in a resident's room, but management let a family place a camera in a resident's room. -They were never told by management the camera was in the resident's room. Telephone interview with the Power of Attorney (POA) for Resident #8 revealed: -She was not aware of the security camera in Resident #8's roommates' room. -"It's an invasion of her privacy." -Resident #8 considered her room as her home and she did not expect "to be spied on." -Management never contacted her about installing the security camera. Interview with the Resident Care Director (RCD) on 10/30/19 at 3:30pm revealed: -The RCD had been employed at the facility since August 2019. -The RCD had been working a lot as a medication aide when needed due to staffing. -The RCD was not coming in at times the day after working on the medication cart. -When the RCD did not come in, duties of the RCD were not getting done in a timely manner. -The RCD reported to the Administrator. Interview with the Special Care Director (SCD) on 10/31/19 at 3:55pm revealed: -She had never been trained to assure at least one person on each shift was trained in cardio pulmonary resuscitation (CPR) and Choking Management. -She had not been trained to identify staff with current CPR and Choking Management certification on the staff schedule.	D980		

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D980	Continued From page 90 -The SCD reported to the Administrator. Interview with the Administrator on 10/31/19 at 4:15pm revealed: -She was responsible for the day to day operations of the facility. -She was in the building 5 days a week and on call 24/7. -The previous management team were hands on and did everything for the staff. -She held staff accountable for their actions, but some staff did not want to change their old ways. -She knew the facility policy were no security cameras in a resident's room. -She never contacted the roommate's power of attorney (POA) to inform them a security camera was being used. -She knew staff were not completing 2-hour rounds and were not doing their job. -She knew you must have at least 1 staff on duty with current training on CPR and choking management for all shifts. -She did not know staff were not contacting the physician for fall incidents that occurred in the facility for the residents. Non-compliance was identified at violation level in the following rule areas: 1. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had training within the last 24 months in Cardio-Pulmonary Resuscitation (CPR) and Choking Management for 4 of 6 sampled employees (Staff A, B, C and F). [Refer to tag 167,10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation)]. 2. Based on observations, record reviews, and	D980		

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SPRING ARBOR OF WILMINGTON	809 JOHN D BARRY DRIVE WILMINGTON, NC 28412

(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
D980	Continued From page 91 interviews, the facility failed to provide supervision for 2 of 6 sampled residents (Resident #3 and #9) related to falls. [Refer to tag 270, 10A NCAC 13F .0901 Personal Care and Supervision (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed physicians for 3 of 6 residents (Resident #3, #9 and #5) related to documented falls (Resident #3 and #9), and Resident #5 with laboratory tests ordered by her Rheumatologist. [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 residents (Resident #8 and #3) were treated with dignity and respect in regard to Resident #8 being monitored by a roommate's security camera without knowledge of being videotaped and Resident #3 being left unattended in her room waiting for staff to assist with her shower. [Refer to tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. _____ Failure of the Administrator to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and injury of residents and constitutes a Type A1 Violation _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 11/01/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 1, 2019.	D980		