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THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey and complaint investigation on 11/13/19-11/14/19. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 09/17/19.	D 000		
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, interviews, and record reviews, the facility failed to provide supervision in accordance with their current symptoms and assessed needs for 3 of 4 sampled residents with a history of falls (Resident #1, #3, and #4). The findings are: Review of the facility's Fall Management Program dated 01/25/17 revealed: -The purpose of the Fall Management Program was to "provide a program of systematic review of	D 270		

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D 270	Continued From page 1 the resident to determine risk of falls and develop appropriate interventions." -"To establish a fall management program 3 main elements were needed including review of the resident's risk factors, planned service plan and interventions that were resident specific, and continuous review of effectiveness of the service plan and interventions." -"An Incident/Accident Report must be completed when a resident fell." -"A service plan with resident specific interventions would be developed with the resident/responsible party by the RCC (Resident Care Coordinator), RCD (Resident Care Director), or designee." -"The resident's service plan would be reviewed/revised in conjunction with the fall review or whenever a resident fall occurred." -"Fall interventions were reviewed for continued effectiveness." -"Interventions were revised according to incident and current resident needs." -"Revised interventions were routinely reviewed and updated to ensure effectiveness." -"Interventions were reviewed with staff, family and the resident for effectiveness." -The Fall Management Program did not include information related to supervision of residents with falls such as increased frequency of monitoring. Review of the facility's "Hotbox" form revealed: -A resident's name should be entered in the Hotbox when they returned from the hospital, had a fall, or if they required increased supervision. -"Document on each shift until the RCD or designee signs that resident should no longer be in the Hotbox." -The document contained a column titled "Initials Out (RCD)."	D 270		

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D 270	Continued From page 2 -For residents returning from the hospital "document time returned and vitals upon return. Document for at least 3 days regarding the reason they were in and any changes in status." -For a resident with falls "document appearance of any redness or bruising and any change in condition or complaints or (lack thereof) for at least 3 days." -For residents requiring increased supervision, they should be "maintained in the hotbox until need for supervision is no longer evident." 1. Review of Resident #3's most current FL-2 dated 07/25/19 revealed: -Diagnoses included renal failure, hypertension, depression, vertigo, and cognitive impairment. -She was intermittently disoriented. -She was semi-ambulatory with a wheelchair. -Resident #3 required assistance with bathing and dressing. Review of Resident #3's Pre-Assessment dated 07/04/19 revealed: -Resident #3 required assistance from staff in all areas of activities of daily living (ADL). -Resident #3 was wheelchair bound and required 2-person assist with transfers. -There was no documentation to address supervision needs. -Resident #3 had a history of falls documented under potential risks. Review of Resident #3's current care plan dated 08/07/19 revealed: -She required total assistance from staff for ambulation and bathing. -She required extensive assistance from staff with dressing, grooming and transferring. -She required limited assistance from staff with toileting.	D 270		

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D 270	Continued From page 3 Observation of Resident #3's room on 11/13/19 at 10:30am revealed: -Resident #3 was in bed. -Resident #3's room was located past the nursing station down the hall that veered until a left turn was made and the room was located on the right side of the hallway. -There was no visible staff on or near the hallway. Review of Resident #3's Fall Review dated 08/05/19 revealed: -Resident #3's mental status was confused. -Her mobility was unsteady, shuffling gait, balance impairment, and unable to transfer or ambulate. -She was incontinent. -Resident #3 required a one-person assist with transfers. -She was non-ambulatory, but she would bear weight during some transfers. -She was at risk for falls. -Resident #3 was reminded to use her pendant to call for assistance when needed. -There was no documentation in regards to increased supervision. -The fall review was updated on 09/17/19, and an order for physical therapy (PT)and occupational therapy (OT) were documented as "additional services" for Resident #3. Review of Resident #3's progress notes revealed: -Resident #3 was found lying in the floor on her back on 08/13/19 at 9:00pm with no apparent injury. -Resident #3 was observed laying in the floor on her right side on 08/14/19 at 9:00pm with a small bleed on the right upper area below the shoulder and reported her wheelchair's wheel got stuck which caused her to fall forward.	D 270		

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D 270	Continued From page 4 Review of Resident #3's Fall Assessment and Intervention -Score/Review Sheet revealed: -This form documented the dates of falls and times, the location of the fall, the action taken, signature of the staff person, and the review date. -Resident #3 fell in her room on 08/13/19 at 9:00pm. Resident #3 was trying to get a tooth pick and was found on her back. Resident #3 was informed to call for assistance when needed. The review was dated 08/15/19. -Resident #3 fell in her bathroom on 08/14/19 at 9:00am. Resident #3 was coming out of the bathroom when the wheel from her wheelchair got stuck and she fell forward. Therapy was requested for evaluation. Resident #3's wheelchair was assessed for issues. The review was dated 08/15/19. -The form documented an intervention for safety on 11/01/19 for Resident #3. When Resident #3 was in her chair, the staff was to ensure the table was next to her so she could reach anything she needed. -The form did not document any of Resident #3's falls after 08/14/19. -There was no documentation to increase supervision for Resident #3. There were no incident and accident reports completed for the falls that occurred on 08/13/19 and 08/14/19. Review of Resident #3's Occurrence Report dated 09/14/19 at 9:30am revealed: -Resident #3 was observed laying on the floor, face down, bleeding from the right side of her head. -The fall was not observed by staff. -There were no specific individualized interventions on the alert sheet.	D 270		

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D 270	Continued From page 5 -Resident #3 was getting out of bed when the fall occurred. -Prior to the fall, Resident #3 was alert and awake at baseline and disoriented and confused after the fall. -Prior to the fall, Resident #3 was weak and fatigued, and after the fall, Resident #3 reported being in pain. -The report documented a history of falls, but there were no dates documented for previous falls. -There were no safety measures in place prior to this fall. -There was no documentation related to increased supervision. -The report documented there was no need to re-educate resident and staff. -It was documented the resident's care plan/service plan was updated. -The resident was not on any current therapy. -Resident #3 was lasted checked on at 9:00am on 09/14/19. Review of Resident #3's Resident Observation Form revealed: -On 09/15/19, Resident #3 was receiving 15-minute checks after she sustained the head laceration and the fractured right collarbone on 09/14/19. -There was no documentation Resident #3 received 15-minute checks on any other days. Review of Resident #3's care plan/service plans revealed no new care plan/service plan in the record after the fall on 09/14/19. Review of Resident #3's hospital final report dated 09/14/19 revealed: -Resident #3 fell and hit the right side of her forehead while eating breakfast.	D 270		

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-There was documentation facility staff needed to "ensure patient is sitting up in chair with back for support, and to continue fall precautions."
-Resident #3 was diagnosed with a head injury and a suspected right distal clavicle fracture.

Review of Resident #3's progress notes dated 09/14/19 revealed Resident #3 returned from the hospital emergency room with sutures that needed to be removed by her primary care provider (PCP) in five days.

Review of Resident #3's physician's orders dated 09/16/19 revealed:
-Resident #3 needed to wear a sling to the right shoulder during the day and the sling was to be removed at night.
-Resident #3 was ordered to have an orthopedic evaluation to treat for the diagnosis of fractured distal right clavicle.

Review of Resident #3's physician visit notes revealed:
-Resident #3 had a follow-up appointment with her PCP on 09/18/19.
-The orthopedic referral was canceled because the referral would not change Resident #3's overall treatment course.
-Resident #3 was without physical deformity at the right distal end of the clavicle and without pain.
-Resident #3 was to continue to wear the sling.

Review of Resident #3's Occurrence Report dated 09/17/19 at 8:40am revealed:
-Resident #3 slid out of the wheelchair, in the bathroom, while being assisted by the personal care aide (PCA).
-Resident #3 fell going to the bathroom getting up and down from the wheelchair.

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D 270	Continued From page 7 -Resident #3 was found lying on her right side after the fall. -Prior to and after the fall, Resident #3 was alert and awake at her baseline. -Prior to the fall, Resident #3 had an unsteady gait, was experiencing weakness/fatigue, and suffered from impaired/dependent mobility/transfers. -Environmental status at the time of the fall included call bell within reach, wheelchair locked, room light on, wheelchair leg rest on, and cleared pathway. -Resident #3 was last checked on at 8:15am on 09/17/19. -Resident #3 had a history of falls. -Safety measures in place prior to this current fall, included the call bell made longer, resident had a pendant, PT and OT was ordered for transfers. -There was no documentation related to increased supervision. Review of Resident #3's Occurrence Report dated 10/01/19 at 7:20am revealed: -Resident #3 was observed laying in bed bleeding from the right side of her head with a huge knot. -Resident #3 was sent to the emergency room for evaluation. Review of Resident #3's final hospital report dated 10/01/19 revealed Resident #3 was evaluated for a hematoma to right forehead status post a fall that occurred on 09/14/19. Review of Resident #3's second final hospital report dated 10/02/19 revealed: -Resident #3 developed an arterial bleed to the right forehead when attempting to remove her sutures from a fall that occurred on 09/14/19. -Resident #3 had a scheduled appointment to follow-up with the wound clinic for further	D 270		

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evaluation.

Review of Resident #3's Occurrence Report dated 10/24/19 at 7:15pm revealed:
-Resident #3 was observed laying on the floor on her left side.
-She was trying to get something off the table in her room.
-Resident #3 was looking for something when the fall occurred in the bedroom.
-Resident #3 was alert and awake at baseline prior to the fall and after the fall.
-Environmental status at the time of the fall included the call bell within reach, wheelchair locked, night light on, call bell on, room light on, wheelchair leg rest on, and the pathway was clear.
-Resident #3 was last checked on at 6:30pm on 10/24/19.
-Resident #3 had a history of falls, but no dates of the falls where documented on the form.
-There were no safety measures in place prior to the current fall listed on the form.
-There was no documentation related to increased supervision.

Review of Resident #3's final hospital report dated 10/24/19 revealed Resident #3 suffered a nondisplaced fracture of the right first and second rib.

Review of Resident #3's record revealed:
-There was no intervention/service plan with specific interventions for Resident #3 developed or documented in the record that included the resident, responsible party, or a designee from the facility per the facility's Fall Management Program.
-There was no documentation of the service plan being reviewed/revised in conjunction with the fall

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review after each fall for Resident #3 per the facility's Fall Management Program.
-There were no fall interventions reviewed after each of Resident #3's falls that resulted in a laceration, fractured right distal clavicle and two rib fractures per the facility's Fall Management Program.
-Resident #3 had no interventions revised according to each incident or current resident's needs after she sustained a head laceration, fractured right distal collarbone, and two fractured ribs per the facility's Fall Management Program.
-Resident #3's interventions were not reviewed and updated to ensure effectiveness after the head laceration, right distal clavicle fracture, and the two rib fractures per the facility's Fall Management Program.
-There were no incident reports for the falls that Resident #3 had on 08/13/19 and 08/14/19 per the facility's Fall Management Program.
-The RCD or designee failed to document on the Fall Assessment and Intervention -Score/Review Sheet for Resident #3's falls occurring on 09/14/19, 09/17/19, and 10/24/19.

Interview with a medication aide (MA) on 11/14/19 at 10:20am revealed:
-Resident #3 was a one-person assist.
-Resident #3 was weak on the days she had dialysis.
-Resident #3 had several falls that resulted in injuries.
-The interventions put in place for Resident #3 included tying a scarf to the end of the pull cord for the call light to make the call light easier for Resident #3 to reach.
-Staff encouraged Resident #3 to call for assistance when needed.
-Resident #3 was placed on more frequent checks at one time, but she could not remember

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when, or the frequency of the checks.
-The personal care aides (PCAs) were responsible for documenting the increased checks on Resident #3 after each fall.
-Increased checks for Resident #3 were documented for 3 days after the fall.

Interview with a PCA on 11/14/19 at 11:38am revealed:
-The 24-hour report was used to document concerns on residents such as falls or going out to the hospital.
-When a resident sustained a fall, staff were required to increase the supervision and document the checks on the "Resident Observation Form."
-She would bring residents with a fall history up front for better supervision.
-Staff was told to ensure Resident #3's call bell was within reach and to provide more frequent checks.
-Staff usually had a morning stand-up meeting at 9:00am on first shift to discuss any issues with residents.

Interview with a second PCA on 11/14/19 at 11:45am revealed:
-The facility used the Hotbox system to document falls.
-When a resident sustained a fall, they were checked on every 30 minutes and the checks were documented on a form.
-Resident #3 required assistance with activities of daily living plus a one-person assist.

Interview with the RCC on 11/14/19 at 11:55am revealed:
-Resident #3's fall review had been updated after each of her falls and placed in her record.
-Resident #3 was not on more frequent checks.

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D 270	Continued From page 11 -"I am not sure if Resident #3's supervision was increased by a member of management." -She had never told staff to increase Resident #3's supervision. -Management could also move residents' rooms closer to the nurse's desk. -There were no rooms available to move Resident #3 closer to the nurse's desk. -Resident #3 was ordered PT/OT, move bedside table closer to resident, and educated resident to ask for assistance when needed. -She did not know if Resident #3 had a bed or chair alarm. Review of the "Hotbox" form dated 08/07/19-11/10/19 revealed: -The "Hotbox" form did not list Resident #3 when she sustained a fall on 08/13/19. -Resident #3 was on the form for a fall sustained on 08/14/19. -Resident #3's name was marked through indicating no other documentation was required. -There was no date indicating when the increased supervision ended and no initials to indicate who stopped the increased supervision for Resident #3 after the fall on 08/14/19. -Resident #3 was listed on the document on 10/02/19 after she returned from the hospital. -Resident #3's name was marked through indicating no other documentation was required. -There was no date indicating when the increased supervision ended and no initials to indicate who stopped the increased supervision for Resident #3 after the fall on 10/24/19. -Resident #3 was listed on the document on 10/24/19 after she had the fall. -There was no date indicating when the increased supervision ended and no initials to indicate who stopped the increased supervision for Resident #3 after the fall on 10/02/19.	D 270		

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D 270	Continued From page 12 -Resident #3's name was marked through indicating no other documentation was required. -Resident #3 was not listed on the" Hotbox" form after she sustained a fall on 09/14/19 when she had a head laceration and a fractured right distal clavicle. -Resident #3 was not listed on the "Hotbox" form after she sustained a fall on 09/17/19. -Resident #3 was not listed on the "Hotbox" form when she had to seek emergency treatment on 10/01/19 when the head laceration from 09/14/19 would not stop bleeding. -Resident #3 was not listed on the "Hotbox" form when she had to seek emergency treatment from two different emergency departments on 10/02/19 when the head laceration from 09/14/19 would not stop bleeding. -Resident #3 was receiving services from home health and the wound clinic to address the head laceration Resident #3 received from the fall on 09/14/19 was not on the "Hotbox" form to provide increased supervision. Review of Resident #3's PT Summary dated 10/04/19 revealed: -Resident #3 was unable to reach with her right arm due to pain, limited range of motion and audible crepitus. -Resident #3 lacked strength and range of motion in bilateral upper extremities when pushing up to stand. -Resident #3 would need stand by assistance from staff when sitting unsupported on the edge of the bed. -Resident #3 was aware that she required assistance with transfers, and she should not complete alone. Interview with Resident #3 on 11/14/19 at 10:17am revealed:	D 270		

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D 270	Continued From page 13 -Staff tied a scarf to the end of the cord that activated the call bell and encouraged her to call for assistance. -Staff would respond to the call bell when she was able to reach the cord to pull it for help. -Staff were not consistent with providing assistance with activities of daily living. -Staff did not check on her more often than normal after her falls. -She was having pain in her right shoulder and she felt pain when she took deep breaths. Interview with the Administrator on 11/14/19 at 4:00pm revealed: -Resident #3's fall prevention interventions included making sure her tray was close to her, to lengthen her call bell by tying a scarf at the end of the pull cord so the resident could reach the cord better, and to educate Resident #3 on using the call bell system. -She had PT to provide transfer training for Resident #3 on 08/28/19 and on 11/06/19. Attempted telephone interview with Resident #3's PCP on 11/14/19 at 2:53pm was unsuccessful. Refer to interview with a MA on 11/14/19 at 10:53am. Refer to interview with a second MA on 11/14/19 at 11:09am. Refer to interview with a PCA on 11/14/19 at 11:47am. Refer to interview with the RCC on 11/14/19 at 3:02pm. Refer to interview with the Administrator on 11/14/19 at 2:38pm.	D 270		

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D 270	Continued From page 14 2. Review of Resident #1's current FL-2 dated 08/26/19 revealed: -Diagnoses included muscle weakness, other abnormalities of gait, lack of coordination, and cerebrovascular disease. -Resident #1 was constantly disoriented, non-ambulatory, and required staff assistance with total care. -Resident #1 was admitted to the facility on 06/16/19. Review of Resident #1's care plan dated 06/19/19 revealed: -Resident #1 needed limited staff assistance with transfers and extensive staff assistance with ambulation. -There was no documentation of updates, change of condition, or increased supervision. Review of Resident #1's Occurrence Report dated 06/27/19 revealed: -On 06/27/19 at 4:15pm, Resident #1 had an unwitnessed fall and was found "on bathroom floor sitting upright on buttocks with back against wall." -There were no documented injuries. -Resident #1 was educated to use the call bell pendant when needing assistance. Review of Resident #1's progress notes dated 06/27/19 revealed: -Resident #1 was "observed in bathroom sitting in upright position on floor." -Resident #1 reported she lost her balance and lowered herself to the floor. Review of Resident #1's Falls Management-Post Fall Assessment Tool attached to the Occurrence Report dated 06/27/19 revealed:	D 270		

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-Resident #1 had a history of falls.
-Resident #1 was going to the bathroom at the time of her fall on 06/27/19.
-Safety measures in place prior to this current fall were documented as "Resident instructed to pull call bell or push pendant when she needed assistance."

Review of Resident #1's Occurrence Report dated 06/28/19 revealed:
-On 06/28/19 at 5:35pm, Resident #1 was found "on the floor in bedroom laying on her back" and reported to staff she was trying to reposition herself in her wheelchair and slipped out onto the floor.
-There were no documented injuries.
-Documented instructions from the Resident Care Coordinator (RCC) included "monitor resident" but did not indicate how often or for how long and "encourage resident to use call bell/pendant when needing help."

Review of Resident #1's progress notes dated 06/28/19 revealed:
-Resident #1 was "observed in bedroom on floor laying on her back."
-Resident #1 stated she was trying to position herself in her wheelchair and slipped out onto the floor.
-She did not hit her head or report any pain.

Review of Resident #1's Falls Management-Post Fall Assessment Tool dated 06/28/19 revealed:
-Resident #1 was in her wheelchair at the time of her fall.
-Resident #1 had a history of falls with a previous fall occurring on 06/27/19.
-Safety measures in place prior to this current fall were documented as "Pendant to call for assistant and physical therapy (PT)/occupational

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therapy (OT)."

Review of Resident #1's Occurrence Report dated 07/05/19 revealed:
-On 07/05/19 at 11:30am, Resident #1 was found in her room at bedside.
-Resident #1 had "slid out of the seat of her wheelchair onto her bottom on floor due to reaching for items on bed."
-Resident #1 sustained an abrasion to her back.
-Resident #1's primary care provider (PCP) had been informed of Resident #1's right-sided weakness and ordered for her to continue "therapy."

Review of Resident #1's progress notes dated 07/05/19 revealed:
-Resident #1 "slid out of her wheelchair and onto her buttocks on the floor in her room."
-Resident #1 was reaching for items on her bed when the incident occurred.
-Resident #1 had a red area and scratch on her upper back.

Review of Resident #1's Falls Management-Post Fall Assessment Tool dated 07/05/19 revealed:
-Resident #1 was "looking for something" at the time of her fall.
-Resident #1 had a history of falling.
-Safety measures in place prior to the current fall were documented as "Educated resident to use pendant when needing assistance. Monitor resident and therapy order requested."

Review of Resident #1's Occurrence Report dated 07/25/19 revealed:
-On 07/25/19 at 3:45pm, Resident #1 was found in her room at bedside.
-Resident #1 was "on the floor face down, her legs were straight ahead ...She was yelling for

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help."
-There were no documented injuries.

Review of Resident #1's progress notes dated 07/25/19 revealed:
-Resident #1 "fell out of wheelchair onto floor in room face down. No bleeding present. Has large knot on forehead."
-Resident #1 was sent to the Emergency Department (ED) "due to head injury."

Review of Resident #1's Incident/Accident Report dated 07/25/19 revealed:
-Resident #1 was found in her bedroom face down beside her bed.
-Resident #1 was trying to pick something up off the floor and lost her balance.
-Resident #1 was transferred to the ED for evaluation due to a head injury and returned back to the facility with no new orders.

Review of Resident #1's Falls Management-Post Fall Assessment Tool dated 07/25/19 revealed:
-Resident #1 was "trying to pick something up off the floor" at the time of her fall.
-Resident #1 had a history of falls with falls occurring on 06/27/19, 06/28/19, 07/05/19 and 07/08/19.
-Safety measures in place prior to this current fall were documented as "pendant, PT/OT, PCP informed of right-sided weakness, gait belt ordered and neuro-eval pending orders."

Review of Resident #1's Occurrence Report dated 08/09/19 revealed:
-On 08/09/19 at 8:05pm, Resident #1 was found "on the floor in the hallway."
-There were no documented injuries.

Review of Resident #1's progress notes dated

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D 270	Continued From page 18 08/09/19 revealed: -Resident #1 "was found on the floor in the hall." -Resident #1 reported she was pushing herself to her room and slipped out of her wheelchair onto the floor. -There was documentation "staff will monitor resident" but did not indicate how often or for how long. Review of Resident #1's record since admission revealed: -Resident #1 experienced 5 unwitnessed falls from 06/27/19-08/09/19. -Resident #1's fall that occurred on 07/25/19 resulted in a head injury and ED evaluation. -There was no Falls Management-Post Fall Assessment Tool completed for Resident #1's fall occurring on 08/09/19 per the facility's Fall Management Program. -There were no Incident/Accident Reports completed for Resident #1's falls occurring on 06/27/19, 06/28/19, 07/05/19, or 08/09/19 per the facility's Fall Management Program. -There was no documentation staff increased supervision of Resident #1 in response to her falls. Review of the facility's "Hotbox" forms revealed: -Resident #1's name was entered on 08/09/19 for a fall and her name had been marked through with an ink pen. -There was no documentation Resident #1 had been added to the "Hotbox" form after her falls on 06/27/19, 06/28/19, 07/05/19 or 07/25/19. Review of Resident #1's progress notes revealed: -After Resident #1's fall on 06/28/19 at 5:35pm, staff documented on her condition one time during the following three days. On 06/30/19 during the 11:00pm-7:00am shift, there was	D 270		

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documentation "Resident has slept throughout the night, no complains [sic]."
-After Resident #1's fall on 07/05/19 at 11:30am, staff documented on her condition two times during the following three days. On 07/07/19 at 3:00pm, there was documentation "Resident up to meals, no complaints, ate well. Resident in room at this time." On 07/07/19 at 11:00pm, there was documentation "Resident up to supper, no complaints. Resident resting in bed at this time."
-After Resident #1's fall on 07/25/19 at 3:45pm, staff documented on her condition two times during the following three days. On 07/26/19 during the 11:00pm-7:00am shift, there was documentation "Resident slept well after returning from the hospital due to her fall on second shift. Resident complained of a headache and was given PRN (when necessary) Mapap 325mg at 12:30am. A body assessment done, no visible new marks or bruises." There was documentation Resident #1's blood pressure was 170/80, her pulse was 80, and her temperature was 98.4. On 07/26/19 on the 7:00am-11:00pm shift, there was documentation "Resident ate breakfast in her room. Resident came to lunch and supper, ate 100 percent both meals with assistance. Resident denies pain/discomfort."
-After Resident #1's fall on 08/09/19 at 8:05pm, staff documented on her condition four times during the following three days. On 08/10/19 at 10:30am, there was documentation "Resident having a great morning. Ate 100 percent of breakfast. No complaints of pain." On 08/11/19 (no documented time), there was documentation "Resident is having a good morning. Ate breakfast in bedroom...." On 08/11/19 at 6:00pm, there was documentation Resident #1 was visiting with family, "no complaints of pain from post fall, no bruise seen at this time...." On

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D 270	Continued From page 20 08/12/19 (no documented time), there was documentation "Resident had a good day. No complaints of pain from fall. Ate meals 100 percent." -"Redness or bruising, change of condition, complaints or (lack thereof)," was not documented on every shift for at least three days, per the Hotbox instructions, after any of Resident #1's falls. Review of Resident #1's "Fall Review" dated 07/08/19 revealed: -Resident #1 used a wheelchair for ambulation. -Resident #1 had "therapy" ordered five days per week. -"Additional services" documented were "educated resident to use her pendant for assistance" after the fall occurring on 06/27/19. -"Additional services" documented were "monitor resident and therapy order requested" after the fall occurring on 06/28/19. -"Additional services" documented were "informed PCP of right-sided weakness, continue therapy" after the fall occurring on 07/05/19. -"Additional services" documented were "neuro-eval and treat and increase frequency of PT to 5 times week" after the fall occurring on 07/25/19. -There was no documentation staff increased supervision of Resident #1 in response to her falls. Review of Resident #1's Fall Assessment & Intervention -Score/Review Sheet revealed: -This form contained columns to record the dates of falls and times, the location of the fall, the action taken, signature of the staff person, and the review date. -Resident #1 fell in the bathroom on 06/27/19 at 4:15pm. Actions taken were "educated to use	D 270		

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her pendant when needing assistance." The review was dated 07/05/19. There was no staff signature documented.
-Resident #1 fell in her room on 06/28/19 at 5:40pm. Actions taken were "monitor to resident and therapy order requested." There was no review date or staff signature documented.
-Resident #1 fell in her room on 07/05/19 at 11:40am. Actions taken were "informed PCP of right-sided weakness. Stated to continue therapy." The review was dated 07/05/19. There was no staff signature documented.
-There was no documentation to increase supervision for Resident #1.

Review of Resident #1's PT treatment notes revealed:
-Resident #1 received PT services with one agency from 06/17/19-07/02/19.
-There was documentation on Resident #1's PT therapist progress and discharge summary, the resident required only "contact guard assist" with transfers, upon start of care on 06/17/19 and required minimal assistance with transfers, upon discharge on 07/02/19.
-Resident #1 received PT services from a different agency from 07/16/19-08/22/19.
-Resident #1 was documented as a "high fall risk" on her PT plan of care dated 07/16/19.
-There was documentation on Resident #1's PT therapist progress note dated 08/01/19 "Patient requires moderate to maximal assistance with most transfers. Her transfer ability varies according to the time of day. She continues to be a high risk of falls and the staff is aware."
-There was documentation on Resident #1's PT daily treatment note dated 08/14/19, PT had "notified med tech of severe right lean and unsafe reaching/positioning" and "advised to not leave resident alone in her room to decrease risk of

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D 270	Continued From page 22 falls." Telephone interview with Resident #1's family member on 11/13/19 at 2:31pm revealed: -Resident #1 resided at this facility from early June 2019 to mid-September 2019. -Resident #1 had several falls during her stay at the facility due to muscle weakness. -Many of Resident #1's falls occurred while she was alone in her room attempting to reach for something she had dropped on the floor. -Resident #1 had difficulty transferring and required two people to do so. -She was not aware of any increase in supervision in response to Resident #1's falls. Interview with a medication aide (MA) on 11/14/19 at 10:53am revealed: -Resident #1 had frequent falls while she resided at the facility. -She was working when Resident #1 was found in the hallway floor on 08/09/19. -She was not instructed to check on Resident #1 more often than every 2 hours in response to her falls. -The staff tried to keep Resident #1 in the common room close to the nurse's station, but she preferred to stay in her own room. -For approximately the last month Resident #1 resided at the facility (September 2019), staff were unable to transfer her from her bed to her wheelchair due to her weakness so they could not bring her to the common room. Interview with a second MA on 11/14/19 at 11:09am revealed: -Resident #1 had frequent falls while she resided at the facility. -Resident #1 often tried to reach for items in her room without calling for help, and she would fall.	D 270		

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-Resident #1's cognition and strength had gradually declined.
-Upon admission, Resident #1 only required one person to transfer her.
-Approximately two weeks after admission, Resident #1 began requiring at least two people to transfer her.
-She did not transfer Resident #1 alone after the first couple of weeks following her admission.
-She thought Resident #1 had been placed on increased checks, but she could not remember when or for how long.

Interview with a PCA on 11/14/19 at 11:47am revealed:
-Resident #1 had frequent falls while she resided at the facility.
-Approximately two weeks after her admission, Resident #1 began to experience cognitive decline and it took four staff to transfer her from that point until her discharge from the facility.
-She did not remember being instructed to check on Resident #1 more often in response to her falls or completing any documentation of increased checks.
-Once Resident #1 was unable to get out of bed (approximately 1 month before her discharge), she took it upon herself to check on Resident #1 about every 45 minutes, but she did not document these checks.

Interview with Resident #1's PT assistant on 11/14/19 at 8:52am and 12:15pm revealed:
-She had provided PT services to Resident #1 from 07/16/19 to 08/22/19.
-Resident #1 was discharged from PT on 08/22/19 due to her not making any progress and needing a higher level of care.
-Resident #1 had a progressive decline in her cognitive and physical ability between start of

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care and her discharge from PT.
-Resident #1's ability to assist with her transfers varied from day to day and PT verbally communicated to facility staff the need to assess Resident #1 on a daily basis.
-On 08/14/19, she had recommended Resident #1 not be left alone in her room to decrease the risk of falls.

Interview with the RCC on 11/14/19 at 3:02pm revealed:
-Resident #1 had frequent falls while she resided at the facility.
-The staff tried to keep Resident #1 in common areas to supervise her.
-She could not remember Resident #1 being placed on more frequent checks beyond the initial 72 hours after a fall, and she could not locate documentation of any increased supervision for Resident #1.
-Some of the interventions implemented to prevent Resident #1's falls included educating her to use her call bell pendant for assistance, PT and OT, a gait belt to use with transfers, and a neurological evaluation.
-She did not know why Resident #1 did not have an increase in supervision in response to her falls.

Interview with the Administrator on 11/14/19 at 3:57pm revealed:
-She could not locate documentation of Resident #1 being placed on more frequent checks than every two hours in response to her falls.
-When Resident #1 was first admitted to the facility in June 2019, she was a one person assist.
-At first, she had a slow decline in cognition and physical ability and then the decline became more rapid.

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D 270	Continued From page 25 -By mid-July or August 2019, Resident #1 required three people to assist her with all activities of daily living (ADLs), including transfers. -Resident #1 should have been placed on more frequent checks in response to her falls, and she did not know why this had not happened. Attempted telephone interview with Resident #1's PCP on 11/14/19 at 2:53pm was unsuccessful. Refer to interview with a MA on 11/14/19 at 10:53am. Refer to interview with a second MA on 11/14/19 at 11:09am. Refer to interview with a PCA on 11/14/19 at 11:47am. Refer to interview with the RCC on 11/14/19 at 3:02pm. Refer to interview with the Administrator on 11/14/19 at 2:38pm. 3. Review of Resident #4's current FL2 dated 12/12/18 revealed: -Diagnoses included Parkinson disease, hypothyroidism, Bell's palsy, dementia, and acute respiratory failure. -The level of orientation was not documented. -Resident #4 needed assistance with bathing. -Resident #4 was non-ambulatory. Review of Resident #4's current Care Plan dated 04/01/19 revealed: -Resident #4 used a walker for ambulation around the facility. -Resident #4 could feed himself.	D 270		

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THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
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-Resident #4 was totally dependent upon staff for toileting, ambulation, bathing, dressing, grooming, and extensive assistance with transfers.

Observation on the initial tour on 11/13/19 between 9:15am -10:30am revealed:
-The door to Resident #4's room was closed.
-Resident #4 was lying in bed wearing a brief and a T-shirt.
-Resident #4's bed was against the wall and a grab halo bar was on the side of the bed that was against the wall.
-Resident #4 was grabbing at the air in front of him and picking at the bed sheet.
-Resident #4 was staring up at the ceiling and mumbling unintelligible words.
-Resident #4 had a hospital arm band on his left wrist.

Observation of Resident #4's door on 11/13/19 at 11:08am revealed the door was closed.

Review of Resident #1's progress notes revealed:
-On 11/08/19, at 9:00am, Resident #4's was found lying on his right side on the floor.
-Staff assisted Resident #4 up and checked for injury.
-Resident #4 denied hitting his head but complained of right shoulder pain and had a small pink/ red area on the top of his right shoulder.
-The physician and Resident #4's Power of Attorney (POA) were notified.
-The Resident Care Coordinator (RCC) was notified.

Review of Resident #4's Incident/Accident report dated 11/08/19 revealed:
-The incident occurred in Resident #4's room and was unwitnessed by the staff.
-Resident #4 was "getting up from his recliner

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without assistance and fell on the floor on his right side."
-Vital signs were obtained, blood pressure (BP) was 142/80, pulse 74, respirations 18, temperature 97.4.
-Resident #4 had no documented injury.
-There was documentation Resident #4 was encouraged to use the call bell for assistance.

Review of Resident #4's Falls Management-Post Fall Assessment Tool dated 11/08/19 at 9:30am revealed:
-The fall occurred in Resident #4's room and was not observed by staff.
-Resident #4 had fallen getting up/down from a chair.
-Resident #4 was alert at baseline prior and after the fall occurred.
-Physical status prior to the fall was unsteady gait and weakness/fatigue and impaired transfers.
-Environmental status at time of fall was the call bell was within reach, room light was on, and the pathway was cleared.
-There was no documentation for history of falls, education, safety measures or medication status.

Review of Resident #4's progress note dated 11/08/19 at 7:00pm revealed:
-Resident #4 was in the dining room and dropped his glass due to his hands were shaking.
-While in the dining room Resident #4 "became very stiff, legs straight out and face turned, shaking all over."
-The physician was called and Resident #4 was transported to the emergency department (ED) for evaluation.
-Vital signs were obtained BP 158/90, pulse 92, temperature 99.4, respirations 22.
-The POA was contacted and would meet Resident #4 at the hospital.

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D 270	Continued From page 28 Review of Resident #4's hospital discharge dated 11/12/19 revealed: -The chief complaint was seizure like activity. -The computed tomography (CT) scan showed no acute findings. -Urinalysis obtained and was positive for a urinary tract infection. -Resident #4 was administered Bactrim for 3 days. -A electrocardiograph (EKG) was obtained that showed criteria for a new infarct compared to the last EKG dated 11/03/19. -Resident #4 was admitted to the hospital on the cardiac unit. -Resident #4 was discharged to the facility on 11/12/19. Review of Resident #4's progress note dated 11/12/19 at 9:00pm revealed Resident #4 returned to the facility. Telephone interview with Resident #4's POA on 11/13/19 at 1:45pm revealed: -He was not aware Resident #4 had returned to the facility on 11/12/19. -He had seen Resident #4 in the hospital on 11/11/19 and was waiting for the hospital to call in regards to a neurological exam. -Resident #4 was not himself on 11/11/19, he was very confused and "talking out of his head." -Normally Resident #4 could carry on a conversation. -Resident #4 was a high risk for falls due to his confusion and would require more assistance. Observation of Resident #4's door on 11/13/19 at 12:20pm revealed the door was closed. Interview with the medication aide (MA) on	D 270		

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D 270	Continued From page 29 11/13/19 at 10:00am revealed: -Resident #4 had returned from the hospital on 11/12/19 at 9:00pm. -Resident #4 was confused and was very different from last week. -Last week, Resident #4 could feed himself and could ambulate around the facility in his wheelchair. -Resident #4 could carry on a conversation last week, and now she could not understand anything he said. -Resident #4 was in bed because it was not safe for him to be in the wheelchair. -Resident #4 was a high risk for falls due to his confusion. -Management had not told her to increase supervision for Resident #4 since he had returned from the hospital on 11/12/19 at 9:00pm. -Resident #4 was a different person since he returned from the hospital. -She was unsure what had happened or what caused the difference in Resident #4's behavior and memory. -She was never told to provide more supervision, frequent checks or to keep Resident #4's door open to visually look in his room as she walked down the hall. -The physician was to see Resident #4 today 11/13/19. Interview with the personal care aide (PCA) on 11/13/19 at 12:22pm revealed: -She provided personal care to Resident #4 on 11/13/19. -Resident #4 could not feed himself or assist with turns when changing his brief since returning from the hospital on 11/12/19. -Resident #4 now required 2 person assist with personal care. -She was told by the MAs not to get Resident #4	D 270		

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up because he was "too weak".
-Resident #4 was "very confused" and not himself since he returned from the hospital on 11/12/19.
-She was never told by management to do more frequent checks or provide increased supervision for Resident #4 since he had returned from the hospital on 11/12/19.
-The facility policy was to check the resident every 2 hours, but she had not documented the checks.
-She thought Resident #4 wanted his door closed for privacy.

Observation of Resident #4's door on 11/13/19 at 2:52pm revealed the door was closed.

Interview with Resident #4's Physician Assistant (PA) on 11/13/19 at 3:15pm revealed:
-He reviewed Resident #4's hospital discharge dated 11/12/19 prior to seeing Resident #4.
-Resident #4 was confused and appeared agitated.
-Resident #4 was not at his baseline, the PA thought it might be from the different surroundings due to staying in the hospital for 5 days.

Observation of Resident #4's door on 11/13/19 at 4:30pm revealed the door was closed.

Observation of Resident #4's door on 11/14/19 at 7:30am revealed the door was closed.

Observation of Resident #4 on 11/14/19 at 9:50am revealed:
-Resident #4 was lying in the bed and was staring up at the ceiling and his hands were reached up picking at the air.
-His speech was garbled and unintelligible.

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D 270	Continued From page 31 Observation of Resident #4's door on 11/14/19 at 1:45pm revealed the door was closed. Interview with a PCA on 11/13/19 at 3:00pm revealed: -She made rounds for all residents every 2 hours. -Resident #4 was very confused and "out of it." -Resident #4 was in bed due to his confusion. -Resident #4 was not able to push his call light for assistance. -She was not told by management to increase supervision by monitoring Resident #4 more often. -She thought Resident #4 was a fall risk since he was confused. -She was never told by management to visually check on Resident #4 every time she walked down the hallway. Interview with the Resident Care Coordinator (RCC) on 11/14/19 at 3:15pm revealed: -She knew Resident #4 was considered a high risk fall due to his confusion, recent hospital admission, and previous fall. -Resident #4 should have been added to the Hotbox tracking system when he returned from the hospital on 11/12/19 and monitored every shift for 72 hours. -She was responsible for informing staff to provide increased supervision to the residents. -She had not informed staff to increase supervision for Resident #4. -She had not placed Resident #4 in the Hotbox system. -She thought the MAs had placed Resident #4 in the Hotbox system for increased supervision and to be monitored for 3 days. Interview with the Administrator on 11/14/19 at 3:22pm revealed:	D 270		

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D 270	Continued From page 32 -Resident #4 was sent out to the ER on 11/08/19 due to a change in condition and a decline in his activities of daily living (ADL's). -She had reviewed the discharge summary dated 11/12/19, "but there was not much there." -Resident #4 was more confused and disoriented since his return from the hospital on 11/12/19. -She thought the RCC had placed Resident #4 in the Hotbox system to be monitored for increased supervision. -She thought the staff were providing more frequent checks for Resident #4 every 30 minutes and documenting the checks. -Resident #4 required increased supervision, and should be maintained in the hotbox until the need for supervision was no longer needed. -The door to Resident #4's room should be left half way open at all times due to his confusion and bed bound status. -Staff should be visually viewing Resident #4 for safety each time they walked down that hallway. -She had never informed the staff to provide increased supervision by completing more frequent checks for Resident #4 due to his change in level of consciousness. -She had never communicated with staff to check Resident #4 every 30-minutes or to keep his door open. -She relied on the RCC to inform the staff of change of condition to the residents and when to provide increase in supervision. Review of the facility "Hotbox" form hanging on the wall in the medication room on 11/13/19 at 3:32pm and on 11/14/19 at 12:15pm revealed Resident #4 was never added to the Hotbox system for the fall on 11/08/19. Refer to interview with a MA on 11/14/19 at 10:53am.	D 270		

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D 270	Continued From page 33 Refer to interview with a second MA on 11/14/19 at 11:09am. Refer to interview with a PCA on 11/14/19 at 11:47am. Refer to interview with the RCC on 11/14/19 at 3:02pm. Refer to interview with the Administrator on 11/14/19 at 2:38pm. Interview with a medication aide (MA) on 11/14/19 at 10:53am revealed: -Every resident in the facility was checked on every 2 hours. -If a resident required checks more often than every 2 hours, the Resident Care Coordiantor (RCC) or Resident Care Director (RCD) would create a form to document the checks. Interview with a second MA on 11/14/19 at 11:09am revealed: -Generally, residents were checked on every one hour, but this was not a set requirement. -If residents required an increase in supervision, the RCC or Administrator would designate how often and for how long the MAs and personal care assistants (PCA) were to perform the increased checks. -The increased checks would be documented on a "Resident Observation" form and given to the RCC once completed. Interview with a PCA on 11/14/19 at 11:47am revealed: -Normally, residents were checked on every two hours. -If more frequent checks were required, the	D 270		

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checks would be documented on a "Resident Observation" form.

Interview with the RCC on 11/14/19 at 3:02pm revealed:
-If a resident had a fall or a hospitalization, she or the RCD would place the resident's name on the "Hotbox" form.
-The MAs could also place a resident in the Hotbox system to be monitored for 72 hours.
-The 'Hotbox" form would alert the MAs to check on the resident once every shift for at least the next 72 hours and document vital signs, changes in condition, or resident complaints in the resident's progress notes.
-She was responsible for reviewing the completion of the Hotbox tracking system.
-If a resident had an increase in the number of falls and they were occurring frequently, they might remain in the Hotbox for longer than 72 hours for increased supervision and/or be placed on more frequent checks such as every 15 minutes or every 30 minutes.
-If a resident was placed on more frequent checks, she or the RCD would place the resident's name on a "Resident Observation" form so MAs and PCAs would be aware of the need for increased supervision, and they would be responsible for signing their initials to document each 15-minute check.
-Once the "Resident Observation" form was completed, staff would give the form to her for filing.
-She or the RCD would determine if a resident needed to be in the Hotbox for longer than 72 hours, or if they needed increased supervision and whether the increased checks should occur every 15 minutes or every 30 minutes.
-She or the RCD would mark through the resident's name on the "Hotbox" form once the

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D 270	Continued From page 35 need for increased supervision had ended. -The facility did not have a policy on how many falls or what frequency of falls would warrant an increase in supervision. -She, the RCD and the Administrator met weekly to discuss residents who had fallen and to plan interventions for preventing future falls. -Staff were required to make sure the residents call bell and pendant were within the residents' reach to prevent falls. -A fall review was completed after each fall by the RCC or RCD. Interview with the Administrator on 11/14/19 at 2:38pm revealed: -She expected all residents to be checked on every 2 hours. -If a resident had a fall, she expected the RCC, RCD, or MAs to place the resident's name in the Hotbox. -When a resident's name was placed in the Hotbox, she expected the MAs to check the resident's condition, including vital signs, one time on every shift for at least the following 72 hours and document the results in the resident's progress notes. -She relied on the RCC to oversee the clinical staff and inform them of anything that occurred with the resident's safety and care. -If a resident needed an increase in supervision due to frequent falls this would be implemented by the RCC or RCD. -The checks would be documented on the "Resident Observation" form. -She expected the RCC or RCD to document results of the fall meetings to communicate and incorporate each resident's interventions. The facility failed to provide supervision for 3 of 4 sampled residents with a history of falls, which	D 270		

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D 270	Continued From page 36 resulted in Resident #3 sustaining a head injury and a suspected clavicle fracture, a head hematoma that required sutures, and two fractured ribs and Resident #1 sustaining a head injury. The failure of the facility to provide supervision resulted in serious physical harm and neglect to Residents #3 and #1 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 12/14/19.	D 270		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect related to providing supervision of residents. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with their current symptoms and assessed needs for 3 of 4 sampled residents with a history of falls (Resident #1, #3, and #4). [Refer	D914		

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D914	Continued From page 37 to Tag 270 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A1 Violation)].	D914		