STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 conducted a Complaint Investigation survey with a desk review on August 11-14, 2020 and August 17-20, 2020 with a telephone exit on August 20, 2020.	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 interviews and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents with frequent falls and injuries in accordance with each resident's assessed needs, care plan and current symptoms (Resident #1 and #3) resulting in the death of one resident (Resident #1), no interventions for prevention of falls (Resident #1 and #3), and one resident with falls hitting her face or head, bruising to the face, seizures, and unresponsiveness that required hospitalization (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/19/19 revealed: -Diagnoses included dementia, history of falls, atrial fibrillation, hypertension, non-displaced fracture of lateral epicondyle of the left humerus (a bone in the upper arm).	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 1	D 270		

-She was ambulatory and required one-person assistance with functional transfers/ambulation to the bathroom with a rolling walker.
-She required one-person assistance from staff for bathing and dressing.
-Recommended level of care was marked other and "assisted living" was written next to it.

Review of the Resident Register for Resident #1 dated 07/01/19 revealed:
-Date of admission was 06/30/19.
-Assistance required was documented as dressing, bathing, getting in/out of bed, toileting, and orientation to time and place.
-Special aids were documented as walker, eyeglasses, wheelchair.
-Date of discharge/transfer was documented as 10/31/19 to "other" with "passed/D/C" written next to it.

Review of Resident #1's Care Plan dated 08/13/19 revealed:
-A walker was the only assistive device marked for mobility and ambulation.
-The "fall precautions" box was not marked.
-There was no documentation for the use of a bed alarm that had been ordered on 07/09/19.
-The services provided box was marked "totally independent including use of cane/walker/wheelchair- needs no personal assistance".
-She was continent of bowel and bladder.
-The hearing and vision sensory loss box was left unmarked with "no problems" written to the side.
-The restorative care box for physical therapy (PT) was marked "requires no restorative management" even though PT had been ordered on 07/09/19.
-Cognitive functioning was marked "oriented in person, place, and time".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 270	Continued From page 2	D 270		

Review of the requested facility records for documentation of fall prevention interventions and rounding for Resident #1 revealed there was no documentation of interventions for fall prevention or rounds.

Review of the record for Resident #1 revealed:
-She had 8 documented falls from 08/17/19 through 10/09/19.
-Six of the 8 falls resulted in injury.
-Two of the 8 falls required transportation to the ER for evaluation and treatment.
-There was no documentation regarding "the resident's condition each shift for 72 hours" or under the ADL section after each fall.

Review of the Incident/Accident Reports for 5 of the falls that resulted in injury revealed:
-On 08/17/19 at 8:30am, she exited her room into the hallway and reported to staff she had fallen in her room with a skin tear documented to her left elbow and first aid was administered.
-On 08/24/19 at 10:00pm, she was found on the floor by the doorway of her room with a skin tear documented to her right elbow and first aid was administered.
-On 08/27/19 at 9:30pm, she had a witnessed fall "in the bathroom on her bottom. She hit her back on the toilet paper holder" with documentation of a skin tear and no first aid was administered.
-On 09/07/19 at 7:25pm, resident said she fell in her room with documentation of a skin tear to her left elbow and first aid was administered.
-On 09/14/19 at 12:00pm, she was found sitting on the floor beside her bed with documentation of a skin tear to her right elbow and first aid was administered.

Review of the Incident/Accident Report for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	**103 APPLACHIAN BLVD ARDEN, NC 28704**

(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 3	D 270		

Resident #1 dated 10/09/19 revealed:
-The description of the accident was documented as she was walking using a walker and accompanied by a Medication Aide (MA) from the dining room to her room to have a chest x-ray when she lost her balance and fell while trying to sit in the wheelchair.
-The fall was witnessed by the x-ray technician, MA, and Certified Nursing Assistant (CNA).
-The section of the report labeled "what does the resident say happened?" was documented as resident "lost her balance while walking in to her bedroom door".
-The diagram of location of injury was documented as a skin tear and swelling with the left thumb/wrist area, the back of the right forearm, and the lower portion of the face circled.
-First aid administered was documented as no.
-Level of consciousness was documented as alert and oriented.
-Resident was taken to the Emergency Room and hospitalized were documented as yes.
-There was documentation the family member was spoken to and notified at 12:30pm.
-There was documentation the FNP was notified by fax at 2:00pm.
-There was a hand-written note at the bottom of the page dated 10/09/19 with "Resident was oriented and talking with staff and medics when left building".
-There was a second hand-written note at the bottom of the page dated 10/11/19 with "Informed today resident expired".

Review of the "Charting Notes" documentation for Resident #1 revealed:
-There was no documentation in the notes for interventions for fall prevention from 07/06/19 through 10/09/19 for Resident #1.
-There was no documentation regarding "the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 4	D 270		

resident's condition each shift for 72 hours" after each fall.
-On 06/30/19 at 11:13pm she was admitted to the facility "alert, awake, and responded to questions", rolled up and down the hall in a wheelchair with no complaints of pain or discomfort, and she was advised to use her pendant that was within reach.
-On 07/07/19 at 11:30pm she had a sitter from 9pm to 7am, required 2-hour checks/assistance for activities of daily living (ADL's), and her family member requested a bed alarm for night time.
-On 07/10/19 at 11:00pm she walked to and from the dining room with a walker.
-On 08/17/19 at 10:51am she fell while ambulating in her room and had a skin tear to her left elbow.
-On 08/17/19 at 4:24pm she was crying and said, "I used to do things myself, but I can't anymore".
-On 08/25/19 at 6:46pm she fell by the doorway around 10pm and had a small skin tear to her right elbow that was bandaged.
-On 09/05/19 at 10:44pm she fell around 3pm today in her room with no injuries noted.
-On 09/07/19 at 9:49pm she reported to staff she had an unwitnessed fall and had sustained a skin tear to her left elbow.
-On 09/13/19 at 9:51pm she was found on the floor with no injuries noted.
-On 09/14/19 at 2:37pm she fell in her room and had a skin tear to her right elbow. Her vital signs were taken and family member and Family Nurse Practitioner (FNP) were notified.
-On 09/14/19 at 9:30pm she complained of left hip pain due to the fall and was transported to the emergency room (ER) for a medical evaluation.
-On 09/18/19 at 5:09pm she returned from the hospital and had a bandage on her right elbow and "no other bruises or skin tears upon arrival".
-On 09/21/19 at 11:49am there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 5	D 270		

documentation for a late entry that occurred on 09/20/19 she was found in her room sitting in the floor in front of the wheelchair with no injuries noted.
-On 09/27/19 at 6:42pm she had "a black spot, blood blister" on the back of her left leg.
-On 10/09/19 at 1:42pm she fell while walking in her room and had a skin tear to her right forearm, left elbow, and swelling to her chin and lips. She was transported to the ER and her family member was notified.

Review of the physician consult notes for Resident #1 revealed:
-07/09/19 Physical Therapy, Occupational Therapy, and a bed alarm were ordered.
-08/27/19 daily blood pressure and pulse checks were ordered to see if hypotension could be the etiology to the residents dizziness- "will consider EKG if dizziness persist" (an EKG is an electrocardiogram that records electrical signals in the heart to determine heart rate, heart rhythm, and other information regarding the heart's condition), and documentation atrial fibrillation with a controlled heart rate and tolerating blood thinner.
-09/03/19 continue working with therapy and advised to use call bell for assistance.
-09/24/19 hydrochlorothiazide (a medication used to treat high blood pressure and swelling due to fluid buildup) changed from 25mg to 12.5mg- "not likely contributing to repeated falls", Keflex (an antibiotic used to treat infections) was ordered for 7 days to treat a right lower extremity wound, lumbar x-ray to rule out acute injury, and daily blood pressure and pulse checks.

Review of the PT notes for Resident #1 revealed:
-07/17/19 there was documentation for start of care for muscle weakness, gait, mobility,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 6	D 270		

repeated falls, high fall risk, touching assist for transfers, and "SpO2 96% however it was initially 81% and improved with verbal cues".
-09/11/19 there was documentation of recommended assistive devices including a short box spring, transfer rail, and a chair with increased height and full arms.
-10/13/19 end of care was documented with a note the resident had been progressing with PT until "hospitalization and subsequent death".

Review of the hospital medical record for Resident #1 dated 10/09/19 through 10/11/19 revealed:
-She was "up lifted" by Emergency Medical Services (EMS) on 10/09/19 from the facility where she was "awake, alert and talkative but En route to the hospital her conscious level deteriorated and on inital presentation she had pupillary asymmetry and was unarousable".
-A computerized tomography (CT) scan was completed on 10/09/19 at 1:59 and revealed the presence of "a massive subdural hemorrhage with brain herniation".
-On 10/09/19 at 2:08pm she was rushed to the trauma bay in the Emergency room when she became unresponsive, had posturing (involuntary flexion or extension of the arms and legs indicating a severe brain injury), had a fixed dilated left pupil, and required intubation (a process of inserting a tube through the mouth into the airway so the patient can be placed on a ventilator to assist with breathing).
-The Discharge Summary on 10/11/19 at 6:55am revealed a diagnosis and cause of death was a subdural hematoma due to one fall and date of expiration was 10/11/19 at 12:55am.

Attempted telephone interview with the responsible person/family member for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 7	D 270		

#1 on 08/12/20 at 1:45pm was unsuccessful.

Telephone interview with the local county Department of Social Services (DSS) Adult Home Specialist (AHS) on 08/12/20 at 2:55pm revealed:
-She had completed a complaint investigation for Resident #1 in October 2019.
-Resident #1's blood thinner medication was discontinued during a hospitalization and was restarted by the PCP per request of Resident #1's family member/responsible person.
-Resident #1 then fell and had to be transported to the hospital where she was admitted and later expired.
-She could not remember if Resident #1 had a bed alarm or any other interventions for fall prevention put into place by the facility.

Attempted telephone interview with the responsible person/family member for Resident #1 on 08/13/20 at 9:38am was unsuccessful.

Attempted telephone interview with the responsible person/family member for Resident #1 on 08/13/20 at 2:04pm was unsuccessful.

Telephone interview with the facility's contracted Radiologic Technician (X-Ray technician) on 08/13/20 at 3:52pm revealed:
-She was the X-Ray technician that performed a chest X-Ray for Resident #1 on 10/09/19 and witnessed her fall.
-She rolled her machine into Resident #1's room and informed her she was going to get an X-ray.
-Resident #1 was sitting on the bed, stood up, and told her that she needed to use the restroom and proceeded to walk towards the bathroom.
-She was plugging in the electrical cord into the outlet when she saw Resident #1 fall towards the right, with her head against the wall and she "just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	**103 APPLACHIAN BLVD ARDEN, NC 28704**

(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 8	D 270		

went down and her head went inside the trash can".
-Resident #1 must have hit her face on the rim of the trashcan because she was bleeding from her lip or mouth.
-She was alone in the room with Resident #1 and ran to the doorway and "yelled for staff to help that she had fallen".
-Staff were in the hallway "passing meds and tending to other residents" when she had to call them for help.
-After staff tended to Resident #1, she completed the chest X-Ray.
-She did not know if Resident #1 was transported to the ER for medical evaluation.

Telephone interview with a second family member for Resident #1 on 08/14/20 at 1:22pm revealed:
-Resident #1 had resided at home by herself until she was admitted to the facility.
-The facility had notified her that Resident #1 had fallen a couple of times before "the last time when she ended up passing away".
-She was told by the facility Resident #1 was walking with her walker with an "assistant" next to her when she fell.
-The "aide" was "right next to " Resident #1 when she fell and "hit her head on the garbage pail".
-Resident #1 took a blood thinner medication and started bleeding internally when she fell and hit her head causing her death.

Attempted telephone interview with third family member for Resident #1 on 08/14/20 at 1:43pm was unsuccessful.

Telephone interview with a MA on 08/17/20 at 1:50pm revealed:
-She had worked at the facility for a year.
-She had cared for Resident #1 once or twice on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 9	D 270		

third shift when she resided at the facility.
-Resident #1 slept at night and ambulated "fine" with a walker.
-Resident #1 did not have a bed alarm but she did have a "bedside rail" that slid between the mattress and box spring on a regular-sized bed to help her reposition.
-Resident #1 had not fallen during any of her shifts when she cared for her.
-She was not aware of any fall prevention interventions for Resident #1.
-The facility's policies and procedures for falls included asking residents what had happened, check them for injuries, check the residents head for injuries and cognitive response, retrieve other staff members to assist the resident off the floor, check vital signs, fill out a incident report, notify family, call the physician and fax the incident report to them, the Director of Nursing (DON) assessed the resident for injuries if she was working, and if a resident had a serious injury they were transported to the ER for a medical evaluation.
-If a resident fell and hit their head, they were sent to the hospital for medical evaluation "even if it's a little bump".
-She had been trained in the past on fall prevention interventions.
-Rounding on residents were completed every 2 hours, but during the day shift "more than that, we do it all day long".
-Rounding and 72-hour checks were documented in the "chart notes".

Telephone interview with a first shift CNA on 08/17/20 at 2:26pm revealed:
-She had worked at the facility for 3 years.
-She had cared for Resident #1 when she resided at the facility.
-Resident #1 used a walker to ambulate and an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 10	D 270		

"assist bar" on her bed she used to get out of bed herself.
-She could not remember how many times Resident #1 had fallen when she resided at the facility.
-She could not remember if Resident #1 had a bed alarm.
-She was working the day Resident #1 fell in her room and saw her after she had fallen.
-Resident #1 said that she had fallen, and her family member was going to be mad at her because she had to go back to the hospital.
-Resident #1 was lying on the floor next to a trash can where she had hit her mouth when she fell and was bleeding from the mouth.
-Resident #1 was alone in her room when she fell and was found when staff made rounds.
-Resident #1 was transported to the ER for a medical evaluation and treatment.
-She had received training at the facility on fall prevention by a PT but did not know how long it had been since she had been trained.
-The fall prevention training included positioning, repositioning, and transferring residents.
-She could not remember if Resident #1 had called for assistance from staff by using her pendant.

Telephone interview with a second MA/CNA on 08/17/20 at 2:51pm revealed she had never taken care of Resident #1 when she resided at the facility.

Telephone interview with the Administrator on 08/17/20 at 3:13pm revealed the 72-hour checks were in the computer under the ADL section in the "charting notes".

Telephone interview with a third MA/CNA on 08/17/20 at 3:25pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 11	D 270		

-She had worked at the facility for 10 years.
-She worked on 10/09/19 when Resident #1 fell in her room hitting her mouth on the trash can and "we couldn't get the bleeding to stop" so she was sent to the hospital.
-She was standing at the doorway and witnessed Resident #1 fall when "she stumbled and tripped over her feet".
-Resident #1 "did not hit her head, she hit her mouth" and there was "a lot of blood coming from her mouth".
-Resident #1 was alert and talking the entire time until she was transported to the hospital.
-She filled out the Incident Report, faxed it to the FNP, and called to notify the family member/responsible person.
-The facility did not have any interventions in place to prevent falls for Resident #1 except rounding every 2 hours.
-Rounding every 2 hours was performed for all residents residing at the facility.
-She could not remember if Resident #1 had a bed alarm.
-Resident #1 ambulated with a walker "pretty good" and needed "light" assistance from staff with ADL's.
-The facility's policies and procedures for falls included filling out an Incident Report and fax it to the FNP, notify family, document the fall in "chart notes", and write the accident on a 24-hour report in the office for a "shift to shift" report.
-The facility did not have a separate policy and procedure for a fall with head injury; the facility would send the resident to the ER for a medical evaluation.
-The Incident/Accident report was placed into the Director of Nursing (DON's) box for her review.
-The facility had provided fall prevention training several times, but she could not remember the details and it "was a while ago".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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		D 270		

Continued From page 12

-The MA was responsible for assessing residents after a fall and determine if the resident needs to go to the hospital for a medical evaluation.

Telephone interview with a fourth family member for Resident #1 on 08/17/20 at 4:33pm revealed:
-Resident #1 was living at home by herself but had to be placed into an assisted living facility due to falls.
-Resident #1 had had other falls while residing at the facility.
-Resident #1 ambulated with a walker and used a wheelchair.
-He was not aware of any interventions provided by the facility to prevent falls for Resident #1.

Telephone interview with the PT assistant/Rehabilitation Program Director on 08/18/20 at 9:46am revealed:
-She had provided physical therapy to Resident #1 when she resided at the facility.
-On admission to the facility, Resident #1 had back pain and drop foot (difficulty lifting the front part of the foot) which contributed to her stumbling.
-Resident #1 was provided an AFO brace (a support brace to control the position and motion of the ankle to compensate for weakness), but she did not like it and would take it off.
-She had recommended in a meeting with the DON, Administrator, and FNP a low box spring, a different chair, a wheelchair to get around, and a "transfer rail" on the bed for Resident #1.
-She could not remember if Resident #1 had a bed alarm on her bed.

Telephone interview with a second shift MA/CNA on 08/18/20 at 11:19am revealed:
-She had worked at the facility for 10 years.
-She had cared for Resident #1 when she resided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 13	D 270		

at the facility; "she was difficult to take care of" because "she wanted to do things herself".
-Resident #1 had several falls while residing at the facility so she would put her into a wheelchair and take her to an activity in the lobby to prevent her from being in her room all the time.
-Resident #1 had a regular full-sized bed.
-Resident #1 did not have an alarm on her chair, wheelchair, or bed.
-She could not remember if Resident #1 had a small rail on her bed.
-Resident #1 had "something on her leg she usually wore walking" when asked if Resident #1 had an AFO brace.
-Resident #1 had a pendant to call for assistance from staff but did not use it.
-Fall prevention interventions for residents that fall often include "we keep them with us, take them to the bathroom, keep an eye on them, and sometimes put them into the bed".
-Interventions performed by staff are documented in the "chart notes".

Telephone interview with the FNP for Resident #1 on 08/18/20 at 2:14pm revealed:
-She provided primary care to Resident #1 when she resided at the facility.
-She received a faxed Incident/Accident Report from the facility for Resident #1's fall and hospitalization on 10/09/19 at 3:18pm.
-Resident #1 was sent to the hospital after she had fallen on 10/09/19 with either a subdural hematoma (a medical emergency caused by a head injury strong enough to burst blood vessels) or hemorrhage (bleeding inside or outside of the body).
-She expected the facility to call her personal cellular phone in an emergency and fax the incident report.
-The facility did not call to notify her of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 14 #1's fall with head injury on 10/09/19. -Resident #1's blood thinner medication may have contributed to the bleed. -Resident #1's blood thinner medication had been previously discontinued during a different hospitalization, but the family member/responsible person wanted the medication restarted at the facility and she reordered the blood thinner against her recommendation of not continuing the medication. -She had received 8 faxed Incident/Accident Reports for Resident #1 from 08/17/19 through 10/09/19. -She did not know if the facility had provided a bed alarm to Resident #1 after she had ordered one on 07/09/19. Telephone interview with the DON on 08/19/20 at 3:23pm revealed: -The facility's policies and procedures for falls include the MA looks at the resident to see what happened and if they sustained any injuries or she will assess the resident if she is on duty, vital signs were taken, and if the resident is bleeding or "not acting right" they were transported to the hospital for a medical evaluation. -The current fall policy was from an old corporation and the facility did not have a "really good fall policy". -The facility did not have a separate policy for resident falls with a head injury. -When a resident had an unwitnessed fall, "we don't always know they have hit their head". -She was responsible for monitoring Incident/Accident Reports and identifying residents as "high risk for falls". -Incident/Accident reports are placed in her box for review after the MA faxed it to the FNP; they "never call" and "only fax" the report.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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		D 270		

Continued From page 15

-New resident admissions are at risk for falls for 2-3 months while being acclimated to a new living environment.
-Staff round on the residents every 2 hours.
-The facility did not have a fall risk assessment tool to track resident falls; she was only able to track the falls by Incident/Accident Reports.
-Staff had received "very little" training on fall prevention.
-Staff meetings were held every morning at 9:30am for first shift staff to discuss any incidents or accidents that occurred, and second and third shift read the "shift report" from the meeting in a memo book.
-She expected staff to respond immediately to a fall, take vital signs, "check them over", fill out an Incident Report and fax it to the FNP.
-The facility had bed and chair alarms available for use.
-Bed alarms are not documented in the resident record when being used because they were a small facility and would verbally share the information in the "shift to shift" report.
-Resident #1 had a bed alarm but did not like it because it made "too much noise" and took it off her bed and threw it in the floor.
-The facility did not try to put the bed alarm back on Resident #1's bed.
-Resident #1 had a wheelchair but would not use it and ambulated with a walker to the dining room for meals.
-Resident #1 did not fall "that much".
-She did not know if Resident #1 had any interventions ordered for fall prevention.
-She was responsible for ordering interventions for fall prevention of residents.
-Staff was not present when Resident #1 fell on 10/09/19 and was sent to the hospital.
-She completes a fall investigation if she questions how a resident fell, "its not a formal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 16	D 270		

Continued From page 16

investigation and it's not documented anywhere".
-She did not perform a fall investigation for Resident #1 because she was hospitalized.

Telephone interview with the Administrator on 08/20/20 at 9:05am revealed:
-She did not know if Resident #1 had a bed alarm ordered.
-Bed alarms were documented in the "chart notes" in the resident record.
-She did not know if there was an "assist bar" on Resident #1's bed but with family's permission they removed the box spring so Resident #1's bed would be lower, and she "just slept" on the mattress.
-She did not know if Resident #1 had multiple falls.
-Resident #1 had physical therapy ordered for a fall prevention intervention.
-The DON was responsible for ordering additional fall prevention interventions if physical therapy alone was not successful at preventing falls.
-She did not know how Resident #1 fell in her room on 10/09/19.
-Resident #1 was on a blood thinner medication and they could not "pinpoint" where the bleeding was coming from, so she was transported to the hospital for a medical evaluation.
-Resident #1 was alert and oriented and talking to staff when she left the facility on 10/09/19 to go to the hospital.
-The facility's policies and procedures for falls depended on the type of fall, the MA or DON assessed the resident, an Incident/Accident Report was filled out and faxed to the FNP, family was notified by telephone, and the FNP was notified by telephone if it was a "true emergency".
-The facility did not have a separate policy for falls with a head injury, but if they hit their head they were "automatically sent out" to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 17	D 270		

-A fall risk assessment was completed every 6 months with the Care Plan.
-Staff received fall prevention training approximately a year ago and it was completed annually along with online computer training.
-The annual fall prevention class was taught by the DON and included fall assessments, filling out Incident Reports, checking vital signs, checking range of motion, documentation of the fall, prevention of falls, scenario's of when to send a resident to the hospital, and a Physical Therapist will demonstrate how to properly transfer and position residents.
-When residents experienced multiple falls the DON was responsible for getting the FNP to order physical therapy.
-Fall prevention interventions were documented in the "chart notes".
-All residents were rounded on every 2 hours and if they are identified as a high fall risk, they round on them hourly.
-The MA could not diagnose a resident and determine if they need to go to the hospital for a medical evaluation and the DON or herself would assess the resident or for after-hours the MA was expected to call and notify the DON or herself.
-She expected the MA to call the residents FNP for any incidents or accidents that involved a "serious situation" such as "bleeding or blood sugars".

Refer to the facility's policies and procedures for falls.

2. Review of Resident #3's current FL2 dated 04/16/20 revealed:
-Diagnoses included Alzheimer's disease, vertigo, restless leg syndrome, left knee pain, insomnia, hypertension and atrophy of thyroid.
-She was ambulatory.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 18 -She required assistance from staff for bathing and dressing. -She was documented to be continent and incontinent of both bowel and bladder. -No assistive device was documented. -No history of or frequent falls was documented. Review of a facility document provide by the Administrator on 08/11/20 at 12:04pm revealed Resident #3 was currently in the local hospital. Review of the Resident Register for Resident #3 revealed an admission date of 02/08/19. Review of the Care Plan for Resident #3 dated 05/28/20 revealed: -Care type for Mobility/Ambulation section had wheelchair and fall precautions checked. -Care type for Services Provided section had transfers/ambulates with occasional supervision/assistance checked. -Care type for Interventions had a handwritten note, "Constant falls, 7 per month, Resident will sit self on floor and then call for help." -Care type for Dressing/Grooming for Services provided had fully dependent and total assistance required in washing, combing hair, clipping nails, brushing teeth, shaving, etc. checked. -Care type for Interventions had a handwritten note, "Needs assist or complete help with" Activities of Daily Living (ADL's), "Resident does not try to do any ADL's and has fall history, unable to comprehend safety awareness." Review of the Record for Resident #3 revealed: - 28 total falls from 03/01/20 through 07/12/20. -10 of those falls resulted in injury and 4 of those falls were documented as hitting her face or head. - The falls in order are as follows:03/01/20,	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 19	D 270		

03/05/20, 03/25/20, 03/30/20, 04/05/20, 04/16/20, 04/17/20, 04/20/20, 04/23/20, 04/26/20, 04/29/20, 05/07/20, 05/11/20, 05/12/20, 05/16/20, 05/19/20, 05/23/20, 05/25/20, 05/30/20 at 10:48am and again at 08/30/20 at 8:06pm, 06/06/20, 06/07/20, 06/16/20, 06/18/20, 06/28/20, 07/02/20, 07/03/20, 07/12/20.
- None of the falls with head injury and initial seizure activity for Resident #3 resulted in her being transportation to the emergency department (ED) for evaluation and treatment.
-There was no documentation Resident #3's family had refused for Resident #3 to go to the hospital.
-There was no documentation regarding "the resident's condition each shift for 72 hours" or under the ADL section after each fall.

Review of the 10 Incidents/Accidents reports for Resident #3 that resulted from accidents hitting her head or face and other incidents revealed:
-On 03/01/20 at 5:00pm- Resident #3 was found on the floor beside the bed, no shoes on, said she slid down chair when transferring to bed, skin tears on right arm, cleansed, applied gauze and bandage, no ED, no interventions noted.
-03/30/20 at 5:00pm-Resident #3 was found on the floor beside her bed, skin tear to right elbow, no ED, no interventions noted.
-04/05/20 at 5:30pm- Resident #3 was found on the floor in front of her dresser, skin tear to the left side of her back, bandage applied, no ED, no interventions noted.
-04/23/20 at 8:30pm- Resident #3 was found on the floor in bathroom, skin tear to left elbow, bandage applied, no ED, no interventions noted.
-06/07/20 at 7:00pm- Resident #3 was found on the floor under the table, said she fell on her face, swelling noted on cheek, no ED, no interventions noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 20	D 270		

-06-16-20 at 1:50pm- Resident #3 was found on the floor near bathroom, skin tare to left elbow, no ED, no interventions noted.
-06/18/20 at 4:45pm- Resident #3 was found was observed falling backwards, hitting her head on floor, no walking device, had 3-5 minute seizure assisted to get up and taken to the dining room, no other injury noted, no ED, no interventions noted.
-07/02/20 at 7:30pm- Resident #3 was found on the floor, rolled out of wheelchair hitting head, big swollen bump to eyebrow, 7/3/20 noted "eyes black due to fall" and then on 07/06/20 noted bruises "covered all her face" from fall, no ED, no interventions noted.
-07/12/20 at 10:16am- Another new large pump knot to her head, ice applied however "did not help" no ED, no interventions noted.
-08/06/20 at 7:15am- Resident #3 was found lying in bed unresponsive, Emergency medical service (EMS) taken to local hospital.

Review of the "charting notes" documentation for Resident #3 revealed:
-There was no documentation in the notes for interventions for fall prevention from 03/01/20 through 08/06/20 for Resident #3.
-There was documentation on 03/06/20 at 9:08pm Resident #3 was repeatedly taking off her pull-ups, putting clothes and shoes all over her room, straightened up Resident #3's room twice, Resident #3 will not keep pull-ups on, "doing hourly checks".
-There was no documentation regarding "the resident's condition each shift for 72 hours" after each fall.
-There were a total of 50 entries from 03/01/20 - 08/06/20, 20 entries documenting other behavioral or care issues and 30 documenting resident being found on the floor or unresponsive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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		D 270		

Continued From page 21

-On 08/13/20 there was a late entry for 08/06/20 documented that "Resident was found during rounds unresponsive", The MA and CNA "could not get the resident to rouse".

Review of the Physician Consult notes for Resident #3 revealed:
-A physician visit summary form dated 04/16/20 revealed an order "to start physical therapy for recurrent falls, gait instability/weakness" by her primary care physician.
-Resident #3 was being followed by Palliative care for Alzheimer's type dementia, hypertension, debility and depression.
-On 01/13/20 theree was documentation from Palliative Care Resident #3 had had a fall requiring 2 staples to the right backside of her head since the last Palliative Care visit on 12/26/19.
- On 07/20/20 there was Palliative Care documentation they were notified on "07/02/20 of a fall with a hemotoma to Resident #3's head, hemotoma was still present raised 1cm with width of 2cm and bruising to the left side of her face, no longer ambulatory on her own, using wheelchair, oriented to person and place noted resident frequently complaining of being dizzy,working with therapy due to recurrent falls and poor safety awareness, staff performs frequent check when resident is in her room for safety."

Review of the Physical Therapy (PT) notes for Resident #3 revealed:
-04/21/20 there was documentation for start of care for unsteadiness on feet and difficulty walking.
-Physical therapy was recieved on 04/21/20 through 08/06/20 for two-three times weekly.
-07/07/20 there was documentation Resident #3 had had a "functional decline since a recent fall",

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 22	D 270		

"impaired strength, gait, balance", Resident #3 had "several recent falls and has had a functional decline since last fall".
-08/06 20 end of care was documented with a note that Resident #3 had been discharged to the hospital due to being unresponsive.

Further review of the record for Resident #3 revealed:
-Resident #3 had a fall with facial fractures on 10/20/19, she was evaluated at the hospital.
-Resident #3 had a CT scan of the spine on 12/31/19 related to a fall and 2 staples to the right backside of her head, she was evaluated at the hospital.
-Resident #3 had a fall with facial trauma on 02/18/20 with a CT scan of the head and spine that was negative for new fractures, she was evaluated at the hospital.
-Occupational therapy was recieved from 12/03/20 through 05/15/20 twice weekly for unsteadiness on her feet with her ADL's.

Review of the hospital medical record dated 08/06/20 through 08/12/20 for Resident #3 revealed:
-Resident #3 was admitted to the local hospital on 08/06/20 with diagnoses of seizures and atrial fibrillation.
-Resident #3 was started on Keppra 500mg twice daily (used to treat seizures) for seizure prevention.
-Resident #3 was noted on 08/08/20 experiencing atrial fibrilliation overnight, breifly requiring Cardizem infusion.
-Resident #3 was started on Eliquis 2.5mg one tablet twice daily (anticoagulant medication used to treat and prevent blood clots and to prevent stroke in people with nonvalvular atrial fibrillation) on 08/10/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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		D 270		

Continued From page 23

-Resident #3 was discharged to skilled nursing on 08/12/20 with diagnosis of seizure, Post-ictal state (period of time immediately following a seizure), vascular dementia and atrial fibrilliation and remained on the medications Keppra and Eliquis.

Telephone interview with a family member for Resident #3 on 08/14/20 at 9:24am revealed:
-Facility staff had called the morning of 08/06/20 to inform him Resident #3 had been sent to the local hospital as she had been found unresponsive when staff had gone in to check on her.
-He was informed from the staff at the local hospital Resident #3 was admitted with seizures and atrial fibrillation on 08/06/20.
-Resident #3 she was discharged from the local hospital and admitted to a skilled nursing facility for rehabilitation on 08/12/20 with diagnoses of seizures and atrial fibrillation.
-He was not aware of any previous seizure type activity prior to her hospitalization.
-He was aware of her numerous falls as the facility had notified him when Resident #3 had fallen.
-The facility had not spoken with him regarding any previous seizure type activity nor interventions to assist Resident #3 with fall prevention during her stay at the facility.
-The facility had notified him they were placing a wander guard on Resident #3 which would be reflected in Resident #3's billing statement.
-He had questioned the facility in regards for the continued need for therapy as Resident #3 was wheelchair bound.
-He had not observed any personal alarms (bed or chair) being used for Resident #3 during her stay at the facility.
-He had never told the facility he did not want her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 24	D 270		

sent out to be evaluated after any fall as he depended on them to make that decision as they were with her and he was not.
-The staff usually did not ask him if he wanted Resident #3 sent out for evaluation.

Telephone interview with a Medication Aide/Certified nursing assistant (MA/CNA) on 08/17/20 at 1:50pm revealed:
-She had been employed with the facility for a total of six years.
-If a resident had a fall, she was to ask the resident what had happened, ask if they were hurt, usually get someone to assist and take the residents vitals.
-The MA was responsible to complete the incident/accident report, fax the physician a copy of the Incident/Accident Report and notify the family.
-They did not call the physician only faxed the report.
-The MA was responsible for completing the 72-hour report, which included checking on the resident after a fall once each shift for 72 hours and documenting it in the computer under the Activities of Daily living (ADLs) section.
-Any resident who fell and hit their head was to be sent out even if it was a small bump, they would send them to the ED because they did not know how hard the resident hit their head.
- Rounds were done on residents every 2 hours, but they saw the residents more often during the day as the doors were open and the residents were out in the facility.
-She had attended some in-service classes on falls provided by the Physical Therapist (PT).
-The MA was responsible to call EMS and if they were not sure what to do, they could call the Director of Nursing or the Administrator.
-Resident #3 had used a walker and tried to be as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 25	D 270		

independent as she could.
-Resident #3's room was at the end of the hall.
-Resident #3 would also use her wheelchair and attempt to do things on her own.
-The last couple of months Resident #3 had been in her wheelchair mostly.
-Resident #3 had had a lot of falls.
-After each fall the staff would take Resident #3 out of her room and place Resident #3 in the hall where staff could supervise Resident #3.
-Sometimes they would take Resident #3 to activities.
-There were no other interventions for the prevention of falls that she was aware of.
-On the morning or 08/06/20 as she was coming on her shift, she was called to Resident #3's room.
-Resident #3 was lying in bed shaking, "locked up" (her body was stiff) and she was unable to make eye contact.
-Third shift staff sent her out to the hospital to be evaluated as she had not begun her shift yet.

Telephone interview with a CNA on 08/17/20 at 2:26pm revealed:
-She had been employed with the facility for three years.
-She was responsible to report any fall to the MA.
-She would put a pillow under their head and go get help.
-She had had some computer training on falls and a therapist had also provided staff with an in-service on falls regarding positioning and transfers.
-The MA would report falls to the DON.
-She was responsible to check on the residents every 2 hours.
-She would go up and down the halls and peek in the resident room, check to see if the resident was dry or if the resident needed anything.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 26	D 270		

-All the residents had a pendant that would ring to the staff pagers if the residents rang for assistance.
-The MA or the DON would assess the resident after a fall or incident.
-The MA or DON made the decision to send the resident out to the ED.
-The MA was responsible to complete the Incident/Accident Report.
-The MA faxed the physician a copy of the Incident/Accident Report and notified the family.
-Resident #3 was using a walker when she was first admitted then declined to a wheelchair.
-Resident #3 would try to transfer herself a lot.
-Resident #3 had a lot of falls.
-Resident #3 said she fell because she "wanted attention".
-She was not sure if the Resident #3 was teasing or being sarcastic about wanting attention..
-She would take Resident #3 to activities or out in the hall or the lobby to get her out of her room.
-She was not aware of any further measure in place for fall prevention.
-She had not observed a bed or chair alarms for Resident #3.
-She was not aware of any other seizure like activity for Resident #3.

Telephone interview with a second MA/CNA on 08/17/20 at 2:51pm revealed:
-She had been employed by the facility for five years.
-She was responsible to assess a resident if they fell, see if the needed to go to the ED, complete the incident/accident form, report vitals, fax the physician a copy of the Incident/Accident Report and notify the family and place the Incident/Accident Report in the DON's box.
-They did not call the physician only faxed the report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 27	D 270		

-If the resident was a diabetic, she was to check their blood sugar.
-If a resident had a fall with a gash to their head, or in intense pain, or rotated limb, she would call the DON and send the resident out to the ED for evaluation.
-Any fall with an injury to the head was to be sent out to the hospital.
-She had training on falls that included safety issues related to falls and keeping residents occupied so they didn't try to get up and fall.
-The staff completed rounds on the residents every 2 hours.
-If a resident needed to be checked on more often the DON would leave them a paper asking staff to check on the resident every hour for 72 hours.
-The MA was responsible to check the resident vitals one time a day for three days.
-If the DON wants it done more than that she will put it on the paper.
-The MA or the DON determines if the resident needs to go to the ED.
-Residents having falls and hitting their heads and/or seizures are sent to the ED.
-If the resident was not like they normally were they send them out to the ED.
-Resident #3 was able to walk at first when she came to the facility.
-Resident #3 declined to a wheelchair over the last several months.
-Resident #3 would fall if you didn't watch her.
-Resident #3 would try to get up on her own.
-Resident #3 had a full-size regular bed, no alarm, with an assist side rail.
-She had never observed Resident #3 fall but had found her in the floor several times in various places.
-She had no chair alarm.
-She would toilet Resident #3 and bring her out in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 28	D 270		

Continued From page 28

the hall or to the lobby to watch her while she was passing medications.
-She knew the residents that fell frequently and just checked on them more frequently.
-The last couple of months staff had to propel Resident #3 in her wheelchair.
-She was not present the day resident went to the hospital.

Telephone interview on 08/17/20 at 3:13pm with the Administrator revealed the 72-hour checks were in the computer under the ADL section in the "charting notes".

Telephone interview with a third MA on 08/17/20 at 3:25pm revealed:
-She had been employed with the facility for ten years.
-She was responsible for assessing the resident after an accident or injury, completing the Incident/Accident Report, faxing the physician and calling the family, chart notes in the computer and the 24-hour report sheet.
-All head injuries were to be sent to the ED.
-Falls were to be reported to the DON by placing the accident/incident report in the DON's box.
-She had had training on falls a long time ago, but it was long ago that she did not remember when or who provided it.
-They did rounds on the residents every 2 hours.
-The MA's are responsible to assess the resident after each fall, determine if they need to be sent out to ED, complete the Incident/Accident Report, fax the physician a copy of the Incident/Accident Report and call the family.
-They did not call the physician only faxed the Incident/Accident Report.
-Resident #3 did not ambulate but used a wheelchair.
-Staff could place Resident #3in her wheelchair,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 29	D 270		

walk to the end of the hall and Resident #3 would try to get up and fall before staff could get back to her.
-Staff would get Resident #3 dressed and bring her down to the lobby to keep an eye on her during the day.
-She wasn't sure if she had a bed alarm or not but remembered she had her own personal full-size bed.
-She stated she and the staff always checked on her because the staff knew she would fall.
-Resident #3 thought she could get up and walk but she couldn't, her legs just would not hold her up anymore.
-She was working on the morning of 08/06/20 when Resident #3 went to the hospital.
- Resident #3 was "not her normal self".
-Resident #3 was breathing heavy, couldn't move and unable to talk and could not make eye contact.
-It was the first time she had seen resident #3 like that.
-She was aware of one other time she had been like that on second shift per staff report.
-She filled out the incident report, another MA called the family and faxed the report to the physician.
-She had seen Resident #3 get out of her wheelchair and fall before staff could reach her.
-She had a recliner she used in her room, no restraints or alarms where used for Resident #3, they only kept her out in the hall where they could see her.

Telephone interview with the PT assistant/Rehabilitation Program Director on 08/18/20 at 9:46am revealed:
-They were contracted with the facility to provide therapies.
-She had meetings with the DON and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 30	D 270		

Administrator where she discussed recommendations for residents from therapy.
-Resident #3 was in the "Steady Steps Program" that worked on balance, exercise and gait to prevent falls.
-The staff tried to keep her out of the room a lot to keep an eye on her.
-She had never worked with Resident #3 or observed Resident #3 fall.
-She was not aware of any therapy recommendations for Resident #3.

Telephone interview with a third MA/CNA on 08/18/20 at 11:12am revealed:
-She had been employed with the facility for 10 years.
-She was responsible for assessing the resident, completing the Incident/Accident Report, faxing the physician a copy of the report and calling the family, and placing a copy in the DON's box.
-It would be her responsibility to determine if a resident needed to go to the hospital or she could call the DON.
-If a resident had more than one fall, they would get an order for a therapy referral.
-The MA's would fax incident reports to the physician but did not call the physician.
-If a resident had a head injury, she would send them out.
-If the family consents to send them out staff would send them to the hospital.
-She reported all falls to the DON, physician and family.
-She had falls training provided by the facility therapist on how to prevent falls but did not remember when.
-Rounds were made every 2 hours to check on residents.
-If the resident needed more frequent checks, they could check on them every hour.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 31	D 270		

-The DON would assess the resident after every fall.
-If the resident fell and could not get up then she would call 911.
-Resident #3 has "had a lot of falls".
-She would take her to the bathroom, she would take Resident #3 to where she was working to keep an eye on her.
-If Resident #3 wanted to go to bed she would put her in the bed and leave her medication cart outside of Resident #3's door at the end of the hallway to keep an eye on her.
-Resident #3 would gets up on her own and tried to walk but she couldn't walk anymore.
-Resident #3 did not have a personal alarm for her chair or bed, nor a mat beside the bed.
-There was carpet on the floor in her room.
-On 06/18/20 she observed Resident #3 "seriously shaking", falling backwards, hitting her head on the floor and appeared to have a 3-5-minute seizure.
-She called for help, put Resident #3 back in her wheelchair and took her to the dining room.
-Resident #3 was shaking and stiff before and after she fell.
-After a few minutes Resident #3 came around.
-Resident #3 had never done anything like that before.
-She asked other staff who were present if Resident #3 had ever done anything like that before and everyone told her no.
-She as aware Resident #3 had not had any type of seizure type activity prior to this event.
-She had not called anyone about the seizure/fall, she just completed the Incident/Accident report, faxed the physician and put a copy in the DON's box.
-When the physician was faxed, they did not call back.
-The family could ask for the resident to be sent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 32	D 270		

out.
-She had called the son and left a message that Resident #3 had fallen but he did not call back that she was aware of.
-"I didn't think she needed to go to the emergency room so I just took her to the dining room."

Telephone interview with the facility contracted Physical Therapist Assistant (PTA) on 08/18/20 at 12:21pm revealed:
-She had been at the facility for 4-5 years.
-She was the primary PTA for Resident #3.
-She had worked with Resident #3 off and on since Resident #3 lived in independent living.
-She had been working with Resident #3 2-3 times weekly since April 21, 202 and discharged her on 08/06/20 when she was discharged to the hospital.
-A month ago, Resident #3 had been able to walk the length of the hall with the PTA, but she had been declining over the past 4 weeks.
-Resident #3 did not ambulate except with therapy.
-Resident #3 had been experiencing more neurological changes related to pushing backwards when standing up and trying to establish her balance.
-She had never observed Resident #3 fall but had assisted her up after finding her on the floor.
-The main preventative measure for falls in place for Resident #3 was for staff to keep Resident #3 out off her room in the hall or lobby trying to keep an eye on her.
-Personal alarms had never been tried with Resident #3 but she felt that was "a good idea for her".
-She had recalled an incident where Resident #3 was believed to have a seizure, but she had never observed this with Resident #3.
-She had encouraged staff to keep Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 33	D 270		

warm and dry to help with the higher tone and muscle spasm issues that Resident #3 was experiencing.
-Resident #3 was more rigid than she had been in her entire life when she worked with her.
-The muscle spams she was having only lasted a second or two, but she would grab her leg and holler out.
-She had spoken with the FNP in person and by email regarding the changes in reduced ambulation, higher tone and muscle spasms.
-She was not present on 08/06/20 when Resident #3 went out to the hospital.
-She was "not surprised" Resident #3 had a neurological event as she was experiencing neurological changes that were evident when she worked with Resident #3 during therapy sessions.

Telephone interview with the facility contracted family nurse practioner (FNP) on 08/18/20 at 2:12pm revealed:
-If there was an emergency at the facility the nurse at the facility could get in touch with her otherwise, the staff just fax the Incident/Accident Report to her.
-She would expect staff to send out residents who were experiencing acute changes and changes in overall well-being.
-Reasons to go to the ED would be change in mental status, change in vital signs, excessive pain and significant injury.
-They had been limiting trips to the ED for x-rays due to COVID-19 as the facility could have mobile x-ray come to the facility.
-Generally, any resident who had a fall and hit their head or face should be sent out.
-The staff should also ask the family what they want.
-Resident #3 had progressive dementia, frequent incontinence of bowels, neuropathy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 34	D 270		

gastroesophageal reflux disease, she experienced frequent falls, was working with therapy almost her entire stay at the facility and Palliative Care was also following Resident #3.
-She had discontinued her Gabapentin trying to get rid of anything that was predisposing her to falls.
-Staff reinforced the use of Resident #3's call bell when needing assistance.
-Staff were keeping Resident #3 in a common area to keep an eye on her.
-Resident #3 was not known for seizures, was never on any medications for seizures and never treated for seizures.
-She was notified on 06/18/20 by fax of an Incident/Accident Report where "Resident was seen falling backwards when walking with no walking device and staff noticed that resident had seizure for 3-5 minutes. She was assisted to get up. No other injury noted."
-She saw Resident #3 on 06/23/20 and wrote an order for continuation of physical therapy.
-She reviewed her last computed tomography (CT) exam.
-She made no med changes for Resident #3 on 06/23/20.
-She had a concern for possible transient ischemic attack (TIA)/cerebrovascular accident (stroke) for Resident #3.
-She had a concern about starting Resident #3 on aspirin.
-She would have ordered a CT scan if she had exhibited any other symptoms.
-She was not aware of any personal alarms used for Resident #3.
-There had been no room changes made to move Resident #3 closer down the hall near the lobby as her room was at the end of the hall.
-She was not aware of anything else the facility could have done to have prevented Resident #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 35	D 270		

falls.
-She was not aware Resident #3 having any issues with atrial fibrillation.
-The staff should have sent Resident #3 out to the ED to be evaluated with the fall and seizure on 06/18/20 as it was new to Resident #3.
-Residents should be sent out anytime there is a head injury as long as family was agreeable.

Telephone interview with a second CNA on 08/19/20 at 7:37am revealed:
-She had been employed with the facility since February of this year.
-She was responsible for reporting any falls or changes in a resident's condition to the MA.
-She was responsible for taking the residents' vitals and getting them ready to send them out.
-She had been shown what to do by the MA regarding falls.
-She had not received any other training on falls since she began her employment in February.
-The MA was responsible for assessing the resident, completing the Incident/Accident Report, faxing the physician a copy of the report and calling the family, and placing a copy in the DON's box.
-It would be the MA's responsibility to determine if a resident needed to go to the hospital or the MA would call the DON.
-Resident #3 "falls a lot on purpose".
-Resident #3 would say she "wanted the attention".
-She would try to take Resident #3 to activities, but the resident would get mad because she wanted to stand up.
-Resident #3 would try to stand up on her own.
-Resident #3 was also prone to slide out of her bed.
-Resident #3 did not have any bed or chair alarms to alert staff to when she was trying to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 36	D 270		

up.
-Staff would sit Resident #3 in the wheelchair in the lobby or living room area and Resident #3 would still try to stand up.
-She was working on 08/06/20 and found Resident #3 sleeping during her last round.
-Resident #3 was "jittering real bad", could not speak and was physically stiff.
-Resident #3 was not acting like herself and she went and got the MA who reported the changes to the DON, who reportedly said to send her out.

Telephone interview with the DON on 08/19/20 at 3:23pm revealed:
-The MA was responsible for assessing the resident, completing the Incident/Accident Report, faxing the physician a copy of the Incident/Accident Report, calling the family, and placing a copy in the DON's box.
-It would be the MA's responsibility to determine if a resident needed to go to the hospital or the MA would call the DON.
-If staff had questions sometimes they would call her, sometimes they would just send the resident out to the ED but she had told staff "If in doubt, send them out."
-She was responsible for ordering interventions for fall prevention of residents.
-Bed alarms are not documented in the resident record when being used because they were a small facility and would verbally share the information in the "shift to shift" report.
-The facility did not have a fall risk assessment tool to track resident falls; she was only able to track the falls by Incident/Accident Reports.
-Staff had received "very little" training on fall prevention.
-The current fall policy was from an old corporation and the facility did not have a "really good fall policy".

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	HAL011151	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 37 -When asked why the facility was not following their policy to call the physician and then fax the Incident/Accident Report she replied that just faxing the physician had been done that way since she had been there. -There was no separate policy for head injuries. -If a resident had a bleeding head injury, they would be sent to the ED. -Sometimes when a resident would fall, they would not know if they had hit their head or not. -The facility did not have a fall prevention program in place and there were no formal fall interventions prior to 08/20/20. -Staff would discuss residents that had falls every morning in the daily meeting. -All staff would attend the morning meeting. -"We know what people fall, were a small facility." -She was responsible for completing the care plans and would check frequent falls on the care plan as the care plan. had minimal space for putting anything else. -She expected staff to respond immediately, check vitals, check the resident over, have her assess the resident if she is in the facility. -The MA was responsible to fill out the Incident/Accident Report. -The MA was the supervisor in charge when she was not there, and it was placed on the assignment sheet. -The MA would place the Incident/Accident Report in her box. -The MA's were only responsible to fax the physician not call the physician. -The FNP would see any resident who had fallen or there was a concern on the following Tuesday when she came to the facility. -The MA's were not to call families between 1:00am and 7:00am regarding Incident/Accident Reports if the resident is not hurt, but to call after 7:00am.	D 270		

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D 270	Continued From page 38	D 270		

-Resident #3 did not have any alarms.
-Resident #3 did have a door alarm at one point back when she was ambulating to let staff know when Resident #3 left her room.
-She would do an informal fall investigation if she had a concern, but it was not a formal investigation and she did not document it, but she would check on it.
-If a resident had a fall and hit their head they needed to be sent out.
-If the resident had seizure type symptoms for the first time or had a seizure they should be sent out.
-If she had been there on 06/18/20 when she fell backwards and appeared to be having a seizure she would have sent her out.
-Resident #3 had no previous history of seizures and she could not answer why staff did not send her out.
-She could not say why Resident #3 was not sent out on 06/07/20, 06/18/20, 07/12/20 after hitting her face or head.
-She was called regarding the incident on 07/02/20 where Resident #3 had fallen and hit her face just above the eyebrow.
-She decided not to send her out because she was told she only had a bump above her eyebrow.
- The facility had chair and bed alarms that could be used for residents with frequent falls.
-The facility had assist bars for the beds, they had taken off the box spring of different residents personal beds in the past to lower the mattress but had not documented this.
-They did not have a place at his point to communicate fall interventions.
-If therapy made a recommendation for a resident, they were responsible to see that the physician orders it.
-Resident #3 had not been able to ambulate in a

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D 270	Continued From page 39	D 270		

long time.
-Resident #3 was in a wheelchair and staff kept her in the hallway or lobby to keep an eye on her.
-The facility did not have any rooms to move Resident #3 closer to the lobby.
-The staff would check on Resident #3 a lot as they were aware she had had numerous falls.
-Resident #3 would do things for attention, as evidence by sitting down in the floor, bowel incontinence in the floor,
-Resident #3 would be brought up from her room for meals, placed her in an activity to be around people.
-Resident #3 was a hard resident to care for.

Telephone interview with fourth MA/CNA on 08/20/20 at 7:31am revealed:
-She had been employed at the facility for 5 weeks although she had been a CNA for 27 years and a MA for 9 years
-She was responsible for assessing the resident, completing the accident/incident report, faxing the physician a copy of the report and calling the family, and placing a copy in the DON's box.
-It would be her responsibility to determine if a resident needed to go to the hospital or she could call the DON.
-She had not had any training by the facility on falls in the 5 weeks she has been with the facility.
-Resident #3 usually slept throughout the night since she started.
-Resident #3 had no falls on third shift that she was aware of.
-Resident # 3 had had no hourly checks since she started.
-If the resident hit their head she would automatically send them out.
-She was the MA on 08/06/20 when Resident #3 was sent to the local hospital.
-She had gone into Resident #3's room to give

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HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 270	Continued From page 40 her her morning medications. -She did not turn her head as she normally did and could not speak. -She went and got a CNA who had been there for some time and they watched Resident #3 for a few minutes deciding this was not normal behavior for Resident #3 and decided to send her out to be evaluated to the hospital. -The physician was faxed, and the family notified, and the DON was told when she arrived at the facility. Telephone interview the Administrator on 08/20/20 at 9:05am revealed: -She expected the resident to be assessed, provided first aide if needed, sent out if needed and the DON to be notified with the Accident/Incident Report being faxed to the physician. -In a true emergency she expected the staff to call the physician. -There was no separate policy for a resident who hit their head. -She expected the staff to automatically send the resident out to be evaluated if they had hit their head when falling. -Staff should ask the family what their wishes are related to being sent to the hospital for an evaluation. -Fall risk are identified by admission paperwork, asking family, and monitoring in the facility for multiple falls. -Fall risk assessments were completed every 6 months during the care planning process. -She expected the residents to be taken care of and she or the DON were to be notified of Accident/Incident Reports with reports being completed in a timely manner. -If a resident was to fall and hit their head the expectation was for that resident to be sent out.	D 270		

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D 270	Continued From page 41	D 270		

-Staff should assess the scene, do an assessment of the resident, vitals, and talk with the resident.
-Staff received fall prevention training approximately a year ago and it was completed annually along with online computer training.
-The annual fall prevention class was taught by the DON and included fall assessments, filling out Incident Reports, checking vital signs, checking range of motion, documentation of the fall, prevention of falls, scenario's of when to send a resident to the hospital, and a physical therapist will demonstrate how to properly transfer and position residents.
-The facility had not provided this training in about a year and the one that had been planned was cancelled due to COVID-19.
-Facility interventions for falls were: physical therapy referral after a fall, look at where the resident was falling, alarms, lower the bed if needed, family to remove box spring, and door alarms.
-The facility did not use the bed alarms as the resident complained the alarms were to sensitive, it would alarm when they rolled over, and the resident could not rest.
-Staff were expected to make rounds every 2 hours but can be check hourly if needed.
-Staff document 72 hours after each fall, documenting their overall condition.
-The DON was responsible for "spearheading" what needed to be done for the resident.
-The DON was responsible for ordering additional fall prevention interventions if physical therapy alone was not successful at preventing falls.
-The DON assessed the resident and follows up if the resident requires hourly checks.
-If the resident had bruising after a fall or continued problems the DON would call the physician and discuss the concerns.

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D 270	Continued From page 42	D 270		

-Alarms were documented in the charting notes if they had one.
-Resident #3 had a wander guard placed on her as she had left the facility twice (in May) and was in the parking lot going back to her apartment and Resident #3 also had a door alarm on her door because she would wander into other residents' rooms.
-She had spoken with Resident #3's family during the yearly care plan meeting.
-Resident #3 was functioning with a walker.
-Resident #3 "likes attention".
-Resident #3 wanted a sitter but her family would not provide one.
-Resident #3 would use the bathroom on the carpet to get attention and was resistant to care.
-Physical Therapy and staff worked with Resident #3 on staying in her wheelchair.
-She was not aware of any seizure activity nor was she aware of the number of falls Resident #3 had experienced
-She did not recall the 06/18/20 incident where Resident fell backwards and appeared to have a 3-5-minute seizure.
-She thought the family had refused for her to go out for falls but she had no documentation to verify that.
-She did not speak with the family specifically about refusing to allow the Resident #3 to go out to be evaluated or specifically about Resident #3's falls.

Refer to the facility's policies and procedures for falls.

____
Review of a "Falls Policy" form had been provided by the Administrator on 08/18/20 at 11:22am revealed:
-In the event of a resident accident/incident

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D 270	Continued From page 43 immediate action would be taken in the best interest of the person and every attempt would be made to comply with their personal preferences in so far as possible. -The Medication Aide Supervisor will be responsible for completing the incident/accident report. -The physician will be notified immediately and the report will be faxed to his/her office for review. -The facility would attempt to notify the residents family member or legal represenative no later than 24 hours from the time if initial discovery and documented in the resident record, the 24 hour report and acute board. -Transfers would not be contingent upon being able to make said notification. -Any incident/accident that involved the resident falling or elopment which does not require medical treatment, with notificationto be as soon as possible but not to exceed 48 hours from the initial discovery or knowledge of the incident by staff and documented on the resident's medical record. -Vital signs were to be recorded in the resident's clinical record with nurses notes regarding the resident's condition each shift for 72 hours. _________________________ The facility failed to provide adequate supervision for 2 of 5 sampled residents (#1 and #3) who had multiple falls with no interventions for fall prevention resulting in a resident who was taking a blood thinner medication, falling causing multiple skin tears and hitting her head causing a sub-dural hematoma, and died (#1); and a second resident who had multiple falls with head injuries, skin tears, a seizure, and unresponsiveness that required hospitalization (#3). This failure resulted in placing residents at serious risk of physical harm and death and	D 270		

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D 270	Continued From page 44 constitutes a Type A1 Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/19/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2020.	D 270		
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 interviews and record reviews, the facility failed to ensure residents received care and services that were adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to supervision. The findings are: Based on interviews and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents with frequent falls and injuries in accordance with each resident's assessed needs, care plan and current symptoms (Resident #1 and #3) resulting in the death of one resident (Resident #1), no interventions for prevention of falls (Resident #1 and #3), and one	D912		

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D912	Continued From page 45 resident with falls hitting her face or head, bruising to the face, seizures, and unresponsiveness that required hospitalization (Resident #3). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D912		