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D 000	Initial Comments The Adult Care Licensure Section conducted an complaint investigation on November 21, 2019 to November 25, 2019	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 5 of 5 sampled residents (Resident #1, #2, #3, #4, and #5) related to falls. The findings are: Review of the facility's "Falls Management Program" revealed: -Residents were to be screened upon admission to the facility to determine factors that may contribute to possible falls. -Staff was to complete an Incident Report in its entirety for any fall. -Staff was to contact the resident's responsible party and primary care physician to notify them of	D 270		

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the fall.
-The Executive Director/Administrator was required to review all incident reports for contents, accuracy, and completeness.
-The Executive Director/Administrator and Care Manager was to determine any immediate interventions required, base on the circumstances of the fall.
-Residents were to have an assessment of possible risks and contributing factors to a fall within 72 hours of a fall.
-Contributing factors and risks of a fall consisted of lighting of location of the fall, clutter or trip hazards, cleared pathways, height of toilet seat, resident wearing shoes, medications administered or changes prior to fall, and proper use of assistive device.
-Residents with two or more falls within a four-week period were to have a physician's order for a physical therapy evaluation.
-All staff was to receive formal training on fall prevention awareness at a minimum of one annually by a qualified professional.
-All staff was to be reminded of fall prevention techniques during staff meetings.
-Staff was to complete a 72 hour follow up on residents falls to investigate possible circumstances contributing to the fall and document observations for the period of 72 hours after the fall.
-The Falls Management team was to review incident reports on a monthly basis.
-The Falls Management team consisted of the Executive Director/Administrator, Care Manager, medication aide/SIC, medication aide/Floor staff and any other discipline as determined by the team.
-The Falls Management team will review all resident falls from the past month for trends.
-Trends was to include: falls occurring on the

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same shift, repeat falls by the same resident, preventable falls due to the environment or medication changes, completeness of 72-hour follow up, interventions needed and documentation.

1. Review of Resident #1's current FL2 dated 07/08/19 revealed diagnoses included acute middle cerebral artery stroke (the largest cerebral artery), coronary artery disease, gastrointestinal bleed, physical deconditioning and anxiety.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/07/18.

Review of Resident #1's Guardianship document revealed Resident #1 was adjudicated incompetent.

Review of Resident #1's record revealed no initial screening upon admission to the facility to determine factors that may contribute to possible falls.

Review of Resident #1's care plan dated 10/02/19 revealed:
-Resident #1 used a walker for ambulation.
-Resident #1 required supervision with toileting, ambulation and locomotion, dressing, grooming and transfers.

a. Review of Resident #1's incident report dated 10/31/19 at 8:31am revealed:
-Resident #1 was found in her room, laying on her back, after an unwitnessed fall.
-Resident #1 had no injuries requiring first aid.
-Resident #1 was alert and verbal and had no complaint of pain.
-Resident #1 stated, "she was dizzy and fell".

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-Vital signs were obtained and blood pressure was 112/89, and pulse 72.
-It was documented the Guardian and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #1's care plan did not require updating.

Review of Resident #1's progress notes revealed:
-On 10/31/19 at 8:42am, a resident notified staff of Resident #1 laying on the floor, Resident #1 reported no injuries, BP 112/89.
-There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision or monitoring.

Review of Resident #1's November 2019 electronic Medication Administration Record (eMAR) revealed:
-The staff did not check vitals for 3 out of 9 shifts per their policy.
-The staff did not document changes or no changes for 3 out of 9 shifts per their policy.

Review of the white rounding book at the nurses station on 11/22/19 at 4:45pm revealed:
-The book was used to document hourly/30

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minute checks on residents.
-There was no documentation for hourly or 30 minute checks documented as performed on Resident #1 for 72 hours after her falls on 10/31/19.

b. Review of Resident #1's incident report dated 10/31/19 at 9:15am (second fall) revealed:
-Resident #1 was found in her room, laying on her back, after an unwitnessed fall.
-Resident #1 had no injuries requiring first aid.
-Resident #1 was alert and verbal and had no complaint of pain.
-Resident #1 stated she stood up and fell.
-Vital signs were obtained and blood pressure was 112/89, and pulse 72.
-Resident #1 was transported to the emergency room.
-It was documented the Guardian and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #1's care plan did not require updating.

Review of Resident #1's progress notes revealed:
-On 10/31/19 at 10:27am Resident #1 was found on the floor by another resident, stated she had sat up in the bed and felt dizzy and slid off the bed.
-There were no additional notes added to

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document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision or monitoring.

Review of Resident #1's November 2019 eMAR revealed:
-The staff did not check vitals for 3 out of 9 shifts per their policy.
-The staff did not document changes or no changes for 3 out of 9 shifts per their policy.

Review of the white rounding book at the nurses station on 11/22/19 at 4:45pm revealed:
-The book was used to document hourly/30 minute checks on residents.
-There was no documentation for hourly or 30 minute checks documented as performed on Resident #1 for 72 hours after her falls on 10/31/19.

c. Review of Resident #1's incident report dated 11/02/19 at 12:16pm revealed:
-Resident #1 was found in her room, laying on her back, after an unwitnessed fall.
-Resident #1 had no injuries requiring first aid.
-Resident #1 was alert and verbal and had no complaint of pain.
-Resident #1 stated, "she slid off her bed".
-Vital signs were obtained and blood pressure was 133/79, and pulse 88.
-It was documented the Guardian and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.

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-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #1's care plan did not require updating.

Review of Resident #1's progress notes revealed:
-On 11/02/19 at 1:27pm, Resident #1 refused to go to the hospital after a fall.
-There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision or monitoring.

Review of Resident #1's November 2019 eMAR revealed:
-The staff did not check vitals for 2 out of 9 shifts per their policy.
-The staff did not document changes or no changes for 1 out of 9 shifts per their policy.

Review of the white rounding book at the nurses station on 11/22/19 at 4:45pm revealed:
-The book was used to document hourly/30 minute checks on residents.
-There was no documentation for hourly or 30 minute documented as performed on Resident #1 for 72 hours after her falls on 11/02/19.

d. Review of Resident #1's incident report dated 11/06/19 at 9:45pm revealed:
-Resident #1 was found in her room, sitting on her bottom, after an unwitnessed fall.
-Resident #1 had no injuries requiring first aid.
-Resident #1 was alert and verbal and had no complaint of pain.

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-Resident #1 stated, "she was dizzy and fell".
-Vital signs were obtained and blood pressure was 145/88, and pulse 72.
-It was documented the Guardian and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #1's care plan did not require updating.

Review of Resident #1's progress notes revealed:
-There was not a progress note documented for the 11/06/19 fall at 8:31am.
-There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision or monitoring.

Review of Resident #1's November 2019 eMAR revealed;
-The staff did not check vitals for 5 out of 9 shifts per their policy.
-The staff did not document changes or no changes for 4 out of 9 shifts per their policy.

Review of Resident #1's hospital history and physical dated 11/09/19 revealed:
-Resident #1 had fallen 2 days ago and a deformity was noted to the right wrist and having

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black stools all week.
-Resident #1 was admitted on 11/09/19 for syncope, upper gastrointestinal (GI) bleed, a fracture of the right distal radius (one of two forearm bones located on the thumb side) and a fracture of the right ulnar styloid (a bone projection located on one of the two forearm bones located on the pinky finger side).
-Resident #1's principle discharge diagnosis included fracture of the right distal radius and ulnar styloid.
-Resident #1's discharge order included skilled services.

Review of Resident #1's progress notes revealed on 11/13/19 Resident #1 would not return from the hospital and would upgrade to a skilled facility.

Review of the white rounding book at the nurses station on 11/22/19 at 4:45pm revealed:
-The book was used to document hourly/30 minute checks on residents.
-There was no documentation for hourly or 30 minute checks documented as performed on Resident #1 for 72 hours after her falls on 11/06/19.

Telephone interview with Home Health Nurse on 11/21/19 at 9:50am revealed:
-Resident #1 was being seen by Home Health Nursing for nursing services.
-Her last visit was on 10/17/19.
-She provided services once a week and services included for neurological checks, safety, and fall prevention and lab draws, if ordered
-She opened Resident #1 to Home Health physical therapy evaluation on 11/08/19 after her last fall on 11/06/19, and after speaking with the Guardian for Resident #1.

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D 270	Continued From page 9 -She educated the medication aides (MAs) and the personal care aides (PCAs) weekly, on checking on Resident #1, ensuring clutter was removed from his room, pathways remained clear, and assistive devices remained within reach. Telephone interview with Resident #1's primary care provider (PCP) on 11/21/19 at 1:52pm revealed: -He was not notified of Resident #1's falls on 10/31/19 and 11/02/19 and 11/06/19. -He was received a fax on 11/07/19 requesting a mobile x-ray because Resident #1 was complaining of right wrist pain, swelling, bruising and unable to move it. There was no mention of the fall on 11/06/19 documented on the fax. -The Home Health Nurse called him on 11/08/19 for a PT referral and he gave a verbal order for an evaluation and treat. -He informed the staff on 11/08/19, Resident #1 required more supervision (every hour), and assistance with activities of daily living to help prevent future falls. -He gave an order to give as needed Tylenol for pain and approved the request for the mobile x-ray. Interview with a MA on 11/21/19 at 2:34pm revealed: -The routine checks were performed on the residents every 2 hours unless there was a behavioral issue or falls as instructed by the Resident Care Coordinator (RCC). -If there were behavioral issues or falls then the checks were every 30 minute as instructed by the RCC. -The every 30 minute checks were documented in the white book at the nurses station as instructed by the RCC.	D 270		

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D 270	Continued From page 10 -The pages in the book at the nurses station had one hour checks at the top but she was instructed by the RCC to mark out the "one hour" and write "30 minutes". -The 30 minute checks included observing the resident, check for "other than" the resident's normal behaviors or issues. -On 10/31/19 at 8:31am, Resident #1 was found on the floor by another resident who informed her. Resident #1 did not complain of pain. -On 10/31/19 at 9:15am, Resident #1 was found on the floor by another resident who informed her. Resident #1 complained of a little pain. -She was informed of Resident #1 falls on 11/02/19 and 11/06/19 by another MA and shift change. -She had not checked Resident #1's vital signs during any of the 72-hour checks except once on 11/08/19 during the 3:00pm to 11:00pm shift. She could not recall the time during the shift she checked Resident #1's vitals. -She had not documented vitals and any changes to Resident #1 on 10/31/19, 11/02/19 and 11/06/19 except on 11/08/19 on 11/08/19 on the 3:00pm to 11:00pm shift. She could not recall the time during the shift she checked Resident #1's vitals. -She did not check on Resident #1 every 2 hours, even though instructed by the RCC, because that was more than 2 MAs could handle because of the amount of care required for all of the residents. Interview with a PCA on 11/22/19 at 3:39pm revealed: -The RCC told her routine checks on the residents were every 2 hours were she was to visualize every resident and assist with anything the resident needed at that time. -She knew Resident #1 had a fall on 10/31/19	D 270		

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because that was her first day of work.
-When Resident #1 took a bath, she helped her get dressed.
-She did not check on Resident #1 every two hours because she only went into the room if the resident needed something or a specific task (time for meal, shower time, ...).
-She was trained to check every 30 minute checks after falls, just to make sure the floor was not cluttered in the resident's room.
-She checked one time during the shift and the floor was clear so she did not check every 30 minutes.

Telephone interview with a second MA on 11/23/19 at 12:00pm revealed:
-She was made aware Resident #1 had falls on 10/31/19, 11/02/19 and 11/06/19 during shift report.
-She was trained by the Resident Care Director (RCD) and RCC there were orders put in the computer to "alert" them to do the every shift documentation on "changes or no changes" and vitals every shift post fall for 72 hours.
-She was alerted when logging into Resident #1's eMAR to document vitals every shift for 72 hours after her falls on 10/31/19.
-She checked Resident #1's vital signs during the 72-hour checks and documented "no change" for 4 out of the 6 shifts she worked.
-The 2 shifts she did not document was because she was too busy with the residents during her shift (medications, falls, vitals, meals and showers).
-She did not check on Resident #1 every two hours for the same above reason.
-She was told by another MA and by the RCC Resident #1 was on every 30 minute checks on 11/03/19.
-The every 30 minute checks were to "lay eyes"

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D 270	Continued From page 12 on the resident and document in the book at the nurses station what the resident was doing or any issues. The book had not been used in awhile. -She did not do the every 30 minute checks just documented Resident #1 was "still on 30 minute checks" because she was too busy with the residents Telephone interview with a third MA on 11/24/19 at 4:00pm revealed: -On 11/06/19 at 9:45pm, Resident #1 was found on the bedroom floor by another MA. -She was informed about the falls on 10/31/19 and a fall on 11/02/19 during shift report. -She performed vital sign checks on Resident #1 on 11/03/19, 11/04/19 and on 11/06/19 after falls. -She did not document any "changes or not" during the 72-hour checks for Resident #1 at all during the month of November. -She did the 30-minute checks on Resident #1 on 11/02/19 and documented them in the book at the nurse's station. -Resident #1 was placed on the 72 hours fall prevention program after each of her falls. -She was told to report and document if anything changed for Resident #1. -She did not know she had to document if the resident had no changes every shift during the 72 hours after a fall. -When the Fall Prevention Program was initiated there was an alert on the eMAR that required you to document every shift vital signs and if there were changes or no changes for 72 hours. -She knew the Fall Prevention Program was not initiated on Resident #1 because she never saw the eMAR alert. -When she was hired the RCC told her the routine checks were every 2 hours and changed with falls to every 30 minutes for 72 hours and document in the progress notes.	D 270		

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D 270	Continued From page 13 -She did not check on Resident #2 every two hours or every 30 minutes after falls during the 72 hours after each fall. -She was always "busy" with her medication for residents and other tasks for her shift. -She documented Resident #1 was on 30 minute checks on 11/02/19 at 11:46pm as a "late entry" from a 1:27pm entry to document Resident #1 was still on 30 minute checks and continue to monitor, because she was "busy" with medications for residents and other tasks for her shift. She "forgot" to document the entry. Telephone interview with Resident #1's Guardian on 11/25/19 at 8:30am revealed: -The first time she saw Resident #1 was on 11/02/19 was when she was called about Resident #1 falling and hitting her head. -She instructed the staff to do every 30-minute checks because Resident #1 hit her head and had a visible bump to her head. -Resident #1 refused to go to the hospital and the emergency medical services refused to transport Resident #1 to the hospital for evaluation despite her being adjudicated incompetent. -She expected the facility to do every 30-minute checks, which would include checking on Resident #1 to assure her safety, ask Resident #1 about any complaints, administer any as needed medications, and to call her and the physician with any issues or complaints. -Resident #1 had a history of falls but she was never told about any injuries. -She was not notified about the fall that occurred on 11/06/19. Refer to interview with the Resident Care Coordinator on 11/22/19 at 11:33am. Refer to interview with the Resident Care Director	D 270		

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D 270	Continued From page 14 on 11/22/19 at 12:00pm. Refer to interview with the Administrator on 11/22/19 at 1:30pm. 2. Review of Resident #2's current FL2 dated 12/31/18 revealed: -Diagnoses included dementia disorientation, seizure disorder, osteoporosis, vitamin D deficiency, vitamin B12 deficiency, and history of hip fracture. -The resident was disoriented intermittently. -The recommended level of care was the assisted living facility. Review of Resident #2's record revealed no initial screening upon admission to the facility to determine factors that may contribute to possible falls. Review of Resident #2's care plan dated 11/28/18 revealed: -Resident #2 was forgetful and needed reminders. -Resident #2 used a walker for ambulation. -Resident #2 was independent in eating, toileting, ambulation, dressing, grooming, and transfers. -Resident #2 required supervision with bathing. -There were no updates to the original care plan dated 11/28/18. a. Review of Resident #2's incident report dated 11/13/19 at 5:30pm revealed: -Resident #2 was found sitting on the floor of his room after an unwitnessed fall. -Resident #2 had no injuries requiring first aid. -Resident #2 was alert and verbal and had no complaint of pain. -Resident #2 stated, "he had slipped and fell."	D 270		

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-Vital signs were obtained and blood pressure was 154/82, and pulse 94.
-The family and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #2's care plan did not require updating.

Review of Resident #2's progress notes revealed:
-On 11/13/19 at 6:28pm, Resident #2's roommate notified staff of resident being on the floor, resident report he just fell, a plastic bag was beside resident's foot and no complaints of pain.
-On 11/13/19 at 11:17pm, Resident #2's temperature 98.6, pulse 67, respirations 18, and blood pressure was 155/90.
-There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision.

b. Review of Resident #2's incident report dated 11/17/19 at 11:00am revealed:
-Resident #2 was found in his room without injury after an unwitnessed fall.
-Resident #2 had no injuries requiring first aid.
-Resident #2 was alert and verbal and had no complaint of pain.
-Vital signs were obtained and blood pressure

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was 151/89, respirations 20, temperature 97.9, and pulse 81.
-The family and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #2's care plan did not require updating.

Review of Resident #2's progress notes revealed:
-An entry dated 11/17/19 at 2:25pm when Resident #2 had a second fall.
-There was no documentation to increase supervision.

c. Review of Resident #2's incident report dated 11/17/19 at 2:00pm revealed:
-Resident #2 was found in his room with a head injury after an unwitnessed fall.
-Resident #2 was sent to the emergency room by ambulance.
-Resident #2 was alert and verbal and had no complaint of pain.
-Vital signs were obtained blood pressure was 138/78, respirations 20, temperature 98.1, and pulse 90.
-The family and the physician were notified.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries

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related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #2's care plan did not require updating.

Review of Resident #2's hospital discharge dated 11/19/19 revealed:
-Resident #2 had fallen and sustained a laceration to left forehead with a significant hematoma.
-Resident #2 was admitted on 11/17/19 for observation and ongoing neurological assessment.
-Resident #2's principle discharge diagnosis was a subarachnoid hemorrhage.
-There were referrals for home health skilled nursing, and physical therapy.

Review of Resident #2's progress notes revealed:
-On 11/19/19, Resident #2 returned from hospital with discharge diagnosis of subarachnoid hemorrhage, "will follow up with physician on next visit."
-On 11/19/19 at 11:07pm, Resident #2's temperature 98.7, pulse 78, respirations 18, and blood pressure was 128/78.
-On 11/20/19 at 6:38am, Resident #2's temperature 98.8, pulse 71, respirations 18, and blood pressure was 151/75.
-On 11/20/19 at 10:12pm, Resident #2's temperature 98.8, pulse 83, respirations 18, and blood pressure was 127/70.
-On 11/21/19 at 1:21pm "resident has done very good today, no complaints on anything".
-There were no additional notes added to document 72-hour monitoring that was required

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according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision.

Review of Resident #2's November 2019 electronic Medication Administration Record (eMAR) revealed:
-Resident #2's vital signs were not documented four out of nine times during the 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation of increased supervision.

Observation of Resident #2's room on 11/21/19 at 9:40am revealed:
-Resident #2's bed was located on the far wall of the room.
-The pathway to his bed from the doorway was wide enough for a walker.
-Along the pathway there was shoes and clothes on the floor.
-Resident #2's surface of his bed was approximately 40 inches off the floor.
-Upon entrance to Resident #2's room he sat up on his bed swinging his feet over the edge of the bed.
-Resident #2 remained sitting on the edge of his bed with his feet dangling approximately 8-10 inches from the floor.

Interview with Resident #2 on 11/21/19 at 9:40am revealed:
-He fell getting off his bed on 11/17/19.
-He could not remember exactly what caused him to fall.
-When he got out of bed he slid to the edge of the bed and reached for his walker wearing his socks.

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-The next thing he remembered he was on the floor and his head was bleeding.
-He routinely got out of his bed with his socks on his feet, stood up, reached for his walker, and sat in the chair at the end of his bed to put on his shoes.
-The staff came into his room to bring him medications, remind him of a meal time, time of a bath, or clean the bathroom.
-The staff did not come into his room to ask him if he needed anything or check on him after his falls.

Interview with Resident #2's roommate on 11/21/19 at 9:50am revealed:
-Resident #2 depended on her to pick up his belongings off the floor.
-She assisted him with making sure his walker was always close by when he needed it.
-The staff did not come into their room to check on Resident #2 more frequently after the falls, or to help with dressing and clearing the floor of items.

Interview with a personal care aide (PCA) on 11/21/19 at 1:45pm revealed:
-She found Resident #2 after his second fall on 11/17/19.
-She did not know Resident #2 had a fall earlier in the day on 11/17/19.
-She was in the dining room cleaning up the dishes after the lunch meal when Resident #2 fell on 11/17/19.
-She checked on residents when they called for her assistance.
-Resident #2 asked her to assist him with dressing and putting his shoes on at times.
-After she assisted Resident #2 with his bath, she helped him dress and put his shoes on.
-Resident #2 would forget to put his shoes on

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when he got out of bed and get up in his socks on the slippery floor.
-She was never told to check on Resident #2 every two hours.
-She was not told to check on Resident #2 more frequently after his falls.

Interview with a first shift medication aide (MA) on 11/21/19 at 10:30am revealed:
-She was made aware Resident #2 had falls on 11/13/19 and 11/17/19 during shift report.
-She was alerted when logging into Resident #2's eMAR to document vitals every shift for 72 hours after his fall.
-She had checked Resident #2's vital signs close to the end of her shift during the 72-hour checks.
-She did not know why she had not documented vitals and any changes to Resident #2 on 11/19/19 to 11/21/19.
-She must have forgotten to document his vitals because she was too busy.
-She did not check on Resident #2 every two hours.
-She was not told to check on Resident #2 more frequently after his falls.

Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed:
-She knew Resident #2 had three falls in the past two weeks.
-Resident #2 was placed on the 72 hours fall prevention program after his last fall on 11/17/19.
-During the 72 hours Resident #2's vital signs were checked every shift and documented.
-She was told to report and document if anything changed for Resident #2.
-She did not know she had to document if the resident had no changes every shift.
-She did not check on Resident #2 every two hours.

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D 270	Continued From page 21 -She helped Resident #2 when he used his call bell requesting assistance. -She had to remind him all the time to use his call bell because he was forgetful. -She was not told to check on Resident #2 more frequently after his falls. Telephone interview with Home Health Nurse on 11/25/19 at 2:01pm revealed: -Resident #2 was being seen by Home Health Nursing, Physical Therapy, and Occupational Therapy. -She opened Resident #2 to Home Health services after he fell on 11/13/19. -She was seeing Resident #2 twice a week for labs, neuro checks, safety, and fall prevention. -She educated the MAs and PCAs on checking on Resident #2 ensuring clutter was removed from his room, pathways remained clear, and assistive devices remained within reach each time she visited the resident. Interview Resident #2's primary care provider (PCP) on 11/25/19 at 1:00pm revealed: -He was notified of Resident #2's falls on 11/13/19 and 11/17/19. -He was scheduled to see Resident #2 today for hospital follow-up visit today. -He was not sure what exactly had caused Resident #2 to fall. -Resident #2 was being seen by Home Health nursing, physical therapy and occupational therapy since Resident #2 fall on 11/13/19. -When he was notified by the facility of Resident #2's fall on 11/13/19 he gave an order for Home Health to treat and evaluate. -Resident #2 required more supervision and assistance with activities of daily living to prevent future falls.	D 270		

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D 270	Continued From page 22 Attempted telephone interview with Resident #2's Physical Therapist on 11/25/19 at 2:30pm was unsuccessful. Attempted telephone interview with Resident #2's Occupational Therapist on 11/25/19 at 2:45pm was unsuccessful. Refer to interview with the Resident Care Coordinator on 11/22/19 at 11:33am. Refer to interview with the Resident Care Director on 11/22/19 at 12:00pm. Refer to interview with the Administrator on 11/22/19 at 1:30pm. 3. Review of Resident #3's current FL2 dated 03/18/19 revealed: -Diagnoses included dementia, overactive bladder, hypothyroidism, deafness, depression, insomnia, hypertension, and anxiety disorder. -The resident was disoriented constantly. -The recommended level of care was the Assisted Living Facility. -The resident was incontinent of bladder. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 07/31/17. Review of Resident #3's record revealed no initial screening upon admission to the facility to determine factors that may contribute to possible falls. Review of Resident #3's care plan dated 11/28/18 revealed: -Resident #3 was forgetful and needed reminders.	D 270		

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D 270	Continued From page 23 -Resident #3 required supervision with eating, toileting, ambulation, dressing, grooming, bathing, and transfers. -There were no updates to the original care plan dated 11/28/18. Review of Resident #3's incident report dated 10/04/19 at 7:00pm revealed: -Resident #3 was found in his room without injury after an unwitnessed fall. -Resident #3 had no injuries requiring first aid. -Resident #3 was sent to the emergency room on 10/04/19 at 7:30pm. -Resident #3 was unresponsive. -Vital signs were obtained and blood pressure was 132/80, respirations 20, and pulse 76. -The family and the physician were notified. -The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift. -The notes section did not contain a post fall assessment. -The evaluation section indicated Resident #3's care plan did not require updating. Review of Resident #3's hospital discharge summary dated 10/04/19 revealed: -Resident #3 diagnosis was a fall with closed head injury. -Resident #3 had a fall with loss of consciousness possibly hitting her head. -Resident #3 denied any pain, no distress, was alert and orientated and released to return to the facility. Review of Resident #3's progress notes revealed: -On 10/04/19 at 10:49pm, "Resident fell in room and was unconscious and became responsive after a few minutes, resident was taking to	D 270		

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emergency by emergency medical services, all scans clear (nurse notified, medtech/sic by phone), resident returned to facility at 10:35pm, family brought resident back themselves, no complaints at this time, will continue to monitor resident."
-On 10/07/19 at 12:05am "Resident had a good night and blood pressure was good."
-On 10/07/19 at 12:56pm "Resident was examined by primary care physician today related to fall on 10/04/19, no new orders."
-There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation indicating an increase in supervision.

Review of Resident #3's October 2019 electronic Medication Administration Record (eMAR) revealed resident's vital signs had been documents every shift for three days from 10/04/19 to 10/07/19.

Interview with Resident #3's responsible party (RP) on 11/21/19 at 9:25am revealed:
-Resident #3 had fallen last month, he did not recall the date.
-He was notified Resident #3 had fallen and was unresponsive.
-When he came to the facility, he asked emergency medical services (EMS) to take her to the hospital.
-By the time the EMS took her to the hospital Resident #3 became more responsive.
-Resident #3 returned to the facility the same evening.
-Resident #3 told him she fell because she was attempting to move too fast.
-He did not know how often staff visited Resident

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D 270	Continued From page 25 #3 throughout the day to check on her. Interview with a personal care aide (PCA) on 11/21/19 at 1:45pm revealed: -She did not know Resident #3 had a fall on 10/04/19. -Resident #3 asked her to help her make her bed at times. -When Resident #3 took a bath, she helped her get dressed. -She did not check on Resident #3 every two hours. -She was too busy to check on every resident every two hours. -She had not been told to check on every resident every two hours or more frequently after her falls. Interview with a first shift medication aide (MA) on 11/21/19 at 10:30am revealed: -She did not know Resident #3 had a fall on 10/04/19. -She was not able to remember all the resident's falls in the past month. -She did not check on Resident #3 every two hours. -She was not told to check on Resident #3 every two hours or more frequently after her falls. Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last month. -She had not been told to do anything differently for Resident #3 to prevent falls. -She had check Resident #3's vital signs on her shift when she worked. -She did not check on Resident #3 every two hours. -She was not told to check on Resident #3 every two hours or more frequently after her falls.	D 270		

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D 270	Continued From page 26 Telephone interview with Home Health Nurse on 11/25/19 at 2:01pm revealed: -She opened Resident #3 to Home Health services after she fell on 10/04/19. -Resident #3 was being seen by Home Health Nursing (HHN) and Physical Therapy (PT). -She was seeing Resident #3 weekly to educate the resident and staff. -She had been educating the staff and Resident #3 weekly on signs and symptoms of recurrent urinary tract infection and fall precautions. -She educated the MAs and PCAs to check Resident #3's environment to keep pathways clear, encourage her to use her call bell, and slow her pace when ambulating to prevent tripping during every visit. Interview Resident #3's primary care provider (PCP) on 11/25/19 at 1:00pm revealed: -He was notified of Resident #3's fall on 10/04/19. -He saw Resident #3 on 10/07/19 to assess her after the hospitalization from the fall. -He was not sure what exactly had caused Resident #3 to fall. -He had treated her for a urinary tract infection and consulted home health. -Resident #3 required more supervision and assistance with activities of daily living to prevent falls. Attempted telephone interview with Resident #3's Physical Therapist on 11/25/19 at 2:30pm was unsuccessful. Refer to interview with the Resident Care Coordinator on 11/22/19 at 11:33am. Refer to interview with the Resident Care Director on 11/22/19 at 12:00pm.	D 270		

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D 270	Continued From page 27 Refer to interview with the Administrator on 11/22/19 at 1:30pm. 4. Review of Resident #4's current FL2 dated 09/19/19 revealed: -Diagnoses included unspecified dementia, right hip fracture, and muscle weakness. -The resident was semi-ambulatory with the use of a wheelchair. -The recommended level of care was the Assisted Living Facility. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 10/01/19. Review of Resident #4's record revealed no initial screening upon admission to the facility to determine factors that may contribute to possible falls. Review of Resident #4's care plan dated 10/14/19 revealed: -Resident #4 was forgetful and needed reminders. -Resident #4 required assistance with ambulation, dressing, grooming, and bathing. -Resident #4 required supervision with transfers. -There were no updates to the original care plan dated 10/14/19. Review of Resident #4's incident report dated 11/01/19 at 12:52pm revealed: -On 10/31/19 at 3:10am, Resident #4 was found in her room with abrasions, bruising, a laceration, and skin tear after an unwitnessed fall. -Resident #4's injury required pressure applied to her head. -Resident #4 stated "she slipped out of bed." -Resident #4 was found sitting on the floor beside	D 270		

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bed, right arm skin tear, and head was bleeding.
-Resident #4 was sent to the emergency room on 10/31/19 at 3:10am.
-Vital signs were obtained and blood pressure was 99/48, respirations 18, temperature 98.6, and pulse 83.
-The Fall Prevention Program directive instructions were initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall.
-The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes".
-The notes section did not contain a post fall assessment.
-The evaluation section indicated Resident #4's care plan did not require updating.

Review of Resident #4's hospital discharge summary dated 10/31/19 revealed:
-Resident #4 diagnoses included a fall with hematoma to left side of head, knot to right forearm with a skin tear.
-Resident #4 was treated in the emergency room and returned to the facility.

Review of Resident #4's progress notes revealed:
-On 10/31/19 at 5:12am, "Resident hit her head and it started bleeding and she has a skin tear on her right arm, she slid out of bed."
-On 10/31/19 at 2:38pm, "Resident observed propelling up and down hallway in wheelchair today, noted to be in a pleasant mood, denies pain at this time.
-On 11/01/19 at 9:03pm, Resident denied pain and started presenting with bruising to her left eye.
-On 11/02/19 at 11:02am, Resident has bruising

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around her left eye, when asked if she had any pain, she said no it hasn't bothering her too bad.
-On 11/03/19 at 6:31am, Resident requested Tylenol, blood pressure 121/72, temperature 96.9, respirations 18, and pulse 90.
-On 11/04/19 at 4:24am, Resident requested Tylenol for right arm pain, blood pressure 117/54, temperature 97.6, respirations 18, and pulse 80.
-There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention Program.
-There was no documentation indicating increase in supervision during the 72-hour monitoring.

Review of Resident #4's October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed resident's vital signs had been documents every shift for three days from 10/31/19 to 11/03/19.

Interview with Resident #4 on 11/21/19 at 1:30pm revealed:
-She fell on her face when she was sitting on the edge of her bed attempting to put her shoe on.
-She did not call out for the staff to help her because they did not help her when she asked for help.
-The staff did not check on her more frequently after she fell.

Interview with Resident #4's responsible party (RP) on 11/21/19 at 9:25am revealed:
-Resident #4 told her with clarity that the staff did not check on Resident #4 every two hours or more frequently since her fall.
-When she visited Resident #4 after her fall the staff did not check on Resident #4 more frequently.

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D 270	Continued From page 30 Interview with a personal care aide (PCA) on 11/21/19 at 2:45pm revealed: -She knew Resident #4 had a fall on 10/31/19 because she saw the bruising on her face. -She helped Resident #4 when she asked for help. -She did not check on Resident #4 every two hours. -No one had told her to check on the residents every two hours. Interview with a first shift medication aide (MA) on 11/21/19 at 10:30am revealed: -She knew Resident #4 had a fall because she saw the bruising on her face. -She did not check on Resident #4 every two hours. -She was not told to check on Resident #4 every two hours or more frequently after falls. Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #4 had a fall last month. -She had not been told to do anything differently for Resident #4 to prevent falls. -She did not check on Resident #4 every two hours. -She was not told to check on Resident #4 every two hours or more frequently after falls. Telephone interview with Home Health Nurse on 11/25/19 at 2:01pm revealed: -She opened Resident #4 to Home Health services after she fell on 10/31/19. -Resident #4 was being seen by Home Health Nursing (HHN) and Physical Therapy (PT). -She had been educating the staff and Resident #4 twice weekly on signs and symptoms of infection related to her wound and fall precautions.	D 270		

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-She educated the MAs and PCAs to check Resident #4's environment to keep pathways clear, encourage her to use her call bell, and lock her wheelchair when transferring during every visit.

Interview Resident #4's primary care provider (PCP) on 11/25/19 at 1:00pm revealed:
-He was notified of Resident #4's fall on 10/31/19.
-He saw Resident #4 to assess her after the hospitalization from the fall.
-He was not sure what exactly had caused Resident #4 to fall.
-He wrote an order for home health nursing and physical therapy.
-Resident #4 required more supervision and assistance with activities of daily living to prevent falls.
Attempted telephone interview with Physical Therapist on 11/25/19 at 2:30pm was unsuccessful.

Refer to interview with the Resident Care Coordinator on 11/22/19 at 11:33am.

Refer to interview with the Resident Care Director on 11/22/19 at 12:00pm.

Refer to interview with the Administrator on 11/22/19 at 1:30pm.

5. Review of Resident #5's current FL2 dated 11/28/18 revealed diagnoses included generalized muscle weakness, memory deficit, hypertension, and cerebral vascular accident.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 04/27/17.

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D 270	Continued From page 32 Review of Resident #5's record revealed no initial screening upon admission to the facility to determine factors that may contribute to possible falls. Review of Resident #5's care plan dated 07/05/19 revealed: -Resident #5 used a wheelchair for ambulation. -Resident #5 required limited assistance with toileting. -Resident #5 required extensive assistance with ambulation and locomotion, dressing, grooming and transfers. a. Review of Resident #5's incident report dated 10/27/19 at 7:00am revealed: -Resident #5 was found in her bathroom, sitting on the toilet holding onto the bar, with a small knot on her head, after an unwitnessed fall. -Resident #5 reported a bump to the forehead which did not require first aid. -Resident #5 was alert and verbal and complained of pain to the forehead. -Resident #5 stated she, "didn't feel good and her head was hurting". -Vital signs were not obtained and Resident #5 was transported to the hospital. -Resident #5 was discharged from the hospital on 10/27/19 with a diagnosis of dehydration and to follow up with the primary care provider (PCP). -The family and the physician were notified. -The Fall Prevention Program directive instructions included an order with the following instructions: monitor for 72 hours with special instructions to chart progress notes daily 10/27/19 to 11/13/19. -The notes section did not contain a post fall assessment. -The evaluation section indicated Resident #5's care plan did not require updating.	D 270		

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D 270	Continued From page 33 Review of Resident #5's progress notes revealed: -There were no progress notes for 10/27/19 to 11/13/19 documented in Resident #5's record or available. -There was no documentation indicating increase in supervision during the 72-hour monitoring. b. Review of Resident #5's incident report dated 11/04/19 at 6:00pm revealed: -Resident #5 was found in her room, lying face first on the floor, after an unwitnessed fall. -Resident #5 had no injuries requiring first aid. -Resident #5 was alert and verbal and had no complaint of pain. -Vital signs were obtained and temperature 97.9, blood pressure was 139/84, respirations, 18 and pulse 66. -Resident #1 was not transported to the emergency room. -The family and the physician were notified. -The Fall Prevention Program directive instructions was initiated with the following instructions: check vital signs for three days every shift, monitor for 72 hours for bruising, change in mental status or condition, pain, and other injuries related to the fall. -The Fall Prevention Program directive instructions included special instructions to document any "changes or no changes". -The notes section did not contain a post fall assessment. -The evaluation section indicated Resident #5's care plan did not require updating. Review of Resident #5's progress notes revealed: -There were no progress notes for 11/04/19 to 11/07/19 documented in Resident #5's record or available. -There was no documentation indicating increase	D 270		

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D 270	Continued From page 34 in supervision during the 72-hour monitoring. Review of Resident #5's November 2019 electronic Medication Administration Record (eMAR) revealed: -The staff did not check vitals for 1 out of 9 shifts per their policy. -The staff did not document changes or no changes for 2 out of 9 shifts per their policy. Review of Resident #5's record on 11/21/19 revealed Resident #5 expired on 11/13/19, not related to the falls. Telephone interview with Home Health Nurse on 11/21/19 at 9:50am revealed: -Resident #5 was being seen by Home Health Nursing for nursing services. -She opened Resident #5 to Home Health on 11/04/19 after her last fall and seizure on 11/04/19 for nursing services, and Occupational Therapy to evaluate due to left hand contractures. -She was seeing Resident #5 twice a week for labs, neuro checks, safety, and fall prevention. -She educated the MAs and PCAs, during visits, about checking on Resident #5 ensuring clutter was removed from her room, pathways remained clear, and assistive devices remained within reach. -On 11/07/19 Resident #5 was evaluated for Hospice services and approved. Telephone interview Resident #5's primary care provider (PCP) on 11/21/19 at 1:52pm revealed: -He was notified of Resident #5's falls on 10/27/19, 10/28/19 and 11/04/19. -He informed the Resident Care Director (RCD), Resident #5 required more supervision and assistance with activities of daily living to prevent future falls especially since Resident #5 was	D 270		

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having seizures (the RCD was present during all of his visits with the residents at the facility).
-Resident #5's last seizure was on 10/04/19.

Interview with a medication aide (MA) on 11/21/19 at 2:34pm revealed:
-The routine checks were performed on the residents every 2 hours unless there was a behavioral issue or falls as instructed by the Resident Care Coordinator (RCC).
-If there were behavioral issues or falls then the checks were every 30 minute as instructed by the RCC.
-The every 30 minute checks were documented in the white book at the nurses station as instructed by the RCC.
-The pages in the book at the nurses station had one hour checks at the top but she was instructed by the RCC to mark out the "one hour" and write "30 minutes".
-The 30 minute checks included observing the resident, check for "other than" the resident's normal behaviors or issues.
-She would check on Resident #5 every 2 hours some of the time and some of the time she would check on Resident #5 more often, because that was more than 2 MAs could handle because of the amount of care required for all of the residents.
-She was told by the RCD after Resident #5's scans on 10/04/19 Resident #5 would continue to have issues with seizures and needed more supervision (more than every 2 hours), and assistance with activities of daily living (ADL's).
-She was told about Resident #5 falls on 10/27/19 and 10/28/19 and 11/04/19 by another MA at shift change.
-She had not checked Resident #5's vital signs during any of the 72-hour checks, because that was more than 2 MAs could handle because of

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the amount of care required for all of the residents.
-She had not documented vitals and any changes to Resident #5 on 10/27/19, 10/28/19 and 11/04/19.

Interview with a personal care aide (PCA) on 11/22/19 at 3:39pm revealed:
-She knew Resident #5 had a fall on 11/04/19 after shift report.
-She helped Resident #5 with a bath, she helped her get dressed and assisted with transfers.
-She was told by the Resident Care Coordinator (RCC), Resident #5 required 2 persons assist with transfers because Resident #5 could have a seizure at any time and would fall.
-She did not check on Resident #5 any more than every two hours.
-She had been told to check on every resident every two hours.
-She was not trained to check more than every 2 hours after falls, just to make sure the floor was not cluttered in the resident's room and always 2 persons assist with transfers.

Telephone interview with Resident #5's family member on 11/22/19 at 4:10pm revealed:
-She was informed about Resident #5's falls.
-She was informed by the MAs that Resident #5 would have 2 people assist her so if she had a seizure she would not get hurt.
-With the falls on 10/27, 10/28//19 and 11/04/19 Resident 5 was "found" and not being assisted.
-If Resident #5 was checked on every 30 minutes she thought the falls could have been avoided or at least less falls.
-There were 6 other falls other than 10/27/19, 10/28/19 and 11/04/19, all without injuries.

Telephone interview with a second MA on

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D 270	Continued From page 37 11/23/19 at 12:00pm revealed: -She was trained by the Resident Care Director (RCD) and RCC there were orders put in the computer to "alert" them to do the every shift documentation on "changes or no changes" and vitals every shift post fall for 72 hours. -The every 30 minute checks were to "lay eyes" on the resident and document in the book at the nurses station what the resident was doing or any issues. The book had not been used in awhile. -She did not do the every 30 minute checks just documented Resident #1 was "still on 30 minute checks" because she was too busy with the residents -She was made aware Resident #5 had falls on 10/28/19, during shift report. -On 10/27/19, she found Resident #5 sitting on her bathroom toilet with a knot on her forehead. -Resident #5 complained of her head hurting but was not sent out to the hospital. -She was alerted when logging into Resident #5's eMAR to document vitals every shift for 72 hours after her falls on 10/27/19. -On 11/04/19, she found Resident #5 face down in her bedroom floor. Resident #5 denied pain and was not sent to the hospital. -She checked Resident #5's vital signs during the 72-hour checks and documented "no change" for 1 out of the 3 shifts she worked. -The 2 shifts she did not document was because she was too busy with the residents during her shift (medications, falls, vitals, meals and showers). -She did not check on Resident #5 every two hours for the same above reason. A telephone interview with a third MA on 11/24/19 at 4:00pm revealed: -She was informed about Resident #5's falls on 10/27/19, 10/28/19 and a fall on 11/04/19 during	D 270		

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D 270	Continued From page 38 shift report. -When the Fall Prevention Program was initiated there was an alert on the eMAR that required you to document every shift vital signs and if there were changes or no changes for 72 hours. -She was alerted when logging into Resident #5's eMAR to document vitals every shift for 72 hours after her falls on 10/27/19, 10/28/19 and 11/04/19. -She did not document any changes or no changes during the 72-hour checks for Resident #5 at all during the month of October or November. -She was always "busy" with her medication for residents and other tasks for her shift. -She could not recall doing the 30-minute checks on Resident #5 on 10/27/19, 10/28/19 and 11/04/19. -Resident #5 was placed on the 72 hours fall prevention program after her fall on 10/27/19, 10/28/19 and 11/04/19. -During the 72 hours Resident #5's vital signs were checked every shift and documented. -She was told to report and document if anything changed for Resident #5. -She did not know she had to document if the resident had no changes every shift. -She did not check on Resident #5 every two hours because she was always "busy" as stated above. Refer to interview with the Resident Care Coordinator on 11/22/19 at 11:33am. Refer to interview with the Resident Care Director on 11/22/19 at 12:00pm. Refer to interview with the Administrator on 11/22/19 at 1:30pm.	D 270		

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D 270	Continued From page 39 Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 11:33am revealed: -She did not remember seeing the Fall Prevention Program policy until today. -The staff member who reported a fall completed an Incident Report when a resident had a fall. -She reviewed the Incident Reports for completeness and assisted the staff in completing the report. -She did not instruct the PCAs and MAs to increase monitoring of residents who had falls. -The PCAs were expected to check on residents as needed and assist residents with personal care. -She initiated the Fall Prevention Program directives for the MAs to document vital signs and parameter notes every shift for 72 hours. -The MAs were to document vital signs every shift for 72 hours. -The MAs were to report and document any changes for the residents during the 72 hours. -She did not check on residents placed on 72-hour checks to review a resident's care. -She did not review the MAs documentation during the 72-hour checks. -She met with the Resident Care Director and Administrator to discuss resident falls monthly. -She was not aware of a formal training for the staff for fall prevention provided annually. Interview with the Resident Care Director (RCD) on 11/22/19 at 12:00pm revealed: -She had not seen the Fall Prevention Program policy until today. -She had not completed a fall screening upon admission of residents to determine factors that may contribute to falls. -No one had told her she was responsible for completing the fall screening upon admission. -She met with the RCC, Physical Therapist, and	D 270		

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D 270	Continued From page 40 Administrator monthly to discuss the falls for the past month. -The RCC reviewed Incident Reports related to all the falls during the first 72 hours after the fall. -She did visits residents who had fallen to assess residents and put interventions in place to prevent future falls. -The PCAs and MAs were expected to check on every resident every hour. Interview with the Administrator on 11/22/19 at 1:30pm revealed: -She knew the residents who had falls. -She had met with the RCD, RCC, and PT to discuss monthly falls. -During the monthly falls meeting the clinical staff presented the names of the residents who had fallen, determine if a fall was preventable and discuss step the team would implement to assist in preventing the fall again. -She did not review each fall incident report on each resident. -She did not visit the residents and discuss their fall with them. -She did not have a system in place to ensure all areas of the facility fall policy was addressed. The facility failed to provide supervision for 5 of 5 sampled residents, based on their assessed needs and facility policy, Resident #1 who had 4 falls in one week with one resulting in two fractures in her right wrist. Resident #2 who had three falls within a two week time period with one resulting in a hospitalization with a diagnosis of subarachnoid hemorrhage, Resident #3 who had fallen and was hospitalized with a closed head injury, Resident #4 who had fallen on a blood thinner and was sent to the emergency room with a diagnoses of traumatic hematoma of forehead and skin tear to upper extremity, and Resident	D 270		

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D 270	Continued From page 41 #5 had three falls within a week with one resulting to a head injury. This failure to provide supervision to residents resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/22/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2019	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the acute health care needs for 1 of 5 sampled residents related to delayed treatment for a resident who had black tarry stools, dizziness and weakness and in regard to delayed treatment for two fractures of the right wrist after a fall, (Resident #1).	D 273		

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D 273	Continued From page 42 The findings are: Review of Resident #1's current FL2 dated 07/08/19 revealed diagnoses included acute middle cerebral artery stroke (the largest cerebral artery), coronary artery disease, gastrointestinal bleed, physical deconditioning and anxiety. Review of Resident #1's care plan dated 10/02/19 revealed: -Resident #1 used a walker for ambulation. -Resident #1 required supervision with toileting, ambulation and locomotion, dressing, grooming and transfers. Review of Resident #1's Guardianship document revealed Resident #1 was adjudicated incompetent. a. Review of Resident #1's Incident Report dated 11/06/19 at 9:45pm, revealed Resident #1 was found in her room, sitting on her bottom, after an unwitnessed fall. Resident #1 stated she was dizzy and fell. Review of Resident #1's hospital history and physical dated 11/09/19 revealed: -Resident #1 was admitted to the hospital 11/08/19 at 11:05 pm. -Resident #1 had fallen 2 days ago and a deformity was noted to the right wrist. -Resident #1 was admitted on 11/08/19 for fracture of the right distal radius (one of two forearm bones located on the thumb side) and a fracture of the right ulnar styloid (a bone projection located on one of the two forearm bones located on the pinky finger side). -Resident #1's principle discharge diagnoses were acute Cameron ulcer, upper GI bleed,	D 273		

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fracture of the right distal radius and ulnar styloid, and hypokalemia.
-Resident #1 was discharged from the hospital to a skilled nursing facility on 11/13/19.

Telephone interview with Resident #1's Guardian on 11/25/19 at 8:30am revealed:
-She was not notified about the fall that occurred on 11/06/19.
-On 11/08/19, she was contacted by the family member informing her Resident #1 fell a few days prior, complained of right wrist pain and swelling and an x-ray was ordered but not done.
-She was asked by the family member to come to the facility and have them send Resident #1 out due to increased pain, swelling and unable to move right wrist.
-Resident #1 had a history of falls but she was never told about any injuries.
-She went to the facility on 11/08/19 and told the facility to send Resident #1 to the hospital for the x-ray.
-Resident #1 was transported to the hospital on 11/08/19 and admitted for GI bleed and fracture of the right distal radius and fracture of the right ulnar styloid.
-The physician at the hospital told her Resident #1's hemoglobin (Hgb) was dangerously low and a low Hgb could lead to dizziness and falls (Hgb, a protein responsible for transporting oxygen in the blood and the normal range is 11.5-15.0).
-She expected the staff to follow up on concerns of the family or complaints from Resident #1 as soon as they were given the concerns.
-It was possible if staff had responded to their concerns, Resident #1 may not have ended up with a GI bleed, dizziness and fractures from the fall.

Telephone interview with Resident #1's family

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member on 11/25/19 at 10:16am revealed:
-She was informed of Resident #1's falls when she visited.
-She was informed by the medication aide (MA) on 11/06/19, Resident #1 fell earlier and during the shower noticed Resident #1's right wrist was swollen and discolored and Resident #1 could not move her fingers.
-She saw Resident #1's right wrist and noticed it was swollen and "crooked".
-She asked the MA to send Resident #1 out to the hospital and was told again could not do anything until told by the Guardian.
-She tried to call the Guardian again, there was no answer and she left a voice mail to call her back.
-On 11/07/19, she reported to 2 different MAs that Resident #1's arm was broken and needed to be seen.
-She was told by one MA the x-ray would be done on 11/08/19. She asked why the x-ray was taking 2 days when Resident #1 was in pain and she was told by one MA it was because "that's when it could be done".
-On 11/08/19, while visiting Resident #1 still had no x-ray so she called the Guardian again and was able to talk to get on the phone.
-She informed the Guardian about Resident #1's falls and arm with pain swelling and unable to move the right wrist and the x-ray was ordered 2 days ago and still had not been done.
-The Guardian came and had the facility send Resident #1 to the hospital.
-On 11/08/19, while at the hospital she was told Resident #1 was admitted for a GI bleed and broken wrist and arm.

Review of Resident #1's progress notes revealed:
-On 11/07/19 at 5:08pm, Resident #1 complained of right wrist pain and she could not bend her

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D 273	Continued From page 45 right wrist. The medication aide (MA) faxed the PCP for an x-ray order. The PCP gave an order for an x-ray. The mobile x-ray was notified, and the MA was told there was a high volume and they would get there as soon as possible. -On 11/08/19 at 7:52am, the Resident Care Director (RCD) documented she spoke with Resident #1's family twice after family member called inquiring about Resident #1's x-ray. The Resident Care Coordinator (RCC) called to make sure mobile x-ray was coming. Mobile x-ray confirmed they would be at the facility today (11/08/19). Resident #1 did not complain of pain, but the RCD noted swelling in Resident #1's right wrist and was currently elevated. There was no documentation Resident #1's swelling was reported to the PCP or of the delay with the mobile x-ray on 11/08/19. -On 11/08/19 at 4:00pm, the RCC spoke with the mobile x-ray and was assured they would be at the facility today (11/08/19). There was no documentation of the delay with the mobile x-ray for Resident #1 was reported to the PCP on 11/08/19. -On 11/08/19 at 4:58pm, the RCC spoke with Resident #1's Guardian to inform the Guardian Resident #1 was going to be sent to the hospital to receive an x-ray of the wrist. There was no documentation of the delay with the mobile x-ray for Resident #1 was reported to the PCP on 11/08/19. -On 11/08/19 at 5:30pm, (recorded as a late entry on 11/09/19 at 2:11pm) Resident #1 was sent to the emergency room due to swelling and pain of the right arm. PCP notified, Guardian notified. Resident #1 was hospitalized due to a broken wrist and GI bleed. -On 11/13/19, Resident #1 would not return from the hospital and would go to another facility.	D 273		

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Review of a picture on 11/25/19 at 10:46am, taken on 11/06/19 by Resident #1's family member revealed:
-The picture was of Resident #1's right arm, wrist and hand.
-There was moderate swelling noted to Resident #1's right wrist from the wrist up the arm approximately 4 inches.

Review of Resident #1's orders dated 11/07/19 revealed an order requesting a mobile x-ray due to complaints of right wrist pain, swelling and bruising. Resident stated she could not move it. On 11/07/19, a faxed ok to the request, diagnoses wrist pain.

A telephone interview with Resident #1's primary care provider (PCP) on 11/21/19 at 1:52pm revealed:
-He was not notified of Resident #1's falls on 10/31/19 and 11/02/19 and 11/06/19.
-He was received a fax on 11/07/19 requesting a mobile x-ray because Resident #1 was complaining of right wrist pain, swelling, bruising and unable to move it. There was no mention of the fall on 11/06/19 documented on the fax.
-He gave an order to give as needed Tylenol for pain and approved the request for the mobile x-ray.
-The staff was to notify him if there was increased pain, swelling, tenderness or the resident could not move the arm, wrist or fingers and he would send Resident #1 to the hospital.
-He did not receive any additional information until after Resident #1 was hospitalized on 11/08/19.
-He was not aware that mobile x-ray was going to take 2 days to get to Resident #1.
-He did not receive any notifications about Resident #1 was having increased swelling and

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or pain other than when he ordered the x-ray on 11/07/19.
-If he had been notified about Resident #1's x-ray being delayed 2 days he would have sent her out to the hospital.

Telephone interview with a second MA on 11/23/19 at 12:00pm revealed:
-She was made aware Resident #1 had falls on 10/31/19, 11/02/19 and 11/06/19 during shift report.
-On 11/06/19, she gave Resident #1 a shower and Resident #1 complained of right wrist pain.
-She noticed Resident #1's right wrist was swollen, purple and blue, Resident #1 could not move her fingers on right hand and the right wrist was painful to the touch.
-She told the RCC and RCD about Resident #1 complaining of pain, discoloration and Resident #1 was unable to move fingers.
-The RCD informed her "they already knew that".
-On 11/07/19 Resident #1 complained of pain and swelling in right wrist.
-She notified the on call physician received order for Tylenol for the pain and continue to monitor and to call if there were any changes.
-She asked the RCD to come and look at Resident #1's wrist again and was told to request an x-ray from the physician.
-She faxed a request to the physician for an x-ray and the physician "ok" the request on 11/07/19.
-On 11/07/19, she called the mobile x-ray and was told it would take 2 days because they were backed up.
-She did not call the physician and let him know the x-ray was going to take 2 days.
-She did let the RCC and RCD know about the x-ray taking 2 days before it could be done.

Interview with the RCC on 11/22/19 at 11:33am

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D 273	Continued From page 48 revealed: -Resident #1 sustained two falls in one day. -Resident #1 complained of right arm and wrist swelling and pain around one of the falls but she could not remember when it was. -She did not notify the PCP about the pain and or swelling. -She did not call the PCP because the MAs would have handled that. -She did not address the family members concerns because she was not the guardian. -She told the RCD about the family members concern afterwards. Interview with the RCD on 11/22/19 at 12:00pm revealed: -Resident #1's family member called her on 11/06/19 and informed her about Resident #1 having right arm swelling and pain, requesting an x-ray for Resident #1. -She informed the family member there was a guardian for Resident #1, and she would need to discuss any issues with the guardian. -On 11/07/19, she requested an order from the physician for an x-ray. -She did not speak with the physician about the falls, swelling or pain of Resident #1's right wrist, or the 2 day delay of the mobile x-ray.. -The MAs were responsible for notifying the physician after falls or complaints and if no response she or the RCC would call. Interview with the Administrator on 11/22/19 at 1:00pm revealed: -The MAs were responsible for notifying the physician with any concerns. -The RCC and RCD were responsible for following up with the physicians with concerns that were not taken care of after the MAs notified the physician.	D 273		

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-She was not aware the x-ray for Resident #1 was going to take two days to receive.
-She expected the MAs to follow up on the complaints and x-ray for Resident #1 with the physician and the RCC or RCD to follow up if there were issues.

b. Review of Resident #1's current FL2 dated 07/08/19 revealed diagnoses included gastrointestinal bleeds (GI bleed) (a bleed from the stomach or intestines in which symptoms include black tarry stools, dizziness and weakness).

Review of Resident #1's progress notes revealed:
-On 10/31/19 at 10:27am, Resident #1 complained of dizziness and then fell, she was sent to the hospital. The PCP and Guardian was notified about the fall. There was no documentation Resident #1's dizziness was reported to the PCP on 10/31/19.
-On 11/01/19 at 9:02am, Resident #1 stated she felt dizzy. There was no documentation Resident #1's dizziness was reported to the PCP on 11/01/19.
-On 11/04/19 at 10:28pm, Resident #1 complained of dizziness, her blood pressure was 139/70, and pulse 86. There was no documentation Resident #1's dizziness was reported to the PCP on 11/04/19.
-On 11/07/19 at 12:09am, Resident #1 fell at 9:45pm after standing up, turned too quickly and fell on her bottom. There was no documentation Resident #1's dizziness was reported to the PCP on 11/07/19.
-On 11/07/19 at 1:52pm, Resident #1 was observed with a very unsteady gait, her blood pressure was 113/63 while sitting and 116/71 while standing. Resident #1 stated she was not feeling well. An order was submitted to the PCP

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for a urinalysis after a foul order was noted with Resident #1's urine (documented by the Resident Care Director). There was no documentation Resident #1's gait was reported to the PCP on 11/07/19.
-On 11/08/19 at 5:30pm, (recorded as a late entry on 11/09/19 at 2:11pm) Resident #1 was sent to the emergency room due to swelling and pain of the right arm. PCP notified, Guardian notified. Resident #1 was hospitalized due to a broken wrist and GI bleed.
-On 11/13/19, Resident #1 would not return from the hospital and would go to another facility.

Telephone interview with Resident #1's Guardian on 11/25/19 at 8:30am revealed:
- Resident #1's family member reported her concerns about Resident #1 having dark stools and complaining of dizziness about a week prior to 11/08/19, but the facility had not sent Resident #1 out for evaluation.
-The family member informed her Resident #1 had a history of GI bleeds and anemia and felt Resident #1's (hemoglobin) Hgb was low.
-She was the new Guardian for Resident #1 and was not aware of Resident #1's health history.
-She went to the facility on 11/08/19 and told the facility to send Resident #1 to the hospital for evaluation of the dark stools, dizziness and wrist pain from a fall.
-Resident #1 was transported to the hospital on 11/08/19 and admitted for a GI bleed and fractures of the right distal radius and fracture of the right ulnar styloid.
-The physician at the hospital told her Resident #1's hemoglobin (Hgb, a protein responsible for transporting oxygen in the blood and the normal range is 11.5-15.0) was dangerously low and a low Hgb could lead to dizziness and falls.
-She expected the staff to follow up on concerns

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of the family or complaints from Resident #1 as soon as they were given the concerns.
-It was possible if staff had responded to their concerns, Resident #1 may not have ended up with a GI bleed, dizziness and fractures from the fall.

Telephone interview with Resident #1's family member on 11/25/19 at 10:16am revealed:
-On 10/31/19, after Resident #1 fell twice she told a MA Resident #1 fell because her "Hgb was low, confused and weakness".
-On 11/01/19, during a visit with Resident #1 she told the MA and the Administrator Resident #1 was confused and disoriented.
-On 11/03/19, Resident #1 had another fall. When she visited Resident #1 was still weak and still dizzy.
-She reported it to the MA and tried to contact the Guardian but was unsuccessful.
-On 11/03/19, during a visit Resident #1 was still weak, and dizzy. She changed Resident #1 and noticed dark stool and reported the dark stools, dizziness and weakness to the MA.
-The MA told her she needed to discuss these things with the Guardian and the staff could not discuss anything with her because she was not the Guardian.
-On 11/03/19, she asked the night shift MA to send Resident #1 to the hospital because Resident #1 could not do anything for herself due to the weakness but they did not.
-On 11/04/19, Resident #1 was continued to be weak, confused and dizzy, unable to ambulate safely, which was causing the falls.
-She called the Administrator and voiced her concerns about Resident #1's weakness, history of low Hgb, falls and possible GI bleed.
-The Administrator told her she could not discuss Resident #1 with her, and she needed to contact

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the Guardian.
-At 7:00pm she reported to another MA Resident #1's stools were dark again and Resident #1 was still confused and weak.
-On 11/08/19, while visiting Resident #1 she informed the Guardian about Resident #1's confusion, weakness, dark stools.
-The Guardian came and had the facility send Resident #1 to the hospital.
-On 11/08/19, while at the hospital she was told Resident #1 was admitted for a GI bleed and broken wrist and arm.
-Resident #1's Hgb was 9 on admission.
-If Resident #1 had been evaluated for a GI bleed when she initially informed the staff, Resident #1 may not have become weak and dizzy, and may not have fallen and the injuries prevented.

Interview with a medication aide (MA) on 11/21/19 at 2:34pm revealed:
-After Resident #1's fall the morning of 10/31/19 at 9:15am, she noticed Resident #1 dragging her left leg. She remembered Resident #1 had a stroke in the past, so she called 911 and Resident #1 was transported to the hospital.
-Resident #1 complained over the next week of dizziness but her speech was good.
-She reported the dizziness and weakness to the RCC and the RCD throughout the week because of Resident #1's recent fall.
-On 11/04/19, after being off for 2 days, a family member informed her Resident #1's was dizzy.
-She informed the RCC about Resident #1's family's complaint.
-The RCC informed her the family member was not the Guardian so the RCC would contact the Guardian.

Telephone interview with a second MA on 11/23/19 at 12:00pm revealed:

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D 273	Continued From page 53 -On 11/06/19 Resident #1's family member had complained about Resident #1 having "dark stools" but she had just given Resident #1 and shower and did not notice any dark stools. -Resident #1's family member had complained about Resident #1 was dizzy and thought Resident #1's Hgb was low and causing the falls but it was a hard situation because the family member was not the guardian and she was told by the RCD and the Administrator she could not discuss issues about Resident #1 with the family member. -It was a difficult position she was in but made the family members concerns know to the RCD and the Administrator. Telephone interview with a third MA on 11/24/19 at 4:00pm revealed: -On 11/04/19, Resident #1's family member thought, because of her history, Resident #1's was experiencing another GI bleed because low because Resident #1 was dizzy, falling and had dark colored stools. -She was concerned about Resident #1 and informed the RCC and the RCD about Resident #1's dizziness and black stools. -She was instructed to assist Resident #1 to the bathroom, increase fluid and make sure Resident #1 ate. -She was still concerned but she was trained by the RCD to report issues to the RCC first then to the RCD. -On 11/06/19, Resident #1's family member came to the facility for a visit and told her Resident #1 was in pain, dizzy, had dark stools and was "bleeding inside". -She again reported her concerns to the RCC and RCD. -She was off the next couple of days. -When she returned to work, she was informed	D 273		

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D 273	Continued From page 54 that Resident #1 was in the hospital for a broken wrist and a GI bleed. Interview with the RCC on 11/22/19 at 11:33am revealed: -Resident #1 did not complain to her about dizziness, dark stools or pain and swelling to right arm. -She remembered Resident #1's family member complaining of Resident #1 having dizziness, dark stools and swelling and pain of the right wrist on and after 10/31/19 to 11/08/19. -She did not call the physician because the MAs would have handled that. -She did not address the family members concerns because she was not the guardian. -She told the RCD about the family members concern of Resident #1's dizziness, dark stools and pain and swelling of the right wrist after the conversation with the family member. Interview with the RCD on 11/22/19 at 12:00pm revealed: -Resident #1's family member called her on 11/05/19 and informed her about Resident #1 having dark stools, dizziness, and requesting a hemoccult for Resident #1. -She informed the family member there was a guardian for Resident #1, and she would need to discuss any issues with the guardian. -On 11/07/19, she requested an order from the physician for a hemoccult. -She did not speak with the physician about the dark stools or dizziness of Resident #1. -The MAs were responsible for notifying the physician after falls or complaints and if no response she or the RCC would call. Review of Resident #1's orders revealed on 11/08/19 a faxed request to the PCP for a	D 273		

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hemoccult stool due to dark stools per family with a return fax on 11/08/19 with an "ok" to the request.

Review of Resident #1's progress notes revealed there were no entries related to hemoccult or black stools.

Telephone interview with a representative from Resident #1's gastroenterologist on 11/21/19 at 3:15pm revealed:
-Resident #1 was being treated for a history of gastrointestinal bleed (GI) bleeds and anemia related to ulcers.
-If the Hgb dropped below 9, it could cause dizziness.
-If the Hgb dropped below 7 a blood transfusion would need to be performed.
-If Resident #1's Hgb was low (9 or below) it could cause dizziness and could contribute to falls because of the low Hgb.

Telephone interview with Resident #1's primary care physician (PCP) on 11/21/19 at 1:52pm revealed:
-Resident #1 had a history of GI bleeds and anemia.
-On 11/08/19, was the first time he was informed about Resident #1 having dizziness, and black stools when the staff called and requested a hemoccult test to be done on Resident #1 because of a report of "dark stools".
-The hemoccult was not completed.
-If he had been notified about Resident # 1's complaint about dizziness he would have sent her out to the hospital

Interview with the Administrator on 11/22/19 at 1:00pm revealed:
-She spoke to Resident #1's Guardian on

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D 273	Continued From page 56 11/04/19 and 11/05/19 after speaking with the family member of Resident #1 concerning the reports by the family member of Resident #1 having dark stools and dizziness. -The family member did not voice anything about dizziness or dark stool at that time. -The MAs were responsible for notifying the physician with any concerns or the requesting orders. -The RCC and RCD were responsible for following up with the physicians with concerns that were not taking care of after the MAs notified the physician. -She expected the MAs to follow up with the complaints for Resident #1 with the physician and the RCC or RCD to follow up if there were issues. The facility failed to provide referral and follow-up for a resident with a history of GI bleeds and complaints of dark tarry stools, weakness, and dizziness which resulted in a delay of treatment for a diagnosed GI bleed and a hemoglobin level which was dangerously low. The facility failed to report 4 falls, the last fall resulted in 2 fractures to her right wrist in which Resident #1 could not move her fingers, experienced pain and swelling for two days prior to being sent out for evaluation. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/22/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2019	D 273		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 57 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to assure 2 of 5 sampled residents (#2 & #4) was treated with respect and dignity by the staff on second and third shifts when speaking to and providing care for the residents (#4) and related to the Administrator removing items from his room without permission and the resident present (#2). 1. Review of Resident #4's current FL2 dated 09/19/19 revealed: -Diagnoses included unspecified dementia, right hip fracture, and muscle weakness. -The resident was semi-ambulatory with the use of a wheelchair. Review of Resident #4's incident report dated 11/01/19 at 12:52pm revealed: -On 10/31/19 at 3:10am Resident #4 was found in her room with abrasions, bruising, a laceration, and skin tear after an unwitnessed fall. -Resident #4's injury required pressure applied to her head. -Resident #4 stated she slipped out of bed. -Resident #4 was found sitting on the floor beside bed, right arm skin tear, and head was bleeding. -Resident #4 was sent to the emergency room on 10/31/19 at 3:10am. Interview with Resident #4 on 11/21/19 at 1:30pm revealed:	D 338		

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D 338	Continued From page 58 -She did not like to ask the staff to help her because the staff was not nice to her on many occasions. -She had asked staff on second and third shift to help her get items off the floor because she could not bend to reach them in her wheelchair, and they acted as if they did not hear her request for help. -When she asked for help, she had to wait a long time so sometimes she had gone ahead and done it herself. -She became angry with the staff one evening after 9:00pm because they were being very loud. -She told the staff they were being too loud, and they told her to mind her own business when things don't involve her. -One of the second shift staff members came into her room sat on her bed after the incident laughed at her and told her she was not going home. -She felt "shunned" by a personal care aide (PCA) on night shift. -During the evening hours after dinner the staff would not speak to her when she was in the living room with other residents. -The staff would look at her, talk to other residents and not include her in a conversation. -Resident #4's responsible party had gone to the Administrator and reported her complaints. -The Administrator did not come to speak to her about a complaint she had about the staff. -She did not think the Administrator even knew her name. Interview with another resident on 11/22/19 at 9:00am revealed: -She saw staff ignore Resident #4 when she asked for help with getting things she dropped on the floor. -She sat with Resident #4 in the common area	D 338		

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after dinner in the evenings and noticed staff did not speak to Resident #4.
-She felt the Administrator was not an approachable person.

Interview with a medication aide (MA) on 11/22/19 at 9:15am revealed:
-She heard Resident #4 complain about other staff members.
-Resident #4 said she did not want to ask those staff members to help her.
-Resident #4 told her she wished all the staff members were as kind as her.
-She did not report the conversations to anyone because she took it as a compliment directed at her because she liked her better than other staff members.

Interview with Resident #4's responsible party (RP) on 11/22/19 at 9:28am revealed:
-Resident #4 had an interaction with one of the staff members that she had reported to the Administrator a couple of weeks ago.
-Resident #4 had become angry with one of the staff members because the staff member was being very loud after 9:00pm one evening a few weeks ago.
-The staff member told Resident #4 to mind her our business that what was going on did not involve her.
-Later in the evening after the interaction the staff member came into Resident #4's room sitting on her bed to discuss the interaction and ended the conversation telling Resident #4 "Ha, ha, ha, you're not going home".
-Resident #4 told her about this interaction and additional times she had felt alienated by the staff.
-She spoke to the Administrator and she told her the staff involved in the incident had been

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reprimanded.
-Resident #4 had been unforgiving of the interactions between her and the staff.
-Resident #4 was determined she was not going to ask the staff to help her unless she needed it.
-She was very concerned the staff members had not been checking on Resident #4 enough resulting in a fall.

Interview with the Administrator on 11/08/19 at 2:30pm revealed:
-Resident #4's RP informed her that a staff member had an inappropriate interaction with the resident.
-She reprimanded the staff member and told the RP.
-She did not discuss the incident and follow up with Resident #4 to reassure the resident the incident had been addressed.
-She did not want Resident #4 to dwell on the incident.

2. Review of Resident #2's current FL2 dated 12/31/18 revealed diagnoses included dementia disorientation, seizure disorder, osteoporosis, vitamin D deficiency, vitamin B12 deficiency, and history of hip fracture.

Review of Resident #2's Resident Register dated 10/10/17 revealed his responsible party was his roommate.

Interview with Resident #2 on 11/22/19 at 1:30pm revealed items belonging to him and his roommate had been removed from their room without their permission.

Interview with Resident #2's responsible party on 11/22/19 at 1:35pm revealed:
-The Administrator had entered her room that she

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shared with Resident #2 last week.
-She was not asked permission to remove items from their room.
-There were items of clothing missing from their room.
-She did not know where the items were moved.
-When she had asked the staff where her stuff was taken, they didn't know.
-She did not feel this was legal for the Administrator to remove items without her being in the room.

Interview with the medication aide (MA) on 11/22/19 at 2:00pm revealed:
-The Administrator entered and removed items from Resident #2's room without asking permission last week.
-It was difficult to get Resident #2 and his roommate to clean up the clutter in their room.

Interview with the Administrator on 11/22/19 at 2:30pm revealed:
-She had removed some items from Resident #2's room.
-She had removed the items after the fire marshal visited the building last week.
-She did not ask permission to remove the items and clear out clutter from Resident #2's room.
-She removed the items when they were not present because Resident #2's roommate would not have allowed her to do so.

Based on record reviews and interviews the facility failed to assure residents were treated with dignity and respect regarding Resident #4 feeling alienated by staff that spoke to her inappropriately and did not provide help when she asked for it. The behavior led to Resident #4 not willing to ask for help and attempting to act independently resulting in a fall with injuries and Resident #2's

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D 338	Continued From page 62 items being removed from his room without permission and the resident present. These failures of the facility to assure residents rights was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation. A plan of protection was provided from the facility in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 8, 2020.	D 338		
D 444	10A NCAC 13F .1208 (g) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (g) With regard to any resident death under circumstances described in G.S. 130A-383, a facility shall notify the appropriate law enforcement authorities so the medical examiner of the county in which the body is found may be notified. Documentation of such notification shall be maintained by the facility and be made available for review by the Division upon request. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure notification of local law enforcement for 1 of 1 resident (Resident #6) who was found unresponsive on her bed. The findings are:	D 444		

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Review of Resident #6's current FL2 dated 05/17/19 revealed diagnoses included non-insulin diabetes, sleep apnea, hypertension, major depression and lupus.

Review of Resident #6's Accident/Incident Reports revealed there were no reports documented or available.

Review of Resident #6's electronic progress notes revealed there were no progress notes documented on 10/22/19 when Resident #6 expired.

Interview with Resident #6's Provider on 11/25/19 at 2:00pm revealed:
-He was notified about Resident #6 after the Paramedics pronounced her deceased on the scene.
-Resident #6 had a history of hypertension and possibly died of a cardiac event.
-He fill out the death certificate and the cause of death was a myocardial infarction.

Telephone interview with a medication aide (MA) on 11/25/19 at 2:15pm revealed:
-On 10/22/19, she found Resident #6 in her bed unresponsive at 8:00pm.
-She had another MA call 911 and started CPR.
-She notified the physician, Resident Care Coordinator (RCC), Resident Care Director (RCD), and the Administrator.
-The RCD notified the Family.
-Resident #6 was pronounced deceased by the EMS.
-Resident #6's death was out of the blue and not expected and surprised her. Resident #6 had not even been sick.
-She did not think she needed to contact the local law enforcement.

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D 444	Continued From page 64 Interview with the RCD on 11/25/19 at 2:30pm revealed: -She was called by the MA about Resident #6 had coded and 911 was on the scene. -When she arrived to the facility the paramedics had pronounced Resident #6 deceased. -There was incident report filled out and the police were not called just the physician and the family because she did not think she had to call the Police. Interview with a second MA on 11/25/19 at 3:30pm revealed: -On 10/22/19 around 8:00pm she was alerted by a second MA that Resident #6 coded and she needed to call 911. -The RCC, RCD and the Administrator was called by the second MA. -Resident #6's death was unexpected. -She did not think that she had to call the local law enforcement. Interview with the Administrator on 11/285/19 at 3:40pm revealed: -On 10/22/19 she was notified by the MA Resident #6 coded and CPR was in progress awaiting 911 to get there. -She notified the family. - Resident #6's death was a surprise and sudden, and not expected at all. -She did not call local law enforcement about Resident #6's death, and did not think that she had to.	D 444		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	C 11/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

(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
D911	Continued From page 65 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Resident Rights. The findings are: Based on record reviews and interviews the facility failed to assure residents were treated with dignity and respect regarding Resident #4 feeling alienated by staff that spoke to her inappropriately and did not provide help when she asked for it. The behavior led to Resident #4 not willing to ask for help and attempting to act independently resulting in a fall with injuries and Resident #2's items being removed from his room without permission and the resident present. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	C 11/25/2019

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D914	Continued From page 66 reviews, the facility failed to ensure residents were free of neglect related personal care and supervision and health care. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 5 of 5 sampled residents (Resident #1, #2, #3, #4, and #5) related to falls. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the acute health care needs for 1 of 5 sampled residents related to delayed treatment for a resident who had black tarry stools, dizziness and weakness and in regard to delayed treatment for two fractures of the right wrist after a fall, (Resident #1). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D914		