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	HAL067004	A. BUILDING: _____ B. WING _____	10/26/2020

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey, with an onsite visit on 10/20/2020 and 10/21/2020 and a desk review survey on 10/22/2020 to 10/23/2020 and 10/26/2020, with a telephone exit on 10/26/2020.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) in accordance with G.S. 131 E-256 upon hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 04/16/20 as a personal care aide (PCA). -There was no documentation of a HCPR check upon hire on 04/16/20. Interview with the Special Care Coordinator (SCC) on 10/21/20 at 2:44pm revealed: -She completed a HCPR for Staff C upon hire. -She did not know why the HCPR was not in Staff C's personnel files.	D 137		

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D 137	Continued From page 1 Telephone interview with the SCC on 10/26/20 at 2:03pm revealed the Executive Director (ED) was responsible for auditing personnel files to ensure all documents were current in the staff files. Telephone interview with the ED on 10/26/20 at 9:26am revealed: -She was responsible for the HCPR checks for housekeeping, maintenance and the kitchen staff. -The SCC was responsible for the HCPR checks for PCAs and medication aides (MA). -She was responsible for auditing personnel files but had not completed an audit as of today, 10/26/20.	D 137		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.	D 176		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related to personal care and supervision, health care, and the use of physical restraints and alternatives.

The findings are:

Observation upon entrance to the facility on 10/20/20 at 9:50am revealed the Administrator was not on-site at the facility.

Interview with the Regional Director (RD) on 10/20/20 at 9:56am revealed:
-The Administrator was out of the facility and he hoped the Administrator would be back at the facility next week.
-The Executive Director (ED) was at the facility today and she was responsible for overseeing housekeeping, maintenance, and dietary services.
-The ED also worked as the Business Office Manager (BOM) and handled insurance payment/reimbursements and personnel files.
-The Special Care Coordinator (SCC) was also at the facility today and she started working at the facility on 03/15/20.

Interview with a personal care aide (PCA) on 10/21/20 at 11:26am revealed:
-She had worked at the facility about 1 year.
-She had not seen the Administrator.
-She thought the Administrator lived in Florida.

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D 176	Continued From page 3 Telephone interview with a medication aide (MA) on 10/23/20 at 4:32pm revealed: -She had worked at the facility since March 2020 and she had only seen the Administrator once or twice at the facility. -She could not remember which months or the dates she saw the Administrator at the facility. Telephone interview with Resident #2's family member on 10/22/20 at 10:21am revealed: -She visited the facility almost every day prior to COVID-19 and currently conducted window visits with Resident #2. -She had not been aware if there was an Administrator since the admission of Resident #2 on 01/17/19 and never met an Administrator. -Her understanding of administration included the ED and the SCC. -The ED handled paperwork and supplies, while the SCC took care of operating the facility and resident care. Telephone interview with the Power of Attorney for Resident #1 on 10/22/20 at 10:03am revealed: -Resident #1 had been at the facility for about 1 and a half years. -He did not know who the Administrator of the facility was. Telephone interview with the primary care provider (PCP) for the facility on 10/22/20 at 9:35am revealed: -She had been seeing residents at the facility for about 1 year. -She had never seen an Administrator in the building. Telephone interview with the SCC on 10/26/20 at 9:10am revealed:	D 176		

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-She did not remember the last time she had seen the Administrator at the facility but it had been "a good bit".
-She spoke with the Administrator during virtual conference calls on Thursdays that also included the ED, the RD and staff from sister facilities.
-She usually talked with the Administrator on the phone or during the virtual meetings about twice a week.
-The Administrator had been to the facility once or twice since the SCC started on 03/16/20.

Telephone interview with the ED on 10/26/20 at 9:25am revealed:
-She worked at the facility on a daily basis 5 days per week and a lot of times she came in on the weekends as well.
-The Administrator had been out for the past few months.
-They had facility virtual meetings weekly that included herself, the SCC, the RD, the Administrator and staff from other sister facilities.
-The Administrator usually participated in the weekly virtual meetings but the meetings were currently being held every other week.
-The virtual meetings started in May or June 2020.

Telephone interview with the RD on 10/26/20 at 9:35am revealed:
-The current Administrator had been the Administrator for 2 to 3 years and she was the Administrator when his company took over the facility in March 2020.
-His management company oversaw finances and getting the building up to code.
-He met the Administrator at the facility a couple of days in March 2020 and they walked through the building and he discussed his concerns about the building itself.

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-They started weekly virtual meetings on 03/25/20 which included the Administrator, the SCC, the ED, and himself.
-He also met with the Administrator one day in July 2020, again about the building in general.
-The Administrator was not on-site at the facility every day but she could be reached by phone by staff if needed.
-The Administrator also did billing for the facility.
-The Administrator was responsible for being in contact with the SCC and the ED and if problems presented, the Administrator needed to be in the facility.
-The Administrator could have done oversight by phone as well.
-If the Administrator had been in the facility, she could have been taken a more hands-on approach to checking on things.
-He was concerned and thought the Administrator needed to be on-site at the facility every day.
-The ED was not a licensed Administrator and the ED had nothing to do with nursing care or issues.

Telephone interviews with the Administrator on 10/26/20 at 10:11am and 12:23pm revealed:
-She had worked at the facility since 2010 and she had been the Administrator for 4 or 6 years.
-She had been out since 07/29/20 but had been able to stay in contact with the SCC, the ED, and the RD and they also had her phone numbers.
-Prior to being out starting on 07/29/20, she tried to go to the facility at lease every other week.
-When at the facility, she would walk through and check the rooms, make sure they had PPE, an adequate food supply, and everything was being ordered.
-She did not review residents' records because the SCC was trained "well" and she assumed the SCC was doing her job.
-When the SCC first started, she did record

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audits during the first 2 months but she had not done any audits since then.
-The last time she was at the facility was in July 2020.
-The last time she spoke with the SCC was on 10/15/20 when she called the SCC via telephone just to see how things were going or if there was anything she could do.
-She probably talked with or emailed the ED or the RD every day or every other day related to the facility.
-She expected the facility staff to follow policies and procedures.
-She would ask questions for example, to make sure new staff were being trained.
-The SCC was supposed to notify her if a resident went to the hospital.
-She got a census report from the ED every Monday via email and if she noticed a resident was in the hospital and staff had not reported it to her, she would call and ask about it.
-The SCC was supposed to send her incident/accident reports for residents or staff but she had not received any so she assumed there had been none to report.
-She was not aware of any falls at the facility because none had been reported to her.
-She was "very" concerned residents had fallen and been injured and it had not been reported to her.
-If she had known about the falls, she would have contacted the SCC and made her do a training with staff related to falls.
-If a resident had a change in condition, the PCA should report it to the MA and the MA should contact the SCC and the PCP and the SCC should contact the Administrator.
-The SCC was in charge of resident care services and the ED was in charge of the kitchen, housekeeping, and maintenance.

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-The RD tried to oversee the SCC and the ED.
-When she was at the facility, she tried to oversee all of them as well.
-She went over and discussed policies and procedures thoroughly with the SCC when the SCC was hired as well as staff from sister facilities trained the SCC.
-None of the issues identified during the survey were reported during the management's weekly virtual meetings but she would have expected them to be reported to her.

Telephone interview with the RD on 10/26/20 at 2:18pm revealed:
-There was never a "clear action" of how long the Administrator was going to be out.
-Once the Administrator was out, their plan included continuing the virtual meetings.
-There were never any issues voiced during the virtual meetings for this facility by anyone.
-If there was a problem, the SCC could call the Administrator and if someone needed to look at something at the facility, they could let him know.
-The Administrator was available by phone and he was available by phone if needed.
-There was some discussion with corporate after the virtual meetings on 10/08/20 and 10/22/20 about whether the Administrator was able to come back to work at the facility.
-He tried to come to the facility at least once or twice a week and if something came up, he would contact the facility's nurse.
-The SCC and the ED had been told that anything that went on in the building should be reported to him.
-He was working on getting a new Administrator for the facility.

Non-compliance was identified in the following rule areas:

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D 176	Continued From page 8 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#3, #4) with a history of falls resulting in serious injuries including a fractured hip and staples in the head (#3) and a hip injury consistent with a fractured hip (#4). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to to meet the acute health care needs for 4 of 5 sampled residents (#1, #3, #4, #5) by failing to report symptoms and a delay in seeking medical care for a resident complaining of stomach pain and vomiting blood (#1); two residents who experienced significant pain and were unable to bear weight after sustaining falls (#3, #5); and a hospice resident who kept trying to climb over bed rails, eventually resulting in a fall and sustaining an injury consistent with a broken hip that resulted in pain and a delay in treating the resident's pain (#4). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).] 3. Based on interviews and record reviews, the facility failed to assure a Geri-chair with tray and bed rails were used only after an assessment and care planning process had been completed through a team process and alternatives had been tried for 1 of 1 residents sampled (#4) who had a history of trying to climb over the bed rails, resulting in the resident falling and sustaining a hip injury consistent with a broken hip. [Refer to Tag D482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A1 Violation)].	D 176		

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D 176	Continued From page 9 The Administrator, who was responsible for the total operations of the facility, failed to ensure the rules and regulations governing supervision, health care, and physical restraints were met and maintained. The Administrator failed to ensure 2 residents at risk for falls were supervised resulting in a broken hip for one resident and a hip injury consistent with a broken hip for a hospice resident. The Administrator failed to ensure health care services necessary to maintina their physical health resulting in a delay in seeking care for 3 residents who had fallen and complained of pain from hip injuries. The Administrator failed to ensure rules were followed for physical restraints for a hospice resident who tried on multiple occasions to climb over the bed rails which led to a fall resulting in a hip injury consistent with a broken hip. The Administrator's failure esulted in serious physical harm and serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/26/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 25, 2020.	D 176		
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.	D 270		

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D 270	Continued From page 10 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#3, #4) with a history of falls resulting in serious injuries including a fractured hip and staples in the head (#3) and a hip injury consistent with a fractured hip (#4). The findings are: Review of the facility's Fall Management Program Policy and Procedure dated 05/05/14 revealed: -The Unit Coordinator is responsible to direct the falls program and coordinate screening of each resident on admission, readmission, quarterly, after a fall, and with a significant change in status in an effort to identify residents at a high risk of falls. The Unit Coordinator is also responsible to oversee the care plan process including revisions and implementation. -Staff respond immediately to residents who fall and provide care and interventions as needed for the safety and well being of the resident. The Supervisor in Charge notifies the Unit Coordinator, Executive Director, Director of Services or Administrator as per facility policy. -Immediately following a fall, the Supervisor in Charge may call a A.R.C. team huddle to gather information regarding the incident that may be helpful in preventing future falls. -After a fall an evaluation and investigation is completed on each incident by the Unit Coordinator and/or the Supervisors to help identify risk(s) and implement measures when possible to prevent future incidents. An attempt to find the root cause of the fall is made.	D 270		

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-The evaluation of the fall may include other factors or other clues.
-Some internal clues: vital signs, behavior, medications, hearing, sleep deprived, gait, balance, strength, acute medical condition, chronic diseases, deconditioning.
-Some external clues: noise level, clutter, activity, lightning, flooring, bed height, unsafe equipment, unstable furniture, improper footwear.
-The Unit Coordinator has a team meeting to discuss the resident's care. This meeting may include the resident's responsible party. They may consider if the problem is recurring and how the supervision of the resident is being carried out, reason(s) of the recurring problem(s), staff approaches and resident's reaction to them.
-The Unit Coordinator communicates with the resident's primary care provider as needed for additional orders. A team approach to problem solve about the specific behavior, and brainstorm about solutions is followed and implementation or revision of intervention(s) are carried out as needed.
-To reduce the risk of injury the facility may consider: low bed, floor mat, helmet, hip protectors, non-slip mat, proper footwear, and lower or removal of side rails.
-The Executive Director or Director of Services is responsible to support the Unit Coordinator and they are responsible to: Oversee or participate in the orientation of all new staff to communicate the facility's focus on resident safety, monitor and guide the program, ensure adequate staffing, provide feedback to all staff each month on the monthly incident reports, monitor for accurate completion of all incident reports and notification of DSS as per adult care home rules and evaluate the program periodically and at least yearly for areas of improvement and may consider the facility commitment and team skills,

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data collection and analysis, staff training, environment and equipment safety, screening and assessment, development of care plan, monitor of resident response to interventions.

1. Review of Resident #3's current FL-2 dated 08/13/20 revealed diagnoses included dementia with behavior disturbances.

Review of Resident #3's care plan dated 08/13/20 revealed:
-The resident was a wanderer.
-The resident had no problems with ambulation.
-The resident was forgetful and needed reminders.
-The resident was always disoriented.
-The resident had normal speech.
-The Activities of Daily Living (ADL) tasks were not rated for the resident.

Review of an accident/incident report dated 07/08/20 for Resident #3 revealed:
-The resident fell on the floor and hit her head.
-The resident was transported by the emergency medical service (EMS) to a local hospital emergency room for evaluation.

Review of a hospital emergency department after visit summary dated 07/08/20 for Resident #3 revealed:
-The resident was seen for fall/head injury.
-The resident was discharged as stable and at baseline related to her fall.

Review of an accident/incident report dated 10/11/20 for Resident #3 revealed:
-The personal care aide (PCA) was providing care to the resident and the resident attempted to move away from the PCA and fell backwards and hit her head on her roommate's Geri chair.

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-The resident was bleeding from the back of her head.
-The resident was transported by the EMS to a local hospital emergency department for evaluation.

Review of a hospital emergency department after visit summary dated 10/11/20 for Resident #3 revealed:
-The resident was seen for a fall to a hard surface while standing and lost her balance.
-The resident was diagnosed with a laceration to the scalp and a rib fracture.
-The resident had to receive staples to her head due to a scalp laceration.

Telephone interview with the SCC on 10/22/20 at 12:40pm revealed:
-After Resident #3's fall on 07/05/20, staff were to ensure items were not in Resident #3's path.
-After Resident #3's fall on 10/11/20, staff were to ensure Resident #3's care included a two person assist.
-Resident #3 should have been monitored more often due to her recent falls.
-The facility staff monitored Resident #3 visually.
-There was no documentation Resident #3 was monitored related to any of her falls.

Review of an accident/incident report dated 10/20/20 for Resident #3 revealed:
-The resident fell in the kitchen.
-The resident had no bruises, but resident was complaining of body pain when she was touched.
-The resident was transported by the EMS to a local hospital emergency department for evaluation.

Review of a hospital emergency department after visit summary dated 10/20/20 for Resident #3

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revealed:
-The resident was seen for a fall, urinary tract infection (UTI), dementia and elevated blood pressure.
-The resident was diagnosed with a UTI, falls frequently and elevated blood pressure.
-The resident had no acute findings from the cervical spine and head computerized tomography (CT) scans.

Observations on 10/20/20 at 10:29am-10:39am revealed:
-The facility was having the floor in the common area repaired.
-There was a glue substance on the floor to lay tile.
-The resident walked on the floor that contained the glue substance.
-The resident was not wearing any shoes.
-The glue stuck to Resident #3's socks.
-The resident was attempting to move but could not due to being stuck to the floor.
-The resident fell on her left side.
-There were no staff in the hallway or common area at the time of Resident #3's fall.
-The Executive Director (ED) was standing with her back to Resident #3 and was prompted that Resident #3 had fallen.
-The ED stated, "where is everybody."
-The ED assisted Resident #3 by lifting her head from the floor and placing a soft object under her head.
-The resident was lying on the floor.
-The resident was stuck to the floor due to the glue substance being on the floor.
-Other staff assisted the ED with Resident #3.
-The Special Care Coordinator (SCC) instructed a medication aide (MA) to call EMS.
-The hospice nurse entered the facility at 10:37am and assessed Resident #3.

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D 270	Continued From page 15 -EMS arrived on 10/20/20 at 10:39am. -The resident's shirt, with resident still wearing it, had to be forcibly removed from the floor due to the glue substance. -Resident #3 was transported to a local hospital emergency department. Interview with the first personal care aide (PCA) on 10/20/20 at 3:20pm revealed: -Resident #3 was not supposed to be in the common area due to the floor being repaired. -She was providing resident care to another resident at the time of Resident #3's fall. -A staff person was supposed to be in the common area at all times. -It was the responsibility of the MA to be in the common area at all times, when not administering medications. Interview with a MA on 10/20/20 at 3:51pm revealed: -All staff were to monitor residents in the hallway and in the common area. -She was not available to monitor the common area during the time of Resident #3's fall. -She was mostly in the common area monitoring residents. -A PCA should be available when an MA was administering medications or not available. -There were 3 PCAs on duty today, 10/20/20. -She notified the PCAs she had to leave the common area . -There should have been someone monitoring the residents in the common area. -There was a barricade to include a bookshelf and chair with a scale to block the common area so that residents would not enter the common area. -Resident #3 went around the barricade.	D 270		

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D 270	Continued From page 16 Observation on 10/20/20 at 4:02pm revealed Resident #3 returned from the hospital. Observation on 10/21/20 at 11:30am revealed Resident #3 was sleep in her bed. Interview with a MA on duty on 10/21/20 at 11:30am revealed Resident #3 was placed back in her bed by the PCAs due to pain. Observation on 10/21/20 at 2:13pm revealed: -Resident #3 was sitting in a chair at a table. -Resident #3 did not appear to be in pain or have discomfort. Interview with a MA on 10/21/20 at 2:13pm revealed Resident #3 did not appear to have pain or discomfort. Observation of Resident #3 on 10/21/20 at 3:04pm revealed resident was sleeping and sitting on the couch in the common area. Telephone interview with the first MA on 10/22/20 at 4:58pm revealed the PCAs wheeled Resident #3 to the dining area and sat her in the common area all day. Telephone interview with Resident #3's family member on 10/22/20 at 3:50pm revealed: -She was aware Resident #3 had fallen 3 times in the last 3 weeks. -The facility notified her Resident #3 had fallen and had been sent out to a local hospital on 10/21/20 at 7:00pm. -A local hospital emergency department notified her on 10/22/20, Resident had a broken hip and needed surgery. Telephone interview with Resident #3's Primary	D 270		

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Care Physician (PCP) on 10/21/20 at 12:19pm revealed:
-She had been notified by the facility of Resident #3's fall on 10/20/20.
-She planned to see Resident #3 when she was at the facility on Friday, 10/23/20.
-She expected staff to keep an eye on Resident #3.
-She expected staff to assist Resident #3 when she was off balance.
-Resident #3 liked to walk.

Interview with the SCC on 10/20/20 at 4:31pm revealed:
-A staff person was to be in proximity of the common area to prevent residents from entering the area.
-A staff person should have been in the common area at the time of Resident #3's fall to ensure residents were not walking in the area.
-It was the responsibility of the PCAs and the MA to communicate who was available to monitor the common area.
-If the PCAs or the MA were not available, the MA should have notified her or someone on the management team because other staff were available to monitor the area.

Telephone interview with the SCC on 10/23/20 at 11:50am revealed:
-Resident #3 walked a lot prior to her fall on 10/20/20.
-After the resident's fall on 10/20/20, there was no discussion for interventions such as a walker, wheelchair, physical therapy, or occupational therapy.
-No interventions were discussed after the fall on 10/20/20 because the hospital discharge note indicated the resident had a urinary tract infection and she was ordered an antibiotic.

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D 270	Continued From page 18 -The hospital discharge notes also noted there were no acute finding from the resident's scans of the spine and head. Interview with the Regional Director on 10/21/20 at 11:15am revealed he expected staff to be in the hallway to prevent residents from entering the common area while the floor was being repaired. 2. Review of Resident #4's current FL-2 dated 09/14/20 revealed: -Diagnoses included Alzheimer's dementia and generalized weakness. -The resident was constantly disoriented. -The resident was semi-ambulatory and incontinent of bowel and bladder. -The resident needed assistance with bathing, feeding, and dressing. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 09/14/20. Review of Resident #4's current assessment and care plan dated 09/16/20 revealed: -The resident non-ambulatory and used a Geri-chair. -The resident had limited range of motion, limited strength, and limited eye-hand coordination with upper extremities. -The resident had daily incontinence with bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be redirected. -The resident was hard of hearing (hears loud sounds/voices) and had a weak speech. -The resident was totally dependent on staff for all activities of daily living including eating, toileting, ambulation, bathing, dressing, grooming, and transferring.	D 270		

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D 270	Continued From page 19 Review of Resident #4's Fall Risk Form dated 09/18/20 revealed: -The resident was assigned a total score of 14. -If total score was 10 or above, the resident was a high risk for falls. Review of Resident #4's Physician Restraint Order dated 09/18/20 revealed: -The medical reason for the restraints was documented as dementia, unable to ambulate independently. -The type of restraint to be used was documented as Geri-chair with tray and bed rails. -The time period for the restraints to be used was documented as Geri-chair while out of bed and bed rails when in bed. -The time interval the restraints must be checked was documented as every 30 minutes. -The time interval the restraints must be removed for exercise/mobility was every 2 hours. -The resident's primary care provider (PCP) signed the order on 09/18/20. Review of Resident #4's incident/accident report dated 09/28/20 at 8:30pm revealed: -The aide was about to walk down the long hall and went to peek in on the resident and found him on the floor. -The resident had climbed over the bed rail. -The resident never cried out. -Staff documented unable to take vital signs. -Staff documented no injury was noticed at the time of the incident. -Actions taken included: checked resident over, hospice was called, and the resident was put back in bed. Telephone interview with a medication aide (MA) on 10/23/20 at 10:06am revealed:	D 270		

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D 270	Continued From page 20 -Resident #4 required 2-person assistance for bathing, dressing, ambulation, and transferring. -The resident could not walk and one side of the resident's bed was against the wall and the other side had a full bed rail in the up position. -The resident would try to slide out of the bottom opening at the end of the bed rail and the end of the bed. -She would get a personal care aide (PCA) to help pull the resident back up to the top of the bed. -The resident would throw his legs over the bed rail. -She had observed Resident #4 do this a couple of times per week since the resident was admitted to the facility. -She had not reported to anyone that the resident would slide down in bed or tried to climb over the rails. -She could not explain why she had not reported it to anyone. -About 3 or 4 nights a week, the resident would not sleep so she checked on him about every 30 minutes. -If the resident was sleeping, she checked on him every 2 hours. -The resident did not have a fall mat or a bed alarm. -On the night of 09/28/20, a PCA was walking down the hall and saw the resident on the floor. -The PCA told her the resident was on the floor. -They did not hear the resident fall or yell out when he fell. -The resident was on the floor next to the bed laying on his stomach with his face turned to the side. -The resident was wearing a t-shirt and his incontinence brief was off. -The bed rail was up and she had "no idea" how he got out of bed.	D 270		

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D 270	Continued From page 21 -The resident was awake and she checked him for bruises, skin tears, and bleeding but she did not see any injuries. -When she asked the resident if areas on his body hurt, the resident would say no. -She was unable to take the resident's vital signs because he would not be still. -She and the PCA assisted the resident back to bed and the PCA covered him up. -She called hospice and the on-call hospice registered nurse (RN) asked if there was swelling or bruising and she told the hospice RN no. -The on-call hospice RN told her if there were any changes throughout the night to call them back. -She did not remember if she reported the fall to the Special Care Coordinator (SCC) but she was supposed to call the SCC for any falls. Telephone interview with a PCA on 10/23/20 at 10:54am revealed: -Resident #4 could not stand up or walk. -The resident was stiff and tall and it usually took 3 staff to assist the resident. -The resident's bed rails were up when he was in bed and the resident would move his legs between the rails and the mattress. -One staff (could not recall who or when) reported the resident had tried to go over the rails. -The resident could move around in bed with his arms and legs. -On 09/28/20, she and the MA were the only two staff working that night because two other staff had quit. -She was checking on Resident #4 and he was on the floor near his bed. -It looked like the resident had gone over the bed rail. -The resident had on his t-shirt and an incontinence brief and he was laying on his side. -The resident as moaning in pain.	D 270		

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-When she tried to turn the resident on his back to get him off his hip, the resident yelled in pain.
-She screamed for the MA and told the MA the resident had fallen and needed to go to the hospital.
-She waited in the room with the resident and after the MA called hospice, they assisted the resident up and to bed and the resident was in pain.
-When they got the resident in bed, the resident was lying on his back and she noticed his right leg was turned outward and it did not look normal.
-She usually checked on residents with restraints every hour, including Resident #4.

Interview with a second MA on 10/21/20 at 3:19pm revealed:
-Resident #4 required assistance with dressing, bathing, incontinence care and everything, including feeding.
-The resident required 2-person assistance with transfers.
-The resident could move around in bed so one side of the bed was against the wall and the other side of the bed had a bed rail in the up position.
-One day during the first week the resident was admitted (could not recall date), she observed the resident with one leg off the end of the bed and the leg was angled around the end of the bed.
-She and another staff person (could not recall who) pulled the resident back up to the head of the bed.
-She did not remember if she reported it to anyone.
-The night shift MA reported to her on 09/29/20 when she came on shift that the resident had fallen on 09/28/20.
-The night shift MA reported the resident had "scooted" to the end of the bed and slid to the floor.

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-The night shift MA reported the resident had no injuries.
-She thought the resident had a fall mat beside his bed but she was not sure.

Interview with a second PCA on 10/21/20 at 3:44pm revealed:
-Resident #4 could not walk and he could barely stand.
-The resident was tall and heavy and it took 2 or 3 aides to provide assistance to the resident.
-The resident had a full bed rail on each side of the bed and one side of the bed was against the wall.
-The bed rail opposite the wall was always up when the resident was in bed.
-Toward the end of first shift on 09/28/20, the resident was "real antsy" meaning he wanted to get out of bed and would not sit still.
-The resident was grabbing at the bed rail and tried to pull himself over the bed rail.
-She thought she put a bed alarm and clipped it to the resident's clothing and bed and she reported to the night shift MA that the resident was "antsy".
-Most of the time during day shift, staff kept Resident #4 in the common areas and they checked on him every 2 hours for incontinence checks.
-The hospice RN told staff the resident's hip was broken but he was not able to have surgery.

Telephone interview with a third PCA on 10/22/20 at 1:38pm revealed:
-Resident #4 was total care except for meal assistance.
-The resident's bed was against the wall and the bed rail on the opposite side of the bed was up when the resident was in bed.
-Most of the time, the resident was up front in the

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common areas.
-She checked on the resident each time she walked time the hall about every 10 to 15 minutes.
-She never saw the resident pulling on the bed rails and she did not recall the resident "scooting" to the end of the bed.
-The resident did not have a bed alarm but the resident had a fall mat they put down just in case the resident tried to get out of bed.
-Before her shift ended at 7:00pm on 09/28/20, she and another PCA put the resident in bed and put the rail up and the resident was "okay".
-Another staff (could not recall who) informed her later that the resident had fallen on 09/28/20.
-Resident #4 was usually checked every 2 hours for incontinence care.

Telephone interview with a third MA on 10/22/20 at 7:48pm revealed:
-Resident #4 had bed rails but he could move around in the bed.
-One evening while she was working (could not recall when), a staff member (could not recall who) reported the resident was trying to get out of bed with the bed rails up.
-She put the resident in the Geri-chair and he calmed down.
-She could not remember if she reported to the SCC that Resident #5 was trying to get out of bed.
-For residents with restraints, she "tried" to check on them every 45 minutes to 1 hour, especially if they tried to get out of bed.

Telephone interview with a fourth MA on 10/23/20 at 12:41pm revealed:
-Resident #4 had bed rails and the resident would "scoot" down to the end of the bed and his feet and would hang off the end of the bed and the

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resident would try to get his leg off the end of the bed.
-She never saw the resident try to go over the bed rails.
-She checked on the resident "a lot", about every 15 minutes.
-She did not know Resident #4 had fallen on 09/28/20 until another MA told her about the fall.

Review of Resident #4's multi-disciplinary facility visit record for hospice dated 09/29/20 revealed:
-The hospice RN went to the facility for a follow-up visit status post resident fall.
-The resident had external rotation, was non-weight bearing to right lower extremity, and yelled in pain with movement.
-During visit with resident yesterday (09/28/20) prior to fall, the resident was able to stand for personal care.
-Telephone call to the resident's family member confirmed comfort care - no need for x-ray.
-Orders for pain management in place.

Telephone interview with Resident #4's hospice RN on 10/21/20 at 10:00am revealed:
-She saw Resident #4 during a hospice visit on 09/28/20 before the resident fell.
-The resident had generalized body stiffening and slowed delayed movement and he could move his arms.
-The resident required 2-person stand by assistance.
-When she saw the resident on 09/28/20, she and one staff stood him up and he could stand in place for about 2 minutes.
-Facility staff had not reported the resident was trying to climb out of bed prior to his fall on 09/28/20.
-It was her understanding the resident was found on the floor at the side of the bed and a skin tear

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was his only injury.
-The next day on 09/29/20, when she came to the facility, the resident was in his Geri-chair with tray.
-Facility staff did not report the resident was having any pain or other symptoms.
-A MA helped her stand the resident up but the resident could not bear weight and the resident cried out in pain.
-The resident's leg was externally rotated, which was a symptom that was consistent with a fractured hip.
-If staff had reported the resident had been trying to get out of bed with the bed rails up, hospice could have addressed the concern and could have tried a bed alarm to alert staff when the resident was trying to get out of bed.
-The resident passed away on 10/03/20.

Telephone interview with Resident #4's family member on 10/23/20 at 9:41am revealed:
-She was aware the resident had bed rails.
-The resident apparently tried to get out of bed on his own and fell.
-She did not know if the resident's bed rails were up at the time of the fall.
-The resident could not stand on his own.
-Prior to the fall, no one had reported the resident had tried to get out of bed on his own.
-She discussed the resident's injury from the fall with a hospice nurse and it was assumed the resident had fractured leg or hip.

Telephone interview with the SCC on 10/23/20 at 11:50am revealed:
-Resident #4 was total care when he was first admitted to the facility on 09/14/20.
-The resident was brought in for generalized weakness, he could not walk, and he mumbled.
-The resident had a slight improvement around

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the end of his first week or going into his second week at the facility.
-The resident started to talk better and he was able to move his arms and legs.
-The resident was not able to stand and he had a Geri-chair with tray and bed rails.
-When the resident improved, he could move his legs and if he did not have bed rails, the resident could roll onto the floor.
-On 09/28/20, the bed rails were up when the resident fell.
-She was told by the MA that the resident put his legs over the rail when he fell on 09/28/20.
-Prior to the fall on 09/28/20, no one had reported to her that the resident had been observed pulling himself over the bed rails.
-Staff had reported the resident had been pulling on the rails but she cold not recall how many times or when.
-She thought she had discussed with the hospice RN about getting a bed alarm for the resident but she could not recall and it was not documented.
-Residents with restraints were supposed to be checked every 30 minutes and released every 2 hours for 15 minutes.
-The staff were supposed to fill out observation sheets every 2 hours when residents were released from restraints but she was not sure if they documented the 30 minute checks.
-She located observation forms for restraints for 3 days for Resident #4 but the forms were incomplete and she could not find any other forms for the resident.
-She was responsible for checking the restraint observation forms but she had not had a chance to check behind staff to see if they had been completing the 30-minute checks and the 2-hour releases for restraints.

Telephone interview with the Administrator on

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D 270	Continued From page 28 10/26/20 at 12:23pm revealed: -She was not aware Resident #4 fell on 09/28/20 and had a hip injury. -She should have received an incident/accident report for Resident #4's fall. -If a resident was trying to climb over bed rails, it should be reported to the PCP and to her. -No one reported to her that Resident #4 was trying to go over the bed rails or get out of the end of the bed. Telephone interview with Resident #4's PCP on 10/23/20 at 11:15am revealed: -She saw Resident #4 one time for a new patient visit. -The resident came to the facility with the intention of going on hospice services. -The resident was already declining when he was admitted to the facility. -The resident had a right knee effusion that caused problems with ambulation. -Facility staff reported the resident had one fall when he climbed out of the chair or the bed (could not recall which). -Staff did not report any issues or injuries with the fall (could not recall when). -She expected facility staff to follow the restraint order and check on the resident every 30 minutes and release every 2 hours. -No one discussed any alternatives to the restraints with her but alternatives could have included increased supervision or a sitter. _____ The facility failed to ensure supervision of Resident #3 and Resident #4 according to their assessed needs. Resident #3 who had a history of falls was unsupervised and walked into an area of the facility undergoing floor repair and got stuck in glue on the floor causing the resident to lose her balance and fall resulting in a hip	D 270		

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D 270	Continued From page 29 fracture. Resident #4, a hospice resident with an order for bed rails who was observed by staff attempting to climb over the bed rails, was not checked on every 30 minutes as required for restrained residents resulting in the resident being found on the floor and sustaining an injury consistent with a hip fracture. The resident later died. The facility's failure to supervise the residents resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/20/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 20, 2020.	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 to meet the acute health care needs for 4 of 5 sampled residents (#1, #3, #4, #5) by failing to report symptoms and a delay in seeking medical care for a resident complaining of stomach pain and vomiting blood (#1); two residents who experienced significant pain and were unable to bear weight after	D 273		

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sustaining falls (#3, #5); and a hospice resident who kept trying to climb over bed rails, eventually resulting in a fall and sustaining an injury consistent with a broken hip that resulted in pain and a delay in treating the resident's pain (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 08/13/20 revealed diagnoses included dementia with behavior disturbances.

Review of an accident/incident report dated 10/20/20 for Resident #3 revealed:
-The resident fell in the kitchen.
-The resident had no bruises, but resident was complaining of body pain when she was touched.
-The resident was transported by the emergency medical service (EMS) to a local hospital emergency room for evaluation.

Review of a local hospital emergency department after visit summary dated 10/20/20 for Resident #3 revealed:
-The resident was seen for a fall, urinary tract infection, dementia and elevated blood pressure.
-The resident was diagnosed with a urinary tract infection (UTI), falls frequently and elevated blood pressure.
-The resident had no acute findings from the cervical spine and head computerized tomography (CT) scans.

Observations on 10/20/20 at 10:29am-10:39am revealed:
-The resident was lying on the floor from a fall.
-The Special Care Coordinator (SCC) instructed a medication aide (MA) to call EMS.
-Resident #3 was transported to a local hospital emergency department.

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D 273	Continued From page 31 First telephone interview with a PCA on 10/22/20 at 4:54pm revealed: -She was not sure what time Resident #3 complained to her of her left leg hurting. -She notified the MA of Resident #3's complaint (not sure of the time). -Resident #3 was sent to the hospital on 10/21/20 due to complaining of her left leg hurting. Second telephone interview with a PCA on 10/22/20 at 5:12pm revealed she placed Resident #3 in a wheelchair to bring her to the dining room for breakfast on 10/21/20. Third telephone interview with a PCA on 10/22/20 at 5:31pm revealed: -She used a wheelchair to transport Resident #3 because the resident appeared to be weak and did not feel good on 10/21/20. -She did not know if Resident #3 could stand on her own because she had another PCA assist with care. -She did not attempt to stand Resident #3 on 10/21/20. -She provided personal care to Resident #3 and she did not appear to be in pain during the 2-hour checks on 10/21/20. -She had another PCA assist her with putting Resident #3 on the couch in the common area on 10/21/20. -Resident #3 complained of pain at dinner (between 4:00pm-5:00pm). Telephone interview with a second PCA on 10/22/20 at 5:36pm revealed: -Resident #3 looked weak on 10/21/20 (not sure of the time). -She did not attempt to walk Resident #3 on 10/21/20, her and another aide stood her up (not	D 273		

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sure of the time).
-She and another aide placed Resident #3 in a chair for dinner (between 4:00pm-5:00pm) and she moaned as if she had discomfort.
-She and another aide notified the MA on duty (not sure of the time).

Telephone interview with the first MA on 10/22/20 at 4:58pm revealed:
-The PCA informed her Resident #3 was having trouble putting pressure on her left side (could not remember which aide told her).
-Resident #3 could not walk or put pressure on her left side due to her fall on 10/20/20.
-She noticed Resident #3 could not stand alone when the PCAs brought her to the dining room for dinner.
-She looked at Resident #3 and told other staff something was wrong with the resident (not sure of the time).
-She attempted to walk Resident #3 after dinner, and she could not put pressure on her left side on 10/21/20.
-She informed the Special Care Coordinator (SCC) something was wrong with Resident #3 on 10/21/20 (not sure of the time).
-She started the paper work before 7:00pm to send Resident #3 to the hospital.
-She informed the night shift MA to call Resident #3's family member, call her primary care physician (PCP) and call EMS on 10/21/20.
-She did not send Resident #3 to the hospital earlier during the day on 10/21/20 because she reviewed hospital discharge summary from 10/20/20 and it did not state anything was wrong with Resident #3.
-When she clocked out on 10/21/20 at 7:03pm Resident #3 had not been sent out to the hospital.

Telephone interview with a second MA on

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10/22/20 at 7:49pm revealed:
-Resident #3 never had to use a wheelchair.
-Resident #3 was normally walking in the facility.
-Resident #3 was not responding when she arrived in the facility on 10/21/20 before 7:00pm (not sure of exact time).
-She noticed Resident #3 was not acting like herself when she arrived in the facility and asked staff what was wrong with her.
-Resident #3 would not sit up.
-She and another staff moved Resident #3's body and you could tell she was in pain.
-The MA on duty notified her she had started paper work to send Resident #3 to the hospital.
-She did not know how long Resident #3 was sitting there without someone noticing her pain.
-She notified the family member and called EMS.

Telephone interview with a family member on 10/22/20 at 3:50pm revealed:
-The facility notified her on 10/21/20 that Resident #3 had fallen and was sent out at 7:00pm.
-The local hospital notified her on 10/21/20, Resident had a broken hip and needed surgery on 10/22/20.

Telephone interview with the Primary Care Physician (PCP) on 10/21/20 at 12:19pm revealed she was not aware of Resident #3's hip fracture from the fall on 10/20/20.

Telephone interview with the SCC on 10/23/20 at 8:15am revealed:
-Resident #3 had trouble standing when she returned from the hospital on 10/20/20.
-Resident #3 was placed in a wheelchair during the day on 10/21/20 because staff told her the resident was limping.
-She was notified on 10/21/20 Resident #3 could not put pressure on her left side (not sure of

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time).
-Resident #3 was saying she was in pain.
-She assessed Resident #3 on 10/21/20 during her dinner while she was eating at the table.
-She did not know what time she assessed Resident #3.
-She lifted Resident #3's left leg and she reacted in discomfort.
-The resident care staff did not notify her immediately of a change in Resident #3.
-She informed the MA to send Resident #3 to the hospital between 5:00pm-6:00pm on 10/21/20.

Telephone interview with the Regional Director on 10/23/20 at 1:54pm revealed he expected staff to send Resident #3 to the hospital as soon as they realized she was in pain.

2. Review of Resident #1's current FL-2 dated 09/17/20 revealed diagnoses included dementia and a gastrointestinal (GI) Bleed.

Review of computerized charting notes for Resident #1 dated 06/12/20 at 12:55am revealed:
-Resident #1 had vomited on the bed and the floor.
-There was no documentation of notification made to the primary care provider regarding vomiting.

Review of computerized charting notes for Resident #1 dated 08/30/20 at 6:56am revealed:
-Resident #1 had vomited at 9:00pm on that night shift.
-There was no documentation of notification made to the primary care provider regarding vomiting.

Review of computerized charting notes for Resident #1 dated 09/08/20 at 12:22am revealed:

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-Resident #1 had vomited and was complaining of stomach pain.
-There was no documentation of notification made to the primary care provider regarding vomiting.

Review of computerized charting notes for Resident #1 dated 09/13/20 at 2:09am revealed:
-Resident #1 had "forcefully vomited" onto the wall.
-There appeared to be blood on his sheets and on the wall.
-Resident #1 was transported to the local hospital by emergency medical services (EMS).

Telephone interview with the primary care provider for Resident #1 on 10/22/20 at 5:00pm revealed:
-She was not made aware of any episodes of vomiting prior to 09/12/20 which led to Resident #1 being hospitalized.
-She would have ordered a GI consult if she had been made aware of monthly episodes of vomiting but would not have been overly concerned if blood was not observed.

Review of records from local hospital emergency department dated 09/12/20 for Resident #1 revealed:
-The Resident was seen in the emergency department for a possible GI bleed.
-The resident reported abdominal pain.
-There were spots of dried blood around the outside of his mouth.
-There was blood found in his stool.

Review of the discharge summary dated 09/18/20 from the local hospital for Resident #1 revealed:
-The Resident was admitted on 09/13/20.
-Resident #1 was seen in the emergency

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department after vomiting blood.
-Resident #1 received 2 units of packed red blood cells while in the emergency department.
-Resident #1 received 1 unit of packed red blood cells following an upper endoscopy procedure on 09/13/20.
-An esophagogastroduodenoscopy (EGD-((Upper Endoscopy))) was attempted on 09/13/20 but could not be completed because the resident's oxygen levels dropped.
-There were no further episodes of hematemesis (vomiting of blood) during his hospital stay.

Interview with the hospice nurse for Resident #1 on 10/21/20 at 10:20am revealed she had been to see Resident #1 at the facility on 10/20/20 and staff had reported he had vomited his breakfast that morning.

Interview with a medication aide (MA)on 10/21/20 at 2:20pm revealed:
-She was not aware of Resident #1 vomiting on 10/20/20.
-She was not aware of any episodes of vomiting prior to Resident #1's hospitalization in September 2020.
-Resident #1 would often complain of not feeling well.

Telephone interview with a second medication aide on 10/22/20 at 7:50pm revealed:
-Resident #1 often complained of not feeling well.
-The first medication aide had reported to her once that Resident #1 had vomited on days but was unsure of the date that had occurred.
-Resident #1 had vomited brown liquid once on night shift while she was on duty.
-She was unsure of the date but remembered charting the incident on computerized charting notes.

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-She did not notify the PCP of vomiting episodes for Resident #1.
-She did not notify the speciel care coordinator (SCC).
-She would verbally relay information about resident care and concerns to the on-coming medication aide but did not report information to SCC.
-She "used to report everything..." to the SCC but had stopped reporting incidents to her because the SCC was no longer answering or returning call when she attempted to reach her.
-She did not know if the first shift oncoming MA reported to the SCC.

Telephone interview with a third medication aide on 10/23/20 at 10:30am revealed:
-She worked night shift and had seen brown liquid vomit twice prior to Resident #1 being sent out to the local hospital for evaluation on 09/12/20.
-She verbally reported occurrences to oncoming medication aides and documented in the computerized charting notes.
-She had not notified the SCC of Resident #1"s vomiting episodes prior to calling EMS on 09/12/20 when she found Resident had vomited dark red blood.
-She expected the SCC to review computerized charting notes for changes in resident conditions.
-She did not notify the PCP of Resident #1 vomiting blood.

Interview with the SCC on 10/21/20 at 9:00am revealed:
-The care staff charted by exception (only exceptions to normal, baseline for a resident) on computerized charting notes.
-Resident #1 was hospitalized in September 2020 for a GI bleed.

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D 273	Continued From page 38 A second interview with the SCC on 10/21/20 at 3:20pm revealed: -Resident #1 "coughed up blood" and was sent to the local hospital emergency department for evaluation in September 2020. -She was not aware of any history of vomiting. -She was not aware of any recent episodes of vomiting. -She was not aware the hospice nurse had documented Resident #1 had vomiting on the morning of 10/20/20. A third telephone interview with the SCC on 10/23/20 at 11:05am revealed: -There was no process in place for reviewing computerized charting notes. -She did not review or audit computerized charting notes. -She expected MAs to notify her of any incident of vomiting by a resident. -She recalled being notified of Resident #1 vomiting prior to 09/12/20. -Sherecalled making verbal notification to the PCP by phone. -There was no documentation of PCP notification of any incident of vomiting by Resident #1. Telephone interview with the executive director on 10/23/20 at 11:16am revealed that she was not aware of any process for reviewing computerized charting notes but she expected the SCC to review the charting. Telephone interview with the Administrator on 10/26/20 at 10:10am revealed: -She expected the SCC to review computerized charting notes for content then print and file in the resident record at the end of each month. -She was not notified of Resident #1 vomiting	D 273		

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blood.

Based on observation, interviews and record reviews it was determined Resident #1 was not interviewable.

3. Review of Resident #4's current FL-2 dated 09/14/20 revealed:
-Diagnoses included Alzheimer's dementia and generalized weakness.
-The resident was constantly disoriented.
-The resident was semi-ambulatory and incontinent of bowel and bladder.
-The resident needed staff assistance with bathing, feeding, and dressing.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 09/14/20.
-The resident required assistance with dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place.

Review of Resident #4's current assessment and care plan dated 09/16/20 revealed:
-The resident was non-ambulatory and used a Geri-chair.
-The resident had limited range of motion, limited strength, and limited eye-hand coordination with upper extremities.
-The resident had daily incontinence with bowel and bladder.
-The resident was always disoriented, had significant memory loss, and must be redirected.
-The resident was hard of hearing (hears loud sounds/voices) and had a weak speech.

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-The resident was totally dependent on staff for all activities of daily living including eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #4's multidisciplinary facility visit record for hospice revealed the resident as admitted to hospice services on 09/16/20.

Review of Resident #4's Physician Restraint Order dated 09/18/20 revealed:
-The medical reason for the restraints was documented as dementia, unable to ambulate independently.
-The type of restraint to be used was documented as Geri-chair with tray and bed rails.
-The time period for the restraints to be used was documented as Geri-chair while out of bed and bed rails when in bed.
-The time interval the restraints must be checked was documented as every 30 minutes.
-The time interval the restraints must be removed for exercise/mobility was every 2 hours.
-The resident's primary care provider (PCP) signed the order on 09/18/20.

Review of Resident #4's incident/accident report dated 09/28/20 at 8:30pm revealed:
-The aide was about to walk down the long hall and went to peek in on the resident and found him on the floor.
-The resident had climbed over the bed rail.
-The resident never cried out.
-Staff documented unable to take vital signs.
-Staff documented no injury was noticed at the time of the incident.
-Actions taken included: checked resident over, hospice was called, and the resident was put back in bed.
-The section on the report for noting the

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responsible party was notified was blank.
-Staff documented hospice was notified on 09/28/20 at 8:47pm.

Review of Resident #4's clinical hospice note dated 09/28/20 (no time noted) revealed:
-Hospice received a call from facility staff stating the resident "keeps climbing over bed rails".
-The resident slid to the floor and had a very minor skin tear which had been covered with a band aid.
-No other injuries were reported and the resident was now asleep per staff.
-The hospice note was signed by the on-call hospice registered nurse (RN).

Review of Resident #4's multi-disciplinary facility visit record for hospice dated 09/29/20 revealed:
-The hospice RN went to the facility for a follow-up visit status post resident fall from 12:05pm to 12:40pm.
-The resident had external rotation and was non-weight bearing to right lower extremity.
-The resident yelled in pain with movement.
-During visit with resident yesterday (09/28/20) prior to fall, the resident was able to stand for personal care.
-Telephone call to the resident's family member confirmed comfort care - no need for x-ray.
-Orders for pain management in place.

Interview with the Special Care Coordinator (SCC) on 10/20/20 at 4:15pm revealed:
-For Resident #4's fall on 09/28/20, staff reported to her that the resident had gone over the bed rails and fell on the floor mat.
-Staff reported they found pieces of the resident's torn clothing on the bed rail.
-Resident #4 had not climbed over the bed rails before to her knowledge.

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D 273	Continued From page 42 Telephone interview with a medication aide (MA) on 10/23/20 at 10:06am revealed: -One side of Resident #4's bed was against the wall and the other side had a full bed rail in the up position. -The resident would try to slide out of the bottom opening at the end of the bed rail and the end of the bed. -She would get a personal care aide (PCA) to help pull the resident back up to the top of the bed. -The resident would throw his legs over the bed rail. -She had observed the resident do this a couple of times per week since the resident was admitted to the facility. -She had not reported to anyone that the resident would slide down in bed or tried to climb over the rails. -She could not explain why she had not reported it to anyone. -On the night of 09/28/20, a PCA told her Resident #4 was on the floor. -The resident was on the floor next to the bed laying on his stomach with his face turned to the side. -The bed rail was up and she had "no idea" how he got out of bed. -The resident was awake and she checked him for bruises, skin tears, and bleeding but she did not see any injuries. -When she asked the resident if areas on his body hurt, the resident would say no. -She and the PCA assisted the resident back to bed and the PCA covered him up. -She called hospice and the on-call hospice RN asked if there was swelling or bruising and she told the nurse no. -The on-call hospice RN told her if there were any	D 273		

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changes throughout the night to call them back.
-She did not remember if she reported the fall to the SCC but she was supposed to call the SCC for any falls.

Telephone interview with a PCA on 10/23/20 at 10:54am revealed:
-Resident #4's bed rails were up when he was in bed and the resident would move his legs between the rails and the mattress.
-One staff (could not recall who or when) reported the resident had tried to go over the bed rails.
-The resident could move around in bed with his arms and legs.
-On 09/28/20, she and the MA were the only two staff working that night because two other staff had quit.
-She was checking on the resident and he was on the floor near his bed.
-It looked like the resident had gone over the bed rail.
-The resident had on his t-shirt and an incontinence brief and he was laying on his side.
-The resident was moaning in pain.
-When she tried to turn the resident on his back to get him off his hip, the resident yelled in pain.
-She screamed for the MA and told the MA the resident had fallen and needed to go to the hospital.
-The MA checked the resident to make sure he was not bleeding and the MA called hospice.
-She waited in the room with the resident and after the MA called hospice, they got the resident up and assisted him to bed and the resident yelled in pain.
-When they got the resident in bed, the resident was lying on his back and she noticed his right leg was turned outward and it did not look normal.
-She thought the resident needed to go to the hospital because he was in pain and his leg did

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not look normal.
-After the fall, when they provided incontinence care, the resident would say "oh, oh, oh, stop, it hurts, it hurts".

Interview with a second PCA on 10/21/20 at 2:58pm revealed:
-Resident #4's bed was against the wall and the other side of the bed had a full bed rail that was in the up position when the resident was in bed.
-The resident had bed rails in case the resident tried to get up to keep him from falling out of bed.
-Before the resident fell on 09/28/20, he could swing his leg around and sit up in bed.
-She had never observed the resident try to get out of bed.
-She was not working when Resident #4 fell on 09/28/20 because he fell on night shift and she usually worked day shift.
-When she came to work the next morning (09/29/20) around 7:00am, the resident was in bed and complained of his hip hurting.
-She was going to get the resident up for breakfast but when she tried to get him up, the resident yelled out and pointed at his hip.
-When she provided incontinence care the resident "hollered loud".
-She reported it to the MA but she could not recall which MA and she also thought it was reported to the SCC.
-The resident was receiving hospice services so he was not sent out to the hospital; he was just left in the bed after that.
-The resident continued to "holler out" when staff changed his incontinence briefs anytime after the fall.

Interview with a second MA on 10/21/20 at 3:19pm revealed:
-Resident #4 could move around in bed so one

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side of the bed was against the wall and the other side of the bed had a bed rail in the up position.
-One day during the first week the resident was admitted (could not recall date), she observed the resident with one leg off the end of the bed and the leg was angled around the end of the bed near the bed rail.
-She and another staff person (could not recall who) pulled the resident back up to the head of the bed.
-She did not remember if she reported it to anyone and she never saw the resident do that again.
-The night shift MA reported to her on 09/29/20 when she came on shift that the resident had fallen on 09/28/20.
-The night shift MA reported the resident had "scooted" to the end of the bed and slid to the floor.
-The night shift MA reported the resident had no injuries.
-No one reported the resident was yelling in pain to her on 09/29/20.
-She thought the hospice RN came sometime the morning of 09/29/20 but she could not recall for sure.

Interview with a third PCA on 10/21/20 at 3:44pm revealed:
-Resident #4 had a full bed rail on each side of the bed and one side of the bed was against the wall.
-The bed rail opposite the wall was always up when the resident was in bed.
-Toward the end of first shift on 09/28/20, the resident was "real antsy" meaning he wanted to get out of bed and would not sit still.
-The resident was grabbing at the bed rail and tried to pull himself over the bed rail.
-She thought she put a bed alarm and clipped it

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to the resident's clothing and bed and she reported to the night shift MA that the resident was "antsy".
-She did not work on 09/29/20 so she did not know how the resident was after his fall on 09/28/20.
-She came back to work 2 or 3 days later and the resident was in "excruciating" pain when they moved him.
-The hospice nurse told staff the resident's hip was broken but he was not able to have surgery.

Interview with a fourth PCA on 10/21/20 at 4:01pm revealed:
-Resident #4's bed rail was up when the resident was in bed and she never saw the resident trying to get out of bed.
-She was not working when Resident #4 fell on 09/28/20.
-When she came to work the next morning on 09/29/20 around 7:00am, the resident was in bed and he moaned a lot when staff tried to stand him up so they put him back in bed.
-She thought she reported it to the MA but she could not remember which MA.
-The resident continued to moan each time staff provided incontinence care on 09/29/20.

Telephone interview with a fifth PCA on 10/22/20 at 1:38pm revealed:
-Resident #4's bed was against the wall and the bed rail on the opposite side of the bed was up when the resident was in bed.
-Before her shift ended at 7:00pm on 09/28/20, she and another PCA put the resident in bed and put the rail up and the resident was "okay".
-The next morning on 09/29/20, she and another PCA were taking the resident out of bed and the resident moaned in pain when the moved him, which was unusual for the resident.

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-If reported, she would have reported it to the MA but she did not know which MA and could not recall if she reported it.
-Another staff (could not recall who) informed her later that the resident had fallen on 09/28/20.

Telephone interview with a third MA on 10/22/20 at 7:48pm revealed:
-Resident #4 had bedrails but he could move around in the bed.
-One evening while she was working (could not recall when), a staff member (could not recall who) reported the resident was trying to get out of bed with the bed rails up.
-She put the resident in the Geri-chair and he calmed down.
-She could not remember if she reported to the SCC that Resident #5 was trying to get out of bed.

Telephone interview with the on-call hospice RN on 10/23/20 at 4:12pm revealed:
-She received a phone call from the facility on 09/28/20 (could not recall the time) about Resident #4.
-The facility staff person (could not recall name) reported Resident #4 was constantly climbing over the bed rails and the resident had slid to the floor.
-She was told the resident had an abrasion on his finger that was covered with a band aid and there was no need for her to come to the facility because the resident was going to sleep.
-The facility staff did not report the resident was in pain or that the resident's leg was turned out.
-If the resident was in pain or if facility staff had reported the resident's leg was turned out, she would have made a visit to the facility to see the resident.
-She told the facility staff person to call her back if

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there were any other issues with the resident or if the resident had any symptoms.
-The facility staff did not call her back any time after the initial call on 09/28/20 to report any symptoms or changes in the resident's condition.
-She emailed Resident #4's routine hospice RN the next morning (09/29/20) about staff reported the resident was continuously climbing over the bed rails.
-The routine hospice RN said the facility had not reported to her that the resident had been climbing over the bed rails because she would have already checked on the concern if she had known.

Telephone interview with Resident #4's hospice RN on 10/21/20 at 10:00am revealed:
-She saw Resident #4 during a hospice visit on 09/28/20 before the resident fell.
-The resident had generalized body stiffening and slowed delayed movement and he could move his arms.
-The resident required 2-person stand by assistance.
-When she saw the resident on 09/28/20, she and one staff stood him up and he could stand in place for about 2 minutes.
-Facility staff had not reported the resident was trying to climb out of bed prior to his fall on 09/28/20.
-It was her understanding the resident was found on the floor at the side of the bed and a skin tear was his only injury.
-The on-call hospice nurse did not come to the facility when the resident fell on 09/28/20 because staff reported the only injury was a skin tear.
-Hospice protocol was for the hospice nurse to follow-up the next day, within 24 hours since the only injury reported was a skin tear.
-The next day on 09/29/20, when she came to the

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facility, the resident was in his Geri-chair with tray.
-Facility staff did not report the resident was having any pain or other symptoms.
-A MA helped her stand the resident up but the resident could not bear weight and the resident cried out in pain.
-The resident's leg was externally rotated, which was a symptom that was consistent with a fractured hip.
-The resident wore incontinence briefs and required staff to change the briefs.
-The hip injury would have caused the resident to be in a lot of pain each time the resident was moved to change his incontinence brief after the fall on 09/28/20.
-No one from the facility had reported the resident was having any pain since his fall on 09/28/20.
-She spoke with the resident's family member on 09/29/20 who decided not to send the resident out to the hospital because of his age and because the resident would not be a candidate for surgical repair of the hip due to his physical condition.
-After his fall on 09/28/20, the resident required Morphine (a narcotic pain reliever) for his pain.
-The resident passed away on 10/03/20.

Telephone interview with the SCC on 10/23/20 at 11:50am revealed:
-Resident #4 was total care when he was first admitted to the facility on 09/14/20.
-The resident was brought in for generalized weakness, he could not walk, and he mumbled.
-The resident had a slight improvement around the end of his first week or going into his second week at the facility.
-The resident started to talk better and he was able to move his arms and legs.
-The resident was not able to stand and he had a

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D 273	Continued From page 50 Geri-chair with tray and bed rails. -When the resident improved, he could move his legs and if he did not have bed rails, the resident could roll onto the floor. -On 09/28/20, the bed rails were up when the resident fell. -She was told by the MA that the resident put his legs over the rail when he fell on 09/28/20. -Prior to the fall on 09/28/20, no one had reported to her that the resident had been observed pulling himself over the bed rails. -She would have expected staff to notify her about the resident trying to get out of bed over the rails. -Staff had reported the resident had been pulling on the rails but she could not recall how many times or when. -The morning after the resident fell on 09/29/20, she observed the resident was lying peacefully in his bed. -The MA or the PCA reported the resident was in pain and that he was wincing and moaning when the resident was moved. -She knew the resident's hospice RN would be coming to the facility that morning so she waited to address the resident's pain with the hospice RN after the RN arrived at the facility (could not recall time). -The hospice RN and a PCA tried to stand the resident and the resident was wincing and moaning in pain. -If staff had reported the resident was trying to go over the bed rails, she would have reported it to hospice. Telephone interview with Resident #4's family member on 10/23/20 at 9:41am revealed: -She was aware the resident had bed rails. -The resident apparently tried to get out of bed on his own and fell (no date provided).	D 273		

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-She discussed the resident's injury from the fall with a hospice nurse and it was assumed the resident had a fractured leg or hip.
-She did not know if the resident's bed rails were up at the time of the fall.
-Prior to the fall, no one had reported the resident had tried to get out of bed on his own.

Telephone interview with Resident #4's PCP on 10/23/20 at 11:15am revealed:
-She saw Resident #4 one time for a new patient visit.
-The resident came to the facility with the intention of going on hospice services.
-The resident was already declining when he was admitted to the facility.
-Facility staff reported the resident had one fall when he climbed out of the chair or the bed (could not recall which).
-Staff did not report any issues or injuries with the fall (could not recall when).

4. Review of Resident #5's current FL-2 dated 10/05/20 revealed:
-Diagnoses included dementia, Alzheimer's disease, displaced intertrochanteric (hip fracture), hypocholesterolemia, major depressive disorder, essential hypertension, chronic obstructive pulmonary disease, and pain in left hip.
-The resident was documented as non-ambulatory and incontinent of bowel and bladder.
-The resident was documented as need assistance with bathing and dressing.

Review of Resident #5's Resident Register revealed:
-The resident was admitted to the facility on 11/30/17.
-The resident was discharged to a skilled nursing

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D 273	Continued From page 52 facility on 10/13/20. Review of Resident #5's current assessment and care plan dated 08/13/20 revealed: -The resident had wandering behavior, disruptive behavior, and was verbally abusive. -The resident had no problems with ambulation or upper extremities. -The resident had occasional incontinence with bowel and bladder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required supervision with eating, ambulation, and transferring. -The resident required limited assistance with toileting, bathing, dressing, and grooming. Review of Resident #5's incident/accident report dated 09/04/20 at 8:12am revealed: -The resident was found on the floor and vital signs were taken. -The medication aide (MA) observed no bruises at this time and would keep a monitor on the resident. -The resident's responsible party was notified on 09/04/20 at 8:30am. -The resident's primary care provider's (PCP) office was contacted on 09/04/20 at 9:00am. -The PCP signed the incident/accident report on 09/17/20 and noted the resident was sent to the emergency room (ER). Review of Resident #5's physical therapy (PT) progress note dated 09/04/20 revealed: -The physical therapy assistant (PTA) noted upon arrival to the facility, staff reported the resident fell that morning (09/04/20) when attempting to ambulate. -Staff reported no injuries on initial assessment. -The resident was taken to her room via	D 273		

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wheelchair and her vital signs were assessed to be within normal limits.
-The resident complained of left lower extremity pain when attempting seated health exercise program and she reported it to facility staff.
-Facility staff attempted to stand the resident with the resident yelling in pain with weight bearing on left lower extremity.
-The resident was returned to the wheelchair with no further activity.
-Facility staff called the resident's family member for further instruction.

Telephone interview with Resident #5's PTA on 10/22/20 at 2:42pm revealed:
-She arrived to the facility around 8:30am on 09/04/20 and Resident #5 was in a wheelchair.
-Facility staff reported to her that Resident #5 had had fallen that morning on 09/04/20 but there were no injuries.
-When she started to do the seated exercises with Resident #5, the resident complained of pain.
-She notified facility staff and facility staff helped her try to assist the resident to stand but the resident complained of left lower extremity pain.
-Once they started movement with the resident, the resident would "holler out" in pain and point at her hip.
-No one at the facility reported the resident was having any symptoms of pain when she arrived to the facility on 09/04/20.
-She told facility staff (could not recall which staff) that the resident needed to be seen for evaluation because there was definitely an injury to the resident's hip.
-She thought the facility staff called the resident's family member to find out if the family member wanted the resident to go to the ER.
-She called back to the facility later that day to

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check on Resident #5.
-She could not recall when she called or who she spoke with on the phone.
-Staff reported the resident had not gone to the hospital and the resident was doing okay.

Review of Resident #5's facility charting notes revealed:
-On 09/04/20 at 9:05am: the resident was found on the floor; observed resident and took vital signs; called the resident's family member and talked with her about sending the resident out. The resident's family member stated to monitor the resident throughout the day and if anything changed to call her back.
-On 09/04/20 at 6:42pm: the resident was transferred to the hospital due to "early fall"; called the resident's family member to let her know that the resident was going to the ER; no answer, left message for her to call the facility.

Review of Resident #5's emergency medical services (EMS) report dated 09/04/20 revealed:
-The call for EMS was received on 09/05/20 at 6:23pm and EMS was at the facility with the resident at 6:31pm.
-When the EMS arrived at the facility, the resident was found sitting upright in a chair, conscious and alert to her normal.
-Facility staff reported the resident fell "a few hours ago" but was unable to give a more accurate time.
-The EMS crew was unable to obtain an accurate history of events due to staff not being present at the time of the fall.
-The resident was normally ambulatory but had not been able to ambulate since the fall.
-The resident was assisted to a standing position so she could be placed on the stretcher.
-While moving, the resident favored her left leg

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and cried out in pain.
-The resident indicated the pain was in the area of her left upper leg.
-The resident's left leg was bent at the knee and the resident refused to straighten her leg.
-The resident's left leg appeared to be shorter and externally rotated.
-The resident was trembling and unable to hold still during transport.

Review of Resident #5's hospital record dated 09/04/20 revealed:
-The resident was admitted to the ER on 09/04/20 after a fall.
-The resident arrived by EMS on 09/04/20 at 6:59pm.
-Upon exam, the resident's left leg was shorted and externally rotated.
-The resident was diagnosed with a left hip fracture and had surgical repair of the fracture on 09/05/20.

Telephone interview with a MA on 10/23/20 at 12:41pm revealed:
-She did not observe Resident #5 fall on 09/04/20 but she heard a noise and went in the dining room and the resident was sitting on her bottom on the floor.
-She observed the resident and pressed on the resident's arms and legs.
-She asked the resident if she was hurt and the resident said no.
-She helped the resident stand up and sit in a chair.
-She thought she checked the resident's vital signs and then she called the family and the PCP.
-She told the resident's family member the resident had fallen but there were no bruises and the resident said she was not hurting.
-The family member told her not to send the

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resident to the hospital but to monitor to the resident.
-Later that evening (could not recall time), the personal care aide (PCAs) provided incontinence care to the resident and reported the resident was hurting.
-She tried to contact the family member but could not reach her so she called the Special Care Coordinator (SCC).
-The SCC told her to send the resident to the hospital.

A second telephone interview with the same MA on 10/23/20 at 4:32pm revealed:
-She could not recall who helped the PTA stand up Resident #5 when she was at the facility.
-She could not recall if the PTA told her to send the resident to the hospital.
-She eventually sent the resident to the hospital because the PCAs kept saying Resident #5 was in pain.

Interview with a PCA on 10/21/20 at 3:44pm revealed:
-On 09/04/20, Resident #5 was in the dining room and when the resident went to stand up, the resident tumbled over and landed on her hip.
-The MA assessed the resident and called the resident's family member.
-The family member did not want the resident sent to the hospital at that time but just wanted staff to observe the resident.
-She put the resident in bed after breakfast and with each incontinence change, the resident hollered and said her side hurt while putting her hand on her hip.
-She reported this to the MA.
-She did not know if the resident's PCP was called because the MA would have done that.
-Resident #5 was in bed most of the day on

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09/04/20.
-She thought the MA finally decided to send the resident to the hospital later that day because the resident continued to hurt.
-The PCAs were responsible for reporting changes in resident's conditions to the MAs and the MAs were supposed to "handle it" from that point.

Attempted telephone interviews with Resident #5's family member on 10/22/20 at 1:08pm and 10/23/20 at 10:03am were unsuccessful.

Telephone interview with the SCC on 10/23/20 at 11:50am revealed:
-When Resident #5 fell on 09/04/20, it looked like she had laid down on the floor.
-She did not recall where the resident fell.
-The resident's PCP was notified of the fall.
-She could not recall if staff notified her of any symptoms or concerns after the resident fell.
-If staff had reported any symptoms to her, she would have reported it to the PCP.
-She did not remember why there was a delay from when the resident fell until she was sent to the hospital; it may have been because staff was monitoring the resident during that time.
-She would expect staff to report the resident's pain to her or the care provider because that would be a change in condition and the resident would need to be evaluated.

Telephone interview with Resident #5's PCP on 10/23/20 at 11:15am revealed:
-She was notified Resident #5 had a fall on 09/04/20.
-She thought the first notification was through her office's electronic messaging system.
-She also spoke with the SCC (could not recall what time) who reported the resident fell and was

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D 273	Continued From page 58 in a lot of pain. -She instructed the SCC to send the resident to the hospital. -If a resident was in pain, the facility did not need her permission to send the resident to the hospital for evaluation. -The facility staff should have sent the resident to the hospital when she complained of pain. _____ The facility failed to assure referral and follow up by failing to report symptoms of pain to the primary care provider (PCP) resulting in delays in medical evaluation and treatment. Resident #3 complained of left side pain after a fall and was unable to apply pressure to her left leg. The resident was later diagnosed with a broken hip. Resident #4 tried multiple times to climb over bed rails, a restraint, with staff failing to report this behavior, resulting in a fall and a delay in reporting pain and a leg deformity to the hospice provider. The resident's fall resulted in a hip injury consistent with a broken hip and the resident later died. Resident #5 who complained of pain and was unable to bear weight after a fall and was later diagnosed with a hip fracture. The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/23/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2020.	D 273		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 59 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of incidents resulting in injury requiring medical treatment and referral to a local hospital for emergency medical evaluation for 5 of 5 sampled residents (#1, #2, #3, #4, #5). The findings are: Review of the facility's Accident/Incident Policy and Procedure revealed: -In case of an accident/incident, the staff will conduct a preliminary examination of the resident to determine if he or she needs to be transported to the hospital. If ambulance is required, call 911. -Call the resident's physician immediately, giving a complete description of the accident/incident and the condition of the resident. The physician will advise as to which procedures are necessary. -Fill out an accident/incident report and fax to the Onslow County Department of Social Services within 24 hours of the accident/incident.	D 451		

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1. Review of Resident #3's current FL-2 dated 08/13/20 revealed diagnoses included dementia with behavior disturbances.

Review of an accident/incident report dated 07/08/20 for Resident #3 revealed:
-The resident fell on the floor and hit her head.
-The resident was transported by the emergency medical service (EMS) to a local hospital emergency room for evaluation.
-There was no documentation the county DSS was notified of the incident that occurred on 07/08/20.

Review of a hospital emergency department after visit summary dated 07/08/20 for Resident #3 revealed:
-The resident was seen for fall/head injury.
-The resident was discharged as stable and at baseline related to her fall.

Review of an accident/incident report dated 10/11/20 for Resident #3 revealed:
-The personal care aide (PCA) was providing care to the resident and the resident attempted to move away from the PCA and fell backwards and hit her head on her roommate's Geri chair.
-The resident was bleeding from the back of her head.
-The resident was transported by the EMS to a local hospital emergency department for evaluation.
-There was no documentation the county DSS was notified of the incident that occurred on 10/11/20.

Review of a hospital emergency department after visit summary dated 10/11/20 for Resident #3 revealed:
-The resident was seen for a fall to a hard surface

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while standing and lost her balance.
-The resident was diagnosed with a laceration to the scalp and a rib fracture.
-The resident had to receive staples to her head due to a scalp laceration.

Review of an accident/incident report dated 10/20/20 for Resident #3 revealed:
-The resident fell in the kitchen.
-The resident had no bruises, but resident was complaining of body pain when she was touched.
-The resident was transported by the EMS to a local hospital emergency department for evaluation.
-There was no documentation the county DSS was notified of the incident that occurred on 10/20/20.

Review of a hospital emergency department after visit summary dated 10/20/20 for Resident #3 revealed:
-The resident was seen for a fall, urinary tract infection, dementia and elevated blood pressure.
-The resident was diagnosed with a UTI, falls frequently and elevated blood pressure.
-The resident had no acute findings from the cervical spine and head computerized tomography (CT) scans.

Telephone interview with the Adult Home Specialist (AHS) on 10/23/20 at 8:03am revealed:
-She received an accident/incident report for Resident #3 on 10/22/20 from the facility.
-The accident/incident report dated 10/22/20 stated Resident #3 was sent to a local hospital on 10/20/20 and sent back, then went out to another local hospital on 10/21/20.
-She had not received an accident/incident report for 10/20/20 as of today, 10/23/20.

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Refer to telephone interview with county AHS on 10/21/20 at 2:07pm.

Refer to interview with the SCC on 10/21/20 at 2:30pm.

Refer to telephone interview with the Regional Director on 10/22/20 at 12:47pm.

2. Review of Resident #1's current FL-2 dated 09/17/20 revealed diagnoses included dementia and upper gastrointestinal (GI) bleed.

Review of an accident/incident report dated 09/12/20 for Resident #1 revealed:
-The resident was found to have vomited blood.
-The resident was transported by the emergency management system (EMS) to a local hospital emergency room for evaluation.
-There was no documentation the county DSS was notified of the incident that occurred on 09/12/20.

Review of records from local hospital emergency department dated 09/12/20 for Resident #1 revealed:
-The Resident was seen in the emergency department for a possible GI bleed.
-The resident reported abdominal pain.
-There were spots of dried blood around the outside of his mouth.
-There was blood found in his stool.

Telephone interview with a medication aide (MA) on 10/23/20 at 10:30am revealed she notified the Special Care Coordinator (SCC) on 09/12/20 of the vomiting of blood and need to for evaluation after calling emergency medical services (EMS).

Refer to telephone interview with county AHS on

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D 451	Continued From page 63 10/21/20 at 2:07pm. Refer to interview with the SCC on 10/21/20 at 2:30pm. Refer to telephone interview with the Regional Director on 10/22/20 at 12:47pm. 3. Review of Resident #2's current FL-2 dated 08/13/20 revealed diagnoses included dementia, diabetes, hypertension, hypothyroidism, sciatica, knee pain, chronic kidney disease, and coronary artery disease. Review of an incident/accident report dated 09/15/20 at 12:35pm for Resident #2 revealed: -Resident #2 was found on the floor. -Resident #2 had a skin tear on her left arm above her hand and a bruise on her left knee. -Resident #2 was sent to the emergency department. -There was no documentation Department of Social Services (DSS) was notified of the incident. Review of the local hospital discharge summary dated 09/15/20 revealed: -Resident #2 had experienced a fall in the facility and EMS was called. -Resident #2 had a small laceration on her left wrist. -Resident #2 was diagnosed with a left wrist fracture of the ulnar styloid. Refer to telephone interview with county AHS on 10/21/20 at 2:07pm. Refer to interview with the SCC on 10/21/20 at 2:30pm.	D 451		

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Refer to telephone interview with the Regional Director on 10/22/20 at 12:47pm.

4. Review of Resident #4's current FL-2 dated 09/14/20 revealed diagnoses included Alzheimer's dementia and generalized weakness.

Review of Resident #4's incident/accident report dated 09/28/20 at 8:30pm revealed:
-The aide was about to walk down the long hall and went to peek in on the resident and found him on the floor.
-The resident had climbed over the bed rail.
-The resident never cried out.
-Staff documented no injury was noticed at the time of the incident.
-The section on the report for noting the responsible party was notified was blank.
-Staff documented hospice was notified on 09/28/20 at 8:47pm.
-The incident/accident report was not signed by the Administrator or Executive Director (ED).
-There was no documentation the incident/accident report was provided to the local county Department of Social Services (DSS).

Refer to telephone interview with county AHS on 10/21/20 at 2:07pm.

Refer to interview with the SCC on 10/21/20 at 2:30pm.

Refer to telephone interview with the Regional Director on 10/22/20 at 12:47pm.

5. Review of Resident #5's current FL-2 dated 10/05/20 revealed diagnoses included dementia, Alzheimer's disease, displaced intertrochanteric (hip fracture), hypocholesterolemia, major depressive disorder, essential hypertension,

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chronic obstructive pulmonary disease, and pain in left hip.

Review of Resident #5's incident/accident report dated 08/18/20 at 1:30pm revealed:
-The resident was found on the floor in another resident's room.
-The resident was asked if she was hurting anywhere and the resident stated no but she seemed a little confused.
-The resident was checked all over and "no injury seen at this time".
-The resident was assisted to her room and she laid on her bed.
-The resident's responsible party was notified on 08/18/20 at 1:43pm.
-The resident's primary care provider's (PCP) office was contacted on 08/18/20 at 1:50pm, waiting on return call.
-The PCP signed the report on 08/19/20 and noted the resident had been admitted to the hospital and the PCP would see the resident next week.
-There was no documentation the incident/accident report was provided to the local county Department of Social Services (DSS).

Review of Resident #5's hospital record dated 08/18/20 revealed:
-The resident was seen by the emergency room (ER) provider on 08/18/20 at 9:16pm with a fever and low blood pressure.
-The resident was admitted to the hospital on 08/19/20 at 1:28am and was diagnosed with sepsis, urinary tract infection, and encephalopathy due to infection.

Review of Resident #5's incident/accident report dated 09/04/20 at 8:12am revealed:
-The resident was found on the floor.

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D 451	Continued From page 66 -The medication aide (MA) noted no bruises at this time and would keep a monitor on the resident. -The resident's responsible party was notified on 09/04/20 at 8:30am. -The PCP signed the incident/accident report on 09/17/20 and noted the resident was send to the ER. -The incident/accident report was not signed by the Administrator/Executive Director. -There was no documentation the incident/accident report was provided to the local county DSS. Review of Resident #5's hospital record dated 09/04/20 revealed: -The resident was admitted to the ER on 09/04/20 after fall. -Upon exam, the resident's left leg was shorted and externally rotated. -The resident was diagnosed with a left hip fracture and had surgical repair of the fracture on 09/05/20. Refer to telephone interview with county AHS on 10/21/20 at 2:07pm. Refer to interview with the SCC on 10/21/20 at 2:30pm. Refer to telephone interview with the Regional Director on 10/22/20 at 12:47pm. _____ Telephone interview with the county Adult Home Specialist (AHS) on 10/21/20 at 2:07pm revealed she had not received any incident/accident reports from the facility since April 2020. Telephone interview with the SCC on 10/21/20 at 2:30pm revealed:	D 451		

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D 451	Continued From page 67 -She notified the residents' PCP and family of accidents and incidents. -She was not aware the county DSS needed to be notified of incidents/accidents in the facility. Telephone interview with the Regional Director on 10/22/20 at 12:47pm revealed: -He was aware the accident/incident reports had to be sent to the county DSS. -He was not aware the county DSS had not been notified of incidents/accidents when residents were seen at the hospital emergency room for evaluation.	D 451		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care	D 482		

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planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on interviews and record reviews, the facility failed to assure a Geri-chair with tray and bed rails were used only after an assessment and care planning process had been completed through a team process and alternatives had been tried for 1 of 1 residents sampled (#4) who had a history of trying to climb over the bed rails,

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D 482	Continued From page 69 resulting in the resident falling and sustaining a hip injury consistent with a broken hip. The findings are: Review of the facility's Restraint Policy revealed: -Restraints were only to be used for the safety and well-being of the resident. -This was only to be done in the case of medical symptoms that warrant the use of restraints such as: confusion with the risk of falls and risk of abusive or injurious behaviors to self. -Alternatives to physical restraints that would provide safety to the resident and prevent potential decline in the resident's functioning shall be provided prior to restraining the resident and documented in the resident's record. -If alternatives have failed and medical symptoms warrant the use of physical restraints, the facility shall ensure the resident is restrained with the least restrictive restraint that would provide safety. -Alternatives that should be tried prior to the use of physical restraints include: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from the chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, providing supportive devices such as wedge cushion, controlling pain, and providing a calm relaxing environment with minimal noise and confusion. -When physical restraints are used, the facility shall engage in a systematic and gradual process towards reducing restraint use by using alternatives. -The Administrator shall assure each resident with medical symptoms that warrant the use of restraints is assessed and a care plan is	D 482		

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D 482	Continued From page 70 developed prior to the resident being restrained. -The assessment shall include: medical symptoms that warrant the use of a restraint; how the medical symptoms affect the resident; when the medical symptoms first appeared; how often the symptoms occur; and alternatives provided and the resident's response. -The care plan shall be individualized and indicate specific care to be given to the resident and shall include: alternatives and how alternatives will be used; the least restrictive type of physical restraint that would provide safety; and care to be provided to the resident during the time the resident is restrained. -The assessment and care planning shall be accomplished through a team process and the team must at least consist of the supervisor or a personal care aide (PCA), a registered nurse (RN), and the resident's representative. -If the resident's representative is not available, there must be documentation the resident's representative was notified and declined the invitation to attend. -The resident's representative shall sign and date a statement they have been informed and consent shall include the type of restraint to be used and the medical symptoms for use. -The use of physical restraints is allowed only with a written order form a licensed physician. -The physician shall update the restraint order at a minimum of every 3 months. -The resident shall be checked and released from the physical restraint and care provided as stated in the care plan at least every 15 minutes for checks and at least every 2 hours for release. -All instances of physical restraint use shall be documented. Review of Resident #4's current FL-2 dated 09/14/20 revealed:	D 482		

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-Diagnoses included Alzheimer's dementia and generalized weakness.
-The resident was constantly disoriented.
-The resident was semi-ambulatory and incontinent of bowel and bladder.
-The resident needed staff assistance with bathing, feeding, and dressing.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 09/14/20.
-The resident required assistance with dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place.

Review of Resident #4's current assessment and care plan dated 09/16/20 revealed:
-The resident was non-ambulatory and used a Geri-chair.
-The resident had limited range of motion, limited strength, and limited eye-hand coordination with upper extremities.
-The resident had daily incontinence with bowel and bladder.
-The resident was always disoriented, had significant memory loss, and must be redirected.
-The resident was hard of hearing (hears loud sounds/voices) and had a weak speech.
-The resident was totally dependent on staff for all activities of daily living including eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-There was no documentation regarding the use of physical restraints.

Review of Resident #4's multidisciplinary facility

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D 482	Continued From page 72 visit record for hospice revealed the resident as admitted to hospice services on 09/16/20. Review of Resident #4's Restraint Assessment dated 09/18/20 revealed: -The medical symptoms that warranted the use of restraints were documented as dementia and non-ambulatory status. -These medical symptoms affected the resident because the resident was unable to ambulate independently and safely. -These medical symptoms were documented as occurring "constantly". -Alternatives that had been provided were documented as physical therapy ordered while the resident was in the hospital (referring to a hospitalization prior to the resident being admitted to the facility on 09/14/20). -The resident's response to the alternative used was documented as non-effective due to decline and resident unable to follow commands. -There was no documentation of any other alternative used. -There was no documentation indicating what type of restraints the resident was assessed to use. -The restraint assessment was signed by the Special Care Coordinator (SCC). -There was no documentation of a team process that included a RN or the resident's family participating in the assessment and care planning for restraints for the resident. Review of Resident #4's Restraint Use Disclosure Statement dated 09/18/20 revealed: -Restraints were only to be used for the safety and well-being of the resident. -Restraints were used only on residents with medical symptoms that warranted the use of such.	D 482		

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D 482	Continued From page 73 -A full assessment was done and a care plan developed which was individualized for the resident. -A physician order was obtained that specified all considerations regarding the use of restraints for that resident. -The resident was checked every 30 minutes and repositioned/exercised every 2 hours. -All measures would be taken to minimize the risk associated with the use of restraints, such as limited mobility, reduced social contact, and development of pressure ulcers. -The type of restraint to be used was documented as Geri-chair with tray and bed rails. -The medical symptoms that warranted the use of restraints was documented as dementia. -The SCC signed on the witness line on 09/18/20. -The line designated for resident/responsible party had the name of the resident's family member printed and "verbal telephone consent" with the date of 09/18/20 written beside it. Review of Resident #4's Physician Restraint Order dated 09/18/20 revealed: -The medical reason for the restraints was documented as dementia, unable to ambulate independently. -The type of restraint to be used was documented as Geri-chair with tray and bed rails. -The time period for the restraints to be used was documented as Geri-chair while out of bed and bed rails when in bed. -The time interval the restraints must be checked was documented as every 30 minutes. -The time interval the restraints must be removed for exercise/mobility was every 2 hours. -The resident's primary care provider (PCP) signed the order on 09/18/20. Review of Resident #4's licensed health	D 482		

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professional support (LHPS) review dated 09/28/20 revealed:
-The resident was dependent upon staff for all activities of daily living.
-Staff assisted the resident with toileting every 2 hours and as needed.
-The nurse checked off physical restraints as a LHPS task for the resident.
-The resident was ambulated per Geri-chair with tray.
-There was not documentation related to the resident's use of bed rails in the evaluation.

Telephone interview with the facility's contracted LHPS nurse on 10/23/20 at 2:57pm revealed:
-She was not included in any team process for the assessment and care planning for Resident #4's physical restraints.
-She had not been asked by the facility to provide this service for any residents at the facility.

Review of Resident #4's incident/accident report dated 09/28/20 at 8:30pm revealed:
-The aide was about to walk down the long hall and went to peek in on the resident and found him on the floor.
-The resident had climbed over bed rail.
-The resident never cried out.
-Staff documented no injury was noticed at the time of the incident.
-Actions taken included: checked resident over, hospice was called, and the resident was put back in bed.
-Staff documented hospice was notified on 09/28/20 at 8:47pm.

Telephone interview with the SCC on 10/20/20 at 4:15pm revealed:
-For Resident #4's fall on 09/28/20, staff reported to her that the resident had gone over the bed

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rails and fell on the floor mat.
-Staff reported they found pieces of the resident's torn clothing on the bed rail.
-Resident #4 had not climbed over the bed rails before to her knowledge.
-The resident was totally dependent upon staff for all activities of daily living when he was first admitted to the facility.
-The resident had started improving and getting stronger and he had even figured out how to take the tray off the Geri-chair.

Review of Resident #4's clinical hospice note dated 09/28/20 revealed:
-Hospice received a call from facility staff stating the resident "keeps climbing over bed rails".
-The resident slid to the floor and had a very minor skin tear which had been covered with a band aid.
-No other injuries and the resident was now asleep.
-The hospice note was signed by the on-call hospice RN.

Telephone interview with the on-call hospice RN on 10/23/20 at 4:12pm revealed:
-She received a phone call from the facility on 09/28/20 (could not recall the time) about Resident #4.
-The facility staff person (could not recall name) reported Resident #4 was constantly climbing over the bed rails and the resident had slid to the floor.
-She was told the resident had an abrasion on his finger that was covered with a band aid.
-She told the facility staff person to call her back if there were any other issues with the resident or if the resident had any symptoms.
-The facility staff did not call her back any time after the initial call on 09/28/20 to report any

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symptoms or changes in the resident's condition.
-She emailed Resident #4's routine hospice RN the next morning about staff reporting the resident was continuously climbing over the bed rails.
-The routine hospice RN said the facility had not reported to her that the resident had been climbing over the bed rails because she would have already checked on the concern if she had known.

Review of Resident #4's multi-disciplinary facility visit record for hospice dated 09/29/20 revealed:
-The hospice RN went to the facility for a follow-up visit status post resident fall.
-The resident had external rotation and was non-weight bearing to right lower extremity.
-The resident yelled in pain with movement.
-During visit with resident yesterday (09/28/20) prior to fall, the resident was able to stand for personal care.
-Telephone call to the resident's family member confirmed comfort care - no need for x-ray.
-Orders for pain management were in place.

Telephone interview with Resident #4's hospice RN on 10/21/20 at 10:00am revealed:
-She saw the resident during a hospice visit the day before he fell on 09/28/20.
-The resident had generalized body stiffening and slowed delayed movement and he could move his arms.
-The resident required 2-person stand by assistance.
-When she saw the resident on 09/27/20, she and one staff assisted him to stand up and he could stand in place for about 2 minutes.
-Facility staff had not reported the resident was trying to climb out of bed prior to his fall on 09/28/20.

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D 482	Continued From page 77 -It was her understanding the resident was found on the floor at the side of the bed and a skin tear was his only injury. -The next day on 09/29/20, when she came to the facility, the resident was in his Geri-chair with tray. -A medication aide (MA) helped her stand the resident up but the resident could not bear weight and the resident cried out in pain. -The resident's leg was externally rotated, which was a symptom that was consistent with a fractured hip. -After his fall on 09/28/20, the resident required Morphine (a narcotic pain reliever) for his pain. -The resident passed on 10/03/20. A second telephone interview with Resident #4's hospice RN on 10/26/20 at 11:07am revealed: -The facility had not asked her to take part in an assessment or care planning process for Resident #4's restraints. -No one had reported to her that the resident had been climbing over the bed rails. -If they had known, they could have tried interventions such as bed alarm, fall mat, or medication adjustments. Telephone interview with a medication aide (MA) on 10/23/20 at 10:06am revealed: -Resident #4 could not walk and he used a Geri-chair with tray and the resident would try to push the tray off but it did not come off. -One side of the resident's bed was against the wall and the other side had a full bed rail in the up position. -The resident would try to slide out of the bottom opening at the end of the bed rail and the end of the bed. -She would get a PCA to help pull the resident back up to the top of the bed.	D 482		

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D 482	Continued From page 78 -The resident would throw his legs over the bed rail. -She had observed the resident do this a couple of times per week since the resident was admitted to the facility. -She had not reported the resident would slide down in bed or tried to climb over the rails. -She could not explain why she had not reported it to anyone. -On the night of 09/28/20, a PCA was walking down the hall and saw the resident on the floor. -The PCA told her the resident was on the floor. -They did not hear the resident fall or yell out when he fell. -The resident was on the floor next to the bed laying on his stomach with his face turned to the side. -The resident was wearing a t-shirt and his incontinence brief was off. -The bed rail was up and she had no idea how he got out of bed. -The resident was awake and she checked him for bruises, skin tears, and bleeding but she did not see any injuries. -When she asked the resident if areas on his body hurt, the resident would say no. -She called hospice and the on-call hospice RN asked if there was swelling or bruising and she told the nurse no. -The next day when she went back to work, the resident was not himself and his right leg could not be touched because he would say it hurt. Telephone interview with a PCA on 10/23/20 at 10:54am revealed: -Resident #4 had a Geri-chair with tray and he could push the tray but it never came off. -The resident's bed rails were up when he was in bed and the resident would move his legs between the rails and the mattress.	D 482		

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THE ARC COMMUNITY	1241 ONSLOW PINES ROAD JACKSONVILLE, NC 28540

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-One staff (could not recall who) reported the resident had tried to go over the rails.
-The resident could move around in bed with his arms and legs.
-On 09/28/20, she and the MA were the only two staff working that night because two other staff had quit.
-She was checking on the resident and he was on the floor near his bed.
-It looked like the resident had gone over the bed rail.
-The resident had on his t-shirt and an incontinence brief and he was laying on his side.
-The resident was moaning in pain.
-She waited in the room with the resident and after the MA called hospice, they assisted the resident to bed and the resident was yelling in pain.
-When they got the resident in bed, the resident was lying on his back and she noticed his right leg was turned outward and it did not look normal.
-After the fall, when they provided incontinence care, the resident would say "oh, oh, oh, stop, it hurts, it hurts".

Interview with a second MA on 10/21/20 at 3:19pm revealed:
-Resident #4 had a Geri-chair with tray and the resident could not remove the tray and she never saw him try to do it.
-The resident could move around in bed so one side of the bed was against the wall and the other side of the bed had a bed rail in the up position.
-One day during the first week the resident was admitted (could not recall date), she observed the resident with one leg off the end of the bed and the leg was angled around the end of the bed.
-She and another staff person (could not recall who) pulled the resident back up to the head of the bed.

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-She did not remember if she reported it to anyone.
-She never saw the resident do that again.
-The night shift MA reported to her on 09/29/20 when she came on shift that the resident had fallen on 09/28/20.
-The night shift MA reported the resident had "scooted" to the end of the bed and slid to the floor.

Interview with a second PCA on 10/21/20 at 3:44pm revealed:
-Resident #4 had a Geri-chair with a tray and the resident would try to take the tray off but she never saw him take it off.
-The resident had a full bed rail on each side of the bed and one side of the bed was against the wall.
-The bed rail opposite the wall was always up when the resident was in bed.
-Toward the end of first shift on 09/28/20, the resident was "real antsy" meaning he wanted to get out of bed and would not sit still.
-The resident was grabbing at the bed rail and tried to pull himself over the bed rail.
-She came back to work 2 or 3 days later and the resident was in "excruciating" pain when they moved him.
-The hospice nurse told staff the resident's hip was broken but he was not able to have surgery.

Telephone interview with a third MA on 10/22/20 at 7:48pm revealed:
-Resident #4 had bedrails but he could move around in the bed.
-One evening while she was working (could not recall when), a staff member (could not recall who) reported the resident was trying to get out of bed with the bed rails up.
-She put the resident in the Geri-chair and he

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calmed down.
-She could not remember if she reported to the SCC that Resident #5 was trying to get out of bed.

Telephone interview with a fourth MA on 10/23/20 at 12:41pm revealed:
-Resident #4 had bed rails and the resident would "scoot" down to the end of the bed and his feet and would hang off the end of the bed and the resident would try to get his leg off the end of the bed.
-She never saw the resident try to go over the bed rails.

Telephone interview with the SCC on 10/23/20 at 11:50am revealed:
-Resident #4 had a Geri-chair with tray and bed rails.
-The Geri-chair was for his ambulation and the tray was for feeding but the resident figured out how to slide the tray but the tray did not actually come off the chair.
-When the resident improved, he could move his legs and if he did not have bed rails, the resident could roll onto the floor.
-On 09/28/20, the bed rails were up when the resident fell.
-She was told by the MA that the resident put his legs over the rail when he fell on 09/28/20.
-Prior to the fall on 09/28/20, no one had reported to her that the resident had been observed pulling himself over the bed rails.
-She would have expected staff to notify her about the resident trying to get out of bed over the rails.
-Staff had reported the resident had been pulling on the rails but she cold not recall how many times or when.
-She did the restraint assessment for Resident #4

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and there was no team involved, including no RN.
-She was not aware the restraint assessment and care planning process was required to be a team process which included a RN.
-If staff had reported the resident was trying to go over the bed rails, she would have reported it to hospice.
-Residents with restraints were supposed to be checked every 30 minutes and released every 2 hours for 15 minutes.
-The staff were supposed to fill out observation sheets every 2 hours when residents were released from restraints but she was not sure if they documented the 30 minute checks.
-She located observation forms for restraints for 3 days for Resident #4 but the forms were incomplete and she could not find any other forms for the resident.
-She had not had a chance to check behind staff to see if they had been completing the 30-minute checks and the 2-hour releases for restraints.

Review of Resident #4's special observation records for restraints revealed:
-There were only three pages documented.
-The page dated 09/30/20 had check offs for 7:30, 9:30, 11:30, 1:30, 3:30, and 5:30 (am or pm not specified for any times).
-At 7:30, staff documented one-on-one with staff, direct observation, eating, fluids served, and the resident was restless.
-At 9:30 and 11:30, staff documented direct observation and the resident appeared to be sleeping.
-At 1:30 and 3:30, staff documented toileted and the resident appeared to be sleeping.
-At 5:30, staff documented "released", toileted, and the resident appeared to be sleeping.
-A second page dated 10/01/20 had check offs for 7:30, 9:30, 11:30, 1:30, 3:30, and 5:30 (am or

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pm not specified for any times).
-At 7:30, staff documented one-on-one with staff, direct observation, eating, fluids served, and the resident was cooperative and talking.
-At 9:30, staff documented toileted and the resident was restless.
-At 11:30, staff documented one-on-one with staff, direct observation, eating, fluids served, and the resident was calm.
-At 1:30, 3:30, and 5:30, staff documented "released", toileted, and the resident appeared to be sleeping.
-A third page dated 10/02/20 had check offs for 7:30am, 9:30am, 3:30 (am or pm not specified), and 5:30 (am or pm not specified).
-At 7:30am and 5:30, staff documented one-on-one with staff, direct observation, eating, fluids served, and the resident was cooperative.
-At 9:30am and 3:30, staff documented toileted and the resident appeared to be sleeping.
-There was no documentation of any other 2 hour restraint releases for 09/30/20, 10/01/20, or 10/02/20.
-There was no documentation for any 30-minute restraint checks for 09/30/20, 10/01/20, or 10/02/20.
-There was no documentation of any other restraint checks or releases for the resident since the restraints were ordered on 09/18/20, including 09/28/20 when the resident was reported to have crawled over the bed rails and fell, resulting in a significant hip injury.

Telephone interview with Resident #4's family member on 10/23/20 at 9:41am revealed:
-She was aware the resident had a Geri-chair with tray and bed rails.
-The resident apparently tried to get out of bed on his own and fell.
-She discussed the resident's injury from the fall

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with a hospice nurse and it was assumed the resident had fractured leg or hip.
-She did not know if the resident's bed rails were up at the time of the fall.
-Someone contacted her about the Geri-chair and bed rails but she could not recall if it was the facility staff or hospice.
-The resident started hospice almost immediately after being admitted to the facility.
-Hospice contacted her after the fall to see what she wanted done for the resident.
-Prior to the fall, no one had reported the resident had tried to get out of bed on his own.
-There were no discussions with facility staff about any interventions or alternatives to restraints.

Telephone interview with Resident #4's primary care provider (PCP) on 10/23/20 at 11:15am revealed:
-She saw Resident #4 one time for a new patient visit.
-The resident came to the facility (admitted 09/14/20) with the intention of going on hospice services.
-The resident was already declining when he was admitted to the facility.
-The resident had a right knee effusion that caused problems with ambulation.
-She signed restraint orders for Resident #4 but she thought the hospice provider should have signed them since they took over his care.
-Facility staff reported the resident had one fall when he climbed out of the chair or the bed (could not recall which).
-Staff did not report any issues or injuries with the fall (could not recall when).
-She expected facility staff to follow the restraint order and check on the resident every 30 minutes and release every 2 hours.

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-No one discussed any alternatives to the restraints with her but alternatives could have included increased supervision or a sitter.

Telephone interview with the Executive Director (ED) on 10/23/20 at 1:25pm revealed:
-She did not handle anything to do with restraints and she was not aware a team process including a RN was required for restraint assessment and care planning.
-The SCC would be responsible for restraints.

Telephone interview with the Regional Director (RD) on 10/23/20 at 1:43pm revealed:
-The SCC was trained on the facility's policies for 6 weeks so the SCC should be aware a team process was required for restraint assessments and care planning.
-The facility could use the LHPS nurse to assist with the team process for restraints.
-The facility should use a team approach for restraint assessments and talk about it and the team should include at least the SCC, a MA, a PCA, and a nurse.
-The SCC was responsible for physical restraints at the facility.

Telephone interview with the Administrator on 10/26/20 at 12:23pm revealed:
-She was not aware Resident #4 fell on 09/28/20 and had a hip injury.
-She was aware a RN needed to participate in the restraint assessment and care planning team process.
-The SCC was responsible for following the facility's policy for restraints.
-If a resident was trying to climb over bed rails, it should be reported to the PCP and to her.
-No one reported to her that Resident #4 was trying to go over the bed rails or get out of the end

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D 482	Continued From page 86 of the bed. -If she had known, they could have looked into alternatives like putting a mattress on the floor. _____ The facility failed to assure policies and procedures for physical restraints were followed for Resident #4 who had a Geri-chair with tray and bed rails. The facility did not use a team process for assessment and care planning, including the use of alternatives prior to using the restraints. Resident #4 was observed by multiple staff trying to climb over or pull over the bed rails eventually resulting in a fall in which the resident sustained an injury to his right hip consistent with a fractured hip causing pain that required the use of narcotic pain medication. The facility's failure resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/23/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2020.	D 482		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect as related to management of	D914		

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D914	Continued From page 87 facilities, supervision, health care, and use of physical restraints and alternatives. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related to personal care and supervision, health care, and the use of physical restraints and alternatives. [Refer to Tag D176, 10A NCAC 13F .0601(a) Management of Facilities With a Capacity or Census of Seven to Thirty Residents (Type A1 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#3, #4) with a history of falls resulting in serious injuries including a fractured hip and staples in the head (#3) and a hip injury consistent with a fractured hip (#4). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to to meet the acute health care needs for 4 of 5 sampled residents (#1, #3, #4, #5) by failing to report symptoms and a delay in seeking medical care for a resident complaining of stomach pain and vomiting blood (#1); two residents who experienced significant pain and were unable to bear weight after sustaining falls (#3, #5); and a hospice resident who kept trying to climb over bed rails, eventually resulting in a fall and sustaining an injury consistent with a broken hip that resulted in pain and a delay in treating the resident's pain (#4). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).]	D914		

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D914	Continued From page 88 4. Based on interviews and record reviews, the facility failed to assure a Geri-chair with tray and bed rails were used only after an assessment and care planning process had been completed through a team process and alternatives had been tried for 1 of 1 residents sampled (#4) who had a history of trying to climb over the bed rails, resulting in the resident falling and sustaining a hip injury consistent with a broken hip. [Refer to Tag D482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A1 Violation)].	D914		