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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a desk review complaint investigation survey on 10/28/20 to 11/10/20 with onsite visits on 10/28/20 and 10/29/20 and a telephone exit on 11/10/20. The New Hanover County Department of Social Services initiated the complaint on 09/11/20.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 3 of 5 sampled residents (Residents #2, #5, and #7) sampled related to a resident with known history of aggressive behaviors resulting in a physical altercation with Resident #2 resulting in unstable cervical spine fractures, multiple abrasions, skin tears to right hand, nasal laceration, and nasal fractures prior to his death on 10/12/20; and residents (#5 and #7) having multiple falls with injuries requiring visits to the emergency room. The findings are: 1. Review of the facility's current "Policy and	D 270		

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D 270	Continued From page 1 Procedure: Resistive, Agitated or Aggressive Behavioral Expressions" dated September 2020 (draft) revealed: -The facility was responsible to advocate and partner with each individual resident to help minimize behavioral expressions, which included agitation and aggression. -It was the responsibility of the facility staff to adjust, modify and anticipate and/or prevent challenging behavioral expressions whenever possible through practice of our person-centered approach to resident care. -In the event of an "extreme emotional response" by a resident or between residents (e.g., rage, panic, hitting, kicking, using an item as a weapon, etc.), the response by available team members would include the following: safety first for all residents; a manager would determine is 911 need to be called for assistance; staff should relocate residents not involved in the situation to another safe area. -Once the "extreme emotional response" had been safely resolved, the Regional Director and Director of Quality and Education should be notified; the primary care provider should be notified regarding the situation and current status/resolution; family member/power of attorney (POA) should be notified, and incident should be documented in the residents' medical record. -The resident (or residents) medical record should be placed in the "Hot Box" to assure that the additional observations and documentation was completed each shift for a designated period of days. -The resident (or residents) care plan would be updated to reflect new approaches, interventions, therapies and/or other new physician orders as indicated. -Education would be provided as needed to staff	D 270		

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members regarding new interventions and approaches to be utilized for specific resident behaviors.

A. Review of Resident #1's current FL-2 dated 11/08/19 revealed:
-Diagnoses included dementia, aphasia, hyperlipidemia, glaucoma, chronic constipation, depression, sinus bradycardia, and hyperplastic colon polyps of colon.
-The resident was ambulatory.
-The resident was intermittently disoriented and wandered.
-The resident's documented level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 10/24/18.

Review of Resident #1's Care Plan dated 02/04/20 revealed:
-The resident was ambulatory.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident required supervision with bathing and eating.
-The care plan documented Resident #1 received medications for mental illness/behavior.
-The care plan documented Resident #1 was not receiving mental health services nor had a referral been made.
-The care plan documented Resident #1 had dementia.
-The care plan documented the resident to have aggressive behaviors.
-The action plan and approach for the residents' aggressive behaviors indicated: "when resident is aggressive give him space and approach later."
-The care plan documented the resident could

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follow instructions.
-The action plan and approach for following directions indicated the resident would follow directions when given step by step.
-The care plan was completed and signed by the Cottage Care Coordinator (CCC) on 02/04/20.
-The care plan was signed and dated by the Primary Care Provider (PCP) on 02/14/20.

Review of Resident #1's Care Plan dated 07/28/20 revealed:
-The resident was ambulatory.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident required supervision with bathing and eating.
-The resident required limited with dressing and toileting.
-The care plan had physically abusive highlighted in yellow for Resident #1.
-The care plan documented Resident #1 received medications for mental illness/behavior.
-The care plan documented Resident #1 was not receiving mental health services nor had a referral been made.
-The care plan documented Resident #1 had dementia and that resident had increased agitation and that the resident was placed on medication due to hitting several staff members.
-The care plan documented Resident #1 was aggressive and the action plan and approach was to give the resident space and approach later.
-The care plan was completed and signed by CCC on 07/28/20.
-The care plan was signed and dated by the PCP on 07/30/20.

Review of Resident #1's progress notes revealed:

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- A communication entry was made on 02/22/20 at 8:00am, Resident #1 was very agitated, kicking and hitting on entrance doors in the memory care. The resident was redirected several times and refused to come eat breakfast. A PRN (as needed) Ativan (used to treat anxiety) was given.
-A communication entry was made on 05/30/20 at 11:45pm, Resident #1 was very irritated at the start of the shift banding on doors. The resident kept going into other residents' rooms. The resident would get angry when staff tried to get him out of their rooms.
-A communication entry was made on 06/07/20 at 9:30pm, Resident #1 was very agitated. The resident banged on a window and kicked the wall in the living room. The resident calmed down after being escorted to room.
-A communication entry was made on 06/10/20 at 4:45pm, Resident #1 was very agitated that evening. The resident hit a staff member on their left shoulder and had tried to hit the staff member earlier without success. The facility called the resident's sister to talk to resident but left a message. The Executive Director was informed of what was going on.
-A communication entry was made on 06/11/20 at 4:45pm, Resident #1 was found in another resident's room asleep.
-A communication entry was made on 06/12/20 at 5:00pm (late entry), Resident was agitated at dinner and threw a sandwich at another resident (no contact/injury) and lifted a chair to throw. A prn was given.
-A communication entry was made on 06/13/20 at 9:00pm, Resident #1 was hitting trash can against the wall. The resident hit staff member in back and chest. The resident was calmed down enough to put trashcan down. A prn Ativan was given.
-A communication entry was made on 06/18/20 at

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D 270	Continued From page 5 3:00pm, Resident #1 was very agitated and aggressive. The resident attacked 2 employees and Resident #3. Resident #1 was sent out to local hospital. -A communication entry was made on 06/18/20 at 9:15pm, Resident #1 became agitated and stared kicking the wall. No prn was given. - A communication entry was made on 06/19/20 at 3:30pm that Resident #1 was very agitated. The resident followed staff and punched staff on back of left shoulder and attempted to kick staff. The resident put his hands on another staff member and grabbed their arm. A prn was crushed and put in beverage at dinner. -A communication entry was made on 06/21/20 at 9:15pm, that Resident #1 was given a PRN for agitation. The resident became agitated during dinner. -A communication entry was made on 06/22/20 at 9:40pm that Resident #1 was slightly agitated but not violent. No prn was given. -A communication entry was made on 06/23/20 at 1:50pm, Resident #1 was pacing most of the morning, expressed mild agitation. A prn was not necessary as the resident could be verbally calmed down. -A communication entry was made on 06/28/20 10:45pm, Resident #1 had been agitated all shift. The resident kept going into his room taking off clothes trying to walk around the community naked. Resident #1 seemed more confused than usual. -A communication entry was made on 06/30/20 at 7:30pm, Resident #1 took clothes off twice that evening and urinated in another residents' room. -A communication entry was made on 07/01/20 at 9:45pm, Resident #1 became agitated before dinner and attempted to hit another resident. A prn was crushed into beverage. Later that evening Resident #1 came out of room naked.	D 270		

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D 270	Continued From page 6 -A communication entry was made on 07/02/20 at 6:30am, Resident #1 had been up all night walking around. The resident became agitated at certain times and kept trying to beat on doors in memory care. The resident went into his room twice and came out completely naked. Staff attempted to give the resident a snack and drink but the resident threw them on the ground. The resident went into other residents' rooms trying to take things out of their rooms. -A communication entry was made on 07/03/20 at 6:00am, Resident #1 became very agitated and started throwing laundry out of basket on kitchen counter, picked up shoe, and began hitting table. The resident hit a staff member on arm when they took shoe. The PCP was notified of incident by fax. -A communication entry was made on 07/05/20 at 10:55pm, Resident #1 was very agitated, spit medications in the face of the Medication Aide (MA), and punched the MA on hand and swung staff member on floor. -A communication entry was made on 07/12/20 at 6:00am, Resident #1 kept going into other resident's room and trying to wake them up. Staff tried to give resident Ativan (crushed in juice) but resident threw drink on the floor. Resident #1 was very aggressive with staff trying to hit them. -A communication entry was made on 07/13/20 at 2:00pm, Resident #1 was a little agitated and became aggressive. -A communication entry was made on 07/13/20 at 4:00pm, Resident #1 was very agitated at the beginning of shift. A prn was given. Resident #1 followed the MA around tried to grab the cups and binders off the medication cart. When staff attempted to escort the resident to his room, the resident grabbed the MA's arm and tried to push the MA back. Resident #1 made a fist and attempt to hit the staff in the face.	D 270		

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D 270	Continued From page 7 -A communication entry was made on 07/14/20 at 2:30pm, Resident #1 became agitated and aggressive around 2:00pm and did not want to cooperate. The resident took 2:00pm medications. Resident #1 pushed the sofa in the living room into another resident that was sitting down. When Resident #1 was asked to stop, the resident charged at the MA and went outside. When Resident #1 came back in, the resident grabbed a wheelchair and tried to chase others. -A communication entry was made on 07/16/20 at 6:30am, Resident #1 was up around 2:00am and very irritated. The resident kept going into other residents' rooms. When staff tried to redirect the resident he would try to hit staff. Resident #1 went into the dining room and urinated on the floor and went back to bed at 2:45am. -A communication entry was made on 07/19/20 at 9:00pm, Resident #1 was physically violent toward staff. The resident walked around agitated and attempted to hit other residents as well. The resident walked in and out of other resident's rooms with items. Emergency Medical Services (EMS) was called but did not take resident to hospital. The PCP was notified. -A communication entry was made on 07/22/20 at 4:00pm, Resident #1 continued to show signs of aggression, undressing and wandering in other resident's rooms. The PCP was notified about aggression. -A communication entry was made on 08/12/20 at 2:45pm, Resident #1 waked around the MCU pushing chairs around all shift, in and out of other resident's rooms, and undressing throughout shift. The resident was not easily directed. -A communication entry was made on 08/14/20 at 2:40pm, Resident #1 was combative with staff and continued to spit on floor. -A communication entry was made on 08/19/20 at 3:00pm, Resident #1 was very aggressive and	D 270		

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combative with staff and residents. The resident tried to grab other resident's food out of their plates.
-A communication entry was made on 08/22/20 at 2:00pm, Resident #1 refused to use restroom but continued to urinate on dining room floor. Resident #1 got physical with another resident multiple times throughout the day.
-A communication entry was made on 08/22/20 at 8:00pm, Resident #1 was combative with staff and tried to kick staff. Resident #1 tried to fight other residents. The resident was found sleep in another resident's bed.
-A communication entry was made on 08/24/20 during the 3:00pm to 11:00pm shift, Resident #1 was sent out to the emergency room. The resident was combative with staff.
-A communication entry was made on 08/27/20 at 2:00pm, that a phone conference with the PCP, the resident's Responsible Party(RP), the Administrator, and the Resident Care Director was held to discuss Resident #1's increased behaviors. The resident's medications were reviewed. The PCP agreed to discontinue the Haldol (used to treat schizophrenia) and Citalopram (used to treat depression). The resident was given a new order for Zoloft (used to treat depression) 50mg every day and Risperdal 0.25mg twice daily. Resident #1's RP requested that staff call RP when the resident became aggressive so the RP could pick the resident up to help calm the resident down. All staff working with Resident #1 was aware of the RP's requests. Staff to continue to monitor and PCP will follow up with Resident #1 in two weeks (09/10/20) to review behaviors and medication (change effectiveness).
- A communication entry was made on 09/02/20 at 2:00pm, Resident #1 was agitated. The resident's RP was called and the resident calmed

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down.
-A communication entry was made on 09/02/20 at 5:00pm, Resident #1 tried to fight staff. The resident's RP was called and came to the facility to calm the resident down. Resident #1 tried to fight his RP.
-A communication entry was made on 09/06/20 at 7:20am, Resident #1 was seen by a staff member walking out of Resident #2's room into the bathroom washing hands. Resident #1 had assaulted the resident who resided in Room #5.
-A communication entry was made on 09/06/20 at 2:15pm, Resident #1's RP came to the facility and took the resident to the emergency room for involuntary commitment, which was not successful.
-A communication entry was made on 09/06/20 at 5:30pm, Resident #1's RP stayed with Resident #1 for the night after the resident came back from the hospital on 09/06/20.
-A communication entry was made on 09/07/20 at 6:05am, staff went to care for Resident #1 around 3:00am. The resident became aggressive and started punching the bed and hitting RP. The RP calmed the resident down enough to get the resident to go back to bed.
-A communication entry was made on 09/08/20 at 2:00pm, Resident #1 was agitated, prn Ativan given. The resident spit out PRN medication on the MA.
-A communication entry was made on 09/08/20 at 3:30pm, Resident #1 left with RP to go to the hospital to be admitted.

Review of Shift to Shift Reports for Resident #1 revealed:
-On 08/31/20 (3:00p to 11:00pm shift), it was noted to call RP for Resident #1 if the resident started having bad behaviors- call RP to get the resident to calm down.

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D 270	Continued From page 10 -On 09/02/20 (7:00am to 3:00pm shift), Resident #1 was agitated. -On 09/02/20 (3:00pm to 11:00pm shift), Resident #1 fought staff. Resident #1's Responsible Party (RP) was called and came to the facility. Resident #1 tried to fight RP. -On 09/03/20 (7:00am to 3:00pm shift), Resident took off clothes. -On 09/03/20 (3:00pm to 11:00pm shift), Resident #1 threw up, had loose stool, and would not keep clothes on. Resident #1 was sent out to the hospital. -On 09/04/20 (7:00am to 3:00pm shift), Resident #1 received a new medication order. -On 09/04/20 (3:00pm to 11:00pm shift), Resident #1 took off clothes and was laying in other resident's beds. -On 09/05/20 (11:00pm to 7:00am shift), Resident #1 assaulted Resident #2. -On 09/06/20 (7:00am to 3:00pm shift), Resident #1 went to the hospital with RP. -On 09/06/20 (3:00pm to 11:00pm shift), Resident #1 was back at the facility at 5:30pm. Resident #1's RP in with resident. -On 09/06/20 (11:00pm to 7:00am shift), Resident #1's RP stayed the night with the resident. Review of Resident #1's emergency room (ER) report dated 06/18/20 revealed: -Resident #1's chief complaint was documented as agitation. -Resident #1 was agitated that morning at facility where the resident had been physically aggressive towards staff. -Resident #1 had increased agitation. -The final impression was documented as dementia with agitation. -Resident #1 was discharged back to the facility with no new orders.	D 270		

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D 270	Continued From page 11 Review of an incident report dated 08/24/20 for Resident #1 revealed: -The type of incident was documented as disruptive behavior. -On 08/24/20 at 5:00pm, Resident #1 tried to hit staff and resident. -The staff were unable to manage the resident with medications. -Emergency Medical Services (EMS) transported Resident #1 to hospital. Review of Resident #1's ER report dated 08/24/20 revealed: -Resident #1's chief complaint was documented as altered mental status. -Resident #1 had been aggressive when staff by kicking and punching them when they were changing the resident. -The final impression was documented as dementia, agitation and aggressive behavior. -Resident #1 was discharged back to the facility with no new orders. Review of Resident #1's ER report dated 09/03/20 revealed: -Resident #1's chief complaint was documented as nausea and dementia. -Resident #1 was combative with facility staff and Emergency Medical Services (EMS) when they attempted to get vital signs. -The final impression was documented as agitation due to dementia. -Resident #1 was discharged back to the facility with no new orders. Review of an incident report dated 09/06/20 for Resident #1 revealed: -The type of incident was documented as disruptive behavior. -On 09/06/20 at 6:00am, Resident #1 had	D 270		

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increased agitation. PRN was given with no effective results.
-EMS transported Resident #1 to the hospital.
-The family and PCP were notified.

Review of Resident #1's ER report dated 09/06/20 revealed:
-Resident #1's chief complaint was documented as agitation.
-The resident had an altercation with another resident that morning.
-The clinical impression was documented as Alzheimer's disease with behavioral disturbance.

Interview on 09/17/20 at 1:55pm with a Personal Care Aide (PCA) who worked third shift on 09/06/20 in the SCU revealed:
-The PCA was on the other side of the building in a residents' room when the PCA heard loud scream of "please stop."
-When the PCA went into Resident #2's room, Resident #2 was on the bed and blood was everywhere.
-Resident #1 was observed in joining bathroom with water running at sink.
-The PCA put a pillow under Resident #2's head and called the Medication Aide (MA) on the phone to come to the unit.
-The PCA got a towel and wiped blood out of Resident #2's eyes.
-The PCA sat Resident #2's head up to keep the resident from choking on his blood.
-When the PCA asked Resident #2 what happened, Resident #2 responded "get him out of here, don't let him in."
-Resident #2 wanted to go to the hospital.
-Resident #1 was last seen by the PCA on 09/06/20 between 3:00am-3:15am and had no issues.
-Since the PCA was hired in July 2020, Resident

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#1 had exhibited agitation and aggressive.
-The PCA had concerns of nervousness about working with Resident #1 due to the residents' behaviors.
-The PCA was not aware of policy for aggressive behaviors and had not been given any instructions on how to deal with Resident #1's aggressive behaviors.
-The only thing the PCA knew to do was to inform the MA of Resident #1's behaviors or agitation.

Telephone interview with the MA who worked third shift on 09/06/20 in the SCU on 09/17/20 at 1:00pm revealed:
-About 6:00am, the MA was in the assisted living section of the building doing a medication pass when the NA called the MA to come to the MCU.
-When the MA got to the MCU, Resident #2 was observed to be sitting up on bed.
-Resident #2 yelled for help and indicated "get him away from me, help me."
-Resident #2 had a gash on forehead.
-There was so much blood it on Resident #2's head it "looked like a murder scene."
-The MA could not determine how bad Resident #2 was injured due to the amount of blood.
-Resident #1 was observed on the floor in the doorway of room.
-Resident #1 was observed to have blood on his hands and forearm.
-The MA called 911 to report a resident attacked another resident and that Resident #2 needed to go to the hospital.
-Prior to the 09/06/20, Resident #1 exhibited aggressive and combative behaviors.
-The facility tried to manage Resident #1's behaviors with medications but medications were not effective.
-There were no other interventions in place other than medication to manage Resident #1's

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D 270	Continued From page 14 behaviors. -When the MA informed the Resident Care Director (RCD) and the Executive Director (ED) that Resident #1's medications were ineffective; the MA was instructed not to interact with Resident #1 if he was aggressive due to his aggressive behaviors. -The MA was instructed by the RCD and the ED to let the resident walk around and do whatever he was doing when he was agitated. -Resident #1 was not on increased supervision and was monitored every 2 hours (which was standard for supervision). -The MA had never been in a situation like the 09/06/20 incident regarding Resident #1 and Resident #2. -The MA was not aware of the policy regarding aggressive behaviors. Interviews with a PCA who worked first shift in the memory care unit on 09/10/20 at 10:40am revealed: -Resident #1 had aggressive behaviors when agitated. -The management staff were aware of Resident #1's aggressive behaviors. -Resident #1 was monitored every 2 hours and there was no change in supervision needs due to Resident #1's aggressive behaviors. -The PCA was not given any instructions on how to handle Resident #1's behaviors. -The PCA was not aware of the policy regarding aggressive behaviors. Interviews with a second PCA who worked first shift in the memory care unit on 09/17/20 at 10:40am revealed: -Resident #1 had aggressive behaviors when agitated. -The management staff were aware of Resident	D 270		

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D 270	Continued From page 15 #1's aggressive behaviors. -Resident #1 was monitored every 2 hours and there was no change in supervision needs due to Resident #1's aggressive behaviors. -The PCA was not given any instructions on how to handle Resident #1's behaviors. -The PCA was not aware of the policy regarding aggressive behaviors. Interview with a MA on 10/27/20 at 1:00pm revealed: -Resident #1 required assistance with dressing, toileting, and grooming needs. -Due to the COVID-19 lockdown, Resident #1 became more aggressive towards staff and residents, as the resident could no longer attend the adult day care program. -A few months' prior, the MA tried to get Resident #1 calm at lunch after the resident charged at the MA with a fork. -The MA had concerns Resident #1 would "seriously" hurt staff, residents, or himself due to his behaviors. -The management staff (RCD, former ED, and previous CCC) were aware of staff's concerns regarding Resident #1's behaviors. -The previous CCC instructed staff to chart behaviors as the CCC was working to get Resident #1 placed to a more suitable facility where behaviors could be managed. -The medications and medication adjustments were the only interventions in place to address Resident #1's behaviors. -Due to Resident #1's medication being ineffective, the residents' behaviors became worse as the resident starting stripping out of clothing, spitting, fighting staff, and urinating in residents' rooms. -Resident #1's PCP was aware the medications were ineffective.	D 270		

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-Resident #1's behaviors were discussed in stand up meetings with management staff.
-As a result of stand up meetings, medications changes were the only intervention to address Resident #1's behaviors.
-The management staff expected staff to document Resident #1's behaviors to help build case to get Resident #1 transferred to a facility where his behaviors could be managed more effectively.
-The MA was not sure if management sought mental health services for Resident #1 as an option, as management really did not tell staff anything or give them direction on how to handle Resident #1.
-The MA was not aware of the facility policy related to aggressive behaviors.
-When the MA had an issue with Resident #1, the MA would attempt to talk to the resident in a calm voice, redirect resident, give PRN medication if needed, document effectiveness of medication, and inform management.

Interview with a second MA on 10/29/20 at 11:15am revealed:
-Resident #1 always walked around agitated and displayed aggressive behaviors.
-Resident #1 tried hitting staff when they attempted to provide care or redirect the resident.
-On 07/14/20, staff intervened to keep Resident #1 from pushing the couch into Resident #4, as the resident sat in a chair.
-The MA informed the previous CCC on 07/14/20 incident regarding Resident #1 and Resident #4.
-Resident #1 constantly took clothes off and walked around the memory care naked, as staff struggled to keep the resident dressed.
-Management staff were aware of Resident #1's behaviors and the concern staff had for their safety and the safety of the residents due to his

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aggression, as his behaviors were discussed in daily stand-up meetings.
-Staff were not given any instructions from management on how to ensure the safety of other residents.
-As a result of the stand-up meetings, staff were instructed to call Resident #1's RP when the resident became agitated so the RP could come to the facility and attempt to calm the resident down.
-Medications were the only interventions in place to address Resident #1's behaviors, which were not effective.
-When Resident #1 was given Haldol, the residents' agitation increased as the resident would urinate in other residents' rooms.
-There were no discussions about seeking mental health services for Resident #1, which should have occurred due to Resident #1's behaviors.
-The MA felt that Resident #1 was no longer appropriately placed at facility due to increased behaviors.
-The previous CCC reported staffs' concerns to the former ED that Resident #1' level of care was no longer appropriate for facility, but interventions were put in place.
-The MA was not aware of facility policy related to aggressive behaviors.
-The only thing the MA knew to do was to report Resident #1's behaviors to the previous CCC and former ED.

Interview with the RCD Assistant on 09/17/20 at 10:30am revealed:
-Resident #1's agitation had increased within the last 2 to 3 months.
-Resident #1 had been known to throw chairs and radio when agitated.
-Resident #1 had been known to hit staff and residents when agitated.

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D 270	Continued From page 18 -Resident #1 had hit Resident #3 and Resident #4, at which time the residents had no visible injuries. -Staff tried to keep Resident #1 away from other residents by taking the resident to his room when agitated. -Resident #1 received PRN medications for behaviors and agitation, but medications were not effective. -Resident #1's PCP was aware Resident #1's medications were not effective. -Resident #1 needed 1:1 supervision due to behaviors but the facility did not provide 1:1 supervision for residents. -The RCD Assistant tried to provide 1:1 to Resident #1 when agitated if time permitted to try to keep resident calm. -Management were aware of Resident #1's behaviors prior to the 09/06/20 incident regarding Resident #2. -Staff were only instructed to call Resident #1's PCP and gave PRN medications when Resident #1 had aggressive behaviors. -Resident #1 was monitored every 2 hours and there had not been any change in supervision needs due to Resident #1's aggressive behaviors. -The ED informed the previous CCC the only thing the facility could do regarding Resident #1's violent behaviors were to call Resident #1's PCP. -The previous CCC expressed concerns to the ED that Resident #1 was "going to hurt someone" (staff or residents) due to aggressive behaviors and facility was no longer an appropriate placement for the resident. -The facility never attempted to get a mental health referral for Resident #1 and was not successful in getting the resident committed involuntary due to his behaviors. -The RCD Assistant was not aware of the facility policy regarding aggressive behaviors.	D 270		

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D 270	Continued From page 19 Telephone interview with the RCD on 11/10/20 at 4:05pm regarding the 09/06/20 incident between Resident #1 and Resident #2 revealed: -The former ED informed the RCD about the incident by phone. -The incident happened about 6:00am. -The NA found Resident #2 on bed in room after the NA heard the resident yell. -Resident #2 was bleeding from nose and gash on the forehead. -Resident #1 was observed at sink of joining bathroom washing hands. -There had been concerns about Resident #1's aggressive behaviors. -Resident #1 was not on increased supervision at any time and was monitored every 2 hours which was standard. -Resident #1's RP did not have the means to provide 1:1 care. -The facility did not have the staff to increase Resident #1's supervision to 1:1. -She would expect a change in supervision needs if a resident exhibited unsafe behavioral concerns, such as Resident #1. -The facility should have provided 1:1 supervision to Resident #1 with shared responsibility of the residents' family. -Due to Resident #1's behaviors, the facility was not an appropriate placement for the resident. Interview with former ED on 09/10/20 at 2:40pm revealed: -On 09/06/20 the MA called the ED regarding an unwitnessed incident regarding Resident #1 and Resident #2. -The MA reported that Resident #2 was heard calling for help. -The MA reported Resident #2 was found sitting beside bed.	D 270		

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-According to the MA, Resident #2 had a gash on forehead and there was "a lot" of blood.
-The former ED was informed that Resident #1 was observed was by the sink in joining bathroom with blood on hands.
-Prior to the 09/06/20 incident, Resident #1 had exhibited increased agitation and had been combative towards staff.
-The facility had tried medication changes to address Resident #1's behaviors.
-Prior to the 09/06/20, the only intervention in place to address Resident #1's behaviors were for staff to call the resident's RP who would come to the facility to calm the resident down when the resident exhibited behaviors.
-Resident #1 was not on increased supervision due to his behaviors, as the resident was monitored every 2 hours, which was standard for supervision.

Review of Resident #1's ER report dated 09/08/20 revealed:
-The resident had significantly assaulted another resident the prior weekend, which caused that resident to suffer nasal and cervical spine fractures.
-Resident #1 was a significant harm risk to other residents and staff at the facility and as admitted to the hospital for management of his agitation.

Telephone interview with a hospital social worker on 09/11/20 at 11:49am revealed Resident #1 was discharged from the hospital to a psychiatric facility on 09/10/20.

B. Review of Resident #2's current FL-2 dated 03/27/20 revealed:
-Diagnoses included dementia, hypertension, depression, and myasthenia gravis.
-The resident's recommended level of care was

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D 270	Continued From page 21 documented as memory care (MC). Review of Resident #2's Resident Register revealed an admission date of 08/18/17. Review of Resident #2's progress notes on 09/06/20 at 7:15am revealed: -Resident #2 was attacked by another resident and sustained a Large skin tear on forehead and nose. -Staff called 911 as they were unable to assess Resident #2 for any other injuries due to bleeding. Review of Resident #2's incident report dated 09/06/20 revealed: -The type of incident was documented as skin tear. -The location of the incident was in the residents' room. -On 09/06/20 at 6:00am, staff heard noise. Resident #2 was found sitting on bed with skin tear on forehead bleeding. The staff held towel on skin tear and applied pressure. -Resident #2 was transported to the hospital by EMS -Resident #2's blood pressure was 97/67. -The family and PCP were notified. Review of Resident #2's ER report dated 09/06/20 revealed: -Resident #2 arrived at the hospital at 6:35am. -Resident #2's chief complaint was documented as "assault victim." The resident was assaulted by a fellow resident. Injuries noted to left eye and nose. -Staff witnessed Resident #2 to be assaulted by another resident. Noted nasal laceration was swelling and deformity and an abrasion to the forehead and skin tear to the right hand. -Resident #2 had oblique laceration across the	D 270		

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bridge of the nose and had significant tenderness and noticeable deviation; central forehead abrasion and contusion.
-Resident #2 had on a cervical collar.
-Resident #2 had left frontal scalp swelling, air fluid level bilateral maxillary sinuses, soft tissue swelling over the nose with nasal bone fractures, prominent fractures of the upper cervical spine including CI and C2 with jumped and locked facets and posterior displacement of the type two dens fracture.
-The final diagnoses were documented as alleged assault, unstable cervical spine fractures, multiple abrasions, skin tear right hand, nasal laceration, and nasal fractures.

Refer to the interview on 09/17/20 at 1:55pm with a PCA who worked third shift on 09/06/20 in the SCU.

Refer to a telephone interview on 09/17/20 at 1:00pm with a MA who worked third shift on 09/06/20 in the SCU.

Refer to the interviews with two PCAs who worked first shift in the SCU on 09/10/20 and 09/17/20.

Refer to interview with a MA on 10/27/20 at 1:00pm.

Refer to interview with a second MA on 10/29/20 at 11:15am.

Refer to interview with the RCD Assistant on 09/17/20 at 10:30am.

Refer to telephone interview with the RCD on 11/10/20 at 4:05pm.

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D 270	Continued From page 23 Refer to interview with former ED on 09/10/20 at 2:40pm. Interview with an Adult Protective Services Social Worker on 09/15/20 revealed Resident #2 died on 09/12/20 at local hospice care center. 2. Review of the facility's resident Fall Risk Program "The ROSE Program" revealed: -Residents were to be screened upon admission and readmission and after every fall to the facility. -Residents were to be screened a minimum of quarterly, or if they had a change in condition. -Resident were to be identified and resident specific interventions were to be implemented. -Intervention included evaluate physical and medical issues, environmental factors, cognitive and sensory changes. -Interventions included physical therapy (PT) and occupational therapy (OT) to determine therapy treatments, communication with physician, staff, residents and family, and education to staff, family, and residents. -In the facility a ROSE care will be placed at room door for identifying high risk residents. -A ROSE label will be placed on any assistance device for residents at high risk. -Resident specific interventions will be added to the resident personal care service log and the activity of daily living log. -Reminders will be discussed regarding residents at risk during the daily stand-up and by management/supervisor in charge each shift. -Weekly fall management meeting included PT and OT staff, care staff, Resident Care Director (RCD), and the Administrator to review each resident identified at risk, effectiveness of current interventions, and any additional falls, recommended changed of interventions. -Documentation by updating care plans, Personal	D 270		

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D 270	Continued From page 24 Care Services (PCS) log and Activity of Daily Living (ADL) logs with changes in risk factors and interventions. 3. Review of the facility Hot Box Policy revealed: -The hot box system was to assure additional attention was given to the residents who may be experiencing a temporary change in condition. -The MAs and the Supervisor in Charge (SIC) were responsible for documenting n the resident record each shift when residents were placed in the hot box system. -Conditions that warrant placement in the hot box system included falls and residents returning from the hospital or rehabilitation and changes in behavior. -The documentation requirements for residents with falls or returning from the hospital were 3 days or longer, if directed. -The RCD or designee will remove the resident from the hot box system when the situation had been resolved. C. Review of Resident #5's current FL-2 dated 12/02/19 revealed: -Diagnoses included low blood pressure, seizure disorder, hypothyroidism, mild dementia, and neuropathy. -The resident was ambulatory. -The resident was intermittently disoriented. -The resident was continent of bowel and bladder. -Recommended level of care was documented as domiciliary (assisted living). Review of Resident #5's care plan dated 07/19/20 revealed: -The resident used a rollator walker for ambulation. -The residents' memory was documented as	D 270		

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adequate.
-The care plan documented orientation as sometimes disoriented.
-The care plan documented Resident #5 was independent with ambulation, transferring, grooming and personal hygiene, and toileting (handwritten noted assist as needed).
-The care plan documented Resident #5 required supervision with eating.
-The care plan documented Resident #5 required limited supervision with bathing and dressing.
-The care plan was signed by the Primary Care Provider (PCP) on 07/21/20.

Review of Resident #5's incident report dated 09/12/20 at 12:25pm revealed:
-The fall was witnessed.
-The resident lost balance and hit head on wall.
-The location of the fall was in the hallway.
-The resident was sent to the ER for evaluation.
-The resident's vital signs were obtained and blood pressure was 128/74, pulse 72, respiration 20, and temperature 98.1 F.
-The family and physician were notified.

Review of Resident #5's progress note dated 09/12/20 at 12:45pm revealed:
-Resident #5 lost balance in the hallway and hit head on the wall.
-Resident #5 was sent to the ER for evaluation.

Review of Resident #5's ER report dated 09/12/20 revealed:
-Resident #5's chief complaint was a witnessed fall.
-The resident hit head on the wall.
-The resident complained of neck and head pain and had mild pain to right foot.
-The resident #5 had a history of multiple falls.
-The resident had an X-ray and CAT scan

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completed with no acute findings.
-Final diagnoses were fall, closed head injury, and cervical strain.
-The resident returned to the facility on 09/12/20 with recommendations for fall precautions.

Review of Resident #5's progress note dated 09/26/20 revealed:
-During the 7:00am to 3:00pm shift, Resident #5 kept sliding down in chair on to the floor.
-It took 3 staff members to help the resident up.
-Resident #5 had no complaints of pain or discomfort.
-Staff will continue to monitor the resident.

Review of Resident #5's incident report dated 09/27/20 at 4:30pm revealed:
-The resident was observed on the floor and stated they hit their head.
-The location of the incident was in the residents' room.
-The resident was sent to the ER for evaluation.
-The family and physician were notified.

Review of Resident #5's progress note dated 09/27/20 revealed:
-The resident had a fall on 09/27/20.
-The resident hit head on the bed rail and had a bump on back of head.
-The resident was sent to the ER for evaluation.

Review of Resident #5's ER report dated 09/27/20 revealed:
-The resident's chief complaint was fall.
-The resident slid and fell back in her room hit head on the floor.
-The resident had a mild headache.
-The resident had an abrasion to the scalp.
-The resident had a CT scan completed with no acute findings.

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D 270	Continued From page 27 -Final diagnoses included fall, minor head injury, and dementia. Review of Resident #5's progress note dated 09/28/20 at 11:04am revealed: -The resident was observed on the floor in front of the residents' bathroom. -The resident had no known injuries. -The resident's physician and family were notified. Review of Resident #5's progress note dated 09/29/20 at 4:45am revealed: -The resident was found on the floor beside the bed. -The resident stated she was trying to get up and fell out of the bed. -The physician was notified by fax. -The RP would be called in morning. -The resident's vital signs were obtained and blood pressure was 132/86, pulse 78, respiration 20, and temperature 98.2 F. Review of Resident #5's progress note date 09/29/20 at 9:58pm revealed: -The resident had leg weakness during shower. -The resident voiced no complaints of pain or discomfort. Review of Resident #5's incident report dated 10/02/20 at 10:30am revealed: -The fall was an unwitnessed fall. -The resident was found on the floor beside her wheelchair. -The resident complained of neck pain and was sent to the ER for evaluation. -The residents' vital signs were obtained and blood pressure was 128/66, pulse 70, respiration 18, and temperature 98.3 F. -The family and physician were notified.	D 270		

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D 270	Continued From page 28 Review of Resident #5's progress note dated 10/02/20 at 11:00am revealed: -The resident was found on floor beside her wheelchair. -The resident complained of neck pain and was sent to the ER for evaluation. -All parties were notified. Review of Resident #5's progress note dated 10/02/20 at 2:00pm revealed the resident had been admitted to the hospital and would be transferred to a new facility after being discharged from the hospital. Review of Resident #5's ER report dated 10/02/20 revealed: -The resident's chief complaint was syncope. -The resident presented to the ER after an unwitnessed fall in her room. -The resident reported feeling lightheaded and fell. -The resident's evaluation revealed generalized weakness which resulted in resident being admitted to the hospital. -The resident was placed in cervical collar due to possible hematoma left scalp. -The final diagnoses were syncope with fall and superficial scalp hematoma. -The resident was discharged from the hospital to hospice on 10/05/20. Review of the ROSE fall program book for Resident #5 on 10/27/20 revealed: -There was no documentation a fall assessment had been completed for Resident #5 upon admission, as the first fall assessment was completed on 02/07/19. -There was documentation of documented fall assessments completed for Resident #5 on	D 270		

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09/17/20 and 09/28/20.
-There was no other fall assessments documented for Resident #5's falls which occurred on 09/12/20 and 09/29/20.
-On 09/14/20 there was documented interventions for Resident #5 which consisted of: Resident showing increased behavior, post going home to stay with family. Educate family on effects that multiple changes in environment can increase confusion and agitation in dementia residents.
-On 09/17/20 there was documented interventions for Resident #5 which consisted of review medications.
-On 09/28/20 there was documented interventions for Resident #5 which consisted of primary care provider to adjust medications.
-On 10/02/20 there was documented interventions for Resident #5 which consisted of the resident required a skilled nursing facility.

Review of Resident #5's record revealed there was no documentation Resident #5's care plan had been updated after 07/19/20 to address falls that had occurred and to address interventions.

Review of the facility fall tracking report for Resident #5 from September 2020 to October 2020 revealed:
-On 09/12/20 at 12:25 pm Resident #5 fell in hallway which required the resident to be sent to the ER due to an injury.
-On 09/16/20 at 2:30 pm Resident #5 was observed on the floor in room and was not sent out to the ER.
-On 09/27/20 at 4:30 pm Resident #5 fell in room which required the resident to be sent to the ER due to an injury.
-On 09/28/20 at 10:57am Resident #5 was observed on the floor in room and was not sent

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out to the ER.
-On 10/02/20 at 10:30am Resident #5 fell in room which required the resident to be sent to the ER due to an injury.
-There was no documentation addressing Resident #5's fall which occurred on 09/29/20.

Review of Personal Care Service (PCS) Logs for Resident #5 for September 2020 and October 2020 revealed no documentations of interventions related to falls.

Interview with a PCA on 10/27/20 at 11:25am revealed:
-Resident #5's care needs declined around April or May 2020, as the required more assistance from staff.
-Resident #5 required assistance with dressing, bathing, and transfers.
-Resident #5 had a recliner and would constantly slid on the edge of the recliner which caused the resident to land on the floor.
-The PCA was aware of several falls Resident #5 had which required the resident to be sent to the ER for evaluation.
-The PCA indicated most of Resident #5's falls occurred when the resident tried to get out of bed or recliner or loss of balance.
-Resident #5 was a "fall risk," as the resident was on the ROSE fall program, which meant the resident had a rose place on door and tag on wheelchair or rollator.
-The PCA completed checks on residents she was assigned to every 2 hours, which was standard for supervision.
-Resident #5 was not on increased supervision due to falls.
-The PCA took it upon herself to check on Resident #5 more as the NA tried to look into the residents' room when she walked by the room to

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make sure Resident #5 was not on the floor.
-The PCA felt that due to Resident #5's decline, the resident needed to be watched constantly as the resident could not recall how to use a call bell.
-The MAs would instruct the PCAs on interventions regarding a resident if determined from daily stand up meetings.
-The PCA was not aware of interventions for Resident #5 regarding falls other than 2 hour checks.

Interview with a MA on 10/28/20 at 12:35pm revealed:
-Resident #5 had several falls which required the resident to be sent out to the ER for evaluation.
-Resident #5 required assistance with dressing, toileting (supervision), and transferring.
-Resident #5 had been using a wheelchair for about 2 months due to unsteady gait.
-Resident #5 had a recliner and would slid out of the recliner onto the floor constantly.
-The facility held stand up meetings where falls and interventions were discussed.
-Resident #5 had no interventions in place other than the 2 hour checks, which was standard for all residents for supervision.
-Resident #5 was on ROSE fall program, which was overseen by the physical therapists.

Interview with a PCA on 10/29/20 at 1:25pm revealed:
-Resident #5 was known to slide to the edge of recliner, place self on the floor and call for help.
-Resident #5 could use call bell but would not use due to cognitive impairment.
-Resident #5 had declined and required "almost" total care.
-Resident #5 was on the ROSE fall program.
-The PCA was not aware of any increased supervision needs for interventions other than the

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D 270	Continued From page 32 standard 2 hour checks. Interview with the Physical Therapy (PT) Assistant Director on 10/27/20 at 11:50am revealed: -Resident #5 was on the ROSE fall program due to the resident's multiple falls. -Resident #5 should have a fall risk assessment completed after each fall. -Falls and interventions were discussed in daily stand up meetings with management. -Due to Resident #5's falls staff reminded the resident to use call bell. -Staff checked on Resident #5 every 30 minutes as an intervention for falls. -Resident #5 had no interventions documented on her PCS Logs. Interview with a MA on 10/08/20 at 1:00pm revealed: -Resident #5 required assistance with toileting and transferring. -Resident #5 used a rollator but was noncompliant at times about using the rollator. -The MA could not give exact number of falls but knew Resident #5 had quite a few falls within the last 1 to 2 months, which required the resident to be sent out to ER for evaluations. -Resident #5 was on the ROSE fall program. -Resident #5's falls were discussed at stand up meeting but no interventions were implemented to address falls other than staff were to remind the resident to use rollator. -Resident #5 was monitored every 2 hours for supervision by the PCAs, which was standard for all residents. Telephone interview with Resident #5 Primary Care Provider (PCP) on 11/04/20 at 11:10pm revealed:	D 270		

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D 270	Continued From page 33 -Resident #5 had dementia. -Resident #5 would slid out of recliner onto the floor at times and would forget to use walker. -The PCP would expect the facility to follow their policy on fall preventions. Telephone interview with Resident #5's RP on 10/27/20 at 1:45pm revealed: -Resident #5 required assistance with toileting and bathing. -Resident #5 had several falls at the facility. -The RP indicated she encouraged the facility to get Resident #5 a wheelchair. -The RP tried to talk to the ED about scheduling care plan meeting to discuss Resident #5's care needs and interventions for falls but a meeting had not been scheduled. -Resident #5 was admitted to the hospital on 10/02/20 due to a fall at the facility and did not returned to the facility. -Resident #5 died on 10/12/20 at a hospice care center. Interview with the RCD on 11/05/20 at 3:10pm revealed: -The RCD was a Licensed Practical Nurse (LPN) and was responsible for overseeing the care of the assisted living residents. -Resident #5 required more hands on assistance with activities of daily living (ADLs). -Resident #5 used a walker as the residents' gait was very unsteady. -She was aware that Resident #5 had several falls with injury while at the facility. -She could not recall all the interventions that were in place for Resident #5. -Staff checked on Resident #5 more frequently due to falls but could not recall the frequency of checks and encouraged the resident to use call bell.	D 270		

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-All residents were checked on every 2 hours at a minimum for supervision.
-Resident #5's supervision needs had not been increased due to falls.
-Resident #5 was on the ROSE fall program.
-Resident #5 had received PT but had not received PT since September 2020.
-Interventions were to be documented on front of the PCS logs to remind staff of interventions when care was given.
-Resident #5 was to have a fall assessment completed after every fall.
-She did not know fall assessments were not completed after each fall for Resident #5 per the ROSE program policy.
-The facility used a "Hot Box" system for residents who had falls and were placed in the hot box system for 3 or more days.
-Resident #5 should be documented in the hot box system after each fall for 3 or more days, which required documentation for those day in the hot box system and in the residents' progress notes.
-Resident #5's care plan was supposed to be updated after each fall to address falls and interventions.
-The previous ED would have been responsible for updating Resident #5's care plan was last completed on 07/19/20.
-The facility had not conducted a care plan meeting with Resident #5's family to discuss fall or interventions to reduce falls for the resident.

The former ED was not available for interview, as the ED's last day of employment with the facility was 10/23/20.

4. Review of Resident #7's current FL-2 dated 06/08/20 revealed:
-Diagnoses included uncontrolled diabetes, major

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neurocognitive disorder, Alzheimer's with behavioral disturbances, and depression.
-The resident was ambulatory and intermittently disoriented.
-The resident was incontinent of bladder and continent of bowel.
-The resident required assistance with dressing.
-The recommended level of care was documented as domiciliary (assisted living).

Review of a facility note for Resident #7 revealed an admission date of 06/30/20.

Review of Resident #7's care plan dated 06/11/20 revealed:
-The resident used a walker for ambulation.
-The resident's orientation was documented as oriented.
-The resident's memory was documented as forgetful and needed reminders.
-The care plan documented Resident #7 was independent with eating and toileting.
-The care plan documented Resident #1 required supervision with ambulation/locomotion, dressing, and transferring.
-The care plan documented Resident #7 required limited assistance with bathing and grooming.
-The care plan was signed by the PCP on 06/15/20.

Review of Initial Licensed Health Professional Support Review for Resident #7 dated 08/11/20 revealed:
-Resident #7 used a walker and wheelchair for mobility.
-Resident #7 had a fall on 07/30/20 and 08/07/20.
-Resident #7 received physical therapy.
-There were no changes noted for Resident #7's plan of care.

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Review of Physical Therapy Discharge Summary for Resident #7 revealed:
-The date of service for physical therapy was 08/03/20 to 09/17/20.
-The resident's diagnoses included muscle weakness, difficulty walking, and unsteadiness on feet.
-It was noted on 09/16/20, Resident #7 had functional decline over the past week and would be transferred to hospice services soon.
-Resident #7 was discharged from therapy on 09/17/20.

Review of Resident #7's incident report dated 07/06/20 at 11:45am revealed:
-The fall was witnessed.
-The resident slipped while ambulating with rollator and used hand rail to caught himself.
-The location of the fall was in the hallway.
-The resident had no injuries and was not sent to the ER for evaluation.
-The resident's vital signs were blood pressure was 144/71, pulse 85, respiration 19, and temperature 96.8 F.
-The RP and physician were notified.

Review of Resident #7's progress note dated 07/06/20 at 4:20pm revealed:
-The residents' rollator slipped on carpet which caused the resident to lose balance.
-The resident caught self on the wall.
-The residents' vital signs were obtained and the resident had no pain or injuries.

Review of Resident #7's incident report dated 07/29/20 at 1:40pm revealed:
-The resident was found on the floor in the hallway.
-The resident was tripped up in rollator and fell.
-The resident was not sent to the ER for

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evaluation.
-The resident's vital signs were obtained and blood pressure was 124/82, pulse 76, respiration 14, and temperature 97.5 F.
-The RP and physician were notified.

Review of Resident #7's progress note dated 07/29/20 at 3:34pm revealed:
-The resident got tripped up on rollator and fell as the resident walked back to his room.
-The family and physician were notified.

Review of Resident #7's incident report dated 07/30/20 at 6:00am revealed:
-The resident was found on the floor in his room beside bed.
-The resident reported rolling out of bed.
-The resident complained of back and knee pain as a result of the fall.
-The resident was assisted up, put back to bed, and given pain medication.
-The resident was not sent to the ER for evaluation.
-The resident's vital signs were obtained and blood pressure was 142/88, pulse 82, respiration 21, and temperature 98.4 F.
-The RP and physician were notified.

Review of Resident #7's progress note dated 07/30/20 at 6:50am revealed:
-The resident was found on the floor in his room beside his bed.
-The resident reported rolling out of bed.
-The resident complained of back and knee pain as a result of the fall.
-The resident was given pain medication.
-The residents' vital signs were taken.
-The physician was notified and first shift were to notify the resident's RP.

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D 270	Continued From page 38 Review of Resident #7's progress note dated 07/31/20 at 2:52pm revealed: -The resident complained of lower back pain. -The resident received x-ray of back, which resulted in negative results. -The resident received medications to manage pain. Review of Resident #7's incident report dated 08/07/20 at 7:32pm revealed: -The resident was found on the floor by staff. -The resident was assisted up and evaluated. -The location of the fall was in the residents' room. -The resident was not sent to the ER for evaluation. -The resident's vital signs were obtained and blood pressure was 156/80, pulse 82, respiration 18, and temperature 98.1 F. -The RP and physician were notified. Review of Resident #7's progress note dated 08/07/20 at 10:45pm revealed: -The resident was found on the floor in the residents' room. -The resident had no known visible injuries, but continued to complain of back pain. -The physician and RP were notified. Review of Resident #7's incident report dated 08/16/20 at 6:45pm revealed: -The resident was found on the floor in the dining room. -The resident was assisted up and evaluated for injuries. -The resident was not sent to the ER for evaluation. -The resident's vital signs were obtained and blood pressure was 135/61, pulse 87, respiration 16, and temperature 98.7 F.	D 270		

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D 270	Continued From page 39 -The RP and physician were notified. Review of Resident #7's progress note dated 08/16/20 at 10:03pm revealed: -The resident was found on floor in the dining room. -The resident had no known visible injuries. -The residents' vital signs were taken. Review of Resident #7's incident report dated 08/24/20 at 5:00am revealed: -The resident was found on the floor in the bathroom. -The resident rang bathroom emergency light. -The resident did not have walker with him. -The resident had no visible injuries and was assisted back to bed. -The resident was not sent to the ER for evaluation. -The resident's vital signs were obtained and blood pressure was 162/73, pulse 87, respiration 23 and temperature 98.0 F. -The RP and physician were notified. Review of Resident #7's progress note dated 08/24/20 at 6:50am revealed: -The resident was found on the floor. -The resident had pulled emergency bathroom light. -The resident did not have walker with him. -The resident complained of back pain and was given pain medication. -The residents' vital signs were taken. -The RP and physician were notified. Review of Resident #7's incident report dated 08/30/20 at 3:00am revealed: -The resident was found on the floor in bathroom in his room. -The resident had no pain and was assisted back	D 270		

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to bed.
-The resident was not sent to the ER for evaluation.
-The resident's vital signs were obtained and blood pressure was 150/61, pulse 82, respiration 19, and temperature 97.5 F.
-The RP and physician were notified.

Review of Resident #7's progress note dated 08/30/20 at 3:00am revealed:
-The resident was found on the floor in his bedroom.
-The resident was not sent out to the ER for evaluation as the resident had no complaints of pain or discomfort.
-The resident was given pain medication and assisted back to bed.
-The residents' vital signs were taken.

Review of Resident #7's incident report dated 09/02/20 at 8:00am revealed:
-The resident was found on the floor in his room.
-The resident had no complaints of pain or visible injuries.
-The resident was not sent to the ER for evaluation.
-The resident's vital signs were obtained and blood pressure was 155/74, pulse 94, respiration 16, and temperature 97.3 F.
-The RP and physician were notified.

Review of Resident #7's progress note dated 09/02/20 at 3:00pm revealed:
-The resident was found on the floor in his bedroom in front of his bathroom.
-The resident had no complaints of pain or injuries.
-The resident's vital signs were taken.

Review of Resident #7's incident report dated

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D 270	Continued From page 41 09/09/20 at 3:15pm revealed: -The resident was found on the floor in his room. -The resident was observed to have a skin tear which was assessed. -The resident was not sent to the ER for evaluation. -The resident's vital signs were obtained and blood pressure was 153/77, pulse 92, respiration 16, and temperature 98.3 F. -The RP and physician were notified. Review of Resident #7's progress note dated 09/09/20 at 9:14pm revealed: -The resident fell on 09/09/20 at the start of the shift. -The resident had a skin tear on right leg, which was bandaged by the MA. -The RP and physician were notified. Review of Resident #7's incident report dated 09/10/20 at 9:00am revealed: -The resident was found on the floor by the bathroom doorway in his room. -The resident stated he lost his footing and fell. -The resident was assisted up and had no visible injuries. -The resident was not sent to the ER for evaluation. -The resident's vital signs were obtained and blood pressure was 148/88, pulse 83, respiration 24, and temperature 97.6 F. -The RP and physician were notified. Review of Resident #7's progress note dated 09/10/20 at 11:00pm revealed: -The resident was found on the floor by the bathroom doorway. -The resident had no visible injuries. -The RP and physician were notified.	D 270		

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Review of Resident #7's incident report dated 09/13/20 at 6:45am revealed:
-The resident was found on the bathroom floor in his room.
-The resident complained of head pain and was sent out to the ER for evaluation.
-The resident's vital sign were obtained and blood pressure was 186/76, pulse 88, respiration 19, and temperature 97.6 F.
-The RP and physician were notified.

Review of Resident #7's progress note dated 09/13/20 at 6:40am revealed:
-The resident was found on the bathroom floor and complained of head and hip pain.
-The resident was sent out to the ER for evaluation.

Review of Resident #7's ER report dated 09/13/20 revealed:
-The resident's chief complaint was a fall.
-It was reported the resident slipped and fell in the bathroom.
-The resident was found on left side on the floor.
-The resident complained of a mild headache and right hip.
-The residents' CT scan revealed no evidence of an acute intracranial abnormality.
-Final diagnoses were fall, closed head injury, and metastatic prostate cancer.

Review of the ROSE fall program book for Resident #7 on 11/05/20 revealed no documentation of fall assessment for falls that occurred on 07/06/20, 07/29/20, 07/30/20, 08/07/20, 08/16/20, 08/24/20, 08/30/20, 09/02/20, 09/09/20, 09/10/20, and 09/13/20.

Interview with the Director of Quality and Education on 11/05/20 at 4:30pm revealed:

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D 270	Continued From page 43 -The Fall Assessments for Resident #7 could not be located. -The Fall Assessments should have been in Resident #7's thinned record since the resident was discharged from the facility on 10/06/20 after the resident had been admitted to the hospital. Review of Resident #7's current and archived record revealed no there was documentation Resident #7's care plan had been updated since completed on 06/11/20 to address falls. Review of the facility fall tracking report for Resident #7 from July 2020 to September 2020 revealed: -On 07/06/20 at 11:45am, Resident #7 was not sent out the ER for evaluation due to a fall in hallway. -On 07/29/20 at 1:40pm, Resident #7 not sent out to the ER for evaluation after being found on the floor in his room. -On 07/30/20, Resident #7 had a fall but no other documentation was noted. -On 08/07/20 at 7:32pm, Resident #7 was not sent out to the ER for evaluation after being found on the floor in his room. -On 08/16/20, Resident #7 was not sent out to the ER for evaluation after being found on the floor in dining room. -On 08/24/20 at 5:00am, Resident #7 was not sent out to the ER for evaluation after being found on the floor in his bathroom. -On 08/30/20 at 3:00am, Resident #7 was not sent out to the ER for evaluation after being found on the floor in his room. -On 09/02/20 at 8:00am, Resident #7 was not sent out to the ER for evaluation after being found on the floor in his room. -On 09/07/20 at 3:15pm, Resident #7 was not sent out to the ER for evaluation after being found	D 270		

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on the floor in his room.
-On 09/12/20 at 3:26am, Resident #7 was not sent out to the ER for evaluation after being found on the floor in his room.

Review of Personal Care Service (PCS) Logs for Resident #7 for July 2020, August 2020, and September 2020 revealed no documentation of interventions related to falls.

Review of Resident #7's fall risk awareness and interventions form revealed:
-On 07/06/20 the resident was placed on the Rose program for 30 days.
-On 07/07/20 the resident received an order for physical therapy.
-On 07/30/20 the family was approached about getting the resident a queen bed to prevent the resident from rolling out of the bed.
-On 08/24/20 the resident was to be fitted for an ankle foot orthosis.
-On 09/03/20 the resident may need to be referred to hospice care.
-On 09/08/20 the resident was to use a wheelchair when staff were unable to assist with walking.
-On 09/10/20 the resident was to use a wheelchair when staff were unable to assist with walking.
-On 09/14/20 the resident was to have one on one provided by a sitter service and the resident was to start hospice.

Interview with a PCA on 11/05/20 at 2:40pm revealed:
-Resident #7 required assistance with toileting, bathing, and dressing.
-Resident #7 used a rollator when admitted to the facility.
-Resident #7 had used a wheelchair the last

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month prior to being discharged.-She could not give exact number but indicated that Resident #7 had a lot of falls in the short time the resident was at the facility.
-She indicated that most of Resident #7's falls occurred in the resident's room when the resident rolled out of bed.
-Resident #7's RP purchased a bigger bed for the resident but the resident continued to fall.
-She could not recall when Resident #7' RP purchased the bed for the resident.
-Resident #7 was weak at time due to his cancer diagnosis.
-Staff encouraged Resident #7 to ask for assistance when needed as the resident did not ask for assistance most of the time.
-Resident #7 was on the ROSE fall program due to falls.
-She was not aware of any interventions for Resident #7 to reduce falls other than the standard 2 hour checks.

Telephone interview with the Physical Therapist (PT) Assistant on 11/10/20 at 1:10pm revealed:
-Fall Assessments were completed regarding Resident #7's falls but assessments could not be located.
-Resident #7 fall interventions included: the family hired a sitter, the resident had a wheelchair, the resident received physical therapy until hospice was recommended, staff were to check on resident frequently, and a higher level of care was recommended after 09/13/20 fall.

Telephone interview with Resident #7's PCP on 11/09/20 at 10:40am revealed:
-The PCP was aware Resident #7 had several falls in the short time of being at the facility.
-The facility informed the PCP of the residents' fall via fax or phone.

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D 270	Continued From page 46 -Resident #7's cancer caused the resident to be very weak. -Resident #7 did physical therapy as much as possible due to his cancer diagnosis. -The family hired a 24-hour sitter for Resident #7 prior to discharge. -The PCP would expect the facility to follow their policy on fall preventions. Telephone interview with Resident #7's RP on 11/10/20 at 11:14am revealed: -Resident #7 had several falls at facility. -Resident #7 used a walker but due to dementia, the resident forgot to use walker and forgot to ask for assistance. -The RP purchased a bigger bed for Resident #7 while at facility about a month after admission. -The RP was not aware of any care plan meeting to discuss falls and interventions. Telephone interview with a family member (FM)of Resident #7 on 11/10/20 at 11:50am revealed: -Resident #7 had several falls at the facility that took a toll on the resident. -The FM was not aware of any interventions the facility provided to address falls. -The FM hired a sitter on 09/13/20 who was to sit with Resident #7 24-hours a day. -The facility staff told a sitter, the facility was responsible for ensuring Resident #7's care needs were met and not the sitter. -The FM was not aware of a care plan meeting to discuss Resident #7's falls and interventions. Interview with the RCD on 11/05/20 at 3:10pm revealed: -The RCD was a Licensed Practical Nurse (LPN) and was responsible for overseeing the assisted living clinical staff to ensure safety measures for the residents.	D 270		

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D 270	Continued From page 47 -The RCD was aware Resident #7 had fallen "a lot" since being admitted to the facility on 06/30/20. -The intervention put in place to reduce Resident #7's falls was for the staff to encourage the resident to use the call bell, as the residents' room was at the end of the hallway. -Most of Resident #7's falls occurred in the residents' room as the resident tried to get up out of bed and go to the bathroom without assistance. -Resident #7's RP purchased a bigger bed for Resident #7. -Resident #7 used a rollator but required standby assistance, as staff did not want the resident to walk down the hall unassisted. -Resident #7 was on the Rose Fall Program. -Resident #7 was to have a fall assessment after every fall but did not happen. -The RCD did not know if a fall assessment was completed for Resident #7 after each fall per the ROSE program policy. -The PT, which was part of the facility staff were responsible for completing the fall assessments and implementing interventions for Resident #7. -Resident #7 was discharged from physical therapy due to recommendation for hospice services. -Resident #7 did not transfer to hospice care prior to being discharged from the facility. -Resident #7 was monitored every 2 hours for supervision which standard protocol for the facility. -The RCD had not increased or changed the supervision needs for Resident #7 due to falls. -Resident #7's family hired a 24-hour sitter to sit with the resident in September 2020. -Even though Resident #7 had a sitter, the facility staff were responsible for the residents' care and monitoring the resident's supervision to ensure	D 270		

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D 270	Continued From page 48 safety. -Resident #7's care plan should have been updated due to interventions and to address falls. -The former Executive Director (ED) would have been responsible for updating Resident #7's care plan dated 06/11/20 to address falls and interventions. -The facility had not conducted a care plan meeting per Rose Program Policy, with Resident #7's family to discuss falls or interventions to reduce falls for the resident. The former ED was not available for interview, as the ED's last day of employment with the facility was 10/23/20. _____ The facility failed to provide supervision for 3 of 5 sampled residents, which resulted in Resident #2 who was assaulted by a Resident #1 (with a history of aggressive behaviors) sustaining unstable cervical spine fractures and nasal fractures; and Residents #5 and #7 having multiple falls with injuries requiring visits to the emergency room. The facility's failure resulted in serious neglect and physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/20 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 10, 2020.	D 270		

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to protect residents from abuse/physical assault for 3 of 3 sampled residents (Residents #2, #3, and #4) in the special care unit as related to Resident #2 being physically assaulted by Resident #1, which resulted in Resident #2 sustaining unstable cervical spine fractures, multiple abrasions, skin tears, nasal laceration, and nasal fractures; and Resident #3 and #4 being hit/grabbed by Resident #1. The findings are: 1. Review of Resident #1's current FL-2 dated 11/08/19 revealed: -Diagnoses included dementia, aphasia, hyperlipidemia, glaucoma, chronic constipation, depression, sinus bradycardia, and hyperplastic colon polyps of colon. -The resident was ambulatory. -The resident was intermittently disoriented and wandered. -The resident's recommended level of care was documented as special care unit (SCU). Review of Resident #1's progress notes from 05/30/20 to 09/06/20 revealed multiple entries that documented the resident's agitation and aggressive behaviors.	D 338		

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D 338	Continued From page 50 Review of Resident #1's progress notes revealed: -A communication entry was made on 09/06/20 at 7:20am that Resident #1 had been seen by a staff member walking out of Room 5 into the bathroom and was observed washing his hands. -Resident #1 had assaulted Resident #2. Review of an incident report dated 09/06/20 revealed: -Resident #1 had increased agitation at 6:00am. -Resident #1 was given a PRN (as needed) medication which was ineffective. -The type of incident was documented as disruptive behavior. -Resident #1 was sent to the emergency room for further evaluation. Interview on 09/17/20 at 1:55pm with a Personal Care Aide (PCA) who worked third shift on 09/06/20 in the special care unit (SCU) revealed: -The PCA was in a residents' room on the other side of the building when the PCA heard a loud scream of "please stop." -When the PCA went into Resident #2's room, Resident #2 was on the bed and blood was everywhere. -Resident #1 was observed in joining bathroom with water running at the sink. -The PCA put a pillow under Resident #2's head and called the Medication Aide (MA) on the phone to come to the unit. -The PCA got a towel and wiped blood out of Resident #2's eyes. -The PCA sat Resident #2's head up to keep the resident from choking on his blood. -When the PCA asked Resident #2 what happened, Resident #2 responded "get him out of here, don't let him in." -Resident #2 wanted to go to the hospital.	D 338		

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D 338	Continued From page 51 -Resident #1 was last seen by the PCA on 09/06/20 between 3:00am-3:15am and had no issues. -Since the PCA was hired in July 2020, Resident #1 had exhibited agitation and aggressive behaviors. -The PCA had concerns of nervousness about working with Resident #1 due to the residents' behaviors. -The PCA was not aware of policy for aggressive behaviors and had not been given any instructions on how to deal with Resident #1's aggressive behaviors. -The only thing, the PCA knew to do was to inform the MA of Resident #1's behaviors or agitation. Telephone interview on 09/17/20 at 1:00pm with the MA who worked third shift on 09/06/20 in the SCU revealed: -About 6:00am, the MA was in the assisted living section of the building doing a medication pass when the PCA called the MA to come to the SCU. -When the MA went to the SCU, Resident #2 was observed to be sitting up on bed. -Resident #2 yelled for help and indicated "get him away from me, help me." -Resident #2 had a gash on forehead. -There was so much blood on Resident #2's head it "looked like a murder scene." -The MA could not determine how bad Resident #2 was injured due to the amount of blood. -Resident #1 was observed on the floor in the doorway of room. -Resident #1 was observed to have blood on hands and forearm. -The MA called 911 to report a resident attacked another resident and that Resident #2 needed to go to the hospital. -Prior to the 09/06/20, Resident #1 exhibited	D 338		

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aggressive and combative behaviors.
-The facility tried to manage Resident #1's behaviors with medications but medications were not effective.
-When the MA informed the Resident Care Director (RCD) and the former Executive Director (ED) that Resident #1's medications were ineffective; the MA was instructed not to interact with Resident #1 if he was aggressive.
-The MA was instructed by the RCD and the former ED to let the resident walk around and do whatever he was doing when he was agitated.
-Resident #1 was not on increased supervision and was monitored every 2 hours (which was standard for supervision).
-The MA had never been in a situation like the 09/06/20 incident regarding Resident #1 and Resident #2.
-The MA was not aware of the policy regarding aggressive behaviors.

2. Review of Resident #2's current FL-2 dated 03/27/20 revealed:
-Diagnoses included dementia, hypertension, depression, and myasthenia gravis.
-The resident's recommended level of care was documented as memory care (MC).

Review of Resident #2's progress notes on 09/06/20 at 7:15am revealed:
-Resident #2 was attacked by another resident and sustained a large skin tear on forehead and nose.
-Staff called 911 as they were unable to assess Resident #2 for any other injuries due to bleeding.

Review of an incident report dated 09/06/20 for Resident #2 revealed:
-On 09/06/20 at 6:00am staff heard noise and found Resident #2 sitting on bed with skin tear on

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forehead bleeding.
-The staff held towel on skin tear and applied pressure.
-The type of incident was documented as skin tear.
-The location of the incident was in the residents' room.
-Resident #2 was transported to the hospital by Emergency Medical Services (EMS).

Review of Resident #2's emergency room (ER) report dated 09/06/20 revealed:
-Resident #2 arrived at the hospital at 6:35am.
-Resident #2's chief complaint was documented as an "assault victim." The resident was assaulted by a fellow resident with noted injury noted to left eye and nose.
-Staff witnessed Resident #2 to be assaulted by another resident. Noted nasal laceration was swelling and deformity and an abrasion to the forehead and skin tear to the right hand.
-Resident #2 had oblique laceration across the bridge of the nose and had significant tenderness and noticeable deviation; central forehead abrasion and contusion.
-Resident #2 had on a cervical collar.
-Resident #2 had left frontal scalp swelling, air fluid level bilateral maxillary sinuses, soft tissue swelling over the nose with nasal bone fractures, prominent fractures of the upper cervical spine including CI and C2 with jumped and locked facets and posterior displacement of the type two dens fracture.
-The final diagnoses were documented as alleged assault, unstable cervical spine fractures, multiple abrasions, skin tear right hand, nasal laceration, and nasal fractures.

Refer to interview on 09/17/20 at 1:55pm with a PCA who worked third shift on 09/06/20 in SCU.

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D 338	Continued From page 54 Refer to telephone interview on 09/17/20 at 1:00pm with the MA who worked third shift on 09/06/20 in the SCU. Interview with the Resident Care Director (RCD) Assistant on 09/17/20 at 10:30am revealed: -Resident #1 had aggressive behaviors when agitated. -Staff tried to keep Resident #1 away from other residents by taking the resident to his room when agitated. -Management was aware of Resident #1's behaviors prior to the 09/06/20 incident regarding Resident #2. -The previous Cottage Care Coordinator (CCC) expressed concerns to the former ED that Resident #1 was going to hurt someone (staff or residents) due to aggressive behaviors and facility was no longer an appropriate placement for the resident. Interview with two MAs who worked first shift on 10/27/20 and 10/29/20 revealed: -Resident #1 had aggressive behaviors towards staff and residents. -There were concerns Resident #1 would "seriously" hurt staff, residents, or himself due to his behaviors. -Management was aware of Resident #1's behaviors and the concern staff had for their safety and the safety of the residents due to his aggression, as his behaviors were discussed in daily stand-up meetings. -Staff were not given any direction from management on how to ensure the residents' safety from Resident #1. Interview with the RCD on 11/10/20 at 4:05pm regarding the 09/06/20 incident regarding	D 338		

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Resident #1 and Resident #2 revealed:
-The former ED informed the RCD about the incident by phone.
-The incident happened about 6:00am.
-The PCA found Resident #2 on bed in room after the PCA heard the resident yell.
-Resident #2 was bleeding from nose and gash on forehead.
-Resident #1 was observed at sink of joining bathroom washing hands.
-There had been concerns about Resident #1's aggressive behaviors.
-Resident #1 was not on increased supervision and was monitored every 2 hours which was standard.
-Resident #1's RP did not have the means to provide 1:1 care.
-The facility did not have the staff to increase Resident #1's supervision to 1:1.
-She would expect a change in supervision needs if a resident exhibited unsafe behavioral concerns, such as Resident #1.
-The facility should have provided 1:1 supervision to Resident #1 with shared responsibility of the residents' family.
-Due to Resident #1's behaviors, the facility was not an appropriate placement for the resident.

Interview with former ED on 09/10/20 at 2:40pm revealed:
-On 09/06/20 the MA called the ED regarding an unwitnessed incident regarding Resident #1 and Resident #2.
-The MA reported that Resident #2 was heard calling for help.
-The MA reported Resident #2 was found sitting beside bed.
-According to the MA, Resident #2 had a gash on head and there was "a lot" of blood.
-The ED was informed that Resident #1 was

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observed was by the sink in joining bathroom with blood on hands.
-Prior to the 09/06/20 incident, Resident #1 had exhibited increased agitation and had been combative towards staff.
-The facility had tried medication changes to address Resident #1's behaviors.
-Prior to the 09/06/20, the only intervention in place to address Resident #1's behaviors were for staff to call the resident's RP who would come to the facility to calm the resident down when the resident exhibited behaviors.
-Resident #1 was not on increased supervision, as the resident was monitored every 2 hours, which was standard for supervision.

3. Review of Resident #3's current FL-2 dated 02/14/20 revealed:
-Diagnoses included dementia, atrial fibrillation, dysphagia, hypernatremia, and depression.
-The resident's level of care was documented as memory care.

Review of a coversheet dated 06/18/20 that was faxed to Primary Care Provider (PCP) at 12:20pm revealed Resident #3 was attacked by another resident.

Review of an incident report dated 06/18/20 for Resident #3 revealed:
-On 06/18/20 at 12:20pm, Resident #3 was sitting at the table waiting for lunch when Resident #1 came over and attacked the resident.
-The residents were removed away from each other.
-Resident #3 was checked for scars and bruises.
-The type of incident was documented alleged abuse from resident/other.
-The location of the incident was "dining room."

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D 338	Continued From page 57 -Resident #3 was not sent out to the emergency room for evaluation. Review of Resident #3's progress notes revealed no documentation that Resident #3 was attacked by Resident #1 on 06/18/20. Interview with the Resident Care Director (RCD) Assistant on 09/17/20 at 10:30am revealed: -Resident #1 had hit Resident #3, but could not recall the date of the incident. -Resident #1 tried to hit staff and other residents when agitated. -Staff tried to keep Resident #1 away from the other residents when agitated. -Management was aware of Resident #1's aggressive behaviors. -There were no interventions in place for staff to manage Resident #1's behaviors other than medication management, which was not effective. -The previous CCC had expressed concerns to the former ED that Resident #1 was "going to hurt someone" (staff or residents) due to aggressive behaviors and facility was no longer an appropriate placement for the resident. -Resident #1 was monitored the standard every 2 hours and had no increased supervision measures in place to monitor increased agitation and aggression. Interview with a MA on 10/27/20 at 1:00pm revealed: -Resident #1 had been more aggressive and combative towards staff and residents during the COVID-19 lockdown. -The MA witnessed Resident #1 hit Resident #3 on 06/18/20. -Resident #1 hit Resident #3 on the shoulder with open hand.	D 338		

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-Resident #3 was not injured as a result of being hit by Resident #1.
-The MA had concerns Resident #1 would seriously hurt himself, staff, and residents due to his aggressive behaviors.
-The MA had expressed concerns of Resident #1's behaviors to management staff.
-The CCC at the time of the 06/18/20 incident informed the MA to continue to chart Resident #1's behaviors, as the CCC was working to get Resident #1 placed to a more suitable facility where behaviors could be managed.
-The former ED did not give staff feedback regarding managing Resident #1's behaviors to keep residents safe.
-The MA completed the 06/18/20 incident report regarding incident with Resident #1 and Resident #3.

Telephone interview with RCD on 11/10/20 at 4:05pm revealed:
-The RCD had no knowledge of the 06/18/20 incident regarding Resident #1 and Resident #3, as the RCD was hired on 07/27/20.
-The RCD was not aware of any changes in Resident #1's supervision needs after the 06/18/20 incident.

4. Review of Resident #4's current FL-2 dated 03/06/20 revealed:
-Diagnoses included dementia, hypertension, B12 deficiency, and hyperlipidemia.
-The resident's level of care was documented as memory care.

Interview with the Resident Care Director Assistant on 09/17/20 at 10:30am revealed the RCD had informed her that Resident #1 had grabbed Resident #4's arms and shook the

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D 338	Continued From page 59 resident, but could not recall date of incident. Refer to the interview with the Resident Care Director Assistant on 09/17/20 at 10:30am. Interview with a PCA on 09/17/20 at 11:35am revealed: -About one month ago Resident #1 tried to take Resident #4's walker. -Staff were able to intervene to keep Resident #1 from hitting Resident #4. -Staff were able to redirect Resident #1 from Resident #4. -Resident #1 was combative and tried to hit staff and residents when agitated. -Staff were not given any instructions from management how to handle Resident #1's aggressive behaviors. Telephone interview with the RCD on 11/10/20 at 4:05pm revealed: -The RCD had no knowledge that Resident #1 grabbed Resident #4. -It was reported to the RCD that Resident #1 gave Resident #4 an unwanted hug. -Resident #1 became more agitated when staff tried to separate Resident #1 and Resident #4. -Resident #4 had no injury from incident with Resident #1. -Staff had shared safety concerns for residents regarding Resident #1's behaviors. _____ The facility failed to ensure each resident was protected from resident to resident altercations resulting in Resident #2 who sustained an unstable cervical spine fractures, multiple abrasions, skin tears, nasal laceration, and nasal fractures; Resident #3 who was hit attacked by	D 338		

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D 338	Continued From page 60 Resident #1 while sitting at lunch table; and Resident #4 being grabbed by Resident #1. The facility's failure resulted in serious neglect and physical harm to residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/20 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 10, 2020.	D 338		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.	D 464		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled residents on the Special Care Unit (#2, #3, and #4) had care plans completed quarterly. The findings are:

1. Review of Resident #2's current FL-2 dated 03/27/20 revealed:
-Diagnoses included dementia, hypertension, depression, and myasthenia gravis.
-The resident was ambulatory.
-The resident was intermittently disoriented and wandered.
-The resident was incontinent bowel and bladder.
-The resident required assistance with bathing and dressing.
-The resident's level of care was documented as memory care.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 08/18/17.

Review of Resident #2's care plan dated 02/04/20 revealed:
-The resident was ambulatory.
-The resident had occasional incontinence with bowel and bladder.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident required total assistance with bathing.
-The resident required supervision with ambulation/locomotion.
-The resident needed extensive assistance with dressing.
-The care plan was completed and signed by the

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D 464	Continued From page 62 Cottage Care Coordinator (CCC) on 02/04/20. Review of Resident #2's record on 09/10/20 revealed no quarterly care plan had been completed since the care plan dated 02/04/20. 2. Review of Resident #3's current FL-2 dated 02/14/20 revealed: -Diagnoses included dementia, atrial fibrillation, dysphagia, hypernatremia, and depression. -The resident was ambulatory and used a walker. -The resident was constantly disoriented and wandered. -The resident was incontinent bowel and bladder. -The resident required assistance with bathing and dressing. -The resident's level of care was documented as memory care. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/11/11. Review of Resident #3's care plan dated 02/04/20 revealed: -The resident was ambulatory and used a rollator. -The resident had occasional incontinence with bowel. -The resident had daily incontinence with bladder. -The resident was sometimes disoriented. -The resident had significant memory loss. -The resident required limited assistance with eating. -The resident required extensive assistance with ambulation/locomotion and transferring. -The resident required total assistance with bathing and dressing. -The care plan was completed and signed by the CCC on 02/04/20.	D 464		

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D 464	Continued From page 63 Review of Resident #3's record on 09/10/20 revealed no quarterly care plan had been completed since the care plan dated 02/04/20. 3. Review of Resident #4's current FL-2 dated 03/06/20 revealed: -Diagnoses included dementia, hypertension, B12 deficiency, hyperlipidemia, and degenerative disc. -The resident was ambulatory. -The resident was constantly disoriented. -The resident's level of care was documented as memory care. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 02/25/17. Review of Resident #4's care plan dated 02/04/20 revealed: -The resident was ambulatory and used a rollator. -The resident had occasional incontinence with bowel and bladder. -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident wandered and required supervision with dressing and eating. -The resident required limited assistance with toileting. -The resident required extensive assistance with bathing. -The care plan was completed and signed by the CCC on 02/04/20. Review of Resident #4's record on 09/17/20 revealed no quarterly care plan had been completed since the care plan dated 02/04/20. Telephone interview with the Resident Care Director (RCD) on 10/15/20 at 4:08pm revealed:	D 464		

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D 464	Continued From page 64 -The RCD was hired on 07/27/20. -The CCC was responsible for completing the care plans in the memory care unit when the RCD was hired. -The care plans were kept in the resident records. -The CCC left the company in August 2020. -The care plans in the memory care unit were to be completed annually, quarterly, and when there was a significant change. -Since the CCC left the company, the RCD has been trained on care plans and would be responsible for competing the care plans in the memory care unit as required. Telephone interview with the former Executive Director (ED) on 10/16/20 at 10:48am revealed: -The CCC was responsible for completing the care plans for the memory care unit prior to leaving the company in August 2020. -The care plans were kept in the resident records. -The care plans for the memory care unit were to be completed annually, quarterly, and when there was a significant change. -The facility had a tickler system in place as monitoring tool to track the care plans and when they were to be completed. -The CCC was responsible for updating the tickler system but the tickler tracking had not been updated as it should have been. -The CCC should have completed a quarterly care plans for Resident #2, #3, and #4 in May 2020 and August 2020, which were not done. -The facility had a new RCD who would be overseeing the care plans for the memory care unit would be completed as required. -The ED would expect the care plans in the memory care unit to be completed annually, quarterly, and when there was a significant change.	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065014	A. BUILDING: _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 65	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Personal Care and Supervision. The findings are: Based on record reviews and interviews the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 3 of 5 sampled residents (Residents #2, #5, and #7) sampled related to a resident with known history of aggressive behaviors resulting in a physical altercation with Resident #2 resulting in unstable cervical spine fractures, multiple abrasions, skin tears to right hand, nasal laceration, and nasal fractures prior to his death on 10/12/20; and residents (#5 and #7) having multiple falls with injuries requiring visits to the emergency room. [Refer to TAG 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 66	D914		
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 record reviews and interviews the facility failed to ensure residents were free from neglect related to Resident Rights. The findings are: Based on record reviews and interviews, the facility failed to protect residents from abuse/physical assault for 3 of 3 sampled residents (Residents #2, #3, and #4) in the special care unit as related to Resident #2 being physically assaulted by Resident #1, which resulted in Resident #2 sustaining unstable cervical spine fractures, multiple abrasions, skin tears, nasal laceration, and nasal fractures; and Resident #3 and #4 being hit/grabbed by Resident #1. [Refer to 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].	D914		