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	HAL030009	A. BUILDING: _____ B. WING _____	02/03/2021

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D 000	Initial Comments The Adult Care Licensure Section conducted a Complaint Investigation. An onsite visit was done on 01/21/21. Survey continued via desk review 01/22/21, 01/25/20 through 01/29/20, and 02/01/21 through 02/03/21 with exit via telephone on 02/03/21.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 exit doors accessible for residents' use had an alarm activated for the safety of 1 of 7 sampled residents (Resident #6) who was constantly disorientated and had wandering and exit seeking behaviors. The findings are:	D 067		

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D 067	Continued From page 1 Observations of the facility on 01/21/21 at various times between 12:25pm and 5:30pm revealed: -At 12:25pm, the front door of the main entrance was locked from the outside, but it unlocked from the inside. -There was no alarm or chiming sound when the door was opened. -There was a door on each side of the breezeway in the main hallway, but there were no observations of staff or residents going out of the breezeway doors. Review of Resident #6's current FL2 dated 05/21/20 revealed: -Diagnoses included Alzheimer's dementia. -Resident #6 was constantly disoriented. -Resident #6 was ambulatory. Review of Resident #6's Care Plan dated 07/16/20 revealed: -Resident #6 had wandering behaviors and was always disoriented. -Resident #6 had significant loss of memory and had to be directed. Review of Resident #6's Progress Notes dated 12/26/20 at 11:33am revealed: -Resident #6 was opening doors in an attempt to go outside. -Safety interventions put into place were to continue to redirect Resident #6 and monitor. Review of Resident #6's Progress Notes dated 12/26/20 at 6:46pm revealed: -Resident #6 was attempting to open the front door to go outside. -Safety interventions put in place were to continue to redirect Resident #6 and monitor.	D 067		

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Telephone interview with a the medication aide (MA) on 02/01/21 at 1:16pm revealed:
-She documented the progress on 12/26/21 at 11:33am and 6:46pm.
-Resident #6 was constantly confused and was constantly on the go.
-There were chime alarms on the front door, but they were hardly ever activated.
-The alarms could be manually turned on and off.
-On 12/26/21 at 11:33am, she was near the nurses' station and had her medication cart facing the front door, when she saw Resident #6 with the front door open and was on her way out, but she had not gotten out yet.
-The door chime was not sounding when she noticed Resident #6 attempting to leave at 11:33am.
-On 12/26/21 at 6:46pm, she was walking down the hallway when she noticed Resident #6 had the front door open.
-The door alarm was not sounding when she noticed Resident #6 attempting to leave the facility at 6:46pm.
-She activated the door alarm on 12/26/21 after Resident #6 attempted to leave the facility at 11:33am and 6:46pm.

Review of Resident #6's Progress Note dated 01/04/21 at 11:20am revealed:
-Resident #6 was attempting to go out the front door.
-The safety intervention put in place was to continue to redirect Resident #6.

Telephone interview with a MA on 02/01/21 at 1:39pm revealed:
-She documented the progress note dated 01/04/21.
-Resident #6 was constantly walking throughout the facility and went to the front door often.

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-Sometimes Resident #6 figured out how to get the front door open by pushing on it.
-On, 01/04/21, she saw Resident #6 with the front door open and the alarm was not activiated to alert staff the door was open.
-MAs and supervisors were responsible for making sure the alarms on the front door and the breezeway doors were activated.
-She did not know why the chime was not activated on 01/04/21 or who turned the alarm off.
-The alarm had to be turned off once it was activated.

Review of Resident #6's Progress Note dated 01/12/21 revealed:
-Resident #6 attempted to go out of the front door.
-Safety interventions put in place for Resident #6 was to continue to redirect Resident #6 and to monitor.

Telephone interview with a MA on 02/01/21 at 1:39pm revealed:
-She documented the progress note dated 01/12/21
-On, 01/12/21, she saw Resident #6 with the front door open and the door alarm was not activited to alert staff the door was open.
-There was no alarm sounding to alert staff the front door was open.
-MA and supervisors were responsible for making sure the alarm was on the front door and the breezeway doors.
-She did not know why the door alarms were was not activated on 01/12/21 or who turned the alarm off.
-The alarm had to be turned off once it was activated.

Review of Resident #6's Progress Note dated

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01/16/21 revealed:
-Resident #6 opened the front door and attempted to go out of the front door.
-Safety intervention put in place was to continue to redirect Resident #6.

Telephone interview with a MA on 02/01/21 at 1:16pm revealed:
-She documented the progress note dated 01/16/21.
-She was walking up the hallway and saw Resident #6 with the front door open.
-Resident #6 had her walker which was between her and the open door. Resident #6 was turned sideways and had a shoulder and a foot out of the door.
-The only thing that prevented Resident #6 from getting completely out of the door on 01/16/21 was that she had her walker.
-There were no alarms sounding to alert staff the front door was open.
-She activated the alarm on 01/16/21 after Resident #6 after she got Resident #6 back in the lobby.

Telephone interview with Resident #6's responsible party on 01/26/21 at 1:40pm revealed she knew Resident #6 had tried to leave the facility several times, but she did not remember when.

Telephone interview with the RCC on 02/01/21 at 9:11am revealed:
-Resident #6 had increased wandering and exit seeking behaviors over the last month or so.
-There was an alarm on the front door and it should have always been on.
-She did not know if the front door was alarmed when Resident #6 attempted to leave the facility on 12/26/20 at 11:33am and 6:40pm, 01/06/21,

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D 067	Continued From page 5 01/12/21, and 01/16/21. Telephone interview with Resident #6's PCP on 01/29/21 at 2:12pm revealed: -He did not know about Resident #6's attempts to leave the facility and would have liked to have been made aware. -Facility staff had to be able to respond to keep Resident #6 from leaving the facility. Telephone interview with the interim Administrator on 02/01/21 at 9:33am revealed: -Resident #6 went to the front door of the facility often, but she had never gotten out. -The alarms should have been alarmed on the front and breezeway doors to alert staff someone was going out and staff should have gotten up to go see who was at the door. -The alarms could be turned off, but they should have been activated at all times. -The doors were not always alarmed when she got to the facilty. -Supervisors were responsible for ensuring the alarms were activated at the beginning of their shifts. _____ The facility failed to assure all exit doors were alarmed when there was at least one identified resident who wandered or was disoriented resulting in Resident #6 attempting to elope from the facility. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 02/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 20,	D 067		

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D 067	Continued From page 6 2020.	D 067		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 6 sampled staff (Staff E) was tested for Tuberculosis (TB) disease upon hire. The findings are: Review of Staff E's, personal care aide (PCA), personnel record revealed: -Staff E was hired on 01/11/21. -There was no documentation a TB skin test was completed for Staff E. Attempted telephone interview with Staff E on 02/02/21 at 4:20pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed: -She did not know Staff E did not have her first step TB skin test.	D 131		

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D 131	Continued From page 7 -The former Business Office manager (BOM) was responsible for making sure TB skin were completed. Interview with the former BOM on 02/03/21 at 1:15pm revealed: -She worked for the facility as the BOM from April 2020 through 01/22/21. -She was responsible for making sure TB skin tests were completed for staff. -TB skin tests should have been completed for all staff upon hire. -She did not know if Staff E had completed her first step TB skin test. -There was an electronic form used to track whether required hiring tasks had been been completed; This form was available to all facility managers. Interview with the acting Administrator on 02/03/21 at 12:09pm revealed: -The former BOM was responsible for making sure TB skin tests were completed upon hire for new staff. -She did not know Staff E had not completed her first step TB skin test. -The facilty was in the process of hiring a new BOM to ensure TB skin tests were completed for new staff going forward.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;	D 137		

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D 137	Continued From page 8 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff F) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff F's, Medication Aide (MA) personnel record revealed: -There was no hire date documented for Staff F. -There was no documentation Staff F had a HCPR check upon hire. Interview with Staff F on 12/30/20 at 5:15am revealed: -She was hired as a Personal Care Aide (PCA) on 04/22/20 and became a MA in 09/2020. -She had only worked at the facility for 7 days. -She did not know if the HCPR was checked for her Telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm revealed: -She was responsible for the HCPR checks for the staff when she was there, but the corporate office also completed HCPR checks. -She thought Staff F was hired prior to her working at the facility. -She did not know there was no documentation of a HCPR check for staff F. Telephone interview with the interim Administrator on 02/03/21 at 12:09pm revealed: -She did not know there was no documentation Staff F had a HCPR.	D 137		

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D 137	Continued From page 9 -A HCPR check should have been completed for Staff F upon hire. Upon exit on 02/03/21, no further documentation was received.	D 137		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (D	D 150		

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and F) who provided personal care to residents had documentation of successful completion of an 80-hour personal care training and competency evaluation program.

The findings are:

1. Review of Staff D, personal care aide's (PCA), personnel record revealed:
-There was no documentation of a hire date for Staff D.
-There was no documentation Staff D had completed an 80-hour personal care training and competency skills check list.

Interview with Staff D on 02/02/21 at 4:50pm revealed:
-She was hired in July 2020 as a personal care aide (PCA).
-She worked in the memory care unit (MCU) and on the assisted living (AL) side of the facility.
-She thought she had her 80-hour personal care training during her first 3 days of trainings in July 2020.
-She assisted residents with personal care including toileting, bathing, and dressing.

Interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed:
-The former Business Office Manager (BOM) was responsible for making sure personal care training was scheduled for PCAs and she was not involved in the process.
-She did not know if Staff D had completed her personal care training.

Interview with the previous BOM on 02/03/21 at 1:15pm revealed:
-She worked for the facility as the BOM from April 2020 through 01/22/21.

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-She instructed staff to complete personal care training on-line by a certain date and then they were to be checked off by the licensed health professional support (LHPS) nurse.
-She did not know if Staff D completed the 80-hour personal care training.
-There was an electronic form used to track whether required hiring tasks had been been completed; This form was available to all facility managers.

Interview with the interim Administrator on 02/03/21 at 12:09pm revealed:
-The previous BOM was responsible for ensuring new staff completed the 80-hour personal care training and she should have coordinated with the RCC, but she did not.
-The 80-hour personal care training and competency should have been completed upon hire and before working independently as a PCA.
-She did know there was no documentation of 80-hour personal care training for Staff D.

2. Review of Staff F's, personal care aide (PCA)/medication aide (MA), personnel record revealed:
-There was no documentation of a hire date.
-There was no documentation Staff F had completed an 80-hour personal care training and competency competency skills check list.

Interview with Staff F on 02/02/21 at 4:33pm revealed:
-She was hired on 04/22/20 as a PCA and started working as a MA in 09/2020.
-She watched videos on how to do personal care during her first 3 days of training when she was hired, but she did not know if the videos were a part of the 80-hour personal care training or if the LHPS nurse checked her off for 80 hours of

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personal care training.
-She assisted residents with personal care including ambulation, transfers, toileting.

Interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed:
-The previous Business Office Manager (BOM) was responsible for making sure personal care training was scheduled for PCAs and she was not involved in the process.
-She did not know if Staff F had completed her personal care training.

Interview with the previous BOM on 02/03/21 at 1:15pm revealed:
-She worked for the facility as the BOM from April 2020 through 01/22/21.
-She instructed staff to complete personal care training on-line by a certain date and then they were to be checked off by the licensed health professional support (LHPS) nurse.
-She did not know if Staff F completed the 80-hour personal care training.

Interview with the acting Administrator on 02/03/21 at 12:09pm revealed:
-The previous BOM was responsible for ensuring new staff completed the 80-hour personal care training and she should have coordinated with the RCC, but she did not.
-The 80-hour personal care training and competency should have been completed upon hire and before working independently as a PCA.
-She did know there was no documentation of Staff F having the 80-hour personal care training.
-The facilty was in the process of hiring a new BOM to ensure TB skin tests were completed for new staff going forward.

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D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 3 of 6 sampled staff (Staff A, D, and E) and for 5 of 39 shifts sampled for 13 days from 01/12/21 through 01/19/21 and 01/25/21 through 01/29/21. The findings are: Review of the facility schedule and current CPR certification for all employees from 01/12/21 through 01/19/21 and from 01/25/21 through 01/29/21 revealed: -The facility had 3 shifts: first shift was from	D 167		

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7:00am to 3:00pm, second shift was from 3:00pm to 11:00pm and third shift was from 11:00pm to 7:00am.
-There were no staff on duty with CPR and Choking Management training for 5 of 39 shifts on 01/13/21 from 11:00pm to 7:00am; 01/14/21 from 11:30pm to 7:00am; 01/15/21 from 11:30pm to 7:00am; 01/16/212 from 12:00am to 7:00am; and on 01/27/21 from 11:00pm to 7:00am.

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A was hired on 06/26/19.
-There was no documentation Staff A had completed training on CPR within the last 24 months.
-There was no documentation Staff A had ever completed CPR and Choking Management.

Attempted telephone interview with Staff A on 02/02/21 at 12:08pm was unsuccessful.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am.

Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm.

Refer to telephone interview with the interim Administrator on 02/03/20 at 12:09pm.

2. Review of Staff D's, personal care aide (PCA), personnel record revealed:
-There was no hire date documented for Staff D.
-There was no documentation Staff A had completed training on CPR within the last 24 months.
-There was no documentation Staff B had ever completed CPR and Choking Management.

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D 167	Continued From page 15 Telephone interview with Staff D on02/02/21 at 4:50pm revealed: -She did not have CPR certification and had never taken the CPR training course. -If there had been an event requiring CPR and no other CPR certified staff was available, she would call 911. Refer to telephone interview with the Resident Care Coordinator on 02/03/21 at 11:20am. Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with the interim Administrator on 02/03/20 at 12:09pm. 3. Review of Staff E's, personal care aid (PCA), personnel record revealed: -Staff E was hired on 01/11/21. -There was no documentation Staff A had completed training on CPR within the last 24 months. -There was no documentation Staff B had ever completed CPR and Choking Management. Attempted telephone interview with Staff E on 02/03/21 at 8:33am was unsuccessful. Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am. Refer to telephone interview with the former Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with the previous Administrator on 02/03/20 at 12:09pm.	D 167		

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D 167	Continued From page 16 Telephone interview with the RCC on 02/03/21 at 11:20am revealed: -She was responsible for making the weekly schedules for the facility. -She assigned the CPR certified staffing schedules in collaboration with the previous BOM. -The former BOM had not worked at the facility since 01/20/21. -She did not have a list of CPR certified staff and she did not know who had current CPR certification. Telephone interview with the previous BOM on 02/03/21 at 1:15pm revealed: -The MAs, supervisors, and care managers usually had current CPR certification. -There were many staff who did not have current CPR certification and the facility needed staff's current CPR cards. -The RCC was responsible for creating the staff schedules and for making sure shifts were staff with at least one CPR certified staff. -There was no list of current CPR certified staff for the RCC to use while creating the schedule. -She had not discussed with anyone who was CPR certified and who was not. -Management should have known because there was an electronic tracking document available for management to see which staff was missing CPR certification in employee records. Telephone interview with the interim Administrator on 02/03/20 at 12:09pm revealed: -There was no documentation of CPR certified staff. -She found some CPR cards, but she thought there were more because she had taught a class at the facility within the last two years. -The RCC created the schedule, and if the	D 167		

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D 167	Continued From page 17 previous BOM did not tell her which staff had current CPR certification, then she did not know. -There should be CPR certified staff on each shift.	D 167		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's	D 255		

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disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 1 of 7 sampled residents (#1) who declined and was put on Hospice and dependent on staff for ambulation and transferring.

The findings are:

Review of Resident #1's current FL-2 dated 08/27/20 revealed:
-Diagnoses included major neurological disorder due Alzheimer with behaviors, hypertension, malignant tumor of colon, chemotherapy induced neuropathy and history of rectal cancer.
-Resident #1 resided in the Memory Care Unit (MCU).
-Resident #1 was constantly disoriented and wandered.
-Resident #1's functional limitation was sight.
-Resident #1's communication needs were verbally (unable to communicate).
-Resident #1 needed personal assistance with bathing, dressing and was incontinent of bladder and bowel.

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D 255	Continued From page 19 Review of Resident #1's care plan dated 09/16/20 revealed: -Resident #1 required limited assistance with eating. -Resident #1 required extensive assistance with toileting, bathing, dressing, grooming and was independent with ambulation and transferring. Review of Resident #1's record revealed: -There was no documented quarterly profile. -In November 2020, Resident #1's health declined significantly causing the resident to be unbalanced with her gait. -Resident #1 had increased weakness that caused her to have frequent falls. -Due to the decline in health Resident #1 was put on Hospice. -Hospice initial assessment was that Resident #1 was now dependent on staff for all Activities of Daily Living (ADLs), including ambulation and transferring. -The decline in Resident #1's ambulation and transferring caused multiple falls resulting injuries. -There was no documented updated care plan that showed Resident #1 had a significant declined and was no longer independent with ambulation and transferring. Review of Resident #1's Hospice care notes from revealed: -Resident #1 was admitted to Hospice services due to the progression of her disease, Alzheimer's/dementia. -Resident #1 had memory deficit with significant memory loss and supervision was required. -Resident #1 had impaired decision-making that jeopardized safety through actions. Resident #1 had decreased strength in upper and lower bilateral extremities, neck and back.	D 255		

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-Resident #1 now required maximum assistance with ambulating and transferring.
-Resident #1 was losing trunk control and was a high fall risk.
-Resident #1 had significant memory loss so that supervision was required due to impaired decision-making, failure to perform usual ADL situations and inability to appropriately stop activities, jeopardizes safety through actions.
-Resident #1 was weak and staff reported Resident #1 required total assistance with all ADLs.

Review of Resident #1's accident/incident reports, progress notes and Hospice notes from August 2020 through January 2021 revealed:
-Between 09/03/20 and 01/19/21 Resident #1 had seventeen documented falls when attempting to ambulate and/or transfer herself without staff assistance.
-According to Hospice notes Resident #1 was no longer independent in ambulating and transferring as documented on the care plan dated 09/16/20.
-There was no documentation the care plan was updated to reflect that Resident #1 current health status being totally dependent on staff for ambulation and transferring.

Telephone interview with Resident #1's guardian and Power of Attorney on 01/27/21 at 4:38pm revealed:
-She remembered Resident #1's care plan being discussed shortly after the resident was admitted to the facility.
-She knew Resident # 1 had a significant change since her admission to the facility because Resident #1 used to walk and was now in a wheelchair.
-Resident #1 was now on Hospice due to her decline in ADLs, mainly ambulation and

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D 255	Continued From page 21 transferring. Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 01/28/21 at 1:03pm revealed: -She was responsible for completing care plans and quarterly profiles for residents in the MCU. -In early November 2020, she noticed that Resident #1 had a significant decline in her health because the resident had decreased appetite, was more confused not acknowledging the presence of people, and the resident was no longer independent with ambulation and transferring. -Due to Resident #1's decline she recommended Hospice to Resident #1's family. -In November 2020, she went out on leave for six weeks and did not update Resident #1's care plan. She also forgot to complete the resident's quarterly profile. -When she returned back to work in December 2020, she forgot about Resident #1's care plan. -She worked for one month and resigned from the facility. Telephone interview with the facility's Primary Care Provider (PCP) on 01/29/21 at 1:51pm revealed: -Resident #1 took a drastic change for the worse two months ago and was now managed by Hospice. -Due to Resident #1's diagnosis of Alzheimer's the resident would continue to decline. Telephone interview with the Hospice nurse on 02/01/21 at 4:22pm revealed: -Resident #1 had declined in ADLs and now required maximum assistance with all ADLs, including ambulation and transferring. -Due to the resident's disease progression she	D 255		

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D 255	Continued From page 22 would continue to decline. -She continually educated staff about the progression of Resident #1's disease, as well as signs and symptoms to watch for.	D 255		
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 A2 VIOLATION Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 3 of 7 sampled residents (#1, #6, and #7) with falls resulting in serious injuries of a fractured arm and a skin tear (#6), a resident who had 9 falls with skin tears, a cut lip, bruising, and an injury to the face (#7), a resident who had seventeen falls with bruises, lacerations, contusions and staples (#1) and a resident with multiple attempts to leave the facility who had a history of confusion, wandering, and exit-seeking behaviors (#6). The findings are: 1. Review of Resident #6's current FL2 dated 05/21/20 revealed: -Diagnoses included Alzheimer's dementia. -Resident #6 was constantly disoriented. -Resident #6 was ambulatory.	D 270		

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a. Review of Resident #6's care plan dated 07/16/20 revealed:
-Resident #6 had wandering behaviors and required redirecting throughout the day.
-Resident #6 was ambulatory and needed a walker to ambulate.
-Resident #6 was always disoriented.
-Resident #6 had significant loss of memory and had to be directed.
-Resident #6 required limited assistance with ambulation and transferring.

Review of Resident #6's Licensed Health Professional Support (LHPS) review dated 01/22/20 revealed the LHPS task provided was ambulation with a walker.

Review of the facility's Accident/Falls/Emergency and Fire Safety Policy revealed there was no documentation regarding supervision of residents.

Observation of the facility on 01/21/21 between 12:27pm and 5:30pm revealed:
-At 12:27pm, Resident #6 was walking in the main hallway, without her walker and wearing a bracelet that read, "Fall Risk." There were no staff in the hallway monitoring or making sure Resident #6 walked with her walker other than the previous Administrator; Resident #6 had stitches on her forehead and bruising on her right wrist.
-At 12:44pm, Resident #6 was observed walking in the main hallway, without her walker, and there were no staff in the hallway.
-At 1:02pm, Resident #6 was observed walking in the main hallway, without her walker, and there were no staff in the hallway.
-At 1:06pm, Resident #6 was observed walking in the back hallway, without her walker, and there

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were no staff in the hallway.
-At 1:26pm, Resident #6 was observed walking in the main hallway, without her walker, and there were no staff in the hallway.
-At 2:53pm, Resident #6 was observed standing in the middle of the main hallway, without her walker, and there were no staff in the hallway.
-At 3:08pm, Resident #6 was observed sitting on the couch in the main hallway, without her walker, and there were no staff in the hallway.
-At 3:33pm, staff was observed brining Resident #6 her walker.
-Resident #6 ambulated throughout the facility with non-skid socks on.
-Resident #6 was holding onto furniture and walls as she ambulated.

Interview with the previous Administrator on 01/21/21 at 12:29pm revealed:
-Resident #6 was wearing the "Fall Risk" bracelet because she had just gotten out of the hospital a few days ago.
-Resident #6's last fall resulted in an abrasion to her forehead.

Review of Resident #6's Progress Notes dated 11/20/20 revealed:
-Resident #6 had an unwitnessed fall in the lobby.
-Resident #6 had 3 skin tears on her left arm.
-Hospice was contacted twice and the facility never received a call back from Hospice.
-Resident #6's speech became slurred and she was sent out to the local emergecy department (ED)
-Resident #6 returned to the facility around 4:30pm on 11/20/20 with a splint on her left arm.
-Resident #6 was diagnosed with a closed fracture to the left arm.

Review of Resident #6's Accident/Incident

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D 270	Continued From page 25 Reports dated 11/20/20 at 7:15am revealed: -Resident #6 had an unwitnessed fall in the hallway at 7:15am. -Resident #6 was observed on the floor in the hallway. -Resident #6 did not complain of pain. -Resident #6 had a skin tear. -Resident #6 was transported to the local hospital ED and returned with a diagnosis of a closed fracture of distal end of left radius. -The Fall Prevention Program was documented as initiated. -Resident #6 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall. -Resident #6's vital signs were to be checked on every shift for three days. Review of Resident #6's local hospital ED summary dated 11/20/20 revealed: -Resident #6 presented in the ED after a fall. -Resident #6 was profoundly altered at baseline with end-stage Alzheimer's dementia. -It was reported staff was standing alongside Resident #6 when she fell backwards for unknown reasons. -It was unknown if Resident #6 hit her head, but she did not lose consciousness. -There were no obvious injuries other than skin tears to the left arm. -It was reported Resident #6 had a brief episode of seizures after the fall. -Vital signs, labs, electrocardiograms (EKG), and imaging were conducted, and Resident #6 was found to have a closed fracture of her left wrist. There was documentation of 30-minute checks for 72 hours, but there was no documentation of increased supervision for Resident #6 beyond 72 hours.	D 270		

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D 270	Continued From page 26 Review of Resident #6's record revealed no documentation of increased supervision or interventions to prevent falls. Attempted interview on 01/25/20 at 4:00pm with the personal care aide (PCA) who discovered the accident/incident on 11/20/20 at 7:15am was unsuccessful. Telephone interview with Resident #6's responsible party on 01/26/21 at 1:40pm revealed: -The facility called her each time Resident #6 had a fall. -She was aware of Resident #6's injuries resulting from froms. -Staff told her Resident #6 did not understand how to use her walker because of her dementia. -Most of Resident #6's falls have been in the hallway. -Staff had not talked to her about any interventions or increase in supervision for Resident #6 to help prevent falls. Telephone interview with Resident #6's Hospice nurse on 01/26/21 at 2:37pm revealed: -She started working with Resident #6 on 11/03/20. -Resident #6 was admitted to Hospice services with a diagnosis of Alzheimer's with late onset and dementia with behavioral disturbance. -She told facility staff to make sure Resident #6 had her walker when she was ambulating and at all times due to her unsteady gate. -Resident #6 had been barefooted at times when she arrived at the facility and she instructed staff to make sure Resident #6 had on non-skid socks. -If Resident #6 had her walker in front of her, she would use it.	D 270		

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-Resident #6 was not able to ambulate safely without her walker.
-When Resident #6 fell on 01/18/21 and the time she fell and broke her arm, she knew Resident #6 did not have her walker.
-She had not seen many staff engage with Resident #6 during her visits to the facility.

Telephone interview with Resident #6's PCP on 01/29/21 at 2:12pm revealed:
-He had been notified of Resident #6's falls and had just taken out sutures from her forehead as a result of her last fall.
-Resident #6 had physical therapy (PT) in the past, but her biggest problem was her dementia and little to no safety awareness.

Telephone interview with the interim Administrator on 02/01/21 at 9:33am revealed:
-Resident #6 ambulated by offices all the time.
-There was no documented supervision for Resident #6 except for 72 hours after a fall.
-Resident #6 was given her walker in the mornings and she ambulated with it.
-When Resident #6 had her walker and changed directions, she left the walker where it was and began ambulating without it.
-Staff should have provided Resident #6 with her walker when they saw her without it.

b. Review of Resident #6's care plan dated 07/16/20 revealed:
-Resident #6 had wandering behaviors and was always disoriented.
-Resident #6 had significant loss of memory and had to be directed.

Review of Resident #6's Progress Notes dated 12/26/20 at 11:33am revealed:
-Resident #6 was opening doors in an attempt to

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go outside of the facility.
-Safety interventions put into place were to continue to redirect Resident #6 and monitor.

Review of Resident #6's Progress Notes dated 12/26/20 at 6:46pm revealed:
-Resident #6 was attempting to open the front door to go outside.
-Safety interventions put in place were to continue to redirect Resident #6 and monitor.

Telephone Interview on 01/26/21 at 9:11am with the medication aide (MA) who documented the progress on 12/26/21 at 11:33am and 6:46pm revealed:
-Resident #6 had attempted to go out of the front door numerous times.
-She was afraid Resident #6 was going to get out of the facility, into the parking lot, and go into the road.
-Resident #6 wandered around the facility from the time she woke up in the morning until the time she went to bed.
-Staff tried to "watch" Resident #6 as much as they could.
-When MAs were passing medications and personal care aides (PCA) were assisting residents with personal care, no one was "watching" Resident #6.

A second telephone interview on 02/01/21 at 1:16pm with the MA who documented the progress on 12/26/21 at 11:33am and 6:46pm revealed:
-On 12/26/21 at 11:33am, she was near the nurses' station and had her medication cart facing the front door, when she saw Resident #6 with the door open and was on her way out of the facility.
-On 12/26/21 at 6:46pm, she was walking down

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the hallway when she noticed Resident #6 with the front door open.
-She told management about Resident #6 attempting to leave the facility and was told to keep documenting.
-She tried to check to see where Resident #6 was every 15 to 20 minutes, but there were times when there were only 2 staff on the floor.
-Staff tried to keep an eye on everybody, but they could not.
-Resident #6 was constantly on the go.
-There was nothing put in place to help prevent Resident #6 from going out the front door.

Review of Resident #6's Progress Note dated 01/04/21 at 11:20am revealed:
-Resident #6 was attempting to go out the front door.
-The safety intervention put in place was to continue to redirect Resident #6.

Telephone interview on 02/01/21 at 1:16pm with the MA who documented the progress note dated 01/04/21 revealed:
-Resident #6 was constantly moving and went to the front door often.
-Sometimes she figured out how to get the front door open.
-On, 01/04/21, she saw Resident #6 with the front door open.
-She periodically tried to check on Resident #6 every 30 minutes or so, but she was never told to increase supervision for Resident #6 except for 30-minute checks for 72 hours after a fall.

Review of Resident #6's Progress Note dated 01/12/21 revealed:
-Resident #6 attempted to go out the front door.
-Safety interventions put in place for Resident #6 was to continue to redirect Resident #6 and to

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monitor.

Telephone interview on 02/01/21 at 1:39pm with the MA who documented the progress note dated 01/12/21 revealed:
-On, 01/12/21, she saw Resident #6 with the front door open.
-She periodically tried to check on Resident #6 every 30 minutes or so, but she was never told to increase supervision for Resident #6 except for 30-minute checks for 72 hours after a fall.

Review of Resident #6's Progress Note dated 01/16/21 revealed:
-Resident #6 opened the front door and attempted going out the front door.
-The safety intervention put in place was to continue to redirect Resident #6.

Telephone Interview on 02/01/21 at 1:16pm with the MA who documented the progress note dated 01/16/21 revealed:
-She was walking up the hallway and saw Resident #6 with the front door open.
-She was not completely out of the door, but she had a shoulder and a foot out of the door.
-The only thing that prevented Resident #6 from getting completely out of the door on 01/16/21 was that she had her walker which was between her and the door.
-Nothing was put in place to help prevent Resident #6 from going out of the facility after this attempt to leave the facility.

Review of Resident #6's record revealed no documentation to of increased supervision and no intervention to prevent wandering and exit-seeking behaviors.

Telephone interview with Resident #6's

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responsible party on 01/26/21 at 1:40pm revealed:
-She knew Resident #6 had tried to leave the facility.
-Facility staff wanted to put Resident #6 in the Memory Care Unit (MCU) so she could not leave the facility, but she was a private pay resident and could not afford the cost of the MCU.
-The facility should be able to watch Resident #6 more so she would not go out the door.

Telephone interview with Resident #6's Hospice nurse on 01/26/21 at 2:37pm revealed:
-She started working with Resident #6 on 11/03/20.
-Resident #6 was admitted to Hospice services with a diagnosis of Alzheimer's with late onset and dementia with behavioral disturbance.
-She knew about Resident #6's attempts to leave the facility and had talked to the Resident Care Coordinator (RCC) and Resident #6's family about Resident #6 going to the MCU.

Telephone interview with the RCC on 02/01/21 at 9:11am revealed:
-Resident #6 had increased wandering and exit seeking behaviors over the last month or so.
-The management team reached out to the family and Resident #6's PCP was aware.
-There was nothing put in place at this time to help prevent Resident #6 from leaving the facility except to redirect Resident #6 from the front door.
-PCAs should be completing 1 on 1 activities with Resident #6.
-All residents were checked on every hour daily.
-There were never any other times Resident #6 had increased supervision except for after a fall.

Telephone interview with Resident #6's PCP on

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01/29/21 at 2:12pm revealed:
-He did not know about Resident #6's attempts to leave the facility and would have liked to have been made aware.
-He thought the facility had talked to Resident #6's family about placing her in the MCU, but her family was resistant because it would cost more money.
-The facility staff had to be able to respond to Resident #6 rapidly to keep her from leaving the facility.

Telephone interview with the interim Administrator on 02/01/21 at 9:33am revealed:
-Resident #6 went to the front door of the facility often, but she had never gotten out.
-The RCC had talked to Resident #6's family about moving her to the MCU, but her family could not afford the MCU at the facility.
-There was no other increased supervision to prevent Resident #6 from leaving the facility.

2. Review of Resident #7's current FL2 dated 09/30/20 revealed:
-Diagnoses included dementia.
-Resident #7 was constantly disoriented.
-Resident #7 was ambulatory and had wandering behaviors.
-Resident #7's level of care was Special Care Unit (SCU) [Memory Care Unit (MCU)].

Review of Resident #7's Care Plan dated 01/16/20 revealed:
-Resident #7 exhibited wandering behaviors.
-Resident #7 was ambulatory and needed a walker.
-Resident #7 was independent with transferring and required supervision/set-up with ambulation.

Review of Resident #7's Progress Notes dated

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D 270	Continued From page 33 08/09/20 revealed: -Resident #7 was found sitting on her bottom on the floor. -Resident #7 was assessed for injuries and staff found a small skin tear on the bottom of her left forearm. -Resident #7 was assisted off the floor, redirected, and encouraged to use her walker when ambulating. Review of Resident #7's Accident/Incident Report dated 08/09/20 revealed: -Resident #7 had an unwitnessed fall in the MCU hallway -Resident #7 was found sitting on her bottom on the hallway floor and had a skin tear to the bottom of her left forearm. -Resident #7's skin tear was cleaned and bandaged. -The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall. -Resident #7's vital signs were to be checked on every shift for three days. There was no documentation of 30-minute checks for 72 hours provided, interventions put in place, and no documentation of increased supervision for Resident #7 beyond 72 hours. Attempted telephone interview on 01/29/21 at 9:23am with the medication aide (MA) who documented the progress note dated 08/23/20 was unsuccessful. Review of Resident 7's Progress Notes dated 08/21/20 revealed: -Resident #7 was found on her knees on the	D 270		

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floor.
-Resident #7 was assisted from the floor onto the bed.
-Resident #7 was assessed for injuries and no injuries were documented.

Review of Resident #7's Accident/Incident Report dated 08/21/20 revealed:
-Resident #7 had an unwitnessed fall in her room.
-Resident #7 was found on her knees in front of her bed.
-There were no injuries noted.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was no documentation of 30-minute checks for 72 hours provided, no interventions put in place, and no documentation of increased supervision for Resident #7 beyond 72 hours.

Attempted telephone interview on 01/29/21 at 9:23am with the MA who documented the progress note dated 08/23/20 was unsuccessful.

Review of Resident #7's Progress Notes dated 08/22/20 revealed:
-Resident #7 was found on her bottom in the hallway with her walker in front of her.
-Resident #7 was assessed for injuries and no injuries were noted.

Review of Resident #7's Accident/Incident Report dated 08/22/20 revealed:
-Resident #7 had an unwitnessed fall in the MCU hallway.

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-Resident #7 was found sitting on her bottom on the floor with her walker in front of her.
-There were no injuries noted.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was no documentation of 30-minute checks for 72 hours provided, no interventions put in place, and no documentation of increased supervision for Resident #7 beyond 72 hours.

Attempted telephone interview on 01/29/21 at 9:23am with the MA who documented the progress note dated 08/23/20 was unsuccessful.

Review of Resident #7's Progress Notes dated 08/23/20 revealed:
-Resident #7 was found in the hallway on the floor on her side.
-Resident #7 was assisted up from the floor and back to her room.
-Resident #7 was assessed for injuries and no injuries were noted.

Review of Resident #7's Accident/Incident Report dated 08/23/20 revealed:
-Resident #7 had an unwitnessed fall in the SCU hallway.
-Resident #7 was found on the floor in the hallway on her side.
-There were no injuries noted.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to

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the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was no documentation of 30-minute checks for 72 hours provided, no interventions put in place, and no documentation of supervision for Resident #7 beyond 72 hours.

Attempted telephone interview on 01/29/21 at 9:23am with the MA who documented the progress note dated 08/23/20 was unsuccessful.

Review of Resident #7's Progress Notes dated 09/21/20 revealed:
-Staff heard a loud noise coming from Resident #7's room and went to check on her.
-Resident #7 was found sitting on her bottom in front of her bathroom door.
-Resident #7 was assessed for injuries and staff found a small cut on her right hand.

Review of Resident #7's Accident/Incident Report dated 09/21/20 revealed:
-Resident #7 had an unwitnessed fall in her bedroom.
-Resident #7 was observed on her floor near her bathroom door.
-Resident #7 had a small cut on her right hand.
-Staff placed a band-aid on Resident #7's finger.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was no documentation of 30-minute checks for 72 hours provided, no interventions

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put in place, and no documentation of increased supervision for Resident #7 beyond 72 hours.

Telephone interview with the previous Memory Care Unit Coordinator (MCUC) on 01/29/21 at 12:34pm revealed:
-She documented the progress note dated 09/21/20 revealed:
-Resident #7 was found in her bedroom and had a scratch on hand; The scratch looked like Resident #7 may have scratched herself trying to catch herself from falling.
-All residents were checked on every hour and taken to the restroom every 2 hours.
-After a fall, residents were checked on every 30-minutes for 72 hours and if there was another fall within the 72 hours, checks increased to every 15-minutes for another 72 hours.
-She did not know if staff were checking on the resident every 30-minutes after a fall because she caught some staff filling out the 30-minute check logs at the beginning of their shifts.
-There was no increased supervision beyond the 30-minute or 15-minute checks for 72 hours for Resident #7 after a fall.

Review of Resident #7's Progress Notes dated 10/29/20 revealed:
-Resident #7 was found sitting on the floor beside her closet door.
-Resident #7 was holding a napkin to her chin.
-Staff contacted Resident #7's mobile urgent care provider through her insurance company and the provider recommended putting ice on her lip.

Review of Resident #7's Accident/Incident Report dated 10/29/20 at 9:20pm revealed:
-Resident #7 had an unwitnessed fall in her bedroom.
-Resident #7 was found sitting on the floor.

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-Resident #7 had bruising on her lip and chin.
-Resident #7's lip was cleaned and she was not sent to the local hospital.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was documentation of 30-minute checks for 72 hours, but there was no documentation of interventions put in place or of increased supervision for Resident #7 beyond 72 hours.

Telephone interview with a Personal Care Aide (PCA) on 10/29/21 at 3:07pm revealed:
-She discovered the accident/incident on 10/29/20.
-She found Resident #7 on the floor in her room with blood on her face and holding a napkin to her chin.
-Resident #7 had been sitting on a chair in her room and appeared to have fallen out of the chair.
-Resident #7 was placed on 30-minute checks for 72 hours and staff kept her door open so they could hear if she fell.
-There was no other increased supervision beyond the 30-minute checks for 72 hours after a fall.

Review of Resident #7's Progress Notes dated 12/15/20 revealed:
-Resident #7 had an unwitnessed fall in her bedroom and was found sitting on her bottom on the floor.
-Resident #7 showed no signs of pain.

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Review of Resident #7's Accident/Incident Report dated 12/15/20 revealed:
-Resident #7 had an unwitnessed fall in her bedroom.
-Resident #7 was sitting on her bottom on the floor.
-There was no documentation of an injury.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was documentation of 30-minute checks for 72 hours, but there was no documentation of interventions put in place or of increased supervision for Resident #7 beyond 72 hours.

Telephone interview with a MA on 01/29/21 at 9:07am revealed:
-She documented the progress note dated 12/15/20 revealed:
-Resident #7 was a high fall risk.
-Resident #7 was found on the floor in her bedroom and stated that she slid out of her chair.
-Thirty-minute checks were implemented for 72 hours after Resident #7's fall on 12/15/20, but there was no other increased supervision or interventions for Resident #7 to help prevent falls.

Review of Resident #7's Progress Note dated 01/14/21 revealed:
-Resident #7 was found laying on her stomach on the floor in the MCU hallway.
-Resident #7 was bleeding and had swelling in her right cheek area under her eye.
-Staff called Resident #7's mobile urgent care provider through her insurance company and the

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provider advised the facility to send Resident #7 out to the emergency department (ED) for evaluation.

Review of Resident #7's Accident/Incident Report dated 01/14/21 at 11:16am revealed:
-Resident #7 had an unwitnessed fall in the MCU hallway.
-Resident #7 was found laying on her stomach on the floor in the hallway.
-Resident #7 had swelling, an abrasion, and a bump on her right cheek under her eye.
-Resident #7 was transported to a local hospital ED.
-Resident #7 returned from the local hospital with swelling and bruising on the right side of her face with no fractures.
-The Fall Prevention Program was documented as initiated and Resident #7 was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall.
-Resident #7's vital signs were to be checked on every shift for three days.

There was documentation of 30-minute checks for 72 hours, but there was no documentation of interventions put in place or increased supervision for Resident #7 beyond 72 hours.

Telephone interview with a MA 01/14/21 at 9:07am revealed:
-She documented the progress note dated 01/14/21.
-Resident #7 was found laying in the hallway near her walker.
-Resident #7 fell in the same place where she had fallen previously.
-She thought Resident #7 had bent down thinking there was something on the floor, lost her

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balance, and fell.
-Resident #7 had an injury to her face and was bleeding from her cheek area.
-Resident #7 was sent to the local ED for evaluation and was placed on 30-minute checks for 72 hours when she returned to the facility.
-There was no other increased supervision or interventions for Resident #7 to help prevent falls.
-Staff documented checking on all residents every hour.

Telephone interview with the interim Administrator on 02/01/21 at 9:33am revealed:
-She had not been aware of Resident #7's falls prior to filling in as interim Administrator over the last week.
-Resident #7 had a rollator walker and had been sitting on the seat of the rollator and using it as a wheelchair by propelling herself with her feet.
-Resident #7 did not know how to use the brakes of her rollator.
-After Resident #7's fall, she should have been placed on 30-minute checks for 72 hours after each of her falls.
-She did not know of any other interventions put in place after the falls and there was no increased supervision other than 30-minute checks for 72 hours after each fall.

Attempted contact with Resident #7's responsible party on 01/29/21 at 10:25am was unsuccessful.

3. Review of Resident #1's current FL-2 dated 08/27/20 revealed:
-Diagnoses included major neurological disorder due Alzheimer with behaviors, reflux esophagitis, dyslipidemia, hypertension, malignant tumor of colon, seasonal allergies, chemotherapy induced neuropathy and history of rectal cancer.
-Resident #1 was constantly disoriented and

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wandered.
-Resident #1's functional limitation was sight.
-Resident #1's communication needs were verbally (unable to communicate).
-Resident #1 needed personal assistance with bathing, dressing and was incontinent of bladder and bowel.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/25/20.

Review of Resident #1's care plan dated 09/16/20 revealed:
-Resident #1 required limited assistance with eating.
-Resident #1 required extensive assistance with toileting, bathing, dressing and grooming.
-Resident #1 was independent with ambulation and transferring.

Review of Resident #1's Primary Care Provider (PCP) consultation notes from 08/27/20 through 12/09/20 revealed:
-On 08/27/20 the PCP documented Resident #1 had severe cognitive impairment, poor vision, and difficulty walking without assistance. Appropriate supervision should be provided.
-On 09/23/20 the PCP recommended to monitor Resident #1 for balance and fall issues.
-On 12/02/20 the PCP documented Resident #1 had unsteady gait along with loss of insight into safety issues from her dementia causing frequent falls.
-The PCP documented Resident #1 had peripheral neuropathy, which was a contributing factor to her falls and likely to worsen to over time.
-On 12/09/20 the PCP documented Resident #1 had recurrent falls due to unsteady gait primarily

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related to her peripheral neuropathy and her dementia.

a. Review of Resident #1's Progress Notes, Accident/Incident reports and Hospice notes from 09/03/20 through 01/19/21 revealed Resident #1 sixteen unwitnessed falls as follows:
-On 09/03/20 at 8:00pm, Resident #1 fell in the hallway. The resident had a bump on her head. It was documented the facility's fall prevention program would be initiated for 72 hours and vital signs checked for three days. There was no documentation the facility's falls program was initiated.
-On 11/03/20, Resident #1 had a recent fall (date unknown) and was becoming weaker. Bruising noted on back of Resident #1's head and right lower hip.
-On 12/02/20 Resident #1 sustained a fall today (no time document) striking her head.
-On 12/07/20, Resident #1 was found on the floor in the dining room. Resident #1 appeared weak. The personal alarm was not on, it was left at bedside and not with the resident.
-On 12/14/20 at 2:19pm, Resident #1 was found on the floor face down. Observed a large "goose egg bruise" on the right side of the resident's forehead. .
-On 12/24/20, Resident #1 was found sitting in another resident's room on the floor. Resident #1 had fallen and had a small bump on the back of her head.
-On 01/10/21, Resident #1 fell out of wheelchair and hit her head.

There was no documentation that a system of increased supervision was put in place or interventions to prevent falls for Resident #1.

Telephone interview with a MA on 01/26/21 at

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9:29am revealed:
-Resident #1 fell constantly. She felt the resident had way too many falls.
-Resident #1 had some witnessed falls, but mostly falls the resident was found lying on the floor.
-Resident #1 usually sustained head injuries and bruises resulting from the falls.
-The former Memory Care Unit Coordinator (MCUC) had been asked about what to do regarding Resident #1's frequent falls, but nothing was put in place.

Telephone interview with a second shift MA on 01/22/21 at 2:47pm revealed:
-Resident #1 had not fallen during any shifts that she had worked.
-The facility's protocol was to supervise Resident #1 every 30-minutes for 72 hours following a fall.
-Supervision of the resident every 30-minutes was done by the MA.
-The MA had to view the resident and determine the resident's location (i.e., room, dining room, etc.), and then document she visually laid eyes on the resident.
-There was no increased supervision put in place to supervise Resident #1 after the 72 hours were completed.

b. Review of Resident #1's progress notes revealed:
-On 09/16/20 at 6:37pm, the Memory Care Unit Coordinator (MCUC) found Resident #1 in a male resident's room in his bed. Resident #1 was laying on her back with her pants undone and pulled below her hips.

Review of Resident #1's accident/incident reports revealed:
-On 09/16/20 at 2:30pm, Resident #1 was lying

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on her back on a male resident's bed with her pants "undone" below her hips. It was documented the resident would be monitored every 30-minutes for 72 hours. There was no documentation the 72-hour monitoring was initiated.
-There was no documentation increased supervision was implemented to keep Resident #1 safe or interventions put in place to keep the resident from falling.

Interview with a second shift medication aide (MA) on 01/21/20 at 4:44pm revealed:
-Resident #1 was checked every 2 hours.
-The only time the resident was checked more frequently was after a fall.
-After a fall the facility's fall prevention program was put in place and the resident was checked every 30-minutes for 72 hours.
-The MAs were responsible for completing 30-minute checks.
-There was no documentation a systems for supervising Resident #1 more frequent was put in place or interventions to prevent falls.

The PCA that found Resident #1 and generated the reports no longer worked at the facility and was not available for interview.

c. Review of Resident #1's progress notes revealed:
-On 10/18/20 at 9:30am, Resident #1 was found on the floor in the hallway.
-Resident #1 complained of head pain. Resident #1 was sent out to the hospital.
-There was no documentation of increased supervision or monitoring for Resident #1.

Review of Resident #1's accident/incident reports revealed:

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-On 10/18/20 at 9:30am, Resident #1 was found on the floor in the hallway.
-Soreness noted, but no injuries.
-It was documented the facility's fall prevention program would be initiated.
-There was no documentation the fall prevention program was initiated.
-There was no documentation of increased supervision or monitoring for Resident #1.

Telephone interview with a first shift MA on 01/22/21 at 3:35pm revealed:
-Resident #1 had a "a lot of falls."
-Resident #1 walked really fast and her feet stumble, which caused her to fall.
-A month ago (unable to recall the exact date) when she worked the Memory Care Unit (MCU), Resident #1 had a fall.
-There was no documentation interventions or increased supervision had been put in place for Resident #1.

Telephone interview with Resident #1's Power of Attorney (POA) on 01/21/21 at 3:12pm revealed:
-She was a nurse and was aware that Resident #1's decline was caused by Alzheimer's loss of motor skills.
-Resident #1 had unsteady gait and needed constant supervision to prevent falls.
-When Resident #1 had a fall she was notified by facility staff or Hospice staff.
-On 10/18/20 the Memory Care Unit Coordinator (MCUC) called and informed her that Resident #1 had a fall and was being sent to the hospital.

The PCA who found Resident #1 on the floor no longer worked at the facility and was not available for interview.

d. Review of Resident #1's progress notes

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revealed:
-On 11/28/20 at 9:00pm, Resident #1 had a fall, "spoke with emergency department (ED) doctor" Resident #1 had a contusion of the scalp.
-The instructions from the ED doctor was to monitor the resident for 48 hours.
-There was no documentation Resident #1 was monitored for 48 hours.
-There was no documentation of increased supervision or interventions to prevent falls was implemented for Resident #1.

Review of Resident #1's accident/incident report revealed:
-On 11/28/20 at 4:55pm, Resident #1 was found lying on the floor in her room. Resident #1 was sent to the ER and diagnosed with a contusion of the scalp.
-It was documented to initiate the facility's fall prevention program for 72 hours and check vital signs for three days.
-There was no documentation the facility's fall prevention program was initiated.
-There was no documentation increased supervision or interventions to prevent falls was put in place for Resident #1.

Review of Resident #1's Hospice care notes revealed on 11/28/20 at 10:35am, Resident #1 was walking in the hallway and fell backward striking her head on the floor.

Review of Resident #1's hospital discharge summary report dated 11/28/20 revealed:
-The reason for the visit was a fall with head injury.
-Resident #1 diagnoses was a fall with contusion of the scalp.
-The scalp was bruised and there was bleeding under the scalp, but the skin was not broken.

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D 270	Continued From page 48 -There was swelling at the site of the bruise. Attempted interview with the MA that generated the reports on 01/28/20 at 3:48pm was unsuccessful. The PCA that found Resident #1 no longer worked at the facility and was not unavailable for interview. e. Review of Resident #1's progress notes revealed: -On 12/02/20 at 11:14am, Resident #1 had an unwitnessed fall in the MCU main bathroom. -The resident showed signs of right hip pain. -There was no documentation Resident #1 was put on the facility's fall prevention program and checked every 30-minutes for 72 hours. -There was no documentation of increased supervision to keep Resident #1 safe. Review of Resident #1's accident/incident report revealed: -On 12/02/20 at 11:07am, Resident #1 was found lying on the floor in the MCU main bathroom. -There was redness was noted, but there was no documentation what part of the body was injured. -It was documented the facility's fall prevention program was to be initiated for 72 hours and vital signs documented. -There was no documentation that showed the facility's fall prevention program was initiated. -There was no documentation increased supervision or interventions to prevent falls was put in place for Resident #1. Attempted interview with the MA that generated the reports on 01/28/20 at 3:48pm was unsuccessful. The PCA no longer worked at the facility and was unavailable for interview.	D 270		

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D 270	Continued From page 49 f. Review of Resident #1's progress notes revealed: -On 12/06/20 Resident #1 had two falls one at 12:04pm, and a second fall at 6:54pm. -Both falls Resident #1 was found lying on the floor (location was not documented). -There was no documentation of increased supervision or interventions to prevent falls for Resident #1. Review of Resident #1's accident/incident reports revealed: -On 12/06/20 at 11:40am, Resident #1 was found lying on the floor. -On 12/06/20 at 4:00pm, Resident #1 found on the floor (no documentation of location of fall). -Resident #1 had a bump on her head. -There was no documentation of increased supervision or interventions to prevent falls for Resident #1. Review of Resident #1's Hospice care notes revealed: -The Hospice nurse documented that while visiting Resident #1 the MCUC informed her that Resident #1 had two falls on 12/06/20. -The first fall happened after the lunch meal. -Resident #1 was ambulating in the hallway unsupervised and the resident fell hitting the back-right side of her head. -The second fall happened after the dinner meal. -Resident #1 was in the hallway unsupervised and fell hitting her head again in the same spot where she hit when she fell earlier. -Due to her mental status of Alzheimer's Resident #1 was unable to rate her pain, but she "winched" when area of her head where she fell was touched. -There was no documentation of increased	D 270		

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supervision or interventions to prevent falls being implemented for Resident #1.

Telephone interview with Resident #1's POA on 01/21/21 at 3:12pm revealed:
-She was the main contact person for Resident #1.
-The Hospice nurse had made her aware that Resident #1 had two falls on 12/06/20.
-She was beginning to notice Resident #1 started having falls more often and she was greatly concerned.

Telephone interview with the Hospice nurse on 01/20/21 at 4:16pm revealed:
-When she visited Resident #1 on 12/06/20, she was informed by the MCUC that Resident #1 had two falls that day.
-She also educated staff about the progression of Resident #1's Alzheimer's disease and she reminded staff that Resident #1 needed continual supervision.

g. Review of Resident #1's progress notes revealed On 12/11/20 at 8:10am Resident #1 was observed on the floor in the living room. There was no documented increased supervision to keep Resident #1 safe.

Review of Resident #1's accident/incident reports revealed:
-On 12/11/20 at 7:33am, Resident #1 was found on the floor in front of her wheelchair.
-It was documented the facility's fall prevention program would be initiated with 30-minute checks for 72 hours.
-There was no documentation the falls prevention program was initiated.
-There was no documentation of increased supervision or interventions to prevent falls being

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D 270	Continued From page 51 implemented for Resident #1. Review of Resident #1's Hospice care notes revealed: -On 12/11/20, the Hospice nurse documented the MCUC reported Resident #1 had two falls today (12/11/20). -The nurse reminded staff to use caution when ambulating and transferring Resident #1. -The Hospice nurse also documented that she reminded staff to provide close supervision. Telephone interview with the Hospice nurse on 01/20/21 at 4:16pm revealed: -When she visited Resident #1 staff reported the resident fell twice on 12/11/20. -She the assessed the resident injury. -Based on reports that she received from staff it appeared Resident #1's falls were increasing, and the resident was experiencing several falls weekly. -With each visit she re-educated facility staff that Resident #1 needed continuous supervision due to the progression of Resident #1's Alzheimer's disease. -Anytime Resident #1 was up she was a fall waiting to happen. The MA that generated the reports no longer worked at the facility and was unavailable for interview. h. Review of Resident #1's progress notes revealed: -On 12/30/20 at 8:10am Resident #1 was observed on her left side laying on the dining room floor. -There was no documentation of increased supervision or interventions to prevent falls for Resident #1.	D 270		

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D 270	Continued From page 52 Review of Resident #1's accident/incident report revealed: -On 12/30/20 at 8:07pm, Resident #1 was found lying on the floor on her left side. -It was documented the facility's fall prevention program would be initiated for 72 hours with checks every 30-minutes. -There was no documentation the facility's falls prevention program had been initiated. -There was no documentation of continued or increased supervision/monitoring put in place beyond 72 hours. Telephone interview with Resident #1's POA on 01/20/21 at 3:12pm revealed: -Resident #1 had many falls. -She often asked the facility what they were doing about the falls, but nothing was done. -She had identified that Resident #1's falls happened mostly during at a specific time of day. -She made arrangements with Hospice to spread their visits with Resident #1 out between the hours of 12:00pm and 4:00pm so that someone would be present with Resident #1 to try and prevent falls. -The facility still never told her how they planned to increase supervision to reduce Resident #1's falls. Telephone interview a first shift MA on 01/27/21 at 1:18pm revealed: -On 12/30/20, she was the MA on duty when Resident #1 fell. -Resident #1 was in the dining room with the sitter from Hospice. -The sitter had left the resident in the dining room and went to make the resident's bed. -The PCA that found Resident #1 on the floor on 12/30/20 informed her that Resident #1 had a fall	D 270		

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in the dining room.
-It was the facility's policy that after a fall the resident was put on the facility's fall prevention program.
-The fall prevention program required the MA to check the resident's whereabouts every 30-minutes for 72 hours.
-The 72 hour checks should be documented to show the checks were completed.
-To her knowledge there were no systems put in place or directions given to supervise Resident #1 more frequently beyond 72 hours.
-No instructions or discussions had been given regarding supervision to prevent Resident #1's falls.
-Sometimes she checked Resident #1 more often by looking in her room when she walked the halls, but even that did not always work and Resident #1 still had falls.
-She did not document each time she checked Resident #1.
-When Resident #1 was up, out of bed she could not take her eyes off the resident for a few minutes because she would be up and moving around.

Telephone interview with the former MCUC on 01/28/21 at 1:06pm revealed:
-The only severe fall that she recalled Resident #1 having happened shortly after she returned to work in December 2020 (unable to recall the exact date).
-Resident #1 fell and hit her head very hard.
-She called EMS to evaluate Resident #1 and not sent to the hospital.
-When she tried to educate staff about Resident #1's condition and to check more frequently staff would not listen to her or follow her instructions.
-Nothing was done about staff not following her suggestions or implementing systems to increase

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supervision to prevent Resident #1's falls.

i. Review of Resident #1's progress notes revealed:
-On 01/07/21 at 2:59pm Resident #1 was on the dining room floor.

Review of Resident #1's accident/incident reports revealed:
-On 01/07/20 at 1:49pm, Resident #1 was found sitting on her bottom on the floor in the dining room.
-There was no increased supervision or interventions to prevent falls put in place for Resident #1.

Interview with the first shift medication aide (MA) on 01/21/21 at 2:53pm revealed:
-Resident #1 had to be watched constantly.
-On 01/07/21 the PCA on duty informed her that Resident #1 was on the floor in the dining room.
-She did not see any injuries, so the resident was gotten off the floor.
-According to the facility's protocol, she completed the accident/incident report and noted the facility's fall prevention program would be initiated.
-All Resident #1's falls happened when the resident was up out of bed.
-She tried to keep an eye on Resident #1 when she was not in the bed, but she was unable to do so because she had work to do.
-Other than the 30-minute checks for 72 hours following a fall no increased supervision had been put in place or interventions for Resident #1 to reduce falls.

j. Review of Resident #1's progress notes revealed:
-On 01/14/21 at 6:49am, the third shift medication

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aide (MA) found Resident #1 laying on her right side on the floor.
-The resident had a bump on the right side of her forehead.
-There was no documentation of increased supervision or interventions to prevent falls put in place for Resident #1.

Review of Resident #1's accident/incident reports revealed:
-On 01/14/20 at 6:15am, Resident #1 was found lying on the floor (location not documented) on her right side.
-The resident had a bump on the right side of her forehead.
-There was no documentation that showed the falls program was implemented.

Telephone interview with Resident #1's POA on 01/20/21 at 3:12pm revealed:
-On 01/14/21, the Hospice nurse called, and informed Resident #1 fell and had a small bump on her head.
-Resident #1 had frequent falls at the facility.
-Resident #1 needed continuous supervision and to her knowledge no increased supervision had been put in place.

Telephone interview with a third shift MA on 01/28/21 at 9:03am revealed:
-On 01/14/21, the PCA found Resident #1 on the floor and informed her the resident had a fall.
-Resident #1 had a little bump on her forehead that was a little raised.
-Some days Resident #1 was in a stage of decline and her balance was not good, which caused her to fall.
-Resident #1 used to walk, but now used a wheelchair.
-When in the wheelchair Resident #1 tried to

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stand up and walk.
-When Resident #1 fell on 01/14/20 it was the end of third shift.
-After Resident #1 was dressed she was left alone in her room because staff had to get other residents up and dressed.
-There was no increased supervision put in place for Resident #1, so the resident was left alone in her room.

k. Review of Resident #1's progress notes revealed:
-On 01/18/21 at 2:38pm Resident #1 was observed laying the MCU hallway on her back.
-There was a gash on the back of the resident's head and her head was bleeding.

Review of Resident #1's accident/incident reports revealed:
-On 01/18/21 at 1:19pm, Resident #1 was found laying in the floor on her back in the MCU hallway.
-The resident had a laceration to the center back of the head.
-Resident #1 was sent to the hospital.
-There was no documentation of increased supervision or interventions to prevent falls put in place to keep Resident #1 safe.

Review of Resident #1's Hospice care notes revealed on 01/18/21 Resident #1 fell hitting her head. Resident #1 went to the hospital and received staples due to the size of the gash in her head.

Review of Resident #1's local emergency responders event report dated 01/18/21 revealed:
-Emergency services were requested at the facility because Resident #1 had a fell.
-Upon arrival staff reported that Resident #1 had

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fallen out of her wheelchair.
-The resident fell backward hitting her head on the wood railing in the hallway.
-Staff reported Resident #1 often tried to get out of her wheelchair.
-There was a 1-inch laceration observed on the back of Resident #1's head and it was bleeding.

Review of Resident #1's hospital discharge summary report dated 01/18/20 revealed:
-The reason for the visit was that Resident #1 had an unwitnessed fall with occipital abrasion.
-Resident #1 was diagnoses with a contusion of the head and was given staples.

Telephone interview with the Hospice nurse on 01/21/21 at 4:16pm revealed:
-On 01/18/21 staff at the facility called to inform her that Resident #1 had a fall and had blood coming from her head.
-The staff informed that Resident #1 had been sent to the hospital.
-Resident #1 received two staples from the injury sustained during the fall.
-Resident #1 frequently had falls and needed extensive supervision.
-She continually reminded staff that Resident #1 often had low blood pressure and should not rise from a sitting position without staff assistance.
-Due to her cognitive deficit Resident #1 needed continuous supervision.

Telephone interview with the Hospice nurse on 02/01/21 at 4:22pm revealed:
-Every staff that she encountered at the facility she made them aware that Resident #1 needed constant monitoring.
-Resident #1 was very unstable and could not be left alone when up.
-The big thing was to keep an eye on Resident #1

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D 270	Continued From page 58 when she was up because a fall was waiting to happen. Telephone interview with a first shift PCA on 01/27/21 at 10:10am revealed: -She observed that Resident #1 was declining and needed more hands on assistance and supervision. -If she took her eyes off Resident #1 for 5 seconds the resident would take off and tumble to the floor because her feet got mixed up. -On 01/18/21 Resident #1 was in the dining room, in her wheelchair. -She was assisting other residents out of the dining room. -She heard another resident scream -She went to the hallway and observed Resident #1 lying on the floor. -Blood was coming from her head. -The resident's chair alarm was not on the chair. -Resident #1 was half-way down the hall from the dining room when she fell. -She thought Resident #1 needed one-on-one supervision. -There was not enough staff for one-on-one supervision for Resident #1. Telephone interview with a second shift PCA on the first shift on 01/27/21 at 10:09am revealed: -Resident #1 did not like to sit still, she liked to get up and go. -The resident only sat still long enough to take a few bites of her meal, and then she got up and tried to leave the table. -When she found Resident #1 on the floor it was after the lunch meal. -There were three staff in the dining room for the lunch meal (MA and PCA). -She had been trying to keep Resident #1 in her wheelchair, but the resident kept getting up.	D 270		

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D 270	Continued From page 59 -After the lunch meal she and the other PCA were cleaning up the dining room and getting the other residents out of the dining room. The MA was busy passing medications. -She heard one of the resident's scream from the hallway "we got a fall." -Resident #1 was half way up the hallway, on the floor, laying on her back. -When the MA went to assess Resident #1, she observed there was heavy bleeding from the resident's head. -The MA called EMS and Resident #1 was taken to the hospital and returned with staples in the back of her head. -Instructions regarding supervising Resident #1 was only to do the 30-minute checks for 72 hours after a fall. -She did the 30-minute checks and documented the checks were done. -No instructions had been given to supervise Resident #1 more often beyond 72 hours after a fall. Telephone interview a first shift MA on 01/27/21 at 1:18pm revealed: -Any time Resident #1 fell she documented the fall. -On Monday, 01/18/21, she was the MA on duty. -The PCA found Resident #1 on the floor. -She was passing medications and the PCA informed her that Resident #1 was on the floor. -The resident was halfway down the hall from the dining room. -Resident #1 was lying on the floor on her back with blood coming from the back of her head. -She called EMS and they evaluated the resident and said she needed staples. -No increased supervision or interventions to prevent falls had been put in place for Resident #1.	D 270		

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D 270	Continued From page 60 Based on record review, observation and interview it was determined Resident #1 was not interviewable. Telephone interview with the former Assistant Administrator on 02/03/21 at 1:48pm revealed: -Resident #1 had dementia and experienced a lot of falls. -The Administrator did not give specific instructions to supervise Resident #1, other than the required 30-minute checks for 72 hours after a fall. -Resident #1's name was always on the "board" indicating she was on the post fall protocol for 72 hours. -Resident #1 needed one-on-one supervision 24/7 and the facility was unable to provide that type of care for Resident #1. -No interventions had been put in place to increase supervision to prevent Resident #1's falls. Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 2:34pm revealed: -She had concerns about Resident #1's falls -Resident #1's name was on the board after a fall to remind staff to increase supervision by checking the resident every 30-minutes for 72-hours. -After the 72 hours there were no increased supervision put in place to prevent Resident #1's falls. Telephone interview with the facility's Primary Care Provider (PCP) on 01/29/21 at 1:51pm revealed: -Resident #1 took a drastic change for the worse two months ago and was now managed by	D 270		

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D 270	Continued From page 61 hospice. -Unless someone was going to walk with Resident #1 every time she got up the resident was going to fall. -The facility could have used electronic devices that would alarm when the resident got up, however the difficulty was staff had to be able to quickly respond each time the resident got up. -Resident #1 needed one-on-one supervision but that was not provided at the facility. _____ The facility failed to provide supervision for 3 of 7 sampled residents, including a resident who had sixteen unwitnessed falls resulting in bruises, contusions and staples (#1), a resident with a fall resulting in a fractured arm a skin tear, and attempted to leave the facility (#6), and a resident with nine falls that resulted in skin tears, a cut lip, bruising, and an injury to the face (#7). This failure placed residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/25/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 5, 2021	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 62 TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up with the physician for 1 of 7 sampled residents (Resident #5) related to not providing timely notification to the physician regarding a wound and not notifying the physician regarding imaging abnormalities as indicated on the discharge summary. The findings are: Review of Resident #5's current FL2 dated 11/27/20 revealed diagnoses included unspecified fracture of right acetabulum, unspecified fall initial encounter, and acute respiratory failure with hypoxia. Review of Resident #5's Resident Register revealed the resident was admitted on 01/09/19. Review of Resident #5's hospital discharge summary dated 11/14/20 revealed: -The resident had a fall on 11/08/20 and was admitted to the hospital. -The resident was discharged to a skilled nursing facility for rehabilitation on 11/14/20. Review of the skilled nursing facility discharge orders revealed Resident #5 was discharged back to the facility on 11/25/20. a. Review of Resident #5's current FL2 dated 11/27/20 revealed there was documentation the resident had purple discoloration of her right heel. Review of Resident #5's physician visit note dated 11/25/20 revealed there was no documentation the physician assessed the resident's right heel.	D 273		

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D 273	Continued From page 63 Review of Resident #5's Home Health progress notes revealed: -On 12/04/20 the Occupational Therapy Assistant (OTA) documented on 12/04/20, Resident #5 had a pressure sore on her right heel, the Occupational Therapist (OT) was notified to obtain a nursing order, the staff at the facility were notified. -On 12/9/20, skilled Home Health care was initiated to assess and treat the resident's right heel. Further review of Resident #5's record revealed: -There was no documentation the primary care provider (PCP) was notified of the resident's skin discoloration on the right heel upon readmission. -The OTA initiated the treatment to the resident's right heel on 12/04/20. Review of a physician note for Resident #5 dated 12/09/20 revealed: -Diagnosis included necrosis (loss of healthy tissues due to disease injury, or lack of blood supply) of right heel secondary to pressure. -There was documentation the resident appeared to have dry gangrene of the skin over the posterior aspect of the right heel. -There was an order to obtain heel cushions and keep in place over the right heel 24 hours a day. Observation of Resident #5 on 02/02/21 at 10:25am revealed: -The resident's right heel had a dried back scab that covered the entire heel of the foot. -The scabbed skin had dried dead skin around the sides of the foot. -There was no discharge or blood coming from the heel. -The resident complained stating that her heel	D 273		

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D 273	Continued From page 64 was very painful. Interview with a medication aide (MA) on 01/29/21 at 10:45am revealed: -When Resident #5 returned to the facility from skilled rehabilitation, she had purple colored skin discoloration on her right heel. -When she noticed the skin discoloration, she notified the previous Memory Care Unit Coordinator (MCUC). -The previous MCUC instructed her not to do anything to the resident's heel and informed that there were no new orders. -When Resident #5 was re-admitted she was bed bound and was unable to get out of bed. -When the resident first returned, she did not complain about her heel, then a week later (around the beginning of December 2020) she began to say she was in pain. -She propped the pillow under her foot an notified the previous MCUC again. -The previous MCUC informed her that she would reach out to the PCP. -The previous MCUC was responsible for notifying the physician of any issues with the resident. Telephone interview with a personal care aide (PCA) on 01/29/21 at 11:30am revealed: -She worked in the Special Care Unit (SCU) and provided care to Resident #5. -She worked third shift the day Resident #5 was re-admitted. -She observed Resident #5's heel to be a purple, blackish in color. -She told the previous MCUC several times about Resident #5's heel and she told me not to do anything to the heel and that she would call the PCP. -Resident #5 complained about her heel stating	D 273		

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that she was in pain.

Interview with the Resident #5's Home Health Nurse on 01/29/21 at 8:36am revealed:
-Resident #5 began services with the Home Health agency on 12/01/20 with Occupational Therapy (OT) and Physical Therapy (PT).
-OT requested a nursing evaluation after the resident complained about pain to her right heel.
-She initiated services with Resident #5 on 12/09/20 after receiving an order from the physician.
-On 12/09/20, she observed black scabbed skin which appeared to be a pressure ulcer.
-The pressure ulcer was unable to be staged because of the layer of skin covering the wound.
-The right heel did not have any cushion and the resident verbalized pain.
-The black scabbed skin was a result of continuous pressure to the skin.
-She educated staff about keeping pressure off the heel.

Telephone interview with the previous MCUC on 01/28/21 at 11:32am revealed:
-She was out on leave at the end of November 2020 and returned early December 2020.
-While she was on leave the Resident Care Coordinator (RCC) was responsible.
-When she returned to work she found out about Resident #5's heel.
-She found out about Resident #5's heel on her first day back early December 2020.
-When she returned, an MA and PCA asked her what they should do to care for Resident #5's heel.
-She notified the PCP of Resident #5's heel, however could not remember the date she notified him.
-She remembered calling the PCP to notify of

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Resident #5's heel.
-After she notified the PCP, he ordered an antibiotic to treat any infection and heel protectors.

Telephone interview with the RCC on 1/29/21 at 8:52am revealed:
-She was responsible for the oversight of care for residents who resided on the Assisted Living Unit of the facility.
-The previous MCUC was responsible for the residents who resided in the SCU.
-Resident #5 resided on the SCU and the previous MCUC was responsible for notifying the PCP of any issues with the residents.
-At the end of November 2020, the previous MCUC was on leave, however she was working from home and could still communicate issues with the PCP.
-She assisted the MCUC whenever she was not in the facility by completing observations.
-She remembered seeing Resident #5's FL2 indicating purple discoloration on the heel of the right foot.
-She did not personally notify the PCP about Resident #5's heel, she thought the previous MCUC notified the physician.

Telephone interview with Resident #5's PCP on 1/28/21 at 12:26pm revealed:
-If any residents had skin discoloration or wound, he would want to be notified immediately.
-He thought he was notified immediately by staff of Resident #5's heel.
-He did not know he was notified 10 days after the resident returned to the facility.
-If he had known upon re-admission, he could have treated the resident sooner.
-He did not know Resident #5's FL2 indicated she had purple discoloration on the back of the heel.

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D 273	Continued From page 67 -He diagnosed Resident #5's right heel as necrosis and dried gangrene. Telephone interview with the Administrator on 01/29/221 at 9:35am revealed: -When a resident was admitted or readmitted to the facility a full body skin assessment was to be completed by the RCC or the previous MCUC. -If there were any issues with the resident's skin, they were to follow-up with the PCP immediately. -The PCP woul see the resident at the next scheduled visits, he visited the facility every Wednesday. -The previous MCUC would have been responsible for notifying the physician of Resident #5's heel. Upon requesting skin assessments on 01/28/21 and 01/29/21, there was no skin assessment completed for Resident #5 on 11/25/20. Based on observations, interviews, and record review it was determined Resident #5 was not interviewable. b. Review of Resident #5's record revealed the resident's hospital discharge summary dated 11/14/20 was faxed to the facility on 12/18/20. Review of Resident #5's hospital discharge summary dated 11/14/20 revealed: -There was documentation of an incidental finding of a nodule on the right lung which appeared to be a primary lung neoplasm (an abnormal mass of tissue). -There was documentation indicating the resident would need outpatient follow-up with the primary care provider (PCP) for a positron emission tomography (PET) scan (an imaging test used to examine organs and tissues) for further	D 273		

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assessment and referral to oncology pending results.

Review of Resident #5's progress notes revealed there was no documentation the physician was notified of results of imaging or was sent the hospital discharge summary.

Interview with Resident #5's responsible party (RP) on 01/29/21 at 11:30am revealed:
-Resident #5 had a fall, went to rehabilitation, and returned to the facility on 11/25/20.
-Resident #5 had not seen any outside medical providers since leaving the hospital in November 2020.
-She had not had any meetings with Resident #5's physician regarding any treatments.

Telephone interview with the previous Memory Care Unit Coordinator (MCUC) on 01/29/21 at 12:41pm revealed:
-When residents returned to the facility after a hospitalization, she was responsible for obtaining the hospital discharge summary, reviewing and sending to the PCP for the Special Care Unit (SCU) residents.
-She had not seen the hospital discharge summary from the hospital visit dated 11/08/20-11/14/20.
-When Resident #5 returned to the facility in November 2020, while she was on leave, so she did not get the report.
-The Resident Care Coordinator (RCC) informed her that she obtained the hospital discharge summary, and everything was handled.
-She thought the RCC reviewed the discharge summary and sent it to the PCP.

Telephone interview with the RCC on 01/29/21 at 8:52am revealed:

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-She requested the hospital discharge summary from the hospital for Resident #5 because she noticed it was not in the facility.
-When the hospital discharge summary was returned 12/18/20, she gave it to the MCUC because she was responsible for reviewing.
-She did not look over the hospital discharge summary because she was responsible for the residents who resided on the assisted living unit.

Telephone interview with the PCP on 01/28/21 at 1:18pm revealed:
-The facility sent hospital discharge summaries for him to review periodically.
-He had not seen Resident #5's hospital discharge summary dated 11/04/20.
-He had not been notified of any imaging abnormalities.
-If he knew about the imaging abnormalities, he would want to talk to the family to determine course of treatment.
-He would also refer the resident to the necessary provider to evaluate and recommend treatment options.
-Imaging abnormalities were urgent, and he would want the discharge summary within two weeks.

Telephone Interview with the Administrator on 01/29/21 at 9:35am revealed:
-When residents returned to the facility after a hospitalization, the MCUC and the RCC were responsible for obtaining the discharge summary, reviewing and sending to the PCP.
-The RCC and MCUC could email the PCP the hospital discharge summary.
-She would expect the MCUC and RCC follow-up with the PCP regarding any concerns that needed to be addressed.
-She would have expected the imagining

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D 273	Continued From page 70 abnormalities to be discussed quickly as it was an urgent matter. _____ The facility failed to ensure timely physician notification for 1 of 7 sampled residents who was readmitted to the facility with skin discoloration to the right heel resulting in the development of a painful necrotic pressure sore and failed to provide the physician, the hospital discharge summary that included findings of a lung nodule which required further assessment resulting in a delay in treatment (Resident #5) . This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/29/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 15, 2021.	D 273		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and	D 468		

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D 468	Continued From page 71 schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 5 of 6 sampled staff (Staff B, C, D, E, and F) who worked in the Special Care Unit (SCU) had received the 6 hours of SCU orientation training within the first week of hire and an additional 20 hours of training within the first 6 months of employment. The Findings are: 1. Review of Staff B's, personal care aide (PCA)/medication aide (MA), personnel record revealed: -Staff B was hired on 04/01/20. -There was no documentation Staff B completed 6 hours of SCU training within the first week of hire and an additional 20 hours of SCU training during her first 6 months of employment.	D 468		

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D 468	Continued From page 72 Telephone interview with Staff B on 02/02/21 at 12:27pm revealed: -She worked in the SCU. -She thought she had completed some SCU training, but she did not have a copy of her certificate. -She completed trainings through an on-line training program, but she did not know how many hours of that training was specific to the SCU. Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff B worked in the SCU. Refer to telephone interview with the RCC on 02/03/21 at 11:20am. Refer to telephone interview with the former Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm. 2. Review of Staff C's, personal care aide (PCA), personnel record revealed: -There was no hire date documented for Staff C. -There was no documentation Staff C completed 6 hours of special care unit (SCU) training within the first week of hire and an additional 20 hours of SCU training during her first 6 months of employment. Telephone interview with Staff C on 02/02/21 at 1:12pm revealed: -She was hired on 07/13/20. -She worked in the SCU. -She completed 26 hours of SCU training at the facility, but she did not remember when.	D 468		

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D 468	Continued From page 73 -She did not have certificate of completion for SCU training. Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff C worked in the SCU. Refer to telephone interview with the RCC on 02/03/21 at 11:20am. Refer to telephone interview with the former Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm. 3. Review of Staff D's, personal care aide (PCA), personnel record revealed: -There was no hire date documented for Staff D. -There was no documentation Staff D completed 6 hours of special care unit (SCU) within the first week of hire and an additional 20 hours of SCU training during her first 6 months of employment. Telephone interview with Staff D on 02/02/21 at 1:12pm revealed: -She was hired in July 2020. -She worked in the SCU. -She did not remember if she completed 26 hours of SCU training. Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff D worked in the SCU. Refer to telephone interview with the RCC on 02/03/21 at 11:20am. Refer to telephone interview with the former	D 468		

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D 468	Continued From page 74 Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm. 4. Review of Staff E's, personal care aide (PCA), personnel record revealed: -Staff E was hired on 01/11/21. -There was no documentation Staff E completed 6 hours of special care unit (SCU) within the first week of hire. Attempted telephone interview with Staff E on 02/03/21 at 8:33am was unsuccessful. Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff E worked in the SCU independently a few times. Refer to telephone interview with the RCC on 02/03/21 at 11:20am. Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm. 5. Review of Staff F's, personal care aide (PCA)/medication aide (MA), personnel record revealed: -There was no hire date documented for Staff E. -There was no documentation Staff D completed 6 hours of special care unit (SCU) within the first week of hire and an additional 20 hours of SCU training during her first 6 months of employment.	D 468		

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D 468	Continued From page 75 Telephone interview with Staff F on 02/02/21 at 1:12pm revealed: -She was hired on 04/22/20. -She worked in the SCU. -She thought she completed the SCU training in September or October 2020. Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff F worked in the SCU. Refer to telephone interview with the RCC on 02/03/21 at 11:20am. Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm. Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm. _____ Telephone interview with the RCC on 02/03/21 at 11:20am revealed: -The previous BOM was responsible for making sure all trainings were completed for staff. -She did not know staff were missing SCU training. Telephone interview with the previous BOM on 02/03/21 at 1:15pm revealed: -She worked at the facility from April 2020 through 01/22/21. -She instructed staff to complete 6 hours of SCU training through the facility's on-line training program, within their first or second day of employment. -Twenty hours of SCU training were to be completed within 30 days. -Staff sometimes did not complete their required trainings within the required time frames and she	D 468		

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D 468	Continued From page 76 reported those instances to management. -She did not know there were staff who had not completed SCU trainings. -She did not conduct any audits of personnel records when she worked at the facility. -There was an electronic form used to track whether required hiring tasks had been been completed; This form was available to all facility managers. Telephone interview with the interim Administrator on 02/03/21 at 12:09pm revealed: -The former BOM should have worked with the RCC to ensure required trainings were completed prior to staff working independently, but she did not. -She did not know SCU training had not been completed by staff. -SCU trainings should have been completed by staff during new hire orientation.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Physical Environment, Health Care, and Personal Care and Supervision.	D912		

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D912	Continued From page 77 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 exit doors accessible for residents' use had an alarm activated for the safety of 1 of 7 sampled residents (Resident #6) who was constantly disorientated and had wandering and exit seeking behaviors. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation).]. 2. Based on interviews, observations, and record review the facility failed to ensure referral and follow-up with the physician for 1 of 7 sampled residents (Resident #5) related to not providing timely notification to the physician regarding a wound and not notifying the physician regarding imaging abnormalities as indicated on the discharge summary. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).]. 3. Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 3 of 7 sampled residents (#1, #6, and #7) with falls resulting in serious injuries of a fractured arm and a skin tear (#6), a resident who had 9 falls with skin tears, a cut lip, bruising, and an injury to the face (#7), a resident who had seventeen falls with bruises, lacerations, contusions and staples (#1) and a resident with multiple attempts to leave the facility who had a history of confusion, wandering, and exit-seeking behaviors (#6). [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).].	D912		

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	HAL030009	A. BUILDING: _____ B. WING _____	02/03/2021

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D935	Continued From page 78	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 79 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff who administered medications had completed a 5, 10, or 15-hour medication administration training course (Staff B, and F), had completed a Medication Clinical Skills Competency Validation (Staff B), and had successfully passed the written state medication administration test (Staff B). The findings are: 1. Review of Staff B's, personal care aide (PCA)/medication aide (MA), personnel record revealed: -Staff B was hired on 06/26/19. -There was no documentation of a Medication Clinical Skills Competency Validation, completion of the 5-hour and 10-hour medication administration training course, and there was no documentation Staff B passed the written medication aide (MA). Review of 2 residents' December 2020 and	D935		

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D935	Continued From page 80	D935		

January 2021 electronic Medication Administration Record (eMAR) revealed:
-Staff B documented the administration of medications 4 days in December 2020.
-Staff B documented the administration of medications 1 days in January 2021.

Interview with Staff B on 02/02/21 at 12:27pm revealed:
-She was hired in April 2020.
-She went to assist a sister facility on 04/10/20 and worked there until she returned to the current facility on 07/10/20.
-She went to work at the sister facility again on 09/19/20 and worked there until she returned to the current facility on 11/03/20.
-She started working as a MA in October 2020 while she was working at the sister facility.
-She completed the 5-hour and 10-hour medication administration training, but she did not remember when.
-She thought she may have been checked off by the facility's licensed health professional support (LHPS) nurse for the 5-hour and 10-hour medication administration training and her medication clinical skills validation at the current facility at the beginning of November 2020.
-She had not taken the medication administration test, but she was scheduled to take the test in February 2021.

Telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm revealed:
-She knew Staff B should have had the 5-hour and 10-hour medication administration training and a medication clinical skills validation at each facility where she worked, but she did not have either at the current facility.
-She waited for the previous LHPS nurse to come

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D935	Continued From page 81	D935		

to the facility to complete Staff B's medication clinical skills validation and 5-hour and 10-hour medication training, but she did not come.
-She knew Staff B administered medications and did not have the 5-hour and 10-hour medication training, the medication clinical skills validation completed, and had not taken the medication administration test.
-She did not tell the previous administrator because he was also aware Staff B did meet the training requirements prior to administering medication.

Telephone interview with the interim Administrator on 02/03/21 at 12:09pm revealed:
-She did not know Staff B was administering medication at the facility prior to completing the medication clinical skills validation and the 5-hour and 10-hour medication training course.
-She did not know Staff B had not taken the medication administration test, but she was scheduled to take the test on 02/11/21.

Refer to the telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am.

Refer to telephone interview with the previoius BOM on 02/03/21 at 1:15pm.

Refer to telephone interview with the interim Administrator on 02/03/21 at 12:09pm.

2. Review of Staff F's, medication aide (MA), personnel record revealed:
-There was no documentation of the date of hire.
-There was documentation of a medication clinical skills competency validation dated 09/29/20.
-There was documentation Staff F passed the written medication aide (MA) exam on 10/13/20.

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D935	Continued From page 82 -There was no documentation of a 5-hour and 10-hour medication administration training course. Review of 3 residents' November 2020, December 2020 and January 2021 electronic Medication Administration Record (eMAR) revealed: - Staff F documented the administration of medications 15 days in November 2020 -Staff F documented the administration of medications 21 days in December 2020. -Staff F documented the administration of medications 3 days in January 2021. Interview with Staff F on 02/02/21 at 12:27pm revealed: -She started working at the facility as a personal care aide (PCA) on 04/22/20. -She became a medication aide (MA) in September 2020. -She completed the 5-hour and 10-hour training before she started administering medication, but she did not remember when. -She had completed her medication clinical skills validation, but she did not remember when. -She passed her written medication administration test in October or November 2020. Telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm revealed she did not know there was no documentation Staff F had completed the 5-hour and 10-hour medication training course. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am. Refer to telephone interview with the previoius BOM on 02/03/21 at 1:15pm.	D935		

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D935	Continued From page 83 Refer to telephone interview with the interim Administrator on 02/03/21 at 12:09pm. _____ Telephone interview with the RCC on 02/03/21 at 11:20am revealed: -The previoius BOM was responsible for making sure all trainings were completed for staff. -She did not know staff were missing the 5-hour and 10-hour medication administration training, the medication clinical skills validation and a staff had not taken and passed the written medication administration test. Telephone interview with the previous BOM on 02/03/21 at 1:15pm revealed: -She worked at the facility from April 2020 through 01/22/21. -She was responsible for making sure staff completed the 5-hour and 10-hour medication administration training course and the medication clinical skills validation. -Staff should not administer medication until they were checked off by the LHPS nurse for medication clinical skills training and the 5-hour and 10-hour medication administration training. Telephone interview with the interim Administrator on 02/03/21 at 12:09pm revealed: -She did not know there was no documentation Staff F had the 5-hour and 10-hour medication training course. -The prevous BOM should have worked with the RCC to ensure required trainings were completed prior to staff working independently, but she did not. -The 5-hour medication training course and the medication administration clinical skills validation should have been completed prior to passing medications and the 10-hour medication training	D935		

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D935	Continued From page 84 course should have been completed within 2 months from the date of hire.	D935		