

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a annual survey with onsite visits March 16, 2021 and March 17, 2021, and a desk review survey March 18, 2021 and March 19, 2021, and a telephone exit on March 19, 2021.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 3 resident sampled (#2), with a history of recent falls. The findings are: Review of Resident #2's current FL-2 dated 10/30/20 revealed: -Diagnoses included Alzheimer's Disease, atrial fibrillation, hypertension and osteoarthritis of the right hip. -Resident #2 was ambulatory, constantly disoriented with wandering behaviors. Review of the Resident Register revealed Resident #2 was admitted to the facility on 11/04/20. Review of Resident #2's care plan dated 11/04/20 revealed:	D 270		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Resident #2 could sometimes get lost in familiar surroundings. -Resident #2 moved slowly or too quickly with motor skills. -Resident #2 required extensive physical assistance with minimal participation with bathing, dressing and grooming. -Resident #2 had noticeable short-term memory deficit. <p>Review of Resident #2's quarterly care plan dated 02/19/21 revealed:</p> <ul style="list-style-type: none"> -Resident #2 had poor gross motor coordination; shuffled gait; stumbled; required assistance with ambulation or transfers when fatigued; beginning postural problems; consistent problems with small motor skills; involuntary muscle movements (shutters, twitches). -Resident #2 bathes and dresses only with physical assistance; may be resistant; is oblivious to grooming. -Resident #2 had noticeable short-term memory deficit. <p>Review of Resident #2's licensed health professional support review dated 02/19/21 revealed:</p> <ul style="list-style-type: none"> -Resident #2 ambulated using assistive devices that required physical assistance from staff. -Resident #2 required other prescribed physical or occupational therapy and application of prescribed best therapy. <p>a. Review of Incident and Accident report for Resident #2 dated 12/30/20 at 10:15pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was in the main lobby area. -The incident was witnessed by staff. -Resident #2 was assisting another resident to a walker, holding the hand of other resident, the other resident threw herself back into a chair 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 2</p> <p>causing Resident #2 to fall forward hitting the floor face first.</p> <ul style="list-style-type: none"> -Resident #2 had blood coming from his head. -The incident was witnessed by staff. -Resident #2's footwear was noted as shoes. -The Primary care Provider (PCP) was notified via "voice". -Staff called 911 and Resident #2 was sent to the emergency room (ER). <p>Review of Resident #2's ER after visit summary dated 12/30/20 revealed:</p> <ul style="list-style-type: none"> -The reason for the visit was a fall accidental. -There were diagnoses of accidental fall and scalp hematoma (localize bleeding outside of blood vessels). <p>Telephone interview with a medication aide (MA) on 03/18/21 at 11:50 am revealed:</p> <ul style="list-style-type: none"> -Resident #2 had had several falls. -Staff tried to keep an eye on Resident #2 (frequency not given). -On 12/30/20, Resident #2 was in the living room with another resident trying to help the other resident get to her walker. -She saw Resident #2 grab the other resident's arm and the other resident pulled backward causing Resident #2 to fall forward. -Staff tried to keep an eye on Resident #2 by sitting him closed to us and trying to keep him in sight. <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's first fall was on 12/30/20 in the living room per the incident and accident report. -The staff was to watch and see if Resident #2 fell again due to 12/30/20 being his first fall. <p>b. Review of Incident and Accident report for</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 3</p> <p>Resident #2 dated 01/09/21 at 7:15pm revealed: -Resident #2 was in the living room. -The incident was not witnessed by staff. -Resident #2 was found on the floor in the living room. -Resident #2 was assessed for injuries vital signs were taken and was assisted back in the chair. -The incident was noted as a fall no injuries. -There was no documentation of PCP notification.</p> <p>Telephone interview with a medication aide (MA) on 03/18/21 at 11:50 am revealed: -Resident #2 had had several falls. -Staff tried to keep an eye on Resident #2 (frequency not given). -On 01/09/21 Resident #2 was found on the floor, the nurse was called and Resident #2 was assessed for injuries and staff assisted the resident back to the chair.</p> <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed: -Resident #2 fell again on 01/09/21 and staff asked for an order for physical therapy (PT). -The order for PT was given on 01/12/21.</p> <p>c. Review of Incident and Accident report for Resident #2 dated 01/11/21 at 3:05am revealed: -Resident #2 was in his bedroom floor next to the closet. -The incident was not witnessed by staff. -Staff went in Resident #2's bedroom and he was lying on the floor next to the closet. -Resident #2 stated he tripped on his shoes. -Staff applied first aid. -Staff got Resident #2 up off the floor and checked his body for bruises and skin tears and took his vitals. -Resident #2 was not sent to the hospital. -The incident was noted as a fall with general</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 4 injury. -There was no documentation of PCP notification. Telephone interview with a medication aide (MA) on 03/18/21 at 6:20pm revealed staff had completed the incident report for the fall on 01/11/21 at 3:05am, but she could not remember the fall. d. Review of Incident and Accident report for Resident #2 dated 01/11/21 at 6:50am revealed: -Staff heard a 'thump' in the room (location not specified). -Staff entered the room and found Resident #2 on the floor. -Resident #2 was on his bottom with his head resting on a chair with non-skid socks on, dressed in an adult brief and shirt with underwear in his left hand. -Resident #2 required two person assist to lift the resident from the floor to the bed. -There were no injuries noted and vital signs were taken. -Resident #2 was not sent to the hospital. -The incident was noted as a fall with general injury. -The PCP was notified via email. -The contributing/environment factors were poor safety judgement. -Resident #2's pre-incident ambulation status was independent. Telephone interview with a medication aide (MA) on 03/18/21 at 6:20 pm revealed: -Resident #2 fall intervention was the 1:1 sitter at all times (dates unknown). -Staff was supposed to check on Resident #2 every hour. -Staff did not document the checks for Resident #2.	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 5</p> <p>-Resident #2 had a merry chair (adaptive equipment) but he could get out of it (date unknown).</p> <p>-Staff kept Resident #2's door cracked so they could check on him.</p> <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed:</p> <p>-Resident #2 fell again on 01/11/21 and was sent out to the hospital.</p> <p>-She did not have time to put any interventions in place between the two falls because the resident was sent out to the hospital.</p> <p>e. Review of Incident and Accident report for Resident #2 dated 01/12/21 at 3:00am revealed:</p> <p>-Resident #2 was found on the floor in the hallway.</p> <p>-Resident #2 said he did not know what happened.</p> <p>-Resident #2 was bleeding from the back of his head.</p> <p>-Staff took his vitals and notified the PCP.</p> <p>-The incident was noted as a fall with suspected head injury.</p> <p>-Resident #2 was sent to the ER.</p> <p>-Resident #2's pre-incident ambulation status was stand by assist.</p> <p>Review of Resident #2's ER after visit summary dated 01/12/21 revealed:</p> <p>-The reason for the visit was a fall accidental.</p> <p>-There was a diagnosis of accidental fall.</p> <p>Review of Resident #2's physician orders dated 01/12/21 revealed and order for physical therapy (PT) to evaluate and treat related to falls, strengthen/conditioning, post hospital stay and traumatic subdural hematoma.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 6</p> <p>Telephone interview with the physical therapist on 03/19/21 at 10:25am revealed: -Resident #2 was not assessed by PT on 01/12/21 due to multiple trips to the ER and having COVID-19. -PT had 30 days from referral to evaluate the resident.</p> <p>Telephone interview with Resident #2's PCP on 03/18/21 at 4:48pm revealed: -Resident #2 returned from the hospital following a fall on 01/12/21 with an international normalized ratio (INR)(type of calculation that measures the time for blood to clot) level of 6.1 (normal range 2.0-3.0). -He thought the INR level of 6.1 was erroneous and Resident #2 was sent back to the hospital within 24 hours. -Resident #2's prothrombin time (PT) (measures how long it takes for a clot to form in a blood sample) results on 01/13/21 was 32.9 which was equivalent to an INR level of 2.8 and was with in normal range.</p> <p>Telephone interview with the Administrator on 03/18/21 at 3:21pm revealed: -Resident #2 fell twice on 01/12/21 and a conference call was made with his family and our interdisciplinary team and the team recommended PT and a 1:1 sitter 24 hours per day. -Resident #2's family was arranging the 1:1 sitter service which started 01/17/21.</p> <p>Review of Resident #2's hospital discharge summary dated 01/15/21 revealed: -Resident #2 was admitted to the hospital on 01/13/21. -Diagnosis included frequent falls. -History of present illness included a history of</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 7</p> <p>orthostatic hypotension causing syncope (fainting, passing out or loss of consciousness), subdural hematoma.</p> <p>-Resident #2 remembered his family member and sometimes knows where he is at baseline.</p> <p>-Resident had fallen multiple times in the last 2 weeks.</p> <p>-Resident #2's falls were unwitnessed.</p> <p>-Family member reported Resident #2 was more sleepy than normal and would swing his left leg around when he walked and thought that his gait was getting unsteady.</p> <p>-Resident #2 experienced dizziness before one episode of falling.</p> <p>-Resident #2 had been to the ER every day for the last 3 days.</p> <p>-Resident #2 reported pain across his forehead.</p> <p>-Resident #2 reported not remembering the fall.</p> <p>-Resident #2 reported weakness in his left leg and pain in the left leg with walking.</p> <p>-Resident #2's computed tomography (CT) (medical imaging) showed subdural hematoma's were stable.</p> <p>-Resident #2's pertinent radiological studies were a CT of the head impressions were: worsening right frontal subdural hygroma (a collection of cerebrospinal fluid) versus development of chronic subdural hematoma with progression from 12/31/20.</p> <p>-Resident #2's subdural fluid collection 1.2 cm on 01/11/21 up approximately 0.6 cm on prior study (12/31/20).</p> <p>Telephone interview with the Administrator on 03/19/21 at 9:06 am revealed:</p> <p>-Resident #2 was allowed to have a compassionate care visit on 01/15/21 for safety due to the sitter agency taking up to 48 hours before they could start.</p> <p>-Resident #2's family was there to alert the staff</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 8</p> <p>when the resident would get up. -Staff was to check on Resident #2 every hour.</p> <p>f. Review of Incident and Accident report for Resident #2 dated 01/16/21 at 8:05am revealed: -Staff found Resident #2 on the floor in his room. -Resident #2 stated he did not remember how he got on the floor or where he was going. -Resident #2 reported being sore. -The fall was not witnessed by staff. -Resident #2 had two skin tears one on each arm. -Staff called the nurse from the Assisted Living side to come and assess Resident #2. -The nurse from the Assisted Living side did not come to assess Resident #2. -The nurse from the Assisted Living side told staff what to do over the phone. -There was no first aid applied. -Staff took the resident's vital signs. -The incident was noted as "found on floor". -The contributing/environment factors were balance issues while standing/ambulating. -Resident #2's pre-incident ambulation status was one-person assist.</p> <p>Review of Resident #2's physician orders dated 01/18/21 revealed and order for physical therapy (PT) to evaluate and treat related to falls, strengthen/conditioning, post hospital stay and traumatic subdural hematoma.</p> <p>Review of Resident #2's physical therapy evaluation and plan of care dated 02/11/21 revealed: -Resident #2 start of care date was 02/11/21. -Resident #2 had diagnoses including generalized muscle weakness, repeated falls and other abnormalities of gait and mobility. -Resident #2's cognitive assessment documented</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 9</p> <p>memory impairment with increased sundowning over the past two months and impaired safety awareness.</p> <p>-Resident #2's reason for admission was for strengthening and gait after COVID-19 illness, decreased mobility due to isolation restrictions and multiple falls prior to illness.</p> <p>-Resident #2 had a history of requiring constant supervision 24 hours per day.</p> <p>-Resident #2 was last seen by physical therapy in late 2020 for increased weakness, poor gait pattern and poor balance.</p> <p>-Resident #2 had a history of requiring an assistive device when ambulating but would at times forget to use the walker due to his memory impairment.</p> <p>-Resident #2 required supervision or touching assistance with walking 150 feet, walking 10 feet on uneven surfaces.</p> <p>-Resident #2 physical therapy frequency was twice a week for 3 weeks.</p> <p>Telephone interview with the physical therapist on 03/19/21 at 10:25am revealed:</p> <p>-Resident #2 was admitted to PT on 02/11/21.</p> <p>-PT had 30 days from referral to evaluate the resident.</p> <p>Telephone interview with the Administrator on 03/19/21 at 9:06 am revealed Resident #2 fell on 01/16/21 and staff were to continue monitoring Resident #2 every hour.</p> <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed:</p> <p>-Resident #2 fell on 01/16/21 and his family was arranging the 1:1 sitter service which started 01/17/21.</p> <p>Interview with the Administrator on 03/17/21 at</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 10</p> <p>12:02 pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's family put a sitter for Resident #2 5 days per week 12 hours per day. -Resident #2 fall risk at night was not as much of a concern so the night sitter was phased out (date unknown). <p>g. Review of Incident and Accident report for Resident #2 dated 02/14/21 at 2:17am revealed:</p> <ul style="list-style-type: none"> -Resident #2 was in the hallway. -Staff was trying to assist Resident #2 to sit down in the living room, Resident #2 pulled away from staff, lost his balance and fell on the floor. -Resident #2 hit his head on the floor, and lost consciousness for a few minutes. -Resident #2's PCP was notified. -Resident #2 was sent to the ER. -The incident was noted as a fall with altered consciousness. <p>Review of Resident #2's hospital discharge summary dated 02/17/21 revealed:</p> <ul style="list-style-type: none"> -Resident #2 was admitted to the hospital on 02/14/21 and discharged on 02/17/21. -There was admission diagnoses of subdural hematoma, acute expansion of chronic intracranial subdural hematoma and frequent falls. -Resident #2 presented to the ER after suffering a fall at the facility from standing with a 1-2 minutes loss of consciousness. -Resident #2 had a history of subdural hematomas measured 1.0 cm on the right and 0.5 cm on the left on 01/12/21. -Resident #2's subdural hematomas measured 1.5 on the right and 1.0 on the left on 02/14/21. <p>Review of Resident #2's physician orders dated 02/17/21 and 02/25/21 revealed and order for physical therapy (PT) to evaluate and treat</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 11</p> <p>related to falls, strengthen/conditioning, post hospital stay and traumatic subdural hematoma.</p> <p>Telephone interview with the physical therapist on 03/19/21 at 10:25am revealed:</p> <ul style="list-style-type: none"> -Resident #2 was discharged from PT on 02/14/21 due to being admitted to the hospital. -Resident #2 was reevaluated and readmitted on 02/22/21. <p>Telephone interview with a medication aide (MA) on 03/18/21 at 6:20 pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 's fall on 02/14/21 resulted in him losing consciousness for 2 to 3 minutes. -Resident #2 was walking without his walker even after we tried to get him to use his walker. -While trying to get Resident #2 to sit down he pulled away and fell. -During that time Resident #2 no longer had a sitter a night. -Resident #2 was up most of the night. -She felt like she could not watch him and the other residents that wandered. -The staff had informed the Administrator staff could not monitor Resident #2 with the sitter gone (date unknown). -The Administrator was supposed to look into getting the sitter back at night but Resident #2's family could not afford it. <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed Resident #2 fell on 02/14/21 and PT resumed services after Resident #2 recovered from an illness on 02/17/21.</p> <p>h. Review of Incident and Accident report for Resident #2 dated 03/04/21 at 5:20pm revealed:</p> <ul style="list-style-type: none"> -Staff found Resident #2 bent over his recliner with his face in the seat of the chair and his knees on the floor. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 12</p> <ul style="list-style-type: none"> -Staff took vital signs and assisted the resident into a wheelchair. -Staff did not witness the fall. -There was no first aid applied. -There was no documentation of Resident #2's PCP being notified. -The incident was noted as a fall with no injuries. <p>Telephone interview with a medication aide (MA) on 03/18/21 at 11:50 am revealed:</p> <ul style="list-style-type: none"> -Resident #2 had several falls. -Staff tried to keep an eye on Resident #2 (frequency not given). -On 03/04/20, Resident #2 was found on the floor in his bedroom. -Resident #2's face was on the footrest of the recliners and his knees were on the floor. -She went and got the Administrator and staff got him off the floor. -Staff took his vital signs and assisted Resident #2 for injuries. <p>Telephone interview with the physical therapist on 03/19/21 at 10:25am revealed Resident #2 was going to be discharged on 03/19/21 due to resident now being a total assist.</p> <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed Resident #2 fell on 03/04/21, PT was continued.</p> <p>Review of Resident #2's care conferences dated 02/23/21 revealed:</p> <ul style="list-style-type: none"> -Resident #2 had numerous falls the past quarter at least two falls requiring ER visits and one of them resulted in a subdural hematoma. -Resident #2 gait was unsteady and he needed a walker. -Resident #2's family would be removing the sitter on nights due to cost. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 13</p> <p>-Resident #2's family felt a bed alarm may have been a better option (to be determined). -Resident #2 had received PT.</p> <p>Review of Resident #2's care conferences dated 03/02/21 revealed: -Resident #2 continued to have sitter in place which had assisted in lowering his fall risk. -Resident #2's family inquired if a safety helmet would be beneficial to help protect him during falls, interdisciplinary team agreed that Resident #2 would likely not keep nor like a helmet for his dignity. -Resident #2's family inquired if the team felt that the evening sitter was still necessary, and all agreed that having the sitter helped to calm Resident #2. -Resident #2's family continued to maintain sitter schedule at this time.</p> <p>Observation of Resident #2 on 03/17/21 at 11:10 am revealed resident lying in bed with a 1:1 sitter at bed side.</p> <p>Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.</p> <p>Interview with Resident #2's sitter on 03/17/21 at 11:10 am revealed: -She started working with Resident #2 shortly after the first fall (date unknown, first documented fall was 12/20/20). -She worked Mondays, Tuesdays, Thursdays, Fridays and Saturdays from 7:00 am to 7:00 pm. -She did all Resident #2's activities of daily living, including feeding, grooming, incontinence care and turning/repositioning while she was there. -Staff brought Resident #2's food tray and medications.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 14</p> <ul style="list-style-type: none"> -Resident #2 was not able to stand after his last fall (03/04/21). -Resident #2 was a 2 person assist since his "brain bleed". -Resident #2 always fell on her days off. -She did not work for the facility she was hired by Resident #2's family. <p>Interview with a medication aide on 03/16/21 at 10:08 am revealed:</p> <ul style="list-style-type: none"> -Resident #2 was a two person assist for the last 4 to 5 days. -Resident #2 had at least 4 falls in the past 3 months. -Resident #2's family hired a 1:1 sitter (date unknown). -Resident #2's sitter did all his activities of daily living while she was at the facility. -Resident #2 did not have a frequency to be check on. -Staff dressed Resident #2 and brought him into the living room to keep an eye on him when his sitter was not in the facility. -Resident #2's sitter worked Monday through Saturday 12 hours per day. <p>Telephone interview with a second MA on 03/18/21 at 11:50 am revealed:</p> <ul style="list-style-type: none"> -Resident #2 had had several falls. -Staff tried to keep an eye on Resident #2 (frequency not given). <p>Telephone interview with a third MA on 03/18/21 at 6:32pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was to be brought out of his room and kept in the common areas so that staff could keep an eye on him when there was no sitter. -Staff was supposed to check on Resident #2 when he was in his room. -The staff did not remember how often staff was 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 15</p> <p>supposed to check on Resident #2 when he was in his room.</p> <p>-Staff checked on Resident #2 as often as they could, every 30 minutes to an hour.</p> <p>-Resident #2 was to be kept in the common areas while awake and staff checked on him as often as they could while he was in his room were all the fall interventions that she could remember.</p> <p>-When staff was assisting other residents, staff could not check on him every 30 minutes to an hour even when he was in the common area.</p> <p>-There were two staff working on the floor at all times.</p> <p>A confidential telephone interview with staff revealed:</p> <p>-Staff were told to keep Resident #2 in the common areas if he was up so staff could see him.</p> <p>-Staff checked on Resident #2 every 2 hours at his scheduled times.</p> <p>-If the staff heard something, they would go check on him.</p> <p>-Resident #2 had a merry chair that helped for a little while.</p> <p>-The sitter helped with monitoring Resident #2.</p> <p>-Sometimes staff could not watch Resident #2 because of other job duties and assisting the other residents.</p> <p>-There were two staff working on the floor, when another resident needed help from both staff the staff could not watch Resident #2.</p> <p>-Staff talked to the Administrator about not being able to monitor Resident #2 and was told to do the best that they could.</p> <p>Telephone interview with Resident #2's family member on 03/17/21 at 3:24 pm revealed:</p> <p>-Resident #2 started having "really" bad falls and his level of care increased.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 16</p> <ul style="list-style-type: none"> -Resident #2's family member had asked the Administrator if the resident could have a bed alarm. -The Administrator informed the family member bed alarms were not allowed in the facility because they may cause a fall, fear of the loud noise and monitors were against the resident's rights. -The family had to provide 24 hour care because the facility could not provide it for Resident #2. -No one at the facility had ever mentioned an increase of the level of care for Resident #2. <p>Interview with the consulting Registered Nurse on 03/17/21 at 12:02 pm revealed:</p> <ul style="list-style-type: none"> -Quarterly fall assessments were completed on Resident #2. -Fall assessments included review of footwear, environmental clutter, type of bed in the room, cognitive assessment and therapy evaluation. <p>Telephone interview with Resident #2's PCP on 03/18/21 at 4:48 pm revealed:</p> <ul style="list-style-type: none"> -Staff were to assist Resident #2 with walking and to use the call bell. -Resident #2 was approaching the point where a level of care change may be warranted. <p>Interview with the Administrator on 03/17/21 at 12:02 pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's family had asked about a bed alarm. -Bed alarms, chair alarms and fall mats, were not allowed in the facility. -Resident #2 typically fell in his room so staff was supposed to bring Resident #2 into the common areas so staff could keep an eye on him. <p>Telephone interview with the Administrator on 03/19/21 at 9:06 am revealed staff had never</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 17</p> <p>voiced any concerns related to not being able to properly monitor Resident #2 when there was no 1:1 sitter available or when Resident #2 was in the common areas.</p> <p>Telephone interview with the Administrator on 03/18/21 at 3:21 pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's sitter services provided by the family decreased from 24 hours per day down to 12 hours per day due to Resident #2 testing positive for COVID-19 on (01/22/21) and the 1:1 sitter service for 7:00 pm to 7:00 am refused to service Resident #2. -The facility provided one dedicated staff to the four COVID-19 positive residents which Resident #2 was one of and was checked on every 15 - 20 minutes while on quarantine (01/22/21). -The 1:1 sitter service for 7:00 pm to 7:00 am restarted on 02/01/21. <p>The facility's failure to provide supervision of a resident (#2) who continued to have multiple falls, which resulted in the resident suffering multiple subdural hematomas, acute expansion of chronic intracranial subdural hematoma, a fall resulting in loss of consciousness for 2 to 3 minutes and head trauma that required three emergency room visits which resulted in serious physical harm and neglect to Resident #2 and constitutes a Type A1 Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/19/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 16, 2021.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2021
NAME OF PROVIDER OR SUPPLIER CYPRESS GLEN RETIREMENT COMMUNITY MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 HICKORY STREET GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 18	D914		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect as related to personal care and supervision.</p> <p>The findings are:</p> <p>Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 3 resident sampled (#2), with a history of recent falls.[Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].</p>	D914		