STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092204	A. BUILDING: _____ B. WING _____	C 09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF CARY	1705 KILDAIRE FARM ROAD CARY, NC 27511

(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 an annual survey on 09/09/21 through 09/10/21 and 09/13/21.	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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 5 residents sampled (#1, #3, #5) including a resident who had 13 falls resulting in injuries and one emergency room (ER) visit (#3), a resident who had 11 falls resulting in injuries and one hospitalization (#5), and a resident who had 21 falls resulting in injuries and one ER visit (#1). The findings are: Review of the facility's Falls Management and Interventions Program revealed: -A fall risk assessment was to be conducted upon move-in and after every fall. -There was to be an evaluation of physical and medical issues, environmental factors, and cognitive and sensory changes. -Physical therapy and occupational therapy were to be included in determination of appropriate therapy and other interventions.	D 270		

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-Communication with the physician, staff, family, and the resident was to be included in identification and implementation of resident specific interventions.
-Staff, family, and the resident were to be educated.
-There was a weekly falls management meeting where residents identified as at risk were reviewed for any additional falls, effectiveness of current interventions, and recommended change in interventions.
-New residents, residents readmitted from a hospital or rehab stay, residents who scored at a "high risk for falls" level, and residents who experienced 2 falls within the last 30 days were placed on the falls management program.
-Staff on all 3 shifts were expected to check on residents proactively and regularly for any unmet need, to see that the resident was safe, that the resident had a call-pendant available, and that indicated interventions were in place.

1. Review of Resident #3's FL-2 dated 02/23/21 revealed:
-Diagnoses included diabetes with neuropathy (numbness and loss of sensation in feet or legs), gait instability, and history of falls.
-She was semi-ambulatory and intermittently oriented.

Review of Resident #3's care plan dated 02/19/21 revealed:
-She required extensive assistance with transferring and toileting.
-She required limited assistance with ambulation.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 07/30/21 revealed she required a two-person assist when transferring.

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D 270	Continued From page 2 a. Review of Resident #3's progress note dated 06/04/21 revealed: -The note was written by a medication aide (MA) at 4:30am. -The MA heard a "groan" when she was in the medication room. -She went into the resident's room and observed the resident lying on her left side next to her bed. -The resident stated she had fallen off the bed, and complained of pain in her neck, legs, and upper back. -The resident "screamed" in pain when the MA tried to move her and requested emergency medical services (EMS) be called. -The resident's power of attorney (POA) was contacted for permission to send her to the emergency room (ER). -EMS was called and the resident was transported to the ER. -The primary care provider (PCP) and the Resident Care Coordinator (RCD) were notified of the incident. The MA who found Resident #3 after the fall on 06/04/21 was not available for an interview. Review of Resident #3's ER Discharge Instructions dated 06/04/21 revealed: -Diagnoses included a closed head injury and a left shoulder bruise. -A computerized tomography (CT) scan of Resident #3's head and spine was completed, and x-rays were taken of both shoulders. -The resident was to return to the ER if she experienced a worsening headache, uncontrolled vomiting, visual changes, or other new symptoms. -She was to stay well hydrated and take tylenol as needed for pain.	D 270		

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D 270	Continued From page 3 -She was to follow up with her PCP as needed. Review of Resident #3's Physician Notification of Fall dated 06/04/21 revealed: -The notification was completed by the MA and faxed to Resident #3's PCP. -It "seemed like [the] resident rolled out of bed." -The resident was found on her left side next to her bed. -The resident reported pain in her neck, legs, and upper back, and was transported to the ED. -The PCP put a check mark in the option labeled "Acknowledged, no changes at this time." -The PCP signed the notification on 06/08/21. Based on record reviews and interviews, there were no interventions put in place after Resident #3's fall on 06/04/21. b. Review of Resident #3's Incident & Accident Report dated 06/10/21 revealed: -The incident report was completed by a MA. -On 06/10/21 at 3:21pm, Resident #3 was observed "sitting on her bottom" with her back against her bed; her unlocked wheelchair was to her left. -The resident stated she was trying to get up to see her family member. -The resident had an abrasion near her left shoulder blade and did not report any pain or discomfort. -The PCP and POA were notified of the incident. -The RCD "witnessed" the MA's response to the incident. Review of Resident #3's progress note dated 06/10/21 revealed: -The note was written by the MA at 3:21pm. -The resident was observed "sitting on her bottom" on the floor in front of her bed.	D 270		

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-The resident stated she was trying to get into her wheelchair to get to her family member.
-She had an abrasion near her left shoulder blade and did not report any pain or discomfort.

Attempted telephone interviews with the MA, who completed the 06/10/21 Incident & Accident Report, on 09/10/21 at 12:19pm and 09/13/21 at 9:13am were unsuccessful.

Review of Resident #3's Physician Notification of Fall dated 06/10/21 revealed:
-The notification was completed by the MA and faxed to Resident #3's PCP.
-The resident had an abrasion near her left shoulder blade.
-The PCP put a check mark in the option labeled "Acknowledged, no changes at this time."
-The PCP signed the notification on 06/15/21.

Based on record reviews and interviews, there were no interventions put in place after Resident #3's fall on 06/10/21.

c. Review of Resident #3's progress note dated 06/12/21 revealed:
-The note was written by a MA at 6:50am.
-Resident #3 was observed "sitting on her bottom" next to her bed.
-She stated she was looking for her family members.
-She had no bruises, her skin was intact, and she did not report pain or discomfort.
-The PCP, POA, and RCD were notified.

Review of Resident #3's Physician Fax Order Form dated 06/12/21 revealed:
-The form was completed by the MA and faxed to Resident #3's PCP.
-The resident was observed "sitting on her

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bottom" beside her bed "looking for her kids and husband."
-There were no bruises and the resident's skin was intact.
-The PCP signed the form on 06/15/21 and ordered collection of a urine sample.

Review of Resident #3's progress note dated 06/16/21 revealed:
-The note was written by a MA at 2:30pm.
-A urine sample was collected and the laboratory was called to pick up the sample.

Telephone interview with the MA, who wrote the 06/16/21 progress note, on 09/10/21 at 5:28pm revealed:
-Safety checks were routinely done every two hours.
-The MA and the personal care aide (PCA) were responsible for completing safety checks.
-The MA was responsible for notifying the PCP, the resident's family, and the RCD of any incidents.
-EMS was called if a resident hit his or her head during a fall or if there was "any blood."
-The MA was responsible for completing an incident report.
-After a fall, the resident was in the "hotbox," requiring documentation on every shift for 72 hours after the fall.
-Resident #3 received "more monitoring" after a fall, usually hourly.
-Staff did not document safety checks on a form or in a log.
-The resident's room used to be "around the corner."
-Several months ago, she was moved to a room that was next to the MA station.
-The resident or her family member would ring for assistance for Resident #3.

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D 270	Continued From page 6 -Resident #3 rang "a lot" for staff assistance. Review of the Weekly Falls Management Meeting Notes dated 06/18/21 revealed: -The RCD facilitated the meeting. -The physical therapy (PT) manager and another staff attended the meeting. -There was a section for documenting falls in the last seven days and the interventions currently in place to minimize future falls. -Resident #3 had a fall on 06/12/21 and "Scoop mattress from [named durable medical equipment supplier]" was listed under what was currently in place to minimize future falls. Review of Resident #3's progress note dated 06/18/21 revealed: -The note was written at 2:00pm and was unsigned. -There was a falls meeting on 06/18/21. -The resident needed a scoop mattress. Observation of Resident #3's bed on 09/10/21 revealed there was not a scoop mattress on her bed. d. Review of Resident #3's progress note dated 06/14/21 revealed: -The note was written by a MA at 11:00pm. -The resident was observed on the floor in her room. -The resident stated she had "wet the bed" and was trying to get to the bathroom. -There did not "seem to be" any injuries. The MA who wrote the progress note after Resident #3's fall on 06/14/21 was not available for an interview. Based on observation, record reviews and	D 270		

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interviews, there were no interventions put in place after Resident #3's fall on 06/14/21.

e. Review of Resident #3's Incident & Accident Report dated 06/23/21 revealed:
-The incident report was completed by a MA.
-On 06/23/21 at 6:55am, Resident #3 was observed on the floor next to her bed.
-The resident was picked up and put back on the bed.
-The PCP and POA were notified of the incident.

Review of Resident #3's progress note dated 06/23/21 revealed:
-The note was written by the MA at 7:00am.
-The resident was observed on the floor next to her bed.
-She was picked up and put back in bed.

The MA who completed the Incident & Accident Report after Resident #3's fall on 06/23/21 was not available for an interview.

Review of Resident #3's Physician Notification of Fall dated 06/23/21 revealed:
-The notification was completed by the MA and faxed to Resident #3's PCP.
-The PCP signed the notification on 06/24/21 and ordered a PT evaluation for fall risk reduction.

f. Review of Resident #3's Incident & Accident Report dated 06/23/21 revealed:
-The incident report was completed by a MA.
-On 06/23/21 at 3:24pm, the resident was observed in her bathroom "sitting on her bottom" and hanging on to the left side of her wheelchair.
-The resident slid to the floor while trying to pick up her clothes.
-The resident complained of pain in her hands and legs.

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-The PCP, POA, and RCD were notified of the incident.

Review of Resident #3's progress note dated 06/23/21 revealed:
-The note was written at 3:41pm and was unsigned.
-The resident had an unwitnessed fall at 3:24pm in her bathroom.
-She stated she was trying to pick up clothes off the floor and slid onto the floor while trying to hang onto the left side of her wheelchair.
-The resident complained of pain in her hands and legs.
-The resident was given tylenol.

Attempted telephone interviews with the MA, who completed the 06/23/21 Incident & Accident Report, on 09/10/21 at 12:19pm and 09/13/21 at 9:13am were unsuccessful.

Based on record reviews and interviews, there were no interventions put in place after Resident #3's fall on 06/23/21.

g. Review of Resident #3's Incident & Accident Report dated 07/12/21 revealed:
-The incident report was completed by a MA.
-On 07/12/21 at 10:30am, Resident #3 was observed on the floor in her room.
-The MA assessed the resident's range of motion, took her vital signs, and assisted her off the floor.
-The PCP and POA were notified of the incident.

Review of Resident #3's progress note dated 07/12/21 revealed:
-The note was written by the MA at 11:00am.
-The resident was observed on the floor in front of the chair in her room.
-She stated she was trying to transfer herself

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from her wheelchair to the chair.
-The resident reported pain in her left leg.
-The resident received tylenol for her pain.

The MA who completed the Incident & Accident Report after Resident #3's fall on 07/12/21 was not available for an interview.

Review of Resident #3's Physician Notification of Fall dated 07/12/21 revealed:
-The notification was completed by the MA and faxed to Resident #3's PCP.
-The resident was having pain in her left leg.
-The PCP put a check mark in the option labeled "Acknowledged, no changes at this time."
-The PCP signed the notification on 07/15/21.

Review of Resident #3's progress note dated 07/15/21 revealed:
-The note was written by the Director of Quality and Education.
-It was documented as a late entry at 4:00pm.
-The PT agency had provided in-service training on a lift support aid to first and second shift staff.
-The resident tolerated the use of the lift support aid.
-Staff were to "reinforce" the use of Resident #3's pendant when she needed assistance and not to get out of bed by herself.

Review of the Weekly Falls Management Meeting Notes dated 07/16/21 revealed:
-The RCD facilitated the meeting.
-The PT manager and the Director of Quality and Education attended the meeting.
-There was documentation Resident #3 was observed on the floor at 11:00am; there was no date listed.
-There were concerns about the resident's cognition.

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-The resident did not remember to use the call light and attempted to get out of bed on her own.
-The PT agency had provided in-service training to staff on a lift support aid on 07/15/21.

h. Review of Resident #3's Incident & Accident Report dated 07/25/21 revealed:
-The incident report was completed by a MA.
-On 07/25/21 at 10:10am, Resident #3 was observed lying on the floor in her room.
-The MA's action taken in response to the incident was to check on the resident every hour.
-The PCP and POA were notified of the incident.

Review of Resident #3's progress note dated 07/25/21 revealed:
-The note was written by the MA; no time was documented.
-The resident was observed on the floor next to her bed.
-The resident did not remember how she got on the floor.
-There were no injuries.
-Staff were going to continue monitoring the resident; no monitoring interval was indicated.

The MA who completed the Incident & Accident Report after Resident #3's fall on 07/25/21 was not available for an interview.

Review of Resident #3's Physician Notification of Fall dated 07/25/21 revealed:
-The notification was completed by the MA and faxed to Resident #3's PCP.
-There were no known injuries from the fall.
-The PCP put a check mark in the option labeled "Acknowledged, no changes at this time."
-The PCP documented that the resident was "in PT."
-The PCP signed the notification on 07/25/21.

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D 270	Continued From page 11 i. Review of Resident #3's Incident & Accident Report dated 08/01/21 revealed: -The incident report was completed by a MA. -On 08/01/21 at 3:05am, Resident #3 was observed "sitting on her bottom" on the floor in her room. -The MA assessed the resident for bruising and pain, took her vital signs, and assisted her into her bed. -The PCP and POA were notified of the incident. Review of Resident #3's progress note dated 08/01/21 revealed: -The note was written by the MA at 7:25am. -The resident had called for assistance with her pendant and was observed "sitting on her bottom" on the floor of her bedroom. -The resident did not have any bruises. -The POA was notified. Review of Resident #3's Physician Notification of Fall dated 08/01/21 revealed: -The notification was completed by the MA and faxed to Resident #3's PCP. -There were no known injuries from the fall. -The PCP put a check mark in the option labeled "Acknowledged, no changes at this time." -The PCP signed the notification on 08/03/21. Telephone interview with the MA, who completed the 08/01/21 Incident & Accident Report, on 09/10/21 at 12:04pm revealed: -When she worked on third shift, she assisted with resident care and completed safety checks. -Resident #3 was on hourly safety checks. -There were no safety checks more frequent than hourly. -The resident liked to dangle both of her feet or one leg out of her bed.	D 270		

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-Staff had "to know when to go in" and check on the resident.
-Most of the resident's falls occurred on third and first shift.
-She did not know what else could be done to prevent the resident from falling out of her bed.

j. Review of Resident #3's Incident & Accident Report for dated 08/01/21 revealed:
-The incident report was completed by a MA.
-On 08/01/21 at 10:50am, the resident was observed sitting on the floor in front of the wheelchair next to her bed.
-The resident said she did not fall and did not remember how she got onto the floor.
-The resident was assessed and placed into her bed; she had no pain.
-The PCP and POA were notified of the incident.

Review of Resident #3's progress note dated 08/01/21 revealed:
-The note was written by the MA at 10:50am.
-The resident was observed on the floor in front of her wheelchair that was next to her bed.
-The resident did not know how she ended up on the floor.
-No injuries were noted, and the resident did not have any pain.
-The PCP and POA were notified of the incident.

Attempted telephone interviews with the MA, who completed the 08/01/21 Incident & Accident Report, on 09/10/21 at 11:57am and 09/13/21 at 9:11am were unsuccessful.

Review of Resident #3's Physician Notification of Fall dated 08/01/21 revealed:
-The notification was completed by the MA and faxed to Resident #3's PCP.
-There were no known injuries.

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-The PCP put a check mark in the option labeled "Acknowledged, no changes at this time."
-The PCP signed the notification on 08/03/21.

Based on record reviews and interviews, there were no interventions put in place after Resident #3's fall on 08/01/21.

Review of Resident #3's progress note dated 08/04/21 revealed:
-The note was written by the Administrator.
-It was documented as a late entry at 12:20pm.
-The Administrator spoke with the PCP on 08/03/21 about the resident being difficult to transfer.
-The PCP stated the resident's family was looking for placement into a higher level of care.

Review of the Weekly Falls Management Meeting Notes dated 08/05/21 revealed:
-The RCD facilitated the meeting and the PT manager attended the meeting.
-Next to Resident #3's name was documented "Alternative placement, referred to Palliative care."

k. Review of Resident #3's Incident & Accident Report dated 08/08/21 revealed:
-The incident report was completed by a MA.
-On 08/08/21 at 3:07am, Resident #3 was observed on her bedroom floor.
-The resident stated she was trying to get to her family member.
-The resident was assessed from head to toe, and there were no apparent signs of injuries.
-Staff assisted the resident back into her bed; vital signs were taken.
-The PCP and POA were notified of the incident.
-"Routine checks" were done.

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Review of Resident #3's progress note dated 08/08/21 revealed:
-The note was written by the MA at 6:30am.
-The resident was observed lying on her bedroom floor.
-There were no apparent signs of injury, and the resident did not report pain or discomfort.
-Staff began "routine checks" throughout the shift.
-The PCP, POA, and RCD were notified of the incident.

Attempted telephone interview with the MA, who completed the 08/08/21 Incident & Accident Report, on 09/13/21 at 9:09am was unsuccessful.

Based on record reviews and interviews, no interventions were implemented after Resident #3's fall on 08/08/21.

I. Review of Resident #3's Incident & Accident Report dated 08/13/21 revealed:
-The incident report was completed by a MA.
-On 08/13/21 at 1:35pm, the resident was observed on the floor next to her bed.
-The resident stated she slipped out of bed onto the floor.
-The resident reported no pain or discomfort and was placed in her wheelchair.
-The PCP and POA were notified of the incident.

Review of Resident #3's progress note dated 08/13/21 revealed:
-The note was written by the MA at 2:00pm.
-The resident was observed sitting on the floor next to her bed.
-The resident stated she slipped out of bed
-She had no pain or discomfort and was placed in her wheelchair.
-The PCP and POA were notified of the incident.

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Attempted telephone interviews with the MA, who completed the 08/13/21 Incident & Accident Report, on 09/10/21 at 11:57am and 09/13/21 at 9:11am were unsuccessful.

Based on observation, record reviews and interviews, no interventions were implemented after Resident #3's fall on 08/13/21.

Review of the Weekly Falls Management Meeting Notes dated 08/13/21 revealed:
-The RCD facilitated the meeting and the PT manager attended the meeting.
-Next to Resident #3's name it read "Speak with family about hospital bed."

Observation of Resident #3's bedroom on 09/10/21 revealed the resident did not have a hospital bed.

m. Review of Resident #3's Incident & Accident Report dated 09/08/21 revealed:
-The incident report was completed by a MA.
-On 09/08/21 at 2:00am, Resident #3 was observed sitting on the floor next to her bed.
-The resident was checked from head to toe; there were no apparent signs of injuries.
-The resident was transferred back to bed, and vital signs were taken.
-The PCP and POA were notified of the incident.

Review of Resident #3's progress note dated 09/08/21 revealed:
-There was a note written by the MA at 6:50am.
-The resident was observed on the floor resting against her bed.
-There were no apparent signs of injury.
-The PCP, POA, and RCD were notified of the incident.

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Attempted telephone interviews with the MA, who completed the 09/08/21 Incident & Accident Report, on 09/10/21 at 11:57am and 09/13/21 at 9:11am were unsuccessful.

Interview with Resident #3's family member on 09/09/21 at 11:34am revealed:
-The resident had short term memory problems and had vivid dreams.
-She experienced multiple falls.
-The resident did not get hurt when she "slides out" of her bed.
-Her last fall/slide was earlier in the week.
-When her feet were over the side of the bed, she would slide out of the bed within 30 minutes.
-He called staff for assistance whenever he observed Resident #3's feet hanging over the side of her bed.

Interview with Resident #3's family member on 09/10/21 at 11:19am revealed:
-Staff routinely checked on the resident "every couple of hours."
-He did not want the resident to have a fall mat because it "would give her a target" to fall on.
-Resident #3 was scheduled to start PT and occupational therapy (OT) the following week.
-It had been "quite a while since her last round of therapy."
-No one at the facility had talked with him or the resident about preventing falls.

Telephone interview with Resident #3's PCP on 09/10/21 at 11:44am revealed:
-She expected staff to check on the resident "frequently," which meant every two hours.
-She did not know if placing pillows under the resident's feet while she was in bed would help.
-She thought a hospital bed with the resident's feet elevated may help, but the resident "wiggles

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a lot."
-She did not remember if Resident #3 had received PT or OT.
-She ordered a fall mat for the resident on 09/09/21.
-There was "not a whole lot else to do" to prevent the resident from falling.

Interview with the PT Area Director on 09/10/21 at 12:31pm revealed:
-Resident #3 was discharged from PT in May 2021 because she had "maximized her potential."
-The resident had no current order for PT.
-The need for PT and OT was determined by the cause of a fall.
-A resident could have behavioral concerns or postural concerns that resulted in falls.
-She thought Resident #3's need for therapy was related to her cognitive condition.
-There were no standard interventions implemented after a fall.
-In general, fall mats were not recommended because they were a trip hazard.
-The resident's family would be responsible for providing a scoop mattress; insurance did not pay for the mattress.
-A hospital bed would not prevent Resident #3 from sliding out of bed.
-Some residents could not be kept from falling; they required more frequent safety checks.
-Some residents did not ask staff for assistance.

Telephone interview with Resident #3's POA on 09/10/21 at 4:27pm revealed:
-The facility notified him every time the resident had a fall.
-The most recent incident was earlier in the week.
-Most of the incidents involved the resident sliding off her bed.
-The resident also tried to transfer without

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assistance and that led to her falls.
-The resident's family member called for staff assistance whenever he noticed the resident attempting to transfer on her own.
-He regularly spoke with the Administrator.
-There had been "numerous" meetings every other week for the past year related to Resident #3's falls.
-He had also met with the RCD and the PT staff.
-Any interventions to prevent falls needed to be within the "bounds of [the resident's] cooperation."
-The resident was moved to a room closer to the MA station months ago.
-Safety checks on the resident had been increased.
-There had been discussion about getting a hospital bed for the resident.
-He did not remember discussing a scoop mattress to prevent falls.
-There had not been discussion about providing a sitter for her.
-Last month, there was discussion about relocating the resident to another facility.
-The PCP contacted him this week about ordering a fall mat for the resident.
-He and the Administrator had a meeting on 09/07/21 about Resident #3's care needs.
-He was trying to find suitable accommodations for Resident #3 and her family member; he had been visiting other facilities.
-The "biggest problem" was Resident #3's level of dementia.
-The resident's situation was "very challenging."

Interview with the Administrator on 09/10/21 at 4:48pm revealed:
-There were not a lot of options for preventing Resident #3 from falling.
-There had not been any discussion about

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providing the resident with a fall mat.
-A fall mat was not an option because it would be a trip hazard.
-A scoop mattress was not provided because the "mattress wasn't really an issue."
-Resident #3 and her family member did not want her to receive a hospital bed; they wanted to keep their matching beds.
-Resident #3 and her family member were not interested in having a sitter in their room.
-She talked with Resident #3's POA on 09/07/21 about the resident's cognitive decline.
-The POA asked if it was time for the resident to be moved out of the assisted living unit of the facility.
-The POA was looking for a facility with a lift because Resident #3 could "barely stand."
-The resident did not typically get hurt when she slid out of the bed.
-She did not "crash" to the floor.

Telephone interview with the RCD on 09/13/21 at 3:50pm revealed:
-Resident #3 was provided with a bed cane and was moved to a room next to the MA station so she could be checked on more frequently.
-He discussed getting a scoop mattress with the resident's POA.
-The POA decided to have a hospital bed provided for the resident instead of a scoop mattress.
-A hospital bed was ordered for the resident on 09/13/21.
-The current plan was to have the hospital bed and safety checks in place.
-The POA was considering moving the resident to a skilled nursing facility.
-He was not sure what else could have been implemented to prevent the falls.

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Based on interviews, observations and record reviews, it was determined Resident #3 was not interviewable.

Attempted telephone interview with the Director of Quality and Education on 09/13/21 at 9:06am was unsuccessful.

Refer to the interview with the Administrator on 09/09/21 at 3:35pm.

2. Review of Resident #5's current FL-2 dated 08/16/21 revealed:
-Diagnoses included fall, essential hypertension, and dementia.
-She was ambulatory and constantly disoriented.

Review of Resident #5's care plan dated 03/12/21 revealed she required no assistance with ambulation or transfers.

a. Review of Resident #5's Incident & Accident Report dated 07/17/21 revealed:
-Resident #5 was changed and as the personal care aide (PCA) went to throw away the trash, she heard a noise coming from Resident #5's room.
-When the PCA reentered the room, Resident #5 was observed on the floor near the door with her back against her closet at 6:40am.
-She had a scratch on her right leg.
-Emergency Medical Service (EMS) was not called, but her family member and primary care physician (PCP) were notified.

Review of Resident #5's progress note dated 07/17/21 at 7:00am revealed:
-Resident #5 was getting changed when the PCA stepped out of the room to throw away trash.
-The PCA heard a bang in Resident #5's room

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and when the PCA went back in to check on her, Resident #5 was on the floor near the door with her back on the closet door.
-There was a small scratch on Resident #5's right leg.
-Her PCP and family member were notified.

The MA who documented the progress note and the Incident Accident Report on 07/17/21 was not available for an interview.

Review of the Resident #5's Physician Notification of Fall dated 07/17/21 revealed:
-The notification was completed by the medication aide (MA) and faxed to Resident #5's PCP.
-A scratch on Resident #5's right leg was documented on the notification.
-Resident #5's PCP signed the notification on 07/20/21.
-There were no orders written by the PCP.

Review of the Weekly Falls Management Meeting Notes dated 07/23/21 revealed:
-The Resident Care Director (RCD) facilitated the meeting.
-The physical therapy (PT) manager was also in attendance at the meeting.
-There was a section to document falls in the last seven days and the interventions currently in place to minimize future falls.
-The intervention documented for Resident #5 was to continue to monitor.

Based on record reviews, there was no documentation of interventions or increased supervision implemented for Resident #5 after her fall on 07/17/21.

b. Review of Resident #5's Incident & Accident

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Report dated 08/01/21 revealed:
-She was observed laying on her right side asleep in another resident's room at 10:15am.
-There was no injury and no complaints of pain.
-Resident #5 was assisted up from the floor, her vitals were obtained, and a skin assessment was completed.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/01/21 at 10:15am revealed:
-She was observed asleep on the floor of another resident's room and she was laying on her right side.
-There were no injuries or complaints of pain.
-Her family was at the facility and was aware.
-Her PCP and the RCD were notified.

Telephone interview with the MA on 09/13/21 at 9:29am who documented the progress note and the Incident Accident Report dated 08/01/21 revealed:
-When a resident had a fall, the protocol was to assess the resident, check the resident's vital signs, see if the resident needed to go out to the local hospital emergency room (ER) and to notify the resident's family, the PCP, and the RCD.
-If a resident hit their head during a fall, staff automatically sent the resident to the local hospital ER unless the family did not want the resident to be sent out.
-If a resident was a high risk for falls, the resident would be on hourly checks as needed after a fall for at least 3 days.
-If the resident was not a high risk for falls, the resident would not receive hourly checks after a fall.
-All residents were checked on every 2 hours.
-When a resident was on hourly checks, staff

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completed an hourly check form and the form was kept in the resident's chart.
-Resident #5 was a high risk for falls.
-She started receiving hourly checks as of 1:30pm on 09/12/21.
-Resident #5 had multiple falls over the last 3 months, but she was not on hourly checks prior to 09/12/21.
-She did not know why Resident #5 had not been on hourly checks.
-She did not know if any interventions were put in place for Resident #5 after her fall on 8/01/21 or after any of her falls.
-She had not been told to do anything differently for Resident #5 after her falls.

Review of Resident #5's Physician Notification of Fall dated 08/01/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-A description of Resident #5's fall and the denial of pain or injury were documented on the notification.
-Resident #5's PCP signed the notification on 08/03/21.

Review of the Weekly Falls Management Meeting Notes dated 08/05/21 revealed:
-The RCD facilitated the meeting.
-The PT manager was also in attendanceat the meeting.
-There was a section to document falls in the last seven days and the interventions currently in place to minimize future falls.
-The intervention documented for Resident #5 was to continue to monitor.

Based on record reviews, there was no documentation of interventions or increased supervision implemented for Resident #5 after

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her fall on 07/17/21.

c. Review of Resident #5's Incident & Accident Report dated 08/07/21 revealed:
-She was observed on the floor of another resident's closet at 11:55am and the door was closed.
-There was no injury noted.
-Resident #5 was assisted from the floor by staff and her family member.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/07/21 at 1:00pm revealed:
-She was observed on the floor of another resident's closet.
-Her family member was present when she was found and assisted staff with getting her up from the floor.

Review of the Resident #5's Physician Notification of Fall dated 08/07/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-A description of Resident #5's fall with no injuries was documented on the notification.
-Resident #5's PCP signed the notification on 08/10/21.
-There were no orders written by the PCP.

Attempted telephone interview with the MA on 09/13/21 at 1:02pm who documented the progress note and Incident & Accident Report dated 08/07/21 was unsuccessful.

Based on record reviews, there was no documentation of interventions or increased supervision implemented for Resident #5 after

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her fall on 08/07/21.

d. Review of Resident #5's Incident & Accident Report dated 08/12/21 revealed:
-She was observed on the floor asleep in front of the nursing station at 12:45pm.
-Two staff lifted Resident #5 from the floor to a chair as she remained asleep; a skin assessment was completed; ice and slight pressure were applied to her nosebleed; and her PCP who was at the facility was to examine her.
-Her vital signs were checked.
-EMS was called and Resident #5's family member was notified.
-There was no injury and no complaints of pain.

Review of Resident #5's progress note dated 08/12/21 at 1:30pm revealed:
-She was observed on the floor in front of the nursing station at 12:45pm.
-Two staff transferred her to a chair as she was very sleepy.
-Her vital signs were checked.
-Her nose started to slightly bleed so ice and pressure were applied.
-Her PCP was notified and was coming to the facility to assess her.
-She denied having any pain.

Review of Resident #5's progress note dated 08/12/21 at 2:20pm revealed:
-Resident #5's PCP assessed her, and her vital signs were very low, especially her blood pressure.
-The decision was made to send her to the local hospital.
-EMS transported her to the local hospital.

Telephone interview with the MA on 09/13/21 at 9:29am who documented the progress note and

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the Incident Accident Report dated 08/12/21 revealed:
-Resident #5 was a high risk for falls.
-She started receiving hourly checks as of 1:30pm on 09/12/21.
-Resident #5 had multiple falls over the last 3 months, but she was not on hourly checks prior to 09/12/21.
-She did not know why Resident #5 had not been on hourly checks.
-She did not know if any interventions put in place for Resident #5 after her fall on 8/01/21 or after any of her falls.
-She had not been told to do anything differently for Resident #5 after her falls.

Review of Resident #5's PCP's consultation notes dated 08/12/21 revealed:
-Resident #5 fell and hit her head.
-Her blood pressure was 80/60 manually at the time of the consultation, and it was previously 130/60.
-She was holding her head in her hand and was unable to report her pain level.
-Due to her drop in blood pressure and head injury, EMS was called, and she was transported to the local hospital emergency room (ER).
-Resident #5 had no current bleeding from her nose.

Review of the Weekly Falls Management Meeting Notes dated 08/13/21 revealed:
-The RCD facilitated the meeting.
-The PT manager was also in attendance at the meeting.
-There was a section to document falls in the last seven days and the interventions currently in place to minimize future falls.
-The intervention documented for Resident #5 was to reassess when she was back from the

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hospital.

Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her fall on 08/12/21.

e. Review of Resident #5's Incident & Accident Report dated 08/17/21 revealed:
-She was observed sitting on the floor in another resident's room at 4:30pm.
-Resident #5 was assisted to her feet.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/17/21 at 5:00pm revealed:
-She was observed siting on the floor in another resident's room at 4:30pm.
-There were no injuries.
-Her family member, PCP, and the RCD were notified.

Review of Resident #5's Physician Notification of Fall dated 08/17/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-No known injury was documented on the notification.
-Resident #5's PCP signed the notification on 08/24/21.
-There were no orders written by the PCP.

Attempted telephone interview with the MA on 09/13/21 at 2:55pm who documented the progress note and Incident & Accident Report dated 08/17/21 was unsuccessful.

Based on record reviews, there was no

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documentation of interventions or increase in supervision implemented for Resident #5 after her fall on 08/17/21.

f. Review of Resident #5's Incident & Accident Report dated 08/21/21 revealed:
-She was observed sitting on the floor in another resident's room at 3:00pm.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/21/21 at 3:15pm revealed:
-She was observed on the floor of the dining hall.
-She had fallen from her chair onto her bottom.
-There were no known injuries.
-Staff would continue to monitor. (There was no documentation how staff would monitor or how often.)

The MA who documented the progress note and the Incident Accident Report dated 08/21/21 was not available for an interview on 09/13/21 at 2:55pm .

Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her first fall on 08/21/21.

g. Review of Resident #5's Incident & Accident Report dated 08/21/21 revealed:
-She was observed lying on the floor face down in the hallway at 6:53pm.
-The action taken in response to the incident was Resident #5 was assisted to her feet and ambulated to her room.
-EMS was not called, but her family member and PCP were notified.

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D 270	Continued From page 29 Review of Resident #5's progress note dated 08/21/21 at 9:00pm revealed: -She was observed laying face down on the floor of the hallway at 6:53pm. -She had no injuries. -She was assisted to her feet and began walking fast and leaning forward. -Her family member, PCP and the RCD were notified. -Staff would continue to monitor. (There was no documentation how staff would monitor or how often.) Review of Resident #5's Physician Notification of Fall dated 08/21/21 revealed: -The notification was completed by the MA and faxed to Resident 53's PCP. -No known injury was documented on the notification. -It was documented this was Resident #5's second fall on 08/21/21. -Resident #5's PCP signed the notification on 08/24/21. -There were no orders written by the PCP. Attempted telephone interview with the MA on 09/13/21 at 2:55pm who documented the progress note and Incident & Accident Report dated 08/21/21 was unsuccessful. Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her second fall on 08/21/21. h. Review of Resident #5's Incident & Accident Report dated 08/22/21 revealed: -She was observed on the floor in the hallway on her hands and knees at 4:25pm.	D 270		

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-Resident #5 was assisted to her feet and ambulated to her room.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/22/21 at 1:30pm revealed:
-She was observed on the floor of the hallway near the living room on her hands and knees at 4:25pm.
-She had an abrasion on both her elbows.
-The areas were cleaned with saline and bandaged with non-stick pads.
-Her family member, PCP and RCD were notified.
-Staff would continue to monitor. (There was no documentation how staff would monitor or how often.)

Review of Resident #5's Physician Notification of Fall dated 08/22/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-An abrasion to both elbows was documented on the notification.
-Resident #5's PCP signed the notification on 08/24/21.
-There were no orders written by the PCP.

Attempted telephone interview with the MA on 09/13/21 at 2:55pm who documented the progress note and Incident & Accident Report dated 08/22/21 was unsuccessful.

Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her fall on 08/22/21.

i. Review of Resident #5's Incident & Accident

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Report dated 08/23/21 at revealed:
-She was observed laying on her right side on the floor of another resident's room at 2:05pm.
-Resident #5 was assisted from the floor by staff.
-She had redness under her right eye.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/23/21 at 2:20pm revealed:
-She was observed on the floor laying on her right side in another resident's room.
-She voiced no complaints of pain, but there was redness observed under her right eye.
-She was assisted up from the floor and back into the common area to be observed.
-Her family member and her PCP were notified.

Review of the facility's Physician Notification of Fall dated 08/23/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-A description of Resident #5's fall was documented with redness under her right eye.
-Resident #5's PCP signed the notification on 08/24/21.
-There were no orders written by the PCP.

Attempted telephone interview with the MA on 09/13/21 at 1:02pm who documented the progress note and Incident & Accident Report dated 08/23/21 was unsuccessful.

Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her fall on 08/23/21.

j. Review of Resident #5's Incident & Accident

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Report dated 08/28/21 revealed:
-She was observed sitting on the hallway floor at 8:45pm.
-Resident #5 was assessed and had a scratch on her right elbow area.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 08/28/21 at 10:30pm revealed:
-She was observed on the hallway floor.
-She had a scratched area on her right elbow.
-She displayed no signs of pain or discomfort.

Review of Resident #5's Physician Notification of Fall dated 08/28/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-A description of Resident #5's fall was documented.
-Resident #5's PCP signed the notification on 08/31/21 and wrote an order to continue to monitor.

Attempted telephone interview with the MA on 09/13/21 at 3:05pm who documented the progress note and Incident & Accident Report dated 08/28/21 was unsuccessful.

Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her fall on 08/28/21.

k. Review of Resident #5's Incident & Accident Report dated 09/05/21 revealed:
-She was observed laying face down on the floor between the bed and the wall of another resident's room at 5:30pm.

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-Resident #5 ambulated to the dining room for supper.
-Her vitals were checked.
-EMS was not called, but her family member and PCP were notified.

Review of Resident #5's progress note dated 09/05/21 at 8:00pm revealed:
-She was observed in another resident's room laying face down on the floor between the bed and the window.
-There were no visible injuries.
-Her family member, PCP and the RCD were notified.
-Staff would continue to monitor. (There was no documentation how staff would monitor or how often.)

Review of Resident #5's Physician Notification of Fall dated 09/05/21 revealed:
-The notification was completed by the MA and faxed to Resident #5's PCP.
-No known injury was documented on the notification.
-Resident #5's PCP signed the notification on 09/07/21.
-There were no orders written by the PCP.

Attempted telephone interview with the MA on 09/13/21 at 2:55pm who documented the progress note and Incident & Accident Report dated 09/05/21 was unsuccessful.

Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #5 after her fall on 09/05/21.

Observation of Resident #5 on 09/09/21 at 10:25am revealed:

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-She was seated in a chair in her room and her family member was standing talking to her.
-Resident #5 had a bruise on her nose and healing scratches on her chin.
-Resident #5 attempted to leave the room several times, but her family member redirected her back into the room.

Interview with Resident #5's family member on 09/09/21 at 10:26am revealed:
-Resident #5 had multiple falls at the facility, but he was not sure how many.
-Resident #5 walked very quickly and he thought that was causing her to fall.
-He was notified about each of Resident #5's falls.
-Her PCP had written an order for PT and occupational therapy (OT) in August 2021.
-He did not use the facility contracted provider for therapy services because Resident #5's insurance did not cover the costs.
-He found a therapy provider for Resident #5, but he was having trouble getting a start date for services.
-The facility staff sent the PT/OT referral to the outside provider and were assisting him with communicating with the provider.
-He did not know of any other interventions or increased supervision in place for Resident #5.

Interview with a MA on 09/10/21 at 10:18am revealed:
-After a fall, staff was to make sure residents were comfortable.
-She had not been told to do anything differently for residents after a fall.
-She checked on residents every hour to 2 hours after a fall, but she did not document anywhere.

Interview with a PCA on 09/10/21 at 10:33am

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revealed:
-Resident #5 was a high fall risk and fell quickly.
-Resident #5 did not have any assistive devices and she did not know of any interventions put in place for her.
-All residents were checked on every 2 hours.
-After a fall, residents were checked on every 1 to 2 hours.
-The first week after a fall, the resident received hourly checks and the second week after a fall, the resident received checks every 2 hours if they had not fallen again.
-There was a form for documenting hourly checks, but she thought the resident had to fall 2 to 3 times consecutively before the form was used.

Interview with Resident #5's family member on 09/10/21 at 10:56am revealed:
-He visited Resident #5 almost daily.
-He arrived at the facility around 9:30am and stayed until around 12:00pm, but he had stayed until around 5:00pm at times.
-Resident #5 went to the hospital on 08/12/21 after having a fall at the facility.
-The hospital wanted to keep her because she was a little dehydrated and they wanted to run scans and give her fluids.
-All Resident #5's tests came back "great."

Interview with Resident #5's PCP on 09/10/21 at 12:00pm revealed:
-She was aware of Resident #5's falls.
-She had made changes to Resident #5's medications.
-Resident #5 walked on her own and she would not use a walker.
-She ordered PT and OT for Resident #5 in August 2021, but she did not know of any other interventions to do for her.

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-Staff should monitor Resident #5 and keep her where they can see her in the open areas of the facility.

Interview with the RCD on 09/13/21 at 3:50pm revealed:
-After a fall, the MA assessed the resident to make sure the resident was not bleeding or hurt.
-If the resident was bleeding or hurt, the resident was sent out to the local hospital.
-Depending on the resident, interventions could include PT, OT, or more frequent safety checks.
-When Resident #5 went to the hospital on 08/12/21, there were medication changes made at the hospital.
-Her current interventions included her family member being there most of the day and safety checks every hour.

Interview with the Administrator on 09/10/21 at 4:20pm revealed:
-Resident #5 was unstable and sometimes fell.
-Staff were checking on Resident #5 multiple times a day, but it was very difficult to document.
-Staff saw her constantly because she was always on the move.
-Resident #5's family member was at the facility daily and essentially acted as a "human restraint" as he was always with her during his visits to ensure she did not fall.
-The PCP said there was no way to prevent falls unless someone was standing with Resident #5 constantly, but that was unrealistic, and it was not going to happen.

Refer to the interview with the Administrator on 09/09/21 at 3:35pm.

3. Review of Resident #1's current FL-2 dated 06/10/21 revealed:

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-Diagnoses included dementia, history of falls, chronic obstructive pulmonary disease (COPD) and insomnia.
-The resident was constantly disoriented.
-The resident was ambulatory.

Review of Resident #1's care plan dated 02/18/21 revealed:
-The resident resisted care and was receiving medication for mental illness behaviors.
-The resident needed supervision with ambulation/locomotion, bathing, dressing and grooming.
-The resident ambulated using a rollator (4 wheeled walker) and a wheelchair.

Review of Resident #1's licensed health professional support (LHPS) quarterly review dated 04/15/21 revealed:
-The resident ambulated with a rollator and a wheelchair.
-The resident needed staff transfer assistance for safety due to recent falls.
- Resident #1 had a pendant (call device) to call staff for assistance in transferring, but she often forgot to use it.

Observation of Resident #1 on 09/09/21 at 11:15am revealed:
-She had a 4 x 2 inch red and purple bruise on her upper left arm.
-She had a 2 x 1 inch dark red healing skin tear on the lower left arm.
-She had a 6 x ½ inch pink bruise on her lower right arm.

Interview with Resident #1 on 09/09/21 at 11:16am revealed:
-She did not remember when or how she received the bruises and skin tears on her arms.

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D 270	Continued From page 38 -She would fall when she stood up from her wheelchair and tried to walk. Review of Incident & Accident Reports and Resident Notes for Resident #1 for the Month of May 2021 revealed: -The resident had 11 unwitnessed falls on 05/01/21, 05/04/21, 05/14/21, 05/16/21, 05/17/21, 05/19/21, 05/24/21, 05/26/12, 05/27/21 (2 falls) and 05/28/21. -The resident had 2 documented injuries and being found without clothes, in the month of May due to unwitnessed falls, as follows: -On 05/01/21 at 8:54pm the Resident was observed on the floor of her room and confused. -She had a quarter-sized hematoma (bruise) on her right eye and bleeding. -The resident was taken by Emergency Medical Services f(EMS) to the local hospital, received 2 staples on the top of her head and was returned to the facility at 12:15am. -The Resident was on hourly checks, (staff) would continue to monitor. -There was no documentation of changes in supervision or other interventions put into place after each fall or for fall prevention for Resident #1. - On 05/24/21 at 2:00pm, the resident was observed laying on her bathroom floor with no clothes on. -There was no documentation of changes in supervision or other interventions put into place after each fall or for fall prevention for Resident #1. -On 05/26/21 at 11:15pm, the resident had an unwitnessed fall in her room; there were noticeable carpet burn marks on the left side of her face. -There was no documentation of changes in supervision or other interventions put into place	D 270		

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after each fall or for fall prevention for Resident #1.

Review of Incident & Accident Reports and Resident Notes for Resident #1 for the Month of June 2021 revealed:
-The Resident had 2 unwitnessed falls on 06/18/21 and 06/24/21.
-On 06/18/21 at 9:32am, the resident had an unwitnessed fall and suffered bruising to the right eyelid and forehead.
-Wound care was provided to Resident #1's right eyelid.
-There was no documentation of changes in supervision or other interventions put into place after each fall or for fall prevention for Resident #1.

Review of Incident & Accident Reports and Resident Notes for Resident #1 for the Month of July 2021 revealed:
-The resident had 1 unwitnessed fall on 07/13/21.
-On 07/13/21 at 6:30am the resident was observed sitting on the floor, in her room, in front of her wheelchair at the room door.
-She had an abrasion under her left eye and a skin tear above her left eyebrow.
-There was no documentation of changes in supervision or other interventions put into place for Resident #1.

Review of Incident & Accident Reports and Resident Notes for Resident #1 for the Month of August 2021 revealed:
-The resident had 6 unwitnessed falls on 08/01/21, 08/02/21 (2 falls), 08/19/21, 08 27/21, 08/28/21 and 08/30/21.
-The resident had 4 documented injuries in the month of August due to unwitnessed falls.
- On 08/02/21 at 7:12pm, the Resident was found

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on the floor beside her bed.
-The resident had carpet burns on her left knee.
-There was no documentation of changes in supervision or other interventions put into place for Resident #1.
-On 08/4/21 on the 3-11pm shift (no time given) it was observed Resident #1 had a black eye and a whelp on her cheek.
-There was no documentation of changes in supervision or other interventions put into place for Resident #1.
-On 08/19/21 at 8:56am, the resident was observed standing in her closet, had a small cut on her lip, blood inside her nose and a bruise on her left cheek.
-There was no documentation of changes in supervision or other interventions put into place for Resident #1.
On 08/27/21 at 7:00am, the Resident was observed on the floor in her room and had reopened a previous wound on her left arm.
-There was no documentation of changes in supervision or other interventions put into place for Resident #1.

Review of Incident & Accident Reports and Resident Notes for Resident #1 for the Month of September 2021 revealed:
-The resident had 1 unwitnessed fall on 09/05/21; there was no documentation of injuries to the resident.
-There was no documentation of changes in supervision or other interventions put into place for Resident #1.

Interview with a personal care aide (PCA) on 09/13/21 at 9:30am revealed:
-She assisted with personal care for Resident #1.
-Resident #1 had a wheelchair to use for assistance in ambulating but would stand up and

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fall; she was a falls risk.
-The resident had dementia that was progressing and was often confused.
-She had a pendant device to use for calling staff for assistance but did not use it.
-Staff were to make rounds and check on residents every 1 hour during the shift.
-She did not know if staff were checking on their assigned residents every hour because there was no documentation of doing the checks.
-Resident #1 stood up real fast from her wheelchair, stood and turned on one foot and got off balance.
-She was not aware of a falls policy or having any changes for supervision for Resident #1 other than the 1-hour checks.

Interview with a second PCA on 09/10/21 at 10:45am revealed:
-She assisted with personal care for Resident #1 and took the resident into the common room to sit and have meals.
-She would let the medication aide (MA) know Resident #1 was in the common room because the resident would try to stand up and would fall.
-Staff needed to watch Resident #1 because she was a falls risk.
-Staff were to check on residents every 1 hour.
-There was no documentation for the 1- hour checks for residents.
-She was told by the MA that Resident #1 was a falls risk and to make rounds to check on her every hour.
-It was the same after each fall; there were no changes for supervision for Resident #1.

Interview with a MA on 09/10/21 at 5:05pm revealed:
-There was a change in Resident #1 in mid-May 2021; she started falling and started using a

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wheelchair.
-Staff were to check on her every 1 hour.
-Staff checked on Resident #1 hourly but she continued to have falls.
-There were no forms to document the hourly checks, staff tried to keep the residents in a semi-circle in the common room.
-The facility did not use restraints and staff continued to complete the hourly checks on Resident #1.

Attempted interview with Resident #1's power of attorney (POA) on 09/10/21 at 4:35pm was unsuccessful.

Interview with the LHPS nurse on 09/13/21 at 9:55am revealed:
-Resident #1 used a walker when she resided in the assisted living (AL) section but when she started having falls, she was moved to the Special Care Unit (SCU) and used a wheelchair.
-She spoke with the manager of the PT department about Resident #1 having therapy sessions.
-Resident #1 had impulsive behaviors that caused her to stand up quickly.
-The Executive Director (ED), PT and the Resident Care Director (RCD) had falls prevention meetings to decide on a plan for falls prevention.
-She was not notified of a plan for falls prevention.
-When she came to visit Resident #1, she checked PT's notes for the resident's current status.
-Staff in the SCU move the residents to the common area during the day to keep them closer for observation and making hourly checks on residents.
-There used to be a form for hourly check

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documentation; she did not know if there were forms available or when staff last used a supervision form.

Interview with the PT therapist on 09/10/21 at 12:50pm revealed:
-Resident #1 started therapy on 06/23/21 when they received an order from Resident #1's PCP.
-The resident had dementia, an unsteady gait, and was having falls.
-Resident #1 was residing in the SCU to have increased supervision to prevent falls.

Interview with the RCD on 09/13/21 at 4:09pm revealed:
- Falls Risk Assessment documentation was reviewed with PT/OT management weekly to discuss resident falls and come up with interventions to prevent future falls.
-He was familiar with Resident #1's falls and her tendency to jump up out of her wheelchair and attempt to walk.
-SCU staff would bring Resident #1 to the common room to sit and be able to watch the resident.
-Staff were aware Resident #1 was a falls risk and they made hourly checks on her and other residents having falls.
-Staff was to complete rounds every 1 hour for supervision.
-He was not aware of a form to document hourly checks for residents having falls before this past weekend (9/12/21).
-Resident #1's record was kept in the "Hot Box" to make staff aware Resident #1 was a falls risk..

Interview with Resident #1's PCP's Office Manager/Nurse on 09/13/21 at 8:43am revealed:
-Resident #1 was last seen on 09/07/21 for a fall on 09/05/21; the resident was constantly jumping

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up out of her wheelchair.
-Resident #1 was seen for falls on 05/04/21, 05/18/21, 05/18/21, 05/20/21, and 05/25/21; on 06/28/21; on 07/13/21 and on 08/03/21, 08/19/21 and 08/31/21.
-Resident #1 suffered gashes on her forehead requiring stitches and bruises on her face and arms.
-PT and Occupational Therapy (OT) was ordered on 06/23/21.
-Resident #1 became restless and wanted to get up and out of her wheelchair without assistance.
-Staff continued to have Resident #1 in the common area but the falls continued.

Interview with Resident #1's PCP on 09/13//21 at 3:45pm revealed:
-Resident #1 was using a walker and had falls.
-The resident needed a wheelchair, but she would not stay seated and had falls. Resident #1 was moved to the SCU to receive closer supervision.
-The Resident was put in the common area during the day and was checked on hourly by staff.
-Resident #1 should have been checked on more frequently than 1 hour to prevent falls.
-Staff needed to provide more supervision to keep Resident #1 from falling.
-The ED talked about what to do in meetings, but there were no changes made to keep Resident #1 from falling.

Interview with the Director of Quality and Education (DQE) on 09/13/21 at 4:09pm revealed:
-She was aware Resident #1 had falls; the resident's record was kept in the "hot box" to remind staff to complete hourly checks until the resident stopped falling.

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D 270	Continued From page 45 -The RCD met with the PT/OT manager weekly to discuss resident falls. -They did not always implement a change for supervision for Resident #1. -There was a need to reassess supervision plans for Resident #1. Refer to the interview with the Administrator on 09/09/21 at 3:35pm. _____ Interview with the Administrator on 09/09/21 at 3:35pm revealed: -The MA was responsible for assessing residents after a fall. -The MA was responsible for notifying the family and the PCP after an incident occurred. -The hospital had requested residents not to be sent to the ED unless there were "serious" injuries. -Staff observed the residents for visible signs of change after a fall. -Incidents were documented in the resident's record. -Interventions varied based upon the resident's PCP. -Hourly safety checks were not necessarily implemented after an incident; each incident was independently evaluated. -When a resident experienced frequent falls, the PCP would be consulted and the family would be contacted to determine if the resident was appropriate for the facility. _____ The facility failed to provide supervision to residents including a resident who was intermittently disoriented, had a diagnosis of dementia, a history of falls, and used a wheelchair for ambulation which resulted in the resident having 13 falls in three months with injuries including an abrasion, complaints of pain	D 270		

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D 270	Continued From page 46 in her neck, legs, upper back, and hand, and one hospital visit which diagnosed a closed head injury and a left shoulder bruise (#3); a resident who was constantly disoriented and had a diagnosis of dementia which resulted in the resident having 11 falls in 3 months and injuries including a scratch on her right elbow, bruising to her nose and face, redness under her right eye, a nosebleed, abrasions to her knees, and one hospitalization (#5); and a resident who was constantly disoriented and had a diagnosis of dementia with 21 falls in five months, one hospital visit for stitches on her head, and injuries including bruises to her right eye, left cheek, and left arm, carpet burns on the left side of her face, carpet burn to her face, an abrasion under her left eye, skin tears to her left cheek and left arm, a black eye, a welt on her cheek, and a cut on her lip (#1). This failure placed residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 13, 2021.	D 270		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the	D 612		

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communicable disease
outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health
department, the specific guidance or directives shall be implemented by the facility.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to notifying the local health department for 2 staff members who tested positive for Covid-19 and weekly testing of residents and staff.

The findings are:

Review of the CDC guidelines dated 03/29/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed:
-A strong infection prevention and control program is critical to protect both residents and healthcare personnel.
-Notify the health department promptly for greater than or equal to one resident or health care personnel (HCP) with suspected or confirmed SARS-CoV-2 infection (including Covid-19).

Review of the updated CDC guidelines dated 04/27/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed:
-Anyone with symptoms of Covid-19, regardless

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of vaccination status, should receive a viral test immediately.
-In healthcare facilities with an outbreak of SARS-CoV-2, recommendations for viral testing HCP, and residents (regardless of vaccination status) remain unchanged.
-In nursing homes with an outbreak of SARS-CoV-2, HCP and residents, regardless of vaccination status, should have a viral test every 3 to 7 days until no new cases are identified for 14 days.

Review of the NC DHHS guidelines dated 05/05/21 for the prevention and spread of the Coronavirus Disease in LTC facilities revealed if a new case of Covid-19 is identified among residents or staff the facility should immediately conduct outbreak testing per the Centers for Medicaid and Medicare Services (CMS) guidance revised 04/27/21 stating -In nursing homes with an outbreak of SARS-CoV-2, HCP and residents, regardless of vaccination status, should have a viral test every 3 to 7 days until the testing identifies no new cases for 14 days since the newest positive case of Covid-19 was identified.

Review of the facility's Infection Control (COVID-19) policy dated January 2021 revealed:
-The purpose of the policy was for guideline on infection prevention and control of outbreaks.
-The policy was to put in place a process to update policy and procedure to reflect new guideline as may be recommended by CDC and local health departments during a declared health emergency.

Telephone interview with the facility's contracted Pharmacy Consultant on 09/10/21 at 11:05am revealed:
-She was scheduled for an onsite pharmacy

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review in August 2021.
-She visited the facility on 08/24/21 and was informed the facility had 2 staff with reported cases of Covid-19.
-She conducted the Quarterly Pharmacy review for August 2021 off site per her company policy and temporary regulations.

Telephone interview with the head communicable disease nurse with the local health department on 09/10/21 at 1:27pm revealed:
-There had not been any reports of staff who tested positive for Covid-19 in August 2021.
-If two staff tested positive for Covid-19 within the month of August 2021, it would be considered an outbreak and it should have been reported to the local health department.
-The local health department staff would have recommended the facility test staff and residents weekly until no residents or staff tested positive for Covid-19 for 14 days.
-The facility should have also let the local department of social services know of any positive cases of Covid-19.

Telephone interview with a staff with the local department of social services on 09/10/21 at 1:33pm revealed the facility had not reported to her any positive cases of Covid-19 in August 2021.

Interview with the Resident Care Director (RCD) on 09/10/21 at 4:20pm revealed:
-There was a staff who reported to work on 08/11/21 for the 7:00am to 3:00pm shift on the 400 hall of the secure memory care unit and was not feeling well.
-He tested the staff onsite for Covid-19 and the rapid test result was negative, but the staff went home early from work.

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D 612	Continued From page 50 -The staff retested on her own on 08/13/21 and reported a positive result for Covid-19 to the RCD on 08/13/21. -The last day the staff worked at the facility was 08/11/21 until 10 days had passed per the facility's policy on staff returning from work due to Covid-19 quarantine. -He was not familiar with all the recommendations of the CDC, CMS and NC DHHS. -The facility had a corporate staff to whom he was responsible to report any positive Covid-19 results and receive guidance. -He reported the staff was positive for Covid-19 to the Senior Director of Quality and Education per the facility's Covid-19 policy. -He was told (not sure by whom) if residents and staff were asymptomatic and were vaccinated, he did not need to test residents and staff for one positive reported Covid-19 case. -He did not receive response for guidance testing of staff or residents. -He did not test any residents or staff for Covid-19. -He had not reported the 08/13/21 case to the health department because that would be up to the Senior Director of Quality and Education or Director of Quality and Education. Interview with a dayshift medication aide/Supervisor (MAS) on 09/10/21 at 4:25pm revealed: -She knew one staff tested positive for Covid-19 in August 2021. -She had not been tested for Covid-19 by the facility in July 2021, August 2021, or September 2021. -The residents had not been tested as a group for Covid-19 in July 2021, August 2021, or September 2021.	D 612		

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(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 612	Continued From page 51 Telephone interview with a second medication aide on 09/13/21 at 1:12pm revealed: -She routinely works third shift. -She felt sick and was tested for Covid-19 by the RCD on 07/27/21 or 07/28/21. -She worked 07/29/21 night shift, but she felt weak the morning of 07/30/21. -She was off on night of 07/30/21, called out on 07/31/21, and went to a local emergency room on 08/01/21 for a Covid-19 test. -She received positive Covid-19 on 08/01/21. -She informed the RCD she was positive for Covid-19 on 08/01/21 via text message. -She was out of work for positive Covid-19 from 07/29/21 to 08/12/21. -She knew about at least one other staff testing positive for Covid-19 since 08/12/21. -As far as she knew, no resident or staff had been tested for Covid-19 since she tested positive. Telephone interview the Administrator on 09/13/21 at 3:16pm revealed: -The facility did not currently have a staff or resident with positive Covid-19 test results. -She knew 2 staff tested positive for Covid-19, one in late July 2021, and one in mid-August 2021. -There were not 2 staff with positive Covid-19 test results within 10 days of each other. -The facility's Covid-19 policy was not specific to testing requirements for staff and residents after one known positive Covid-19 test result was provided to the facility. -She thought 2 positive Covid-19 test results constituted an outbreak of Covid-19. -If one staff tested positive today and one tested positive tomorrow, the facility should inform the Senior Director of Quality and Education or	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092204	A. BUILDING: _____ B. WING _____	C 09/13/2021

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D 612	Continued From page 52	D 612		

Director of Quality and Education and the local health department.
-She would interview staff who worked in the area with the positive staff, and test residents that had exposure to the staff or resident that tested positive.
-She had not consulted the local health department of guidance regarding one staff testing positive for Covid-19 because she was not aware of the most recent guidelines for one case being reported to the health department.

Telephone interview with the Senior Director of Quality and Education from the corporate office on 09/13/21 at 3:38pm revealed:
-The RCD reported the cases of positive Covid-19 at the facility correctly to the Senior Director of Quality and Education via electronic mail per facility Covid-19 policy.
-The RCD would not be responsible to test all residents or staff unless directed to do so by the Senior Director of Quality and Education.
-She thought the health department was routinely notified and residents along with staff tested for an outbreak of Covid-19 when 2 or more positive Covid-19 test results were reported at the same time.

Telephone interview with the Director of Quality and Education on 09/13/21 at 4:45pm revealed:
-She and her department of 3 other staff were responsible to track and provide guidance for the RCDs in the corporation's facilities.
-She was made aware of the Covid-19 positive test results in the facility by the RCD.
-The local health department should have been contacted for guidance and residents along with staff tested for Covid-19 after the first staff had positive results on 08/03/21.
-It was an oversight on her part that the health

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D 612	Continued From page 53 department was not notified and the RCD was not advised to begin weekly testing for the staff and residents according to the latest CDC and NC DHHS guidelines.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 5 residents sampled (#1, #3, #5) including a resident who had thirteen falls resulting in injuries and one emergency room (ER) visit (#3), a resident who had 11 falls resulting in injuries and one hospitalization (#5), and a resident who had twenty one falls resulting in injuries and one ER visit (#1). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).].	D912		