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D 000	Initial Comments The Adult Care Licensure Section and the Richmond County Department of Social Services conducted an annual and follow up survey and a complaint investigation on 12/01/21 - 12/03/21.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures at 11 of 13 fixtures accessible to residents were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F which included sink and shower fixtures within in residents' rooms and the common bathroom in the Special Care Unit (SCU) where residents showered. The findings are: Review of the facility's current license effective 01/01/21 through 12/31/21 revealed the facility was licensed for a capacity of 114 beds including a 54-bed Special Care Unit (SCU). Review of the facility's census report dated	D 113		

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12/01/21 revealed:
-There were 40 residents residing in the SCU.
-There were 42 residents residing in the assisted living (AL) section of the facility.
-The total census was 82 residents.

Review of a facility's hot water temperature records dated 09/14/21 through 11/23/21 revealed:
-On 11/23/21, it was documented for the left hallway of the SCU "out of order will be here between 11/29/21-12/03/21."
-There was no documentation hot water temperatures were checked at the applicable 6 fixtures in both common bathroom on the left and right hallways of the SCU from 09/23/21 to 11/23/21.

Observations in the SCU on 12/01/21 at 9:47am revealed:
-The SCU was divided into 2 different hallways.
-There were 20 residents on the right side of the hallway.
-There were 20 residents on the left side of the hallway.
-Each side of the SCU had a common bath with a sink, a bathtub, and a shower.
-A resident's room located on the left hallway of the SCU, the hot water temperature at the sink and the shower fixture was 70 degrees F.
-A resident's room located on the left hallway of the SCU, the hot water temperature at the sink fixture was 89 degrees F and the hot water temperature at the shower fixture was 77 degrees F.
-In two residents' rooms located on the left hallway of the SCU, the hot water at the sink fixture would not come out of the sink fixture when turned to on position.
-A resident's room located on the left hallway, the

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hot water temperature at the shower fixture was 70 degrees F.
-A resident's room located on the left hallway, the hot water temperature at the shower fixture was 79 degrees F.
-In the common bathroom on the left hallway, the hot water temperature at the sink fixture was 68 degrees F and the hot water temperature at the shower fixture was 80 degrees F.
-In the common bathroom on the right hallway,the hot water temperature at the shower fixture was 81 degrees F.

Interview with a resident who resided on the left hallway of the SCU on 12/01/21 at 10:00am revealed the shower was "always" cold, and she would take a sponge bath at her sink within her room.

Observation in the SCU on the right hallway on 12/01/21 at 10:32am revealed the door to the common bathroom on the right side of the SCU was closed to a resident receiving a shower.

Interview with a personal care aide (PCA) on 12/01/21 at 10:35am revealed:
-The hot water heater on the left side of the SCU was out of order, she was not sure how long this had been in place.
-For residents who resided on the left side of the SCU, she would assist them to the shower in the common bathroom on the right side of the SCU hallway.
-For residents who resided on the left side of the SCU who received a bed bath, she would obtain hot water from the common bathroom on the right side of the SCU hallway to the residents' rooms.
-She did not receive any complaints from the residents who resided on the left side of the SCU who received a shower/bed bath in the SCU

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D 113	Continued From page 3 today that the water was cold. Interview with the Special Care Unit Coordinator (SCUC) on 12/01/21 at 10:54am revealed: -The hot water heater on the left side of the SCU was classified as out of order around the end of November 2021 when the pilot light would not stay lit. -A new hot water heater had been ordered and was due to arrive any day. -The PCAs would check the water temperatures in the common bathroom on the right hallway before assisting residents with bed bath or a shower. -She received complaints today, 12/01/21, from staff and residents that the water temperature was cold. Interview with the Administrator on 12/01/21 at 12:44pm revealed: -The hot water heater on the left side of the SCU was non-operational. -The new hot water heater was expected to arrive at the facility between 11/30/21-12/03/21. -There were not any water temperatures from the right hallway of the SCU that had been reported to her. -She was not aware the hot water temperature at the shower fixture was 81 degrees F in the common bathroom on the right side of the SCU. -She would have expected to receive notification from the Maintenance Director as soon as the abnormal water temperature was discovered. -She would have expected to the Maintenance Director to troubleshoot the abnormal water temperature upon discovery also. Observation in the SCU on the right hallway on 12/02/21 at 10:44am revealed the hot water temperature at the shower fixture in the common	D 113		

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bathroom was 81 degrees F.

Interview with the Administrator on 12/02/21 at 4:25pm revealed she was not aware the shower in the common bathroom on the right hallway of the SCU hallway was 81 degrees F.

Second interview with a PCA on 12/02/21 at 4:52pm revealed:
-The residents who received showers today in the SCU were showered in the common bathroom on the right side of the SCU hallway.
-She was not sure how many residents received a shower in the SCU today.
-Residents who she assisted today with a shower voiced complaints the shower was "too hot."
-The shower water did not feel cold to her.

Interview with the Maintenance Director on 12/03/21 at 12:14pm revealed:
-There were two hot water heaters on the SCU.
-One hot water heater provided hot water to the right side and the other hot water provided to the left side of the SCU.
-Around 11/24/21, he had received complaints via the Administrator, the water on left side of the SCU was cold.
-He attempted to re-light the pilot light of the hot water heater on the left side of the SCU, but the pilot light would not stay lit.
-When he was trouble-shooting the pilot light of the hot water heater on the left side of the SCU, he noticed water was leaking from the hot water heater and the bottom pan was rusted out.
-The findings were reported to the Administrator, and a discussion with the recommendation to purchase a new hot water heater was had the same day.
-The hot water heater for left side of the SCU had arrived yesterday, 12/02/21, and would be

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D 113	Continued From page 5 installed by a plumber on Tuesday, 12/07/21. -The water temperatures on each side of the SCU were monitored weekly by him. -Three rooms on each side of the SCU were checked and documented on the water temperature logs. -He thought he had checked water temperatures for both common bathrooms, but he did not document the temperatures on the water temperature logs. -Today, 12/03/21, the water temperatures in the SCU in the common bathroom on the right side where residents showered until the hot water heater would be replaced was 101.8 F. -When he turned the shower fixture on, it was not turned all the way to the right and that was how the water temperature of 101.8 F was obtained. -It was important for the water temperatures to be maintained between 100 F and 116 F, each resident deserved to have warm water when they showered or bathed; they deserved to feel clean.	D 113		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four	D 188		

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additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)
(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure the required staffing hours for the assisted living (AL) unit with a census of 40 residents were met for 10 of 18 shifts sampled from 10/22/21, 10/26/21, 10/30/21-10/31/21, and 11/06/21-11/07/21.

The findings are:

Review of the facility's current license effective 01/01/21 through 12/31/21 revealed the facility

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was licensed for a capacity of 114 beds including an assisted living (AL) unit with a capacity of 64 beds.

a. Review of the facility's census report dated 12/01/21 revealed there were 40 residents who resided in the AL unit on 10/26/21, which required 16 staff hours on first, second, and third shifts.

Review of individual time sheets dated 10/26/21 revealed there were 8.15 staff hours provided on first shift, leaving the shift short 7.85 hours.

Review of individual time sheets dated 10/26/21 revealed there were 7.9 staff hours provided on second shift, leaving the shift short 8.1 hours.

b. Review of the facility's census report dated 12/01/21 revealed there were 40 residents who resided in the AL unit on 10/30/21, which required 16 staff hours on first, second, and third shifts.

Review of individual time sheets dated 10/30/21 revealed there were 13.22 staff hours provided on second shift, leaving the shift short 2.78 hours.

Review of individual time sheets dated 10/30/21 revealed there were 2.0 staff hours provided on third shift, leaving the shift short 14.0 hours.

c. Review of the facility's census report dated 12/01/21 revealed there were 40 residents who resided in the AL unit on 10/31/21, which required 16 staff hours on first, second, and third shifts.

Review of individual time sheets dated 10/31/21 revealed there were 8.63 staff hours provided on third shift, leaving the shift short 7.37 hours.

d. Review of the facility's census report dated

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12/01/21 revealed there were 40 residents who resided in the AL unit on 11/06/21, which required 16 staff hours on first, second, and third shifts.

Review of individual time sheets dated 11/06/21 revealed there were 0.0 staff hours provided on first shift, leaving the shift short 16.0 hours.

Review of individual time sheets dated 11/06/21 revealed there were 4.8 staff hours provided on second shift, leaving the shift short 11.72 hours.

Review of individual time sheets dated 11/06/21 revealed there were 2.0 staff hours provided on third shift, leaving the shift short 14.0 hours.

e. Review of the facility's census report dated 12/01/21 revealed there were 40 residents admitted to the AL unit on 11/07/21, which required 16 staff hours on first, second, and third shifts.

Review of individual time sheets dated 11/07/21 revealed there were 10.55 staff hours provided on first shift, leaving the shift short 5.45 hours.

Review of individual time sheets dated 11/07/21 revealed there were 12.3 staff hours provided on second shift, leaving the shift short 3.7 hours.

Interview with an AL resident on 12/01/21 at 10:10 am revealed:
-Staff were frequently unable to answer call lights within an hour, but she was unable to recall a specific date.
-Staff were frequently unable to assist her with showering more than one time each week, but she was unable to recall a specific date.

Interview with a second AL resident on 12/01/21

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at 10:29 am revealed staff did not answer her calls for assistance on multiple occasions, but she did not remember the dates and times.

Interview with a third AL resident on 12/01/21 at 10:42 am revealed:
-Staff answered calls for assistance thirty minutes to an hour after the resident used the call button.
-Staff was always in a rush to assist him, which made him feel belittled.

Interview with a forth AL resident on 12/01/21 at 11:00 am revealed she was concerned for her safety because staff did not always come when she called for assistance.

Interview with a fifth AL resident on 12/01/21 at 11:00 am revealed staff frequently rushed through her care needs which caused them to handle her in a rough manner.

Interview with a sixth AL resident on 12/01/21 at 11:10 am revealed she frequently did her own "bird baths" in her sink because there was not enough staff to help her with showering.

Interview with the Administrator on 12/03/21 at 5:30pm revealed:
-The facility had intermittently been short staffed since September 2021.
-She had switched to 12 hour shifts to ensure staff coverage for both the AL and SCU.
-She offered 8 hour shifts for staff who could not work 12 hours.
-The facility has provided staff with incentives to ensure staffing.
-She allowed staff to sometimes bring their children to work with them just to ensure staff coverage.

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D 188	Continued From page 10 -Some staff would even work double shifts to include 24 hour and 36-hour shifts. -Administrative staff (she, the Administrative Assistant, Resident Care Director (RCD), and Special Care Unit Coordinator (SCUC) would take call 7 days in a row, starting at 5:00pm every Friday through 5:00pm the following Friday, rotating weeks. -All administrative staff were cross trained as MAs and PCAs. -She did not have a copy of the administrative on call scheduled. -She last staffed a 12 hour shift the first week of November 2021. -The SCUC last staffed a 12 hour shift the first week of November 2021. -The MA would call the administrative staff on call when there were staff call outs for the AL and/or SCU. -The on call administrative staff would attempt to find coverage. -If staff coverage could not be found, the on call administrative staff would provide staff coverage for the AL and/or SCU. -The facility transporter was also a PCA and would staff at times. -She last used a staffing agency in October 2020 and had full staff coverage at that time. -She had not used a staffing agency since. -She last spoke with corporate management regarding staffing on 11/29/21. -They discussed the status of applicants and the response from potential hires to an online staffing website. -She completed the staff scheduled at the beginning of every month and would revise as needed such as call outs or when staff quit. -She tried to review the staff schedule every day to ensure the facility was not short staffed.	D 188		

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D 270	Continued From page 11	D 270		
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 review the facility failed to provide supervision in accordance with the residents' assessed needs for 4 of 12 sampled residents (#8, #9, #10, #12) who resided in the Special Care Unit and sustained unwitnessed falls (#8, #9, #10, #12) and eloped from the facility (#12). The findings are: Review of the facility's policies revealed there was no falls or supervision policy. Interview with the Administrator on 12/02/21 at 10:51am revealed: -The facility did not have a falls policy. -Fall assessments were not performed on resident at all. -There were no residents who resided in the SCU who required increased supervision. -She expected staff to perform routine every 2-hour rounds on residents in the SCU. -During every 2-hour rounding she expected staff to visually see what the residents were doing. -Residents who were in gerichairs with a tabletop,	D 270		

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full bed rails, and geri-tents were expected to have increased supervision to every 15 minutes.
-She expected resident supervision to be documented in the activities of daily living (ADL) log and the supervisor 24-hour communication book.

Interview with the medication aide/supervisor (MA/S) on 12/03/21 at 11:00am revealed:
-She would report to the oncoming shift if residents were a fall risk and or had unsteady gait.
-Some residents who fell were placed on every 15-minute supervision for 24 hours.
-If a resident fell and had an unsteady gait after the fall the resident was placed on every 15-minute supervision.
-It was left up to staff to determine if a resident needed every 15-minute supervision or not.
-Every 15-minute supervision checks were documented in the supervisor 24 hour log book.
-The facility did not have a supervision or falls policy.
-She had never discussed or expressed any SCU resident falls with the Administrator.

Telephone interview with a second MA/S on 12/03/21 at 11:53am revealed:
-Residents who were fall risks should be supervised every 15 minutes by all staff.
-Residents who had falls were to be placed on 15-minute supervision checks after the fall for one week.
-Increased supervision was to be documented in the 24-hour supervisor book.
-The falls documentation was to be documented in the 24-hour supervisor log.

1. Review of Resident #8's current FL-2 dated 09/20/21 revealed:

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-Diagnoses included dementia, atherosclerotic heart disease of native coronary artery, and congestive heart failure.
-She was a resident in the Special Care Unit (SCU).
-She was intermittently disoriented.
-She required staff assistance with bathing and dressing.
-She was ambulatory without an assistive device indicated.

Review of Resident #8's plan of care dated 11/01/21 revealed:
-She required total assistance with toileting.
-She required extensive assistance with ambulation, dressing, grooming, and transfers.

Review of Resident #8's incident/accident (I/A) report dated 10/04/21 at 8:50pm revealed:
-Resident #8 was found lying on the floor in the dayroom.
-There was documentation of a hematoma/bruise to the resident's face/forehead.
-There was documentation of Resident #8 having an unusual occurrence of constantly walking.
-She had a bruise to her face.
-Her treatment documented was observation.

Review of Resident #8's nurse's notes dated 10/04/21 revealed:
-On 8:50 pm, Resident # 8 was found on the floor in the common area after a day of constant walking.
-Resident #8's family, doctor, and hospice services were notified, and hospice will be checking Resident #8.
-Hospice assessed Resident #8 at 10:50 pm on 10/04/21.Interview with the Administrator on 12/02/21 at 10:51am revealed:
-Resident #8 resided at the facility for about 3

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weeks.
-Resident #8 was ambulatory with a walker.
-The facility did not initiate fall interventions for Resident #8.
-There was no reason why.

Interview with the MA/S on 12/03/21 at 11:00am revealed:
-Resident #8 ambulated with a walker and had an unsteady gait when using the walker.
-Resident #8 was a falls risk because she had an unsteady gait even with the walker.
-The facility did not initiate any fall risk interventions for Resident #8.
-Resident #8 was never on increased supervision.
-Resident #8 was supervised every 2 hours to make sure her incontinent brief was dry and to see if she needed help getting up.
-She could not remember how many falls Resident #8 sustained while in the SCU.

Telephone interview with a second MA/S on 12/03/21 at 11:53am revealed:
-She did not remember Resident #8's unwitnessed fall on 10/04/21.
-Resident #8 was a fall risk on admission.
-There were no fall interventions in place for Resident #8 while at the facility.
-She did not know why.
-Resident #8 was not increased staff supervision.

Review of Resident #8's I/A report dated 10/17/21 at 5:30am revealed:
-Resident #8 was found lying on the floor in another resident's room.
-There was documentation Resident #8 sustained a head injury.
-The type of head injury was not documented.
-Her treatment documented was hospital.

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D 270	Continued From page 15 Review of Resident 8's progress notes dated 10/17/21 revealed: -At 6:00am Resident #8 was found on the floor in another resident's room and later sent to the local emergency room after contact with hospice. -Resident #8 returned on 10/17/21 with a glued laceration on an undisclosed location. Review of Resident #8's local hospital emergency department notes dated 10/17/21 revealed: -Diagnoses included fall, head injury, laceration of scalp. -Resident #8 was treated due to a head injury sustained during a fall. -The fall was unwitnessed at the facility. -Resident #8 had a 1.5-centimeter laceration with swelling located to the back-right side of her head. -Resident #8's laceration was repaired using tissue adhesive. Telephone interview with Resident #8's hospice nurse on 12/03/21 at 1:55pm revealed: -The facility called the on-call service at 5:11am on 10/17/21 to notify that Resident #8 had a fall with a head injury. -Resident #8 was bleeding from her head. -She sent Resident #8 to the hospital for medical evaluation. -If a resident had a fall, was alert and oriented, answered questions appropriately and denied pain she expected the facility to call hospice before sending to the hospital for medical evaluation. Review of Resident #8's I/A report dated 10/22/21 at 5:30pm revealed: -Resident #8 was found lying on the floor in the TV room on her left face.	D 270		

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-Resident #8 had "slobber" coming from her mouth.
-Resident #8 "was not responding well".
-Resident #8's left eye was swollen and black.
-There was documentation of a facial injury with a hematoma/bruise.
-There was documentation Resident #8's family called for emergency medical services (EMS).
-There was documentation Resident #8 was admitted to the hospital due to facial fractures and a urinary tract infection (UTI).

Review of Resident 8's progress notes dated 10/22/21 revealed:
-At 5:40 pm, Resident #8 was found on the floor in the common area laying on her right side with swelling and blackness to her right eye.
-Resident #8 was drooling and not responding.
-Hospice and family were contacted.
-Staff remained with Resident #8 who began mumbling.
-Family contacted emergency medical services.
-EMS arrived and transported Resident #8 to the local hospital.

Review of Resident #8's local hospital discharge summary dated 10/24/21 revealed:
-Resident #8 was admitted from 10/22/21 to 10/21/21.
-Diagnoses head injury, orbital fractures, facial fractures, falls, and urinary tract infection.
-Resident #8 was admitted due to "significant" orbital and facial fractures sustained from to a fall while at the facility.
-Physical exam on discharge revealed ecchymosis to the left face with yellowing on the edges.
-The resident as discharged home on hospice.

Interview with the Administrator on 12/02/21 at

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D 270	Continued From page 17 10:51am revealed: -She reviewed video surveillance of the fall Resident #8 sustained on 10/22/21. -Resident #8 was in the SCU television room unsupervised when she fell. -Resident #8 stood and tripped over her feet falling on her face. -Resident #8 had eye swelling and discoloration after the fall. -She videoed with her cell phone the video surveillance of Resident #8's 10/22/21 fall. Review of a video of Resident #8 provided by the Administrator on 12/03/21 revealed: -There was a timestamp date of 10/22/21 at 5:35pm. -Resident #8 was unsupervised in the SCU day room. -Resident #8 stumbled backwards with a walker. -Resident #8 fell on her left side striking her left face on the floor. Interview with a personal care aide (PCA) on 12/03/21 at 9:34am revealed: -She walked into the Veranda room to escort another resident outside to smoke. -She saw Resident #8 lying face down on her left side on the floor. -She and another staff rolled Resident #8 to her back. -Resident #8 was not unresponsive. -She palpated Resident #8's body and she complained of neck pain. -The side of Resident #8's left eye and her left cheek bone were swollen and purple. -Resident #8 had facial grimace and would try to move away when touched. Interview with the MA/S on 12/03/21 at 11:00am revealed:	D 270		

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D 270	Continued From page 18 -On 10/22/21, around 5:00 to 6:30pm, Resident #8 was sitting on the couch in the day room with her walker in front of her. -She was passing medications when staff called out to her Resident #8 was on the floor in the day room. -When she arrived to the day room on 10/22/21, Resident #8 was laying on her left side face down. -She rolled Resident #8 on her back. -Resident #8's left eye was swollen. -Resident #8 tried to speak but her speech was slurred. -Normally Resident #8 could speak well and follow commands. -The resident reported head and eye pain when asked. -The facility did not put any fall interventions such as increased supervision in place for Resident #8 between her first fall on 10/04/21 through her last fall on 10/22/21. -There was no reason why. Review of Resident #8's I/A report dated 10/07/21 at 12:00am revealed: -Resident #8 was found lying on the floor in her room during shift change. -There was documentation Resident #8 had a head injury. -The type of injury was not documented. -The section to document vital signs was blank. -Her treatment documented was observation. Requests for the 24 hour supervisor logbook was not provided by survey exit 12/03/21. Attempted interview with Resident #8's PCP on 12/03/21 at 11:45am was unsuccessful. 2. Review of Resident #12's FL-2 dated 11/01/21	D 270		

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revealed:
-Diagnoses included vascular dementia, non-traumatic subcortical hemorrhage of right cerebral hemisphere, and type 2 diabetes mellitus with diabetic polyneuropathy without long term insulin.
-He was a resident in the Special Care Unit (SCU).
-He required personal care assistance with bathing and dressing.
-He was semi-ambulatory.

Review of Resident #12's plan of care dated 11/01/21 revealed:
-He had wandering behaviors and resisted care.
-He was ambulatory with assist or a device.
-Resident #12 was totally dependent on staff for toileting and bathing.
-Resident #12 required extensive staff assistance with ambulation, dressing, grooming, and transfer.

Review of Resident #12's physician order dated 11/01/21 revealed there was an order for a wheelchair seatbelt.

Observation of Resident #12 on 12/01/21 at 09:27 am revealed:
-Resident #12 was self-propelling in a wheelchair.
-Resident #12 was wearing a hospital band with date of service 12/01/21.
-There was bruising on Resident #12's right arm.
-Resident #12 was not wearing the wheelchair seatbelt.

Review of Resident #12's I/A report dated 10/29/21 at 3:00pm revealed:
-He reported he was attempting to independently transfer from his wheelchair to his bed when he fell.

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-He was documented as disoriented.
-He had skin tears on his left elbow.
-First aid was provided by the staff.
-The incident was not witnessed by staff.
-The I/A report was faxed to the resident's PCP on 10/29/21 at 3:30pm.
-His family member was notified on 10/29/21 at 3:30pm.
-The report was signed by his PCP on 11/08/21.

Interview with the MA/S on 12/03/21 at 11:00am revealed:
-She complete Resident #12's I/A report dated 10/29/21.
-Resident #12 sustained an unwitnessed fall on 10/29/21.
-Staff heard Resident #12 fall in his room.
-Resident #12 was sitting on the floor between his bed and transfer chair.
-Resident #12 had a skin tear to his right elbow.
-She assisted Resident #12 off the floor.
-She cleaned Resident #12's wounds.
-She faxed Resident #12's PCP the I/A report.
-Resident #12 was not placed on fall interventions or increased supervision after the 10/29/21 fall.

Review of Resident #12's I/A report dated 11/01/21 at 9:30am revealed:
-He fell out of his chair in the hallway.
-He had skin tears on his left forearm, right arm and left finger.
-First aid was provided by the staff.
-The incident was not witnessed by staff.
-A copy of the I/A report was faxed to his PCP on 11/01/21 at 2:00pm.
-His family member was notified of the occurrence on 11/01/21 at 10:15am.
-The report was signed by his PCP on 11/08/21.

Review of Resident 12's progress notes dated

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D 270	Continued From page 21 10/26/21 revealed: -Resident #12 fell out of his wheelchair at which time he reopened old wounds as well as caused new wounds. -Resident #12 received in house first aide for these wounds. -The time was documented as 9:30am. Interview with the MA/S on 12/03/21 at 11:00am revealed: -Resident #12 sustained an unwitnessed fall on 11/01/21. -Resident #12 was sitting in the doorway of the SCU dining room trying to get up. -Resident #12 had skin tears to his elbows. -She assisted Resident #12 off the floor. -She cleaned Resident #12's wounds. -She faxed Resident #12's PCP the I/A report. -There was no increased supervision initiated for Resident #12 after the 11/01/21 fall. Review of Resident #12's I/A report dated 11/07/21 at 11:40am revealed: -He was found in the SCU courtyard where he fell into the fence while in his wheelchair. -He was alert and had skin tear injuries to his head, face, right elbow, and finger. -He was bleeding and had a knot on his head. -The resident was transported to the hospital. -The I/A was not witnessed by staff. -A copy of the I/A report was faxed to his PCP on 11/07/21 at 11:40am. -His family member was notified of the I/A on 11/07/21 at 11:40am. -The DSS was documented as notified of the I/A on 11/08/21 at 10:37am via email. -The resident's PCP signed the report on 11/08/21. Review of Resident #12's progress notes dated	D 270		

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D 270	Continued From page 22 11/07/21 revealed: -There was documentation Resident #12 fell out of his wheelchair, hitting a fence, outside of the building at which time he sustained injury to their nose, right eye, right arm and left finger. -Resident #12 was sent to the local emergency room. -The time was documented at 11:40am. Review of Resident #12's local hospital emergency department (ED) visit note dated 11/07/21 revealed: -The resident arrived at 12:33pm with a chief complaint of a head injury. -Diagnoses included abrasions of multiple sites. -The resident rolled himself out the door and down a ramp, lost control of the wheelchair, and rolled down the hill and struck a fence while in the wheelchair at the bottom of the hill. -The length of travel was 20 to 30 feet. -The resident remained in the wheelchair. -The resident had scattered abrasions to his face and right arm. Interview with the MA/S on 12/03/21 at 11:00am revealed: -Resident #12 fell in the SCU courtyard while unsupervised on 11/07/21. -Staff saw Resident #12 walking up the ramp alone. -Resident #12's transfer chair was at the bottom of the ramp in the courtyard. -Resident #12 was bleeding from his nose and face and his left elbow was scrapped. -She cleaned and dressed Resident #12's wounds. -She faxed Resident #12's PCP the I/A report. -Resident #12 was transported to the hospital by EMS. -There were no fall interventions or increased	D 270		

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supervision initiated for Resident #12 after the 11/07/21 fall.
-There was no reason why.

Review of Resident #12's I/A report dated 11/11/21 at 4:30pm revealed:
-He was found lying on the floor in the doorway of another resident's room.
-He was disoriented.
-No injuries were documented.
-There were no documentation vital signs were obtained by staff.
-The I/A was unwitnessed by staff.
-A copy of the I/A report was faxed to his PCP on 11/11/21 at 4:50pm.
-His family member was notified of the I/A on 11/11/21 at 4:45pm.
-His PCP signed the report on 11/22/21.

Review of Resident #12's progress notes dated 11/11/21 revealed:
-Resident #12 was found on the floor in another resident's room.
-The resident had no complaints of pain and no visible injury.
-The time was documented at 4:30pm.

Interview with the MA/S on 12/03/21 at 11:00am revealed:
-She complete Resident #12's I/A report dated 11/11/21.
-She was told by another staff member Resident #12 had an unwitnessed fall.
-She walked in to find Resident #12 sitting in the floor of another resident's room.
-Resident #12 did not have any visible injuries.
-There were no fall interventions or increased supervision checks for Resident #12.
-Resident #12's PCP was faxed the I/A report.

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D 270	Continued From page 24 Review of Resident #12's I/A report dated 11/12/21 at 6:35pm revealed: -He was found on the floor kneeling across his bed. -He was disoriented. -The I/A was witnessed by two other residents who were assisting Resident #12 into bed at the time of the fall. -The I/A was not witnessed by staff. -The resident did not complain of pain or injury. -There was documentation Resident #12 refused vital signs. -A copy of the I/A report was faxed to his PCP on 11/12/21 at 7:00pm. -His family member was notified on 11/12/21 at 7:00pm. -His PCP signed the report on 11/15/21. Interview with the MA/S on 12/03/21 at 11:00am revealed: -She complete Resident #12's I/A report dated 11/29/21 -On 11/12/21, she was told by staff Resident #12 had an unwitnessed fall in his room. -She walked in to find Resident #12 laying across the side of his bed with his knees on the floor. -She faxed Resident 12's PCP an I/A report. -There were no fall interventions or increased supervision in place for Resident #12 after the fall. Review of Resident #12's I/A report dated 11/29/21 at 9:45am revealed: -He was found on the floor in the SCU day room. -He was disoriented and did not know what happened. -There was documentation Resident #12 refused staff to obtain vital signs. -The I/A was not documented as witnessed by staff.	D 270		

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-The I/A was documented as witnessed by two residents.
-His left toenail, specific digit not specified, was torn and bleeding.
-The SCU staff provided first-aid by applying a bandage.
-His PCP was notified of the I/A in person on 11/29/21 at 10:00am.
-The resident's family member was notified of the I/A on 11/29/21 at 10:05am.
-The report was signed by his PCP on 11/29/21.

Interview with the MA/S on 12/03/21 at 11:00am revealed:
-Resident #12 was ambulatory with a transfer chair (combines the function of a wheelchair with portability of a rollator, meant to be pushed by a caregiver as small wheels make it impossible to self-propel) and a walker.
-Sometimes Resident #12 would hold on to the transfer chair handles to walk instead of using the walker.
-She complete Resident #12's I/A report dated 11/29/21.
-On 11/29/21, she heard a loud noise in the SCU day room.
-She walked in to find Resident #12 on the floor by his transfer chair trying to get up.
-She assisted Resident #12 to the couch.
-Resident #12 had a cut to his left third toe.
-She placed a bandage on the resident's toe.
-She faxed Resident #12's PCP the I/A report.
-There were no fall interventions or increased supervision in place for the Resident #12.

Review of Resident #12's I/A report dated 10/26/21 at 11:00am revealed:
-He was found on the floor of his room, wrapped up in a cover, and alert.
-He had skin tear injuries on his right elbow and

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right hand.
-First aid was provided by staff.
-The I/A was not witnessed by staff.
-The report was faxed to his PCP on 10/26/21 at 12:00pm.
-His family member was notified on 10/26/21 at 11:30am.
-The Department of Social Services was notified on 10/28/21 at 8:50 am.
-His PCP signed the report on 11/08/21.

Review of Resident #12's I/A report dated 12/01/21 at 4:55am revealed:
-He was found by a PCA alert and laying down in his room.
-The PCA observed swelling of his face but did not indicate the location on his face.
-The cause of Resident #12's facial swelling was not documented.
-There was documentation vital signs were not obtained.
-The I/A was not witnessed by staff.
-The resident was transported to the hospital.
-A copy of the report was faxed to his PCP on 12/01/21 at 5:07am.
-His family member was notified of the I/A on 12/01/21 at 5:07am.
-The Administrator was notified of the I/A on 12/01/21 at 9:00am.
-The report was not signed by his PCP.

b. Interview with a PCA on 12/03/21 at 9:34am revealed:
-Resident #12 was in the SCU courtyard.
-She was in the kitchen assisting with dinner and saw Resident #12 outside the facility by the trash cans through the kitchen windows on 11/28/21 just before 6:00pm.
-Resident #12 was unsupervised.

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Interview with the Administrator on 12/03/21 at 5:26pm revealed:
-Resident #12 was in the SCU courtyard on 11/28/21, unattended.
-There was no staff in the courtyard on 11/28/21 with Resident #12.
-Resident #12 lifted the cover to the courtyard emergency unlock button and pressed the button to unlock the gate.
-Resident #12 exited the courtyard unsupervised.
-A PCA saw Resident #12 through the dining room window on facility grounds.

Interview with the MA/S on 12/03/21 at 11:00am revealed:
-The SCU facility exit door to the SCU courtyard was no locked and was not alarmed.
-The courtyard had a gate that was locked and alarmed.
-There was emergency unlock button in the courtyard that would unlock the courtyard gate.
-There was no reason why Resident #12 was not placed on increased supervision.

Review of Resident #12's I/A reports on 12/03/21 revealed there was no documentation Resident #12 was found outside the SCU courtyard unsupervised.

Telephone interview with Resident #12's PCP on 12/03/21 at 11:30am revealed:
-She expected the facility to have a falls policy.
-She expected the facility to follow their falls policy if they had one.
-She expected the facility to ensure residents with falls were evaluated by their PCP and mental health to determine the reason for falls if the facility did not have a falls policy.
-She expected any residents who sustained head injuries as the result of a fall to be sent to the

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hospital for medical evaluation.
-She expected the facility to send any resident with an unwitnessed fall who could not determine if there was a head injury to be sent to the hospital for medical evaluation.
-She expected the facility to send any resident who reported a head injury to the hospital for medical evaluation.
-She was not told by the facility Resident #12 fell sustaining injuries to the face and nose resulting in bleeding.

Requests for the 24 hour supervisor logbook was not provided by survey exit 12/03/21.

3. Review of Resident #10's FL-2 dated 10/08/21 revealed:
-Diagnoses included Parkinson's disease, Alzheimer's disease, chronic obstructive pulmonary disease, chronic respiratory failure, diabetes mellitus type 2, cerebrovascular disease, hypothyroidism, and syncope with history of collapse.
-He was a resident in the Special Care Unite (SCU).
-He was semi-ambulatory with a walker, intermittently disoriented, and wandered.
-There was an order for Plavix 75 milligrams (mg) daily (a blood thinner used to prevent heart attacks and strokes. Falls while on blood thinners may cause internal bleeding even if there's no external sign of injury)

Review of Resident #10's care plan dated 10/08/21 revealed:
-He had wandering behaviors, he was verbally abusive, and he resisted care.
-He had limited ability with ambulation.
-He was ambulatory with assist or a device.
-He was totally dependent upon staff with bathing.

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-He required extensive staff assistance with toileting, dressing, and transfers.

Review of Resident #10's electronic medication administration record (eMAR)
for October 2021 November 2021 revealed:
-There was an entry for Plavix 75mg daily.
-There was documentation Resident #10 was administered Plavix at 5:00am from 10/10/21 - 10/16/21 and 10/18/21 - 10/31/21.
-There was documentation Resident #10 was administered Plavix at 5:00am from 11/01/21 - 11/26/21 and 11/29/21 - 11/30/21.

Review of Resident #10's incident/accident (I/A) report dated 10/11/21 at 5:45am revealed:
-Resident #10 was found lying on the floor by the bathroom.
-The fall was unwitnessed by staff.
-He stated he was going to the bathroom and slipped on the floor.
-His area of injury was his head.
-The type of head injury was not documented.
-There was documentation vital signs were not obtained.
-Hospice was notified by phone on 10/11/21 at 6:00am.
-Resident #10's primary care provider (PCP) was notified on 10/11/21 at 6:05am.
-His treatment documented was observation.

Review of Resident #10's progress notes dated 10/11/21 revealed:
-At 5:45am Resident 10 was found on the floor with no visible injury.

Review of Resident #10's I/A report dated 10/26/21 at 11:00am revealed:
-Resident #10 was found on his bedroom floor asleep.

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-The fall was unwitnessed.
-Resident #10 sustained a skin tear to his head.
-Resident #10 refused staff to obtain vital signs.
-Resident #10's PCP was notified by fax on 10/26/21 at 2:45pm.
-His treatment documented was observation.

Interview with the medication aide/supervisor (MA/S) on 12/03/21 at 11:00am revealed:
-Resident #10 was dependent upon staff for bathing and dressing.
-Resident #10 was ambulatory with a wheelchair.
-She completed Resident #10's I/A report dated 10/26/21.
-She did not remember what happened.

Telephone interview with a second MA/S on 12/03/21 at 11:53am revealed:
-Resident #10 was found on the floor in his room between two beds.
-There was a scratch on Resident #10's head and the skin were red.
-She thought the resident slipped from his wheelchair onto the floor.
-She called and reported the injury to the resident's hospice provider.
-The resident's hospice provider evaluated the resident about 2 hours later.
-She did not remember fall interventions or increased supervision being initiated for Resident #10.

Review of Resident #10's I/A report dated 11/08/21 at 5:30am revealed:
-Resident #10 slid from his wheelchair twice.
-Resident #10 slid from his wheelchair trying to transfer from the wheelchair to the bed toilet without staff assistance.
-The falls were documented as unwitnessed.
-The type of occurrence was documented as

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fall/slip/found on floor.
-Resident #10 was disoriented.
-There was no documentation if the occurrence was witnessed or unwitnessed.
-There was no injury documented.
-Hospice was notified.
-Resident #10's PCP was notified by fax on 11/08/21 at 6:30am.
-There was no treatment documented.

Interview with the MA/S on 12/03/21 at 11:00am revealed:
-She completed Resident #10's I/A report dated 11/08/21.
-She found Resident #10 on his bedroom floor between two beds.
-Resident #10 did not have signs or symptoms of injury.
-She notified the resident's hospice provider.
-She faxed the resident's PCP the I/A report.

Review of Resident #10's I/A report dated 11/09/21 at 2:45pm revealed:
-Resident #10 was found on the floor by staff in the TV lounge.
-Resident #10 was disoriented.
-He had no complaints of pain or visible signs of injury.
-Resident #10 refused staff to obtain vital signs.
-Hospice was notified.
-Resident #10's PCP was notified by fax on 11/09/21 at 5:00pm.
-There was no treatment documented.

Interview with the first MA/S on 12/03/21 at 11:00am revealed:
-She completed Resident #10's I/A report dated 11/09/21.
-A SCU resident told her Resident #10 was on the floor in the SCU television room.

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-She discovered Resident #10 sitting down on the television room floor.
-Resident #10 told her he lost his balance and fell.
-Resident #10 did not have signs or symptoms of injury.
-She called Resident #10's hospice provider.
-She faxed Resident #10's PCP the I/A report.
-Fall interventions to include increased supervision was not implemented for Resident #10 after the fall on 11/09/21.

Review of Resident #10's I/A report dated 11/11/21 at 6:30am revealed:
-Resident #10 was found on the floor in his bedroom.
-The fall was unwitnessed.
-Resident #10 denied pain or injury.
-There was no documentation of vital signs.
-His treatment was documented as observation.
-His PCP was notified on 11/11/21 by fax but there was no documentation of the time of the notification.

Review of Resident #10's I/A report dated 11/13/21 at 4:30pm revealed:
-Resident #10 was found on the floor in his room.
-It was an unwitnessed fall.
-He stated he hit his on the right side but did not have complaints of pain or other injury.
-There was no documentation vital signs were obtained.
-The hospice provider was notified.
-His treatment was documented as observation.
-His PCP was notified on 11/13/21 by fax.

Review of Resident #10's I/A report dated 11/07/21 at 11:30am revealed:
-Resident #10 was found on his bedroom floor.
-The fall was documented as unwitnessed.

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-Injury was documented as none.
-There was documentation hospice was notified.
-Resident #10's PCP was notified by phone and fax on 11/07/21 at 12:30pm.
-His treatment documented was none.

Telephone interview with Resident #10's hospice nurse on 12/03/21 at 1:55pm revealed:
-Resident #10 was admitted to the facility with a rolling walker and a rollator.
-Resident #10 was ordered a wheelchair and a lower bed on 11/04/21.
-Most of Resident #10's falls were due to slipping from his wheelchair and the bed.
-The facility called the on-call hospice messaging system on 12/03/20 at 6:05am to notify that Resident #10 had fallen.
-The facility reported Resident #10 did not sustain injuries with the fall.
-When she arrived Resident #10 was sitting in his wheelchair without distress.
-She was notified by the facility on 11/13/21 that Resident #10 had fallen.
-The resident reported to her he hit his head and hurt his foot during the fall.
-She evaluated the resident and there were no complaints or signs of injury.
-She expected the facility to have provided increased supervision for Resident #10 because of the frequency of falls.
-She could not specify the frequency of supervision for Resident #10 because she did not know the facility's staffing status.

Requests for the 24 hour supervisor logbook was not provided by survey exit 12/03/21.

Attempted interview with Resident #10's PCP on 12/03/21 at 11:45am was unsuccessful.

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D 270	Continued From page 34 4. Review of Resident #9's FL-2 dated 10/11/21 revealed: -Diagnoses included major neurocognitive disorder due to Alzheimer's disease, dementia with behavioral disturbances, hypothyroidism, bipolar, anemia, insomnia, hypertension, and anxiety. -She was a resident in the Special Care Unit (SCU). -She was constantly disoriented, had wanderering behaviors, was verbally abusive, and she resisted care. -She was ambulatory without an assistive device indicated. Review of Resident #9's care plan dated 10/11/21 revealed: -She had wandering behaviors, she was verbally abusive, she resisted care, and she had disruptive behavior/socially inappropriate. -Resident #9 was independent with toileting, ambulation, dressing, grooming, and transfer. -Resident #9 required limited assistance with bathing. Observation of Resident #9 on 12/01/21 at 9:29am revealed the was ambulating independently. Review of Resident #9's incident/accident (I/A) report dated on 10/21/21 at 3:00 pm revealed: -She reported to staff that she fell in her room and hit her head. -She complained of right-sided head pain and requested Tylenol. -Staff documented the resident was disoriented, but there were no visible signs of injury. -The incident was not witnessed by staff. -The report was faxed to her primary care provider (PCP) on 10/21/21 at 3:35 pm.	D 270		

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D 270	Continued From page 35 -Her family member was notified on 10/21/21 at 3:30 pm. -Her PCP signed the report on 11/01/21. -The treatment documented was observation. Interview with the medication aide/supervisor (MA/S) on 12/03/21 at 11:00am revealed: -Resident #9 walked to the nurse's station and reported she fell from her bed. -Resident #9 told her she hit her forehead when she fell. -Resident #9 did not have signs or symptoms of an injury. -Resident #9 was not sent to the hospital for medical evaluation . -There were no fall interventions or increased supervision initiated for Resident #9 after the 11/03/21 fall. -Resident #9's PCP was faxed the I/A report. Review of Resident #9's I/A report dated 11/07/21 at 11:45 pm revealed: -She was found on the on the floor next to her bed after she had called for help. -She stated she rolled out of the bed onto the floor. -Staff documented the resident was disoriented, but there were no injuries. -Resident #9 refused staff to obtain vital signs. -The I/A was documented as not witnessed by staff. -Her PCP was notified in person on 11/08/21 at 10:00 am. -Her family member was notified on 11/08/21 at 7:00 am. -Her PCP signed the report on 11/08/21. -The treatment documented was none. Interview with the MA/S on 12/03/21 at 11:00am revealed:	D 270		

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-She completed the I/A reported dated 11/07/21.
-Resident #9 was calling staff for help.
-She found Resident #9 sitting on the floor of her bedroom.
-Resident #9 told her she rolled out of the bed.
-She assisted Resident #9 off the floor and to bed.
-Resident #9 did not complain of pain.
-Resident #9 did not have visible signs or symptoms or injuries.
-She faxed Resident #9's PCP the I/A report.
-There were no fall interventions or increased supervision for Resident #9 after the 11/07/21 fall.

Review of Resident #9's incident/accident (I/A) report dated 10/10/21 at 8:30 am revealed:
-Resident #9 reported to staff that she fell in the hallway.
-Resident #9 reported to staff she "busted her head in 4 places".
-Staff documented no physical injuries could be found.
-The incident was unwitnessed by staff.
-The report was faxed to her PCP on 10/10/21.
-Her family member was notified on 10/10/21 at 9:00 am.
-Her PCP signed the report on 10/11/21.
-The treatment documented was observation.

Telephone interview with Resident #9's PCP on 12/03/21 at 11:30am revealed:
-She expected the facility to follow their falls policy if they had one.
-She expected the facility to ensure residents with falls were evaluated by their PCP and mental health to determine the reason for falls if the facility did not have a falls policy.
-She expected any residents who sustained head injuries as the result of a fall to be sent to the hospital for medical evaluation.

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D 270	Continued From page 37 -She expected the facility to send any resident who reported a head injury to the hospital for medical evaluation. -She was not told by the facility Resident #12 fell sustaining injuries to the face and nose resulting in bleeding. Requests for the 24 hour supervisor logbook was not provided by survey exit 12/03/21. _____ The facility failed to provide supervision to 4 of 12 sampled residents (#8, #9, #10, #12) ,who resided in the Special Care Unit, which resulted in Resident #8 sustaining 4 falls with head injuries from 10/04/21 to 10/22/21. On 10/22/21 she had an unwitnessed fall face first and was unresponsive which required EMS transport to the emergency department where she was diagnosed with facial fractures. Resident #10 had 8 unwitnessed falls with documented injuries to include 2 with head injuries and Resident #10 lost control of his wheelchair and rolled down the wheelchair ramp in the SCU courtyard unsupervised, crashing into a fence which required a hospital visit where he was evaluated for a head injury and diagnosed with multiple abrasions to his face on 11/07/21 and who eloped on 11/30/21 from the SCU courtyard when staff saw him by the trash dumpster out the kitchen window. The facility's failure to supervise these residents resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/03/21. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 2, 2021	D 270		

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D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff for 1 of 3 sampled residents (#8) in accordance with the facility's policies and procedures who had unwitnessed falls with head injuries. The findings are: Review of the facility's Emergency and Accident Policy dated 10/29/2004 revealed: -An emergency was any sudden situation that required prompt action. -An accident was an unexpected, unplanned event which may or may not cause injury. -Staff were to send or yell for help, evaluate, the situation, and call or direct someone to call 911 if necessary. -Residents who may be injured were to be kept sitting or lying down. -Staff were to determine if the resident was	D 271		

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conscious and breathing.
-Staff were to monitor the resident's vital signs and administer first aid as appropriate.
-Staff were to stay with the resident until Emergency Management Services (EMS) or the supervisor responded.

Review of Resident #8's current FL-2 dated 09/20/21 revealed:
-Diagnoses included dementia, atherosclerotic heart disease of native coronary artery, and congestive heart failure.
-She was a resident in the special care unit (SCU).
-She was intermittently disoriented.
-She was ambulatory without an assistive device.

Review of Resident #8's plan of care dated 11/01/21 revealed she required extensive assistance with ambulation, dressing, grooming, and transfers.

Review of Resident #8's I/A report dated 10/22/21 at 5:30pm revealed:
-Resident #8 was found lying on the floor in the TV room on her "left face".
-Resident #8 had "slobber" coming from her mouth.
-Resident #8 "was not responding well".
-Resident #8's left eye was swollen and black.
-There was documentation of a facial injury with a hematoma/bruise.
-There was documentation Resident #8's family called for emergency medical services (EMS).
-There was documentation Resident #8 was admitted to the hospital due to facial fractures and a urinary tract infection (UTI).

Review of Resident 8's progress notes dated 10/22/21 revealed:

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D 271	Continued From page 40 -At 5:40pm Resident #8 was found on the floor in the common area laying on her right side with swelling and blackness to her right eye. -Resident #8 was drooling and not responding. -Hospice and family were contacted (no time indicated). -Staff remained with Resident #8 who began mumbling. -Family contacted emergency medical services (no time indicated). -EMS arrived and transported Resident #8 to the local hospital. Review of Resident #8's local hospital discharge summary dated 10/24/21 revealed: -Resident #8 was admitted from 10/22/21 to 10/24/21. -The hospital arrival time was not documented. -Diagnoses included head injury, orbital fractures, facial fractures, falls, and urinary tract infection. -Resident #8 was admitted due to "significant" orbital and facial fractures sustained from to a fall while at the facility. -Physical exam on discharge revealed ecchymosis to the left face with yellowing on the edges. -The resident as discharged home on hospice. Interview with the Administrator on 12/02/21 at 10:51am revealed: -She reviewed video surveillance of the fall Resident #8 sustained on 10/22/21. -Resident #8 was in the SCU television room unsupervised when she fell. -Resident #8 stood and tripped over her feet falling on her face. -The MA/S responded and evaluated Resident #8 for visible injuries. -Resident #8 had eye swelling and discoloration after the fall.	D 271		

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D 271	Continued From page 41 -Staff called Resident #8's hospice nurse. -The resident's hospice nurse was going to the facility to assess the resident. -Staff called Resident #8's family member after calling the hospice nurse. -Staff did not call 911 for EMS to evaluate the resident. -Resident #8's family member called EMS. -Staff did not know EMS had been called. -Resident #8 laid on the floor for 1 hour and 20 minutes from the time of fall to when EMS arrived for the resident. -Resident #8's hospice nurse arrived shortly after EMS arrived. -She was concerned with how long Resident #8 laid in the floor without evaluation by EMS or a medical provider. -Staff should have called EMS when they realized how long it was going to be before the resident's hospice nurse would arrive. -She videoed with her cell phone the video surveillance of Resident #8's 10/22/21 fall. Review of a cell phone video of Resident #8 provided by the Administrator on 12/03/21 revealed: -There was a timestamp date of 10/22/21 at 5:35pm. -There was no staff in the SCU day room with Resident #8. -Resident #8 stumbled backwards with a walker. -Resident #8 fell on her left side striking the left side of her face on the floor. -Three staff responded to Resident #8 with in 1 minute 35 seconds after the fall. -Staff rolled Resident #8 to her back. -Resident #8 did not move from the time of her fall at 5:35pm but the video ended at 5:39pm. Interview with a personal care aide (PCA) on	D 271		

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12/03/21 at 9:34am revealed:
-She walked in the veranda room to escort another resident outside to smoke.
-She saw Resident #8 lying face down on her left side on the floor.
-She and another staff rolled Resident #8 to her back.
-Resident #8 was not unresponsive.
-She palpated Resident #8's body and she complained of neck pain.
-She told the MA/S to call 911.
-The MA/S told her 911 could not be called because she was a hospice resident and a Do Not Resuscitate [(DNR) a medical order written by a PCP that directed staff not to perform cardiopulmonary resuscitation(CPR) if a person's breathing or heart stops].
-The side of Resident #8's left eye and her left cheek bone were swollen and purple.
-Resident #8 had facial grimace and would try to move away when touched.
-She was trained to notify the MA/S when a resident sustained an unwitnessed fall then the MA/S would take over the resident.

Interview with the first shift MA/S on 12/03/21 at 11:00am revealed:
-On 10/22/21, around 5:00 to 6:30pm, Resident #8 was sitting on the couch in the day room with her walker in front of her.
-She was passing medications when staff told her Resident #8 was on the floor in the day room.
-When she arrived to the day room on 10/22/21, Resident #8 was laying on her left side face down.
-On 10/22/21, the resident was unresponsive and had a "twitch" to her head and to her arm.
-She rolled the resident on her back.
-The resident's left eye was swollen.
-Resident #8 tried to speak but her speech was

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slurred.
-Normally the resident could speak well and follow commands.
-She called Resident #8's hospice nurse shortly after.
-She did not remember the time frame.
-The hospice nurse told her it would take about 35 to 45 minutes for her to arrive at the facility.
-She did not call 911 for EMS to evaluate Resident #8.
-She instructed a PCA to remain with Resident #8, who was left on the floor of the day room, while she returned to her medication cart to complete the medication pass.
-The resident became more alert over time.
-The resident reported head and eye pain when asked.
-The Administrator checked on Resident #8 and directed her to notify the resident's family member.
-She called Resident #8's family member and reported the fall.
-About 10 - 15 minutes after she called Resident #8's family member EMS arrived for the resident.
-Resident #8's hospice nurse arrived after EMS left the facility with the resident.

Telephone interview with Resident #8's hospice nurse on 12/03/21 at 1:55pm revealed:
-After hours hospice calls were processed through an on-call system that would transcribe the message into a text.
-On 10/22/21 at 5:40pm, the on-call system received a call from the MA/S that Resident #8 had fallen and was unresponsive.
-She also received a call on her cell phone from the facility notifying her Resident #8 had an unwitnessed fall, was responsive, and denied pain.
-She was never told by staff Resident #8 was

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unresponsive with the fall.
-She told the facility she was on her way home, would turn around, and evaluate the resident.
-When she arrived at the facility, EMS was pulling out of the facility with the resident.
-If the facility had told her when they called her that Resident #8 was unresponsive with injuries, she would have directed the facility to notify 911 for transport to the hospital for medical evaluation to ensure safety and no life-threatening injuries.
-Hospice did not provide emergency care for residents when there could be life threatening injuries.
-Hospice provided comfort and palliative care for the resident.

Interview with the Administrator on 12/02/21 at 10:51am revealed: MOVE I/V DOWN
-She expected the staff to follow the facility's Emergency and Accident Policy for all I/As.
-She did not expect staff to call the resident's PCP to inform them of a fall.
-She expected staff to fax the incident/accident report to the resident's Primary Care Provider within 24 hours when a resident sustained a fall, witnessed or unwitnessed.
-She expected staff to refax the I/A report to the resident's PCP if the PCP did not sign and return the I/A report within 7 to 10 days of the original fax.
-The resident's PCP made weekly visits to the facility and were provided with I/A reports at those visits.
-She expected staff to notify the resident's hospice provider within 24 hours instead of the PCP if the resident was receiving hospice and sustained a fall, witnessed or unwitnessed.
-Residents who fell and sustained knots, lacerations, and/or bruising were to be sent to the hospital for medical evaluation.

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D 271	Continued From page 45 -She expected residents who sustained injuries to be sent to the hospital for evaluation. -As of 10/27/21, she expected staff to evaluate a resident for injuries and perform range of motion, complete an I/A report, fax to the PCP, and notify the family. As of 10/27/21, she expected staff to call 911 for all residents who sustained falls with visible injures to include residents with hospice or a PCP. -She did not expect staff to send residents who fell and were without visible injuries to the hospital for evaluation. Interview with a medication aide/supervisor (MA/S) on 12/03/21 at 11:00am revealed: -She had been trained by the facility when a resident sustained an unwitnessed fall to ask if the resident was experiencing pain and look for signs/symptoms of injury such as bleeding, swelling, discoloration, or deformity. -If a resident had signs/symptoms of injury call 911 for EMS evaluation for residents who did not have hospice. -Hospice residents who had sustained an unwitnessed fall with signs/symptoms of injury she was trained to call the hospice provider and not 911. -The facility did not have a falls policy. -The resident's primary care provider (PCP) was notified of falls by faxing the incident/accident (I/A) report. -The fax confirmation verified the fax was transmitted. -The only way she could confirm the PCP received the fax notification of falls was when the facility received the I/A report signed by the PCP. -It would take between 1 day to 2 weeks to receive the signed I/A reports back from the PCP. -She would give the faxed I/A reports to the	D 271		

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D 271	Continued From page 46 Administrator after they were faxed to the PCP. Telephone interview with a second medication aide/supervisor (MA/S) on 12/03/21 at 11:53am revealed: -If a resident who was not receiving hospice services had an unwitnessed fall with facial injuries, head injuries, or was bleeding they were to be sent to the hospital for medical evaluation. -If a resident who was on hospice services had an unwitnessed fall and a head injury or was bleeding was to be sent to the hospital for medical evaluation. -Hospice was to be notified for a resident who was on hospice services and had a fall without injuries. Telephone interview with the facility's PCP on 12/03/21 at 11:30am revealed: -She expected the facility to have a falls policy. -She expected the facility to follow their falls policy if they had one. -She expected the facility to ensure residents with falls were evaluated by their PCP and mental health to determine the reason for falls if the facility did not have a falls policy. -She expected any residents who sustained head injuries as the result of a fall to be sent to the hospital for medical evaluation. -She expected the facility to send any resident with an unwitnessed fall who could not determine if there was a head injury to be sent to the hospital for medical evaluation. -She expected the facility to send any resident who reported a head injury to the hospital for medical evaluation but had not discussed her expectation with the facility staff. Requests for the supervisor 24-hour communication book were not provided by survey	D 271		

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D 271	Continued From page 47 exit. _____ The facility failed to immediately respond to the emergency needs for Resident #8 who had an unwitnessed fall onto her face sustaining swelling and bruising to the left eye and cheek, and was unresponsive. The resident laid on the floor for 1 hour and 20 minutes before EMS arrived after being called by a family member. The resident was admitted to the hospital with facial fractures. The facility's failure to respond immediately resulted in substantial risk of serious injury and neglect to the resident and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/03/21 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 2, 2021	D 271		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by:	D 307		

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D 307	Continued From page 48 TYPE B VIOLATION Based on observations, interviews, and record review the facility failed to ensure the ordered therapeutic diet (pureed) was served for 1 of 7 sampled residents (#7) who was diagnosed with dysphagia (difficulty swallowing). The findings are: Review of Resident #7's current FL-2 dated 09/20/21 revealed: -Diagnoses included gastroesophageal reflux disease (GERD), chronic erosive gastritis, and hiatal hernia. -Diet was checked in the section titled nutrition status. -There was no documentation of clarification of the type of diet ordered. Review of Resident #7's esophagogastroduodenoscopy [(EGD) an endoscopic procedure that allows your doctor to visually examine the esophagus, stomach and duodenum] report dated 07/01/21 revealed: -Diagnoses included esophageal obstruction, food in the esophagus causing injury, pharyngoesophageal phase dysphagia (aspiration of food in the trachea during swallowing), and hiatal hernia. -The resident had an esophageal stricture (narrowing of the esophagus which impedes swallowing of foods or medications. Symptoms include dysphagia, the feeling of food being stuck in the throat, and choking episodes). -An esophageal dilation (stretching of an esophageal stricture) was performed. -Food was found in the lower third of the resident's esophagus. -The food was removed.	D 307		

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D 307	Continued From page 49 -A pureed diet was ordered. -A repeat EGD was to be scheduled at the next available appointment. Review of Resident #7's local hospital after visit summary dated 07/01/21 revealed: -Diagnoses included dysphagia, gastritis, and esophagitis. -There was documentation the resident was to have a puree (foods soft and pudding like prepared without lumps so they can be swallowed safely) diet only. -There were instructions for a dysphagia eating plan. -The instructions were: do not eat foods that had to be chewed; avoid foods hard, dry, sticky, chunky, lumpy or stringy. -If a food was not originally a smooth texture it may be able to be eaten after pureeing (with a blender) or moistening, for example bread was to be soaked in milk and pureed, whole meat was not allowed, French toast was to be pureed to a smooth, moist texture, and pureed foods were helpful for people with moderate to severe swallowing problems. Review of Resident #7's Primary Care Provider (PCP) visit note dated 07/13/21 revealed: -Diagnoses included dysphagia, esophageal stricture. -The resident was to be on a pureed diet. -The resident had a repeat EGD on 07/07/21. -Whole pills were found which prevented completion of the study. -Medications were ordered crushed. Review of the therapeutic menu for 12/02/21 revealed there was not a pureed breakfast meal listed on the menu.	D 307		

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D 307	Continued From page 50 Observation of the kitchen on 12/02/21 from 7:15am - 7:30am revealed: -On opposite ends of the kitchen were entrances to the Assisted Living (AL) and Special Care Unit (SCU) dining rooms. -The Dietary Manager (DM) preparing resident plates and a dietary assistant (DA) was serving residents their meals. -There was a therapeutic diet list dated November 2021 attached to the bulletin board. Review of the facility's therapeutic diet list dated November 2021 revealed Resident #7 was documented to have a pureed diet. Observation of the breakfast meal on 12/02/21 at 7:37am revealed: -Resident #7 was sitting at a table located in the dining room. -The dietary aide served Resident #7 two whole link sausages, 1 slice of French toast, and grits with cheese in the dining room. -Resident #7 coughed twice while eating breakfast. -Resident #7 ate 100 percent of his breakfast meal. Observation of Resident #7 on 12/02/21 at 9:30am revealed: -The resident had a tracheostomy approximately a centimeter in size. -The tracheostomy was open and draining. -Wheezing was heard at the tracheostomy. Interview with Resident #7 on 12/02/21 at 8:00am revealed: -He was normally served a pureed diet. -He was normally served a pureed breakfast meal, but was not served a pureed diet for the breakfast meal today, 12/02/21.	D 307		

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D 307	Continued From page 51 Interview with the Dietary Manager (DM) on 12/02/21 at 7:25am revealed there were no residents on the Assisted Living (AL) side who were on therapeutic diets. Interview with the Dietary Manager (DM) on 12/02/21 at 7:59am revealed: -There was a therapeutic diet list on the bulletin board in the kitchen for all staff to view. -She reviewed the therapeutic diet list every morning before beginning to prepare meals to ensure the residents were served the correct diet. -Resident #7 was ordered a pureed diet. -Normally the dietary aide (DA) would tell her who was in the dining room to be served. -She would prepare the plate for those residents and the DA would serve the residents. -This morning, 12/03/21, the DA did not tell her Resident #7 was in the dining room. -She asked the DA if she had served Resident #7 breakfast. -The DA told the DM she served Resident #7 a regular diet for breakfast. -She told the DA to bring Resident #7's plate back to the kitchen and serve him a pureed diet. -She did not follow up with the DA to ensure Resident #7 did not eat the regular diet because she was overwhelmed with the breakfast meal. -There was no process in place to ensure the therapeutic diet list was followed. Interview with the DA on 12/02/21 at 8:10am revealed: -She relied on her memory to serve residents the correctly ordered therapeutic diet. -She remembered the residents who were on the therapeutic diet list. -Resident #7 was ordered a puree diet because of swallowing problems.	D 307		

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D 307	Continued From page 52 -She served Resident #7 a regular diet during the breakfast meal today, 12/03/21, because she was nervous. -Normally she would serve Resident #7 a puree diet. -The DM told her Resident #7 was to be served a pureed diet after she served the resident a regular diet and he had already consumed the meal, -The DM told her to take the regular diet plate away from Resident #7. -She forgot to take the regular diet plate away from Resident #7 after the DM told her because she was busy serving breakfast to other residents. Interview with the Administrator on 12/02/21 at 10:30am revealed: -Resident #7 was the only resident on the AL side who was ordered a therapeutic diet. -Resident #7 was on a pureed diet because of swallowing problems. -Resident #7 had a tracheostomy. -The therapeutic diet list was posted in the kitchen for all staff to review. -She expected the DM to review the therapeutic diet list every day before preparing meals to ensure residents were served the correctly ordered diet. -She expected the DA to review the therapeutic diet list every day to ensure residents were served the correctly ordered diet. -She expected the DA to tell the DM who she needed to serve during each meal and the DM to prepare the resident's plate according to the therapeutic diet order. -She expected the DA to have immediately removed Resident #7's regular diet plate when the DM told her the resident was served the wrong ordered diet during breakfast meal today,	D 307		

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12/02/21.
-She expected the DM to have followed up with the DA to ensure Resident #7's incorrectly served breakfast tray had been served the correctly ordered diet during breakfast today, 12/02/21.
-She would make random meal observations and compare the resident's therapeutic diet orders to what the resident was served.
-It was the responsibility of the Resident Care Director (RCD) to complete the FL-2's.
-She expected the RCD to review all physician's orders and visit notes from the previous FL-2 to current dated to ensure the new FL-2 was completed accurately and orders were not missed.
-She did not check behind the RCD to ensure FL-2s were complete and orders clarified because she would staff when short staffed.
-She expected the RCD to have reviewed Resident #7's diet orders and physician notes from his last FL-2 to the current FL-2 dated 09/20/21 to ensure the current FL-2 contained the correct and complete therapeutic diet order.

Interview with the RCD on 12/02/21 at 4:32pm revealed:
-She was on leave from 09/23/21 through 11/08/21.
-She completed Resident #7's current FL-2 dated 09/20/21.
-She overlooked Resident #7's diet order on the resident's current FL-2 dated 09/20/21.
-She was responsible to review orders, physician visit notes, hospital notes, and FL-2's to ensure orders were not missed.
-She would review physician visit notes, hospital notes, and orders from the previous FL-2 to current when completing yearly FL-2's for the providers to sign.

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D 307	Continued From page 54 Telephone interview with Resident #7's PCP on 12/03/21 at 11:00am revealed she was unavailable for interview. Attempted telephone interview with Resident #7's gastroenterologist on 12/03/21 at 12:31pm was unsuccessful. _____ The failure of the facility to serve a pureed diet as ordered for 1 of 7 sampled residents (#4) who had a diagnosis of dysphagia related to an esophageal stricture requiring a tracheostomy, and had a history of esophageal obstruction from food being stuck in her esophagus. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/02/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 17, 2022.	D 307		
D 461	10A NCAC 13F .1304 Special Care Unit Building Requirements 10A NCAC 13F .1304 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements:	D 461		

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D 461	Continued From page 55 (1) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Facility Services for review and approval. (2) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (3) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices. (4) Where exit doors are not locked, a system of security monitoring shall be provided. (5) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building. (6) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable space for medication storage, and storage area for the residents' records. (7) Living and dining space shall be provided within the unit at a total rate of 30 square feet per resident and may be used as an activity area. (8) Direct access from the facility to a secured outside area shall be provided. (9) A toilet and hand lavatory shall be provided within the unit for every five residents. (10) A tub and shower for bathing of residents shall be provided within the unit. (11) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided.	D 461		

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

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4 exit doors accessible for residents' use was equipped with a security monitoring system that activated for the safety of all residents in the Special Care Unit (SCU) which included one resident (Resident #12) who was constantly disoriented and who eloped from the facility without staff knowledge.

The findings are:

Review of Resident #12's FL-2 dated 11/01/21 revealed:
-Diagnoses included vascular dementia, non-traumatic subcortical hemorrhage of right cerebral hemisphere.
-He was a resident in the SCU.
-He was semi-ambulatory.

Review of Resident #12's plan of care dated 11/01/21 revealed he had wandering behaviors.

Review of Resident #12's record revealed there was no accident/report for 11/28/21.

Interview with a personal care aide (PCA) on 12/03/21 at 9:30am revealed:
-Resident #12 was very active.
-He had an unsteady gait and would sometimes leave his walker behind when ambulating.
-Resident #12 eloped from facility grounds last weekend on Sunday, 11/28/21 at approximately 6:00pm through the courtyard gate located outside of the right exit door off the SCU.
-He was found outside of the facility's back gate

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by waste management personnel by the facility's trash cans.

Observations of the exit door and exit gate from the facility on 12/03/21 at 2:15pm and intermittently throughout the day until 5:00pm revealed:
-The exit door at the end of the hallway on the right side of the SCU hallway was not locked and there was no alarm sounding device when the exit door to the facility was opened.
-The exit door lead to an approximately 10-foot long wooden ramp.
-At the end of the ramp on the left side of the fence there was an emergency exit button with the following outlined, "In Case of Emergency Lift Cover-Push Button."
-The emergency button was encased by a clear cover with a label at the bottom that outlined, "Lift Here."
-Above the emergency exit button there was a 12-button keypad.
-The 10-foot wooden ramp lead to a courtyard that was surrounded by wooden fence.
-The upper left corner of the wooden fence had a lock in place.

Observations of the exit door and exit gate from the facility on 12/03/21 at 2:15pm revealed:
-The clear case over the emergency button was lifted easily, the emergency button was pushed, and there was an audible shrieking alarm outside in the courtyard.
-The fence was pushed open which lead off facility grounds.
-Approximately 3 feet from the exit, out of the back gate, the facility trash cans were next to the left.
-There was no staff that came outside to courtyard upon activation of the emergency

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release button.

Interview with the Special Care Unit Coordinator (SCUC) on 12/03/21 at 2:20pm revealed:
-The exit door at the end of the hallway on the right side of the SCU hallway that lead to the outside secured courtyard was never locked or alarmed.
-The facility wanted to give the resident access to the courtyard.
-When the emergency button was pushed an audible alarm would be activated outside and an alarm would ring to computer at the nurses' station.

Observations of the exit door and exit gate from the facility on 12/03/21 at 5:21pm revealed:
-The exit door at the end of the hallway on the right side of the SCU hallway was not locked and there was an alarm sounding device when the exit door to the facility was opened.
-The clear case over the emergency button was lifted easily, the emergency button was pushed, and there was an audible shrieking alarm outside in the courtyard.
-The fence was pushed open which led off facility grounds.
-There was no staff that came outside to courtyard upon activation of the emergency release button.

Observation of the nurses' station in the SCU on 12/03/21 at 5:30pm revealed there was no alarm activated at the nurses' station alerting staff the emergency release button had been pushed.

Second interview with a personal care aide (PCA) on 12/03/21 at 5:35pm revealed the alarm that activated at the nurses' station alerting staff the emergency release button had been pushed only

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worked sometimes.

Second interview with the SCUC on 12/03/21 at 5:40pm revealed she was not sure why the alarm at the nurses' station did not activate when the emergency release button had been pushed.

Interview with the Maintenance Director on 12/03/21 at 5:45pm revealed:
-He was in process of re-starting the alarm system for the emergency release button so the alarm would be activated at the nurses' station within the SCU.
-He was not aware until this evening (12/03/21) the alarm was not activated at the nurses' station.

Interview with the Administrator on 12/03/21 at 5:26pm revealed:
-The facility exit door on the the hall in the SCU exited into the SCU courtyard with a gate.
-The facility exit door on the hall in the SCU was not locked and did not alarm when opened.
-The facility exit door on the Richmond Hall in the SCU had always been unlocked and unarmed.
-There was no process in place for monitoring of the facility exit door into the courtyard on the Richmond Hall in the SCU to alert staff when residents entered the courtyard.
-The courtyard gate was locked and alarmed.
-There was an emergency unlock button that was not secured closed at the courtyard gate.
-When the cover to the emergency unlock button was lifted a "screamer" alarm would sound at the box.
-The emergency unlock alarm would not sound in the building.
-When the courtyard gate opened an alarm would sound at the nurses' desk in the SCU.
-On 11/28/21, Resident #12 lifted the cover to the courtyard emergency unlock button and pressed

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D 461	Continued From page 60 the button to unlock the gate. -Resident #12 exited the courtyard unsupervised. -The courtyard gate alarm sounded at the SCU nurses' desk. -A PCA saw Resident #12 through the dining room window at the trash cans located by the SCU courtyard. -There was no process in place to ensure residents did not exit the SCU courtyard by pressing the emergency unlock button. Based on observations, interviews, and record reviews, it was determined Resident #12 was not interviewable. _____ The facility failed to ensure 1 of 4 exit doors was equipped with a security monitoring device that activated when the door was opened which was accessible to all residents in the SCU and to 1 of 1 sampled resident (#12) residing at the facility who was assessed to be constantly disoriented with known wandering behaviors eloped from the facility on 11/28/21 without staff knowledge (Resident #12) and was found by a waste management worker. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/03/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 17, 2022.	D 461		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff	D 465		

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D 465	Continued From page 61 (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of the residents residing in the Special Care Unit (SCU) for 10 shifts out of 18 total shifts from 10/22/21, 10/26/21, 10/30/21-10/31/21, and 11/06/21-11/07/21. The findings are: Review of the facility's current license effective 01/01/21 through 12/31/21 revealed the facility was licensed for a capacity of 114 beds including a 54-bed Special Care Unit (SCU). Review of the facility's census report dated 12/01/21 revealed: -There were 40 residents residing in the SCU. Review of the facility resident census dated 10/30/21 revealed there was a SCU census of 41 residents, which required 41 staffing hours on first and second shifts and 32.8 staffing hours on third shift. Review of the staff time sheets dated 10/30/21	D 465		

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revealed 38.32 hours were provided on first shift, leaving the shift short 2.68 hours.

Review of the staff time sheets dated 10/30/21 revealed 32.62 hours were provided on second shift, leaving the shift short 8.38 hours.

Review of the staff time sheets dated 10/30/21 revealed 7.98 hours were provided on third shift, leaving the shift short 24.82 hours.

Review of the facility resident census dated 10/31/21 revealed there was a SCU census of residents, which required 41 staffing hours on first and second shifts and 32.8 staffing hours on third shift.

Review of the staff time sheets dated 10/31/21 revealed 34.85 hours were provided on first shift, leaving the shift short 6.15 hours.

Review of the staff time sheets dated 10/31/21 revealed 22 hours were provided on third shift, leaving the shift short 10.8 hours.

Review of the facility resident census dated 11/06/21 revealed there was a SCU census of 40 residents, which required 40 staffing hours on first and second shifts and 32.8 staffing hours on third shift.

Review of the staff time sheets dated 11/06/21 revealed 37.55 hours were provided on second shift, leaving the shift short 2.45 hours.

Review of the staff time sheets dated 11/06/21 revealed 12.02 hours were provided on third shift, leaving the shift short 20.78 hours.

Review of the facility resident census dated

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D 465	Continued From page 63 11/07/21 revealed there was a SCU census of 41 residents, which required 41 staffing hours on first and second shifts and 32.8 staffing hours on third shift. Review of the staff time sheets dated 11/07/21 revealed 38.55 hours were provided on first shift, leaving the shift short 1.45 hours. Review of the staff time sheets dated 11/07/21 revealed 34.02 hours were provided on second shift, leaving the shift short 5.98 hours. Review of the staff time sheets dated 11/07/21 revealed 25.65 hours were provided on third shift, leaving the shift short 7.15 hours. Interview with the Administrator on 12/03/21 at 2:34pm revealed: -If there was a staff member who called out for a scheduled shift, the Administrator would reach out to other staff members for coverage. -If another staff member could not work the shift that was short, the Activity Director (AD), the Resident Care Director (RCD), the Special Care Unit Coordinator (SCUC), and herself would work on the floor to ensure the facility met the minimum staff requirements. -The last time she picked up a floor shift at the facility was on night shift (10:00pm-7:00am) on 11/06/21 but due to being a salaried employee she did not clock in. -The entire staff was doing the best they could to cover the staffing shortages throughout the facility. Interview with the facility's licensed practical nurse on 12/03/21 at 5:31pm revealed: -She started working at the facility on 09/30/21 auditing residents' charts.	D 465		

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D 465	Continued From page 64 -Before she became a permanent staff member on 12/02/21, she would pick up shifts here and there. -She recently picked up an extra shift working on the Tuesday prior to Thanksgiving on night shift in the SCU. -She had observed the facility's management team which included the SCUC and the Administrator working on the floor previously; she could not recall the dates. Interview with a first shift personal care aide (PCA) on 12/03/21 at 5:35pm revealed: -She thought there had to be five PCAs working in the SCU to appropriately staff the SCU. -When there was only three PCAs working (there were no dates provided) one PCA would work the right hallway of the SCU, the second PCA would work the left hallway of the SCU, and the third PCA would act as a floater between the left and right hallways. -The medication aide would assist the PCAs with the residents' personal care. -She had observed the Administrator and the SCUC working on the floor previously; she could not recall the dates. Interview with a second first shift PCA on 12/03/21 at 5:40pm revealed sometimes the facility did not have enough staff, she could not recall specific dates. Interview with the SCUC on 12/03/21 at 5:40pm revealed: -The AD, the RCD, and the Administrator would work on the floor when there were identified staffing shortages. -She worked a lot of hours to cover staffing shortages which would be obvious when the timesheets were reviewed.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R-C 12/03/2021

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D 465	Continued From page 65 -The Administrator and she picked up a night shift in the SCU approximately three weeks ago but she could not recall the specific date. Second interview with the Administrator on 12/03/21 at 5:30pm revealed: -The facility had intermittently been short staffed since September 2021. -She had switched to 12 hour shifts to ensure staff coverage for both the AL and SCU. -She offered 8 hour shifts for staff who could not work 12 hours. -The facility has provided staff with incentives to ensure staffing. -She allowed staff to sometimes bring their children to work with them just to ensure staff coverage. -Some staff would even work double shifts to include 24 hour and 36-hour shifts. -Administrative staff (she, the Administrative Assistant, RCD, and SCUC) would take call 7 days in a row, starting at 5:00pm every Friday through 5:00pm the following Friday, rotating weeks. -All administrative staff were cross trained as MAs and PCAs. -She did not have a copy of the administrative on call scheduled. -She last staffed a 12 hour shift the first week of November 2021. -The SCUC last worked a 12 hour shift the first week of November 2021. -The MA would call the administrative staff on call when there were staff call outs for the AL and/or SCU. -The on call administrative staff would attempt to find coverage. -If staff coverage could not be found, the on call administrative staff would provide staff coverage for the AL and/or SCU.	D 465		

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D 465	Continued From page 66 -The facility transporter was also a PCA and would provide at times. -She last used a staffing agency in October 2020 and had full staff coverage at that time. -She had not used a staffing agency since. -She last spoke with corporate management regarding staffing on 11/29/21. -She completed the staff schedule at the beginning of every month and would revise as needed for call outs or when staff quit. -She tried to review the staff schedule every day to ensure the facility was not short staffed. The facility failed to ensure the minimum number of staff were always present to meet the needs of the residents residing in the Special Care Unit (SCU) for 10 shifts out of 18 total shifts from 10/22/21, 10/26/21, 10/30/21-10/31/21, and 11/06/21-11/07/21. On 10/31/21 on first shift, the staffing hours were short by 6.15 hours. On 10/30/21 on second shift, the staffing hours were short by 8.38 hours. There were 4 nights shifts in the SCU the staffing shortage was greater than 7 hours on 10/30/21 (24.82 hours short), on 10/31/21 (10.8 hours short), on 11/06/21 (10.8 hour short), and on 11/07/21 (7.15 hours short). The facility's failure to provide enough staffing to residents who required a licensed special care unit was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/03/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 17, 2022.	D 465		

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D912	Continued From page 67	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Personal Care and Supervision, Nutrition and Food Service, Special Care Unit Building Requirements and Special Care Unit Staff. The findings are: 1. Based on observations, interviews, and record review the facility failed to provide supervision in accordance with the residents' assessed needs for 4 of 12 sampled residents (#8, #9, #10, #12) who resided in the Special Care Unit and sustained unwitnessed falls (#8, #9, #10, #12) and eloped from the facility (#12). [Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff for 1 of 3 sampled residents (#8) in accordance with the facility's policies and procedures who had unwitnessed falls with head injuries. [Refer to tag	D912		

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D912	Continued From page 68 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A2 Violation)]. 3. Based on observations, interviews, and record review the facility failed to ensure the ordered therapeutic diet (pureed) was served for 1 of 7 sampled residents (#7) who was diagnosed with dysphagia (difficulty swallowing).[Refer to tag 0307, 10A NCAC 13F .0904(e)(1) Nutrition and Food Service (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4 exit doors accessible for residents' use was equipped with a security monitoring system that activated for the safety of all residents in the Special Care Unit (SCU) which included one resident (Resident #12) who was constantly disoriented and who eloped from the facility without staff knowledge. [Refer to tag 0461, 10A NCAC 13F .1304 Special Care Unit Building Requirements (Type B Violation)]. 5. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of the residents residing in the Special Care Unit (SCU) for 10 shifts out of 18 total shifts from 10/22/21, 10/26/21, 10/30/21-10/31/21, and 11/06/21-11/07/21. [Refer to tag 0465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type B Violation)].	D912		