STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033005	A. BUILDING: _____ B. WING _____	R-C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation on January 13-15, 2016.	{D 000}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings and floors in the resident rooms located on B hall were cleaned. The findings are: Observation of room #201 on 1/13/16 at 11:15 a.m. revealed: -The cream tiled floor had brown dried stains. -On all four walls, the paint had peeled. Observation of room #202 on 1/13/16 at 11:19 a.m. revealed all four walls had brown stains, peeled paint and multiple indentions. Observation of room #203 on 1/13/16 at 11:24 a.m. revealed the bottom of one of four walls had indentions. Observation of room #207 on 1/13/16 at 11:41 a.m. revealed: -Rust stains were at the bottom of the door posts, which led to the bathroom.	{D 074}		

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{D 074}	Continued From page 1 -Three of four walls had chipped paint. -The hand sink, which was located in the resident's room, had a jagged edge. Interview with a resident on 1/13/16 at 11:41 a.m., who lived in room #207, revealed: -The resident did not have any problems with the cleanliness of the room or the sink. -Housekeeping cleaned the resident's room daily. Observation of room #208 on 1/13/16 at 11:46 a.m. revealed three of four walls had indentions. Observation of room #213 on 1/13/16 at 11:49 a.m. revealed three of four walls had indentions. Observation on 1/15/16 at 10:21 a.m. revealed a housekeeper was cleaning B hall. Interview with the same house keeper who was cleaning B hall on 1/15/16 at 10:21 a.m. revealed: -House keeping cleaned the walls and floors daily. -Maintenance does repairs to the facility. Interview with a second house keeper on 1/15/16 at 2:30 p.m. revealed: -The walls in the facility are cleaned weekly and as needed. -The floors are cleaned daily. -The walls in the resident's rooms were last cleaned "last week" (between 1/3-1/9/16). Interview with the maintenance staff on 1/15/16 at 2:30 p.m. revealed: -Currently, the facility was making repairs in the building. -The facility was in the process of repairing the rooms. -The contractor had not started on the repairs in	{D 074}		

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{D 074}	Continued From page 2 the rooms. Interview with a Medication Aide (MA) on 1/15/16 at 10:28 a.m. and a second MA on 1/15/16 at 2:36 p.m. revealed no residents had complained about the cleanliness of the facility. Interview with the Administrator on 1/15/16 at 3:40 p.m. revealed: -She was aware of the repairs needed in the building. - Currently, the facility was making repairs in the building. -All of the residents' rooms will be repainted. -Housekeeping cleaned the walls and floors daily and as needed. -If a wall was damaged, housekeeping reported the damage to Maintenance for repairs.	{D 074}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. TYPE B VIOLATION Based on observations, interviews, and record	{D 270}		

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{D 270}	Continued From page 3 review, the facility failed to ensure that the level of supervision for the resident was modified after repeated falls continued for 1 of 7 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 11/18/15 revealed the resident's diagnoses included seizure disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, glaucoma, hypothyroidism, and osteoporosis. Review of the Resident's Register revealed Resident #2 was admitted to the facility on 8/03/09. Observation of Resident #2 on 1/13/16 at 2:22 p.m. revealed the resident was resting across her bed in her bedroom. Review of Incident Reports on 1/14/16 at 8:30 a.m. revealed: -For the month of October 2015, falls for Resident #2 were noted on 10/07/15 and 10/29/15. -For the month of November 2015, a fall was noted for Resident #2 on 11/21/15. -For the month of December 2015, falls were noted for Resident #2 on: 12/23/15, 12/25/15 (found on floor by facility staff), 12/26/15, 12/26/15 (found on the ground outside of facility), 12/26/15 (3x's), 12/27/15 (found on ground outside of facility), and 12/29/15 (found on the kitchen floor of facility). -For the month of January 2016, a fall was noted for Resident #2 on 1/07/16 (found on bathroom floor of bedroom in facility). Review of injuries on Incident Reports for	{D 270}		

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{D 270}	Continued From page 4 Resident #2 revealed: -The resident had a fall on 10/07/15 with a left ankle injury with an Emergency Room (ER) visit. -A fall occurred on 10/29/15 for the resident. She was assessed due to bumping her head during an ER visit -The resident fell on 11/21/15 and was assessed due to bumping her head at the ER -The resident fell on 12/23/15 resulting in a head injury, abrasion to nose, and right knee. The resident was sent to the ER. -The resident fell on 1/07/16 which resulted in a lump and an abrasion to her left knee. First aid was provided to the resident. -The resident fell on 1/14/16 reopening old areas on both knees. First aid was provided by the facility staff. Interview with Resident #2 on 1/14/16 at 9:18 a.m. revealed: -Resident felt that she was doing well at the facility. -Facility staff help her with personal care tasks to include bathing, dressing, and toileting as needed daily. -She falls when she is heading to the administrator's office sometimes. -Resident said she had falls because she has had seizures and walked too fast at times. -Resident does not remember how or when she has fallen and when she has had a seizure. -Resident said she received medicine for seizures twice a day. -Resident thought the seizure medications were helping her. -Resident said she felt dizzy before she would "blacks out." -She said when she had awakened, she was already on the floor or ground and does not remember what had happened.	{D 270}		

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{D 270}	Continued From page 5 -Resident had a small handheld call bell located on her nightstand. -She had a wheeled walker. -Resident said she felt dizzy during the interview and begun to stare straight ahead. Resident fell immediately from her bedside to the floor. Facility staff assisted resident when called by the surveyor. Interview with the Personal Care Aide (PCA) for Resident #2 on 1/14/16 at 9:35 a.m. revealed: -She said the resident falls often at least 2-3 times each month. -Facility staff asked resident to slow down when she was observed walking too fast with her walker. -She was not sure if resident falls occurred as a result of seizures. -The resident ran at times with the walker and falls. -The facility staff visually checked on all the residents every 2 hours. -She performed 30-minute visual checks of all her assigned residents. -She escorted the resident out to smoke and prompted her to slow down with the walker as needed. Interview with the Medication Aide Supervisor (MAS) for Resident #2 on 1/14/16 at 9:40 a.m. revealed: -She stated that the resident did a lot of running with her walker and fell often. -Facility staff prompted the resident to slow down. -The facility staff assisted her in and out of the building to the patio area to smoke. -Facility staff modeled how to walk with the walker with the resident. -She monitored the resident closely and checked on the resident often about every hour.	{D 270}		

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{D 270}	Continued From page 6 -She said all the facility staff are familiar with the resident's routine to include her wake up and resting times and the three areas where she normally spent her time. -The resident was only up for meals, to go outside to smoke, and rested on her bed the majority of the time. -The resident used her handheld call bell and called for "help" sometimes. -She was not sure if the resident falls are due to seizures. Interview with the second Personal Care Aide (PCA) for Resident #2 on 1/14/16 at 10:28 a.m. revealed: -When falls occurred, she called for the Medication Aide and did not leave or move the resident. -She monitored all of the residents every 30-minutes. -Facility staff were only required to check on Resident #2 every 2 hours. -The resident has had a lot of falls. -She was not sure if resident was falling due to having seizures but knew that the resident had seizures. -When resident was observed walking too fast and even jogging with her walker, she stopped her and walked with her. Telephone interview with the Physician's office for Resident #2 on 1/14/16 at 11:53 a.m. revealed: -There were no written doctor's orders for specified times for supervision checks for the resident. -The doctor was aware the resdient had falls but was not aware of all falls for the resident. -The doctor said the resident's current walker with wheels was appropriate for her with staff support as needed.	{D 270}		

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{D 270}	Continued From page 7 -The doctor was not aware that the resident ran with the walker and fell often. -Facility staff should monitor the resident more frequently as needed to help prevent falls. -The resident was last seen by the doctor on 1/07/16 following a fall with injury. -The next doctor's visit for the resident was scheduled for the upcoming week. Interview with the second Medication Aide (MA) for Resident #2 on 1/14/16 at 3:44 p.m. revealed: -She had observed the resident laying on the floor twice but did not observe her falls. -Resident was alert each time that she found her on the floor. -The resident has had a lot of falls. -After a fall, she checked the resident's vitals to include blood pressure, range of motion (ROM), and assisted her up to her walker. -She checked the resident every 30-minutes after a fall. -She has not observed the resident having a seizure or engaged in any behaviors prior to her falls. -She knew the resident was a "fall precaution person" because it was noted on her Medication Administration Record (MAR). -All staff performed 2 hour checks of all residents with 30-minute checks periodically throughout the shift for residents with fall precautions. -She informed the Resident Care Coordinator (RCC) of the resident's falls. -She did not inform the doctor of the times she found resident on the floor because no injuries were found. Interview with the third Personal Care Aide (PCA) for Resident #2 on 1/14/16 on 3:57 p.m. revealed: -The resident has had a lot of falls.	{D 270}		

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{D 270}	Continued From page 8 -She had worked with this facility and residents for the past 21 years and knew the resident very well since her arrival to the facility. -She knew the resident's routine well of mostly laying across her bed, going out to smoke, and heading to the dining area when its time to eat. -She was not sure if seizures caused her falls. -She checked the resident every 15-minutes because of her many falls. -The resident falls quickly and it was difficult to catch her in time. -The resident tried to get attention from others at times when she fallen. -The resident's behaviors were good but she would curse at staff and peers at times when upset. -The resident's behaviors included walking too fast with her walker at times while heading out to smoke or heading down the hallway. -The facility staff asked her when she was observed walking too fast with the walker to slow down and she did when asked. -She informed the Medication Aide (MA) when resident falls occurred. Interview with the Resident Care Coordinator (RCC) for Resident #2 on 1/15/16 at 11:13 a.m. revealed: -The Resident had been sent out to the hospital due to a fall around 10:30 a.m. that morning. -The Resident was running with her walker down the hallway and fell bumping her head. -The RCC said she bumped her head "very hard." -The Resident fell very quickly. -Staff were not able to stop the resident in time when she was observed running. -The Resident was sent out as a precaution to be evaluated. -The RCC was in the process of completing the	{D 270}		

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{D 270}	Continued From page 9 incident report. Interview with a resident at the facility on 1/15/16 at 11:45 a.m. revealed: -The Resident had seen Resident #2 fall many times. -The Resident had not seen Resident #2 passed out or have a seizure. -Resident #2 lost her balance a lot and fell often. -She would "yell or shout" before she fell sometimes. -The Resident had to go get staff to help Resident #2 sometimes when she had fallen. -The Resident had seen Resident #2 stare "straight ahead and not talk" while he was outside smoking with her a few times. Interview with a second resident of the facility on 1/15/16 at 12:02 p.m. revealed: -Resident #2 has had many falls and seizures. -He knew the resident had seizures and received medicine for them because Resident #2 told him, she was his friend and they spent a lot of time together. -He had seizures as well and said he knew what a seizure "looked like." -He definitely knew the resident had seizures because he had caught her several times before she would fall while she "lost control of her bowels" at the same time. -He informed staff the resident had a seizure, a toileting accident, and almost fell but he caught her several times. -Resident #2 had seizures when standing and sitting down. -When the resident had a seizure, she would say "she felt dizzy, stare off, and not answer him" when he would speak to her. -Not all of the resident's seizures resulted in a fall	{D 270}		

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{D 270}	Continued From page 10	{D 270}		

because the resident was sitting down a few of those times when she had the seizures.
-The Resident #2 had tremors, shaked a lot, and he had helped her down to the floor many times.
-Facility staff did assist when they were told that a seizure or a fall occurred.
-Facility staff assisted in cleaning up the resident's "loose bowel" accidents after her seizures and checked her vitals after a fall.
-He felt the resident should have been sent to the hospital to be checked many times after a seizure or fall.
-Resident #2 had a "bad habit" of running with her walker and falling.
-Facility staff did send the resident out to the hospital when she was hurt after a fall.
-He would like for the resident to be checked by another doctor to make sure her medications are working "good enough for her" to help with her seizures which may "stop some of her falls."

Interview with the Resident Care Coordinator (RCC) on 1/15/16 at 2:38 p.m. revealed:
-All residents, including Resident #2, are monitored and checked every 2 hours by facility staff.
- The Resident received 30-minute checks after a fall occurred.
-The Resident was seated most of the time when seizures occurred.
-She sent the resident out because the length of the seizure is unknown when the resident has had one.
-The RCC was aware that the resident has had numerous falls.
-Facility staff prompted the resident to slow down when she was observed walking or running with her walker.
-The RCC said the facility had tried a walker without wheels over a year ago and this did not

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{D 270}	Continued From page 11 work because the resident did not like to use it and preferred to walk without it. -The RCC said there had been no change made or ordered by the doctor regarding the resident's level of supervision. -Two hour checks were not documented but was the facility standard for the resdient. -Facility staff were always present throughout the building, in the hallways, to assist residents when needed. -The RCC will ask the resident's doctor on next week for a referral to the Neurologist for the resident. -The RCC did not have another contact number for the resident's guardian to be contacted successfully. Interview with the Administrator for Resident #2 on 1/15/16 at 3:00 p.m. revealed: -She was aware the resident had several falls. -When falls occurred, the residents were assessed, asked if they are hurting, an incident report was completed, the family notified, and 99% of the time the residents were sent out to the emergency room. -All residents were monitored and checked every 2 hours by facility staff. -Disoriented residents were monitored and checked by facility staff every 30-minutes. -The resident was not on the disoriented list and received 2 hour checks. -The facility relied on the doctor's recommendations regarding the frequency of checks needed for the resident. -A wheelchair had been tried with the resident a little over a year or so ago as well as a cane and walker without wheels but none of these worked for the resident. -The resident's current walker with wheels had worked the best for her but she would ask the	{D 270}		

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{D 270}	Continued From page 12 RCC to followup with the doctor on next week to determine f there were any other possible options for the resident. -The administrator had talked with the resident many times about slowing down and taking her time so she would not fall as often. -The resident had seizures but had not fallen because of seizures to her knowledge. -She was aware the resident has had increased falls and had a Falls Protocol. -Facility staff were trained at least annually regarding falls. -Facility staff were always present in the hallways to assist all residents in between the 2 hour checks when needed. -The administrator was unable to contact the resident's guardian after repeated attempts following the holidays due to their contact numbers no longer working. -The family would receive a certified letter or visit from the local authorities, as deemed appropriate, to obtain update contact information and to inform them of the resident's falls with injuries, hospital/ER visits, and overall status. Resident #2's Guardian could not be reached by the end of the survey. The facility submitted a Plan of Protection dated 1/15/16, which revealed: -Immediately the facility will notify Resident #2's primary care physician about the resident's seizures and falls. -Resident #2 will be monitored every 30 minutes by the nurse aide. The nurse aide will document the monitoring. -A supervisor will check the monitoring and the Resident Care Coordinator will check the documentation of monitoring weekly. -Residents will be assessed who has had two to	{D 270}		

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{D 270}	Continued From page 13 three falls within the past seven days. -The residents primary care physician will be contacted of the falls and will give guidance to staff. -Inservices will be provided to staff on falls and falls precautions. CORRECTION DATE FOR THE UNABATED TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 14, 2016	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure that the physician was notified of the increase in the number of seizures and falls for 1 of 7 sampled residents (#2). Review of Resident #2's current FL2 dated 11/18/15 revealed the resident's diagnoses included seizure disorder, chronic obstructive	{D 273}		

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	HAL033005	A. BUILDING: _____ B. WING _____	R-C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 14 pulmonary disease, gastroesophageal reflux disease, glaucoma, hypothyroidism, and osteoporosis. Review of the Resident's Register revealed Resident #2 was admitted to the facility on 8/03/09. Observation of Resident #2 on 1/13/16 at 2:22 p.m. revealed the resident resting across her bed in her bedroom. Review of Incident Reports on 1/14/16 at 8:30 a.m. revealed: -For the month of October 2015, falls for Resident #2 were noted on 10/07/15 and 10/29/15. -For the month of November 2015, a fall was noted for Resident #2 on 11/21/15. -For the month of December 2015, falls were noted for Resident #2 on: 12/23/15, 12/25/15 (found on floor by facility staff), 12/26/15, 12/26/15 (found on the ground outside of facility), 12/26/15 (3x's), 12/27/15 (found on ground outside of facility), and 12/29/15 (found on the kitchen floor of facility). -For the month of January 2016, a fall was noted for Resident #2 on 1/07/16 (found on bathroom floor of bedroom in facility). Review of Resident #2's Progress Notes revealed: -Fourteen falls were noted for the resident from June 1, 2015 through November 1, 2015. -The resident was seen in the ER for six of the falls that occurred from June 1, 2015 through January 7, 2016. Review of injuries on Incident Reports for Resident #2 revealed: -Resident had a fall on 10/07/15 with a left ankle	{D 273}		

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{D 273}	Continued From page 15 injury found during the ER visit. -A fall occurred on 10/29/15 for the resident. She was assessed due to bumping her head during an ER visit -Resident fell on 11/21/15 and was assessed due to bumping her head at the ER -The resident fell on 12/23/15 resulting in a head injury, abrasion to nose, and right knee. The resident was sent to the ER. -Resident fell on 1/07/16 which resulted in a lump and an abrasion to her left knee. First aid was provided to the resident. -Resident fell on 1/14/16 reopening old areas on both knees. First aid was provided by the facility staff. Telephone interview with the Physician's office for Resident #2 on 1/14/16 at 11:53 a.m. revealed: -The doctor was aware of the 1/07/16 fall because it required an emergency room visit. -The doctor was made aware of the majority of the falls for the resident that required an ER visit. - The doctor was not made aware of all of the resident's falls. -The doctor said he had spoken with the facility staff recently, after the fall on 1/07/16, regarding not being notified or made aware of all falls for this resident. -Prior to January 2016, the doctor's office had an old computer system with the falls written down as these were reported by the facility for the resident. -The majority of the falls written down for the resident were the falls that required a hospital visit. -The doctor's office had no written record of falls for the resident not requiring an ER visit. -The doctor's office is currently being notified of all falls for the resident since the fall on 1/07/16 when the doctor reminded the facility to "do a	{D 273}		

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{D 273}	Continued From page 16	{D 273}		

better job of notifying him of all falls."
-The new computer system could record the number of falls, with and without injury, for all residents when notified by the facility.
-Facility staff notified the doctor's office of all falls and incident reports since the resident fell on 1/07/16.
-The doctor was not notified of the fall for the resident that occurred on 1/14/16 at the facility in the resident's bedroom during a "seizure like" episode.
-The doctor was not notified of seizures unless these required a hospital visit.
-Resident was given a seizure protocol due to having a diagnosis of seizures.
-The doctor wanted to be made aware of all of the resident's falls with and without injury due to the increase in the frequency of the resident's falls.
-The doctor wanted to be made aware of the frequency of seizures and falls occurring with the resident in order to make changes as needed.
-The doctor did not have enough information from the facility regarding the resident's increased number of falls to recommend changes to included her walker.
-The resident received Keppra 1,000 mg tablet and Depakote 500 mg to address seizures.
-Labs results from the doctor's office were within normal range since July 2015.
-New lab work will be drawn next week during the onsite visit with the resident.

Telephone interview with Resident #2's Psychiatrist on 1/14/16 at 2:57 p.m. revealed:
-Resident received Depakote and Zoloft for behaviors.
-The psychiatrist was made aware by facility staff during in-house once every four to six month visits to the facility of the increase in the resident's behaviors to include walking too fast

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{D 273}	Continued From page 17 and running at times with her walker. -The psychiatrist was aware the resident had several falls. -The psychiatrist said he had worked with the resident since 2012 and was aware that she had several falls. -There were no concerns expressed regarding the increase in the number of the resident's falls. -The psychiatrist said that most of the resident's falls were related to her rushing outside to go smoke. -He said the resident could be "very difficult to deal with at times." -The Resident argued with the psychiatrist often about her medications. -Resident said her medications needed to be increased and would complain of back pain in an attempt to receive more medication. -The psychiatrist said the resident would have more falls with a medication increase. -Medications were administered at the most appropriate dose for the resident. -Medications were scheduled to be given at times when side effects were less likely to attribute to her falls. -The psychiatrist did not inform the resident's physician of the increased falls or behaviors for the resident reported to him by the facility staff during in-house visits to the facility. -The last Depakote level ordered and taken by the psychiatrist for the resident was on 1/24/15. -The Depakote level on 1/24/15 was elevated at 110 which was above the normal range for Depakote of 50 - 100 according to the psychiatrist. -The Depakote level was retaken for the resident on 2/21/15 and was noted at 87 which was within normal range. -The psychiatrist signed an order on 3/06/15 for the resident's Depakote level to be checked every	{D 273}		

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{D 273}	Continued From page 18 6 months. -The psychiatrist did not order another Depakote level check for the resident since the last recheck performed on 2/21/15. -The psychiatrist said that a Depakote level would be drawn next week for the resident. Interview with a resident on 1/15/16 at 12:02 p.m. revealed: -Resident #2 has had many falls and seizures. -He said he knew the resident had seizures and received medicine for them. -He had seizures as well and said he knew what a seizure "looked like." -He definitely knew the resident had seizures because he had caught her several times before she would fall while "losing control of her bowels" at the same time. -He informed staff the resident had a seizure and almost fell but he had caught her several times. -Resident #2 has had seizures when standing and sitting down. -When she had a seizure, she would "say she felt dizzy, stare off, and not answer him." -Resident #2 had tremors, shaked a lot, and he had helped her down to the floor many times. -Facility staff did assist when they were told that a seizure or fall occurred. -Facility staff assisted in cleaning up the resident's "loose bowel" accidents after her seizures and checked her vitals after a fall. Interview with the Resident Care Coordinator (RCC) on 1/15/16 at 2:38 p.m. revealed: -All residents were monitored and checked every 2 hours by facility staff. - The resident received 30-minute checks after a fall occurred.	{D 273}		

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{D 273}	Continued From page 19 -The resident was seated most of the time when seizures occurred. -She sent the resident "out" because the length of the seizure was unknown when the resident had one. -She was aware the resident has had numerous falls. -Facility staff prompted the resident to slow down when she was observed walking or running with her walker. -There had been no change made or ordered by the doctor regarding the resident's level of supervision. -The RCC would ask the resident's doctor on next week for a referral to the Neurologist for the resident. -She said the doctor's office was made aware of all falls, behaviors, and seizures for the resident. Interview with the Administrator on 1/15/16 at 3:00 p.m. revealed: -She was aware the resident had several falls. -When falls occurred, the residents were assessed, asked if they are hurting, an Incident Report was completed, the family notified, and 99% of the time the residents were sent out to the emergency room. -All residents were monitored and checked every 2 hours by facility staff. -Disoriented residents were monitored and checked by facility staff every 30-minutes. -The resident was not on the disoriented list and received 2 hour checks. -The facility relied on the doctor's recommendations regarding the frequency of checks for the resident. -The resident has had seizures but had not fallen because of seizures to her knowledge. -The resident had behaviors of walking too fast	{D 273}		

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{D 273}	Continued From page 20 and running at times with her walker which caused her to fall. -She was aware that the resident has had increased falls and had a Falls Protocol. -The doctor was contacted about what to do to help reduce the resident's falls over a year ago or so when a wheelchair and walker without wheels was tried. -A wheelchair was tried, then a walker without wheels, and both devices did not help prevent or reduce falls for the resident. -Facility staff were trained at least annually regarding falls, seizures, behaviors, etc. -Facility staff were always present in the hallways to assist all residents in between the 2 hour checks when needed. -The RCC would follow up with the doctor when he visted the facility next week (between 1/17-1/23/16) to discuss the resident's increased falls and concerns regarding seizures and behaviors. Resident #2's Guardian could not be reached by the end of the survey. _____ The facility submitted a Plan of Protection dated 1/15/16, which revealed: -Immediately the facility will notify Resident #2's primary care physician about the resident's seizures and falls. -Resident #2 will be monitored every 30 minutes by the nurse aide. The nurse aide will document the monitoring. -A supervisor will check the monitoring and the Resident Care Coordinator will check the documentation of monitoring weekly. -Residents will be assessed who has had two to three falls within the past seven days. -The residents primary care physician will be	{D 273}		

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{D 273}	Continued From page 21 contacted of the falls and will give guidance to staff. -Inservices will be provided to staff on when to contact the resident's primary physician. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 14, 2016	{D 273}		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the kitchen and dining room was cleaned. The findings are: Observation of the dining room on 1/13/16 at 10:20 a.m. revealed: -The bottom of the door post located at the entrance dining room door on the dining room on B hall had peeled paint. -One of four walls in the large dining room had dried brown stains. -The wall paper on one of four walls, which was located in the front of the dining room, had black streaks and stains on the lower part of the wall. -The metal, which was located on the lower part of the door, had rust.	{D 282}		

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{D 282}	Continued From page 22 Observation in the kitchen on 1/13/16 at 11:04 a.m. revealed: -The wall attached to the hand sink had dried brown stains. -The walls behind and beside the ice machine had dried brown stains. -The rubber was peeling off the top of the ice machine. -The vent cover, which was located on the outside at the bottom of the reach in freezer had brown and white dried stains. -The gray metal back door, which led to the outside, had brown rust stains on the lower part of the door. The upper area of the door had peeled paint. -The bottom of the door posts had brown rust stains. -The corners near the floor of 2 of 4 walls had build-up dried brown stains. Interview with a Cook on 1/15/16 at 2:15 p.m. revealed: -The walls in the kitchen and dining room are cleaned every two weeks. -The walls in the dining room were last cleaned on Thursday 1/7/16. -Dietary cleaned the outside of the ice machine. Interview with a resident on 1/13/16 at 11:41 a.m. revealed the resident did not have a problem with the cleanliness of the dining room. Interview with the maintenance staff on 1/15/16 at 2:30 p.m. revealed: -Dietary was responsible for cleaning the bottom of the reach-in freezer vent cover. -He cleaned the vent cover as needed and when instructed by the Administrator. Interview with a Medication Aide (MA) on 1/15/16	{D 282}		

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{D 282}	Continued From page 23 at 10:28 a.m. and a second MA on 1/15/16 at 2:36 p.m. revealed no residents had complained about the cleanliness of the dining room. Interview with the Administrator on 1/15/16 at 3:40 p.m. revealed: -She supervised dietary. -Repairs are currently being done in the entire facility. -The walls in the dining room, the door in the kitchen are on the list to be repaired. -The walls in the dining room should be cleaned daily and as needed. -She checked the cleanliness in the kitchen daily.	{D 282}		
{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 observation, interview and record review, the facility failed to assure residents received adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to supervision and health care referral and follow-up. The findings are: 1. Based on observations, interviews, and record review, the facility failed to ensure that the level of supervision for the resident was modified after	{D912}		

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{D912}	Continued From page 24 repeated falls continued for 1 of 7 sampled residents (#2). [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type B Violation)] 2. Based on observations, interviews, and record review, the facility failed to ensure that the physician was notified of the increase in the number of seizures and falls for 1 of 7 sampled residents (#2). [Refer to Tag D273, 10A NCAC 13F .0902(b). (Type A2 Violation)]	{D912}		