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	FCL088010	A. BUILDING: _____ B. WING _____	R-C 04/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORE'S HOME #3	65 TORE'S DRIVE BREVARD, NC 28712

(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
C 000	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted an annual and follow-up survey on March 30-31, 2016 with an exit conference via telephone on April 4, 2016.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure 4 of 5 sampled staff (Staff A, B, D, and E) were tested upon employment for tuberculosis (TB) in compliance with control measures adopted by the Commission for Health Services. The findings are:	C 140		

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C 140	Continued From page 1 A. Review of Staff A's personnel record revealed: -Staff A was hired on 2/21/06 as an Supervisor-In-Charge (SIC). -A TB skin test dated 6/28/06 with negative results. -No documentation of TB skin test upon hire. Interview with Staff A, SIC, on 3/30/16 at 8:45am revealed: -She had been employed at the facility for 9 years. -She routinely worked on the 11pm-7am shift providing care to the residents. Interview with the Facilities' Manager on 3/31/16 at 8:55am revealed he had been unable to find documentation of any TB tests for Staff A other than the one dated 6/28/06. B. Review of Staff B's personnel record revealed: -Staff B was hired on 3/26/15 as an SIC. -A TB skin test dated 7/5/15 with negative results. -A TB skin test dated 7/18/15 with negative results. -No documentation of TB skin test upon hire. Interview with the Facilities' Manager on 3/31/16 at 8:55am: -The facility had been several months late getting the 2 step TB test completed on Staff B. -He was not sure why the first test had not been completed upon hire. -"I was going to ask [Staff B] what happened with that." C. Review of Staff D's personnel record revealed: -Staff D was hired on 5/21/07 as an SIC. -A TB skin test dated 10/22/04 with negative results.	C 140		

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C 140	Continued From page 2 -A TB skin test dated 10/27/07 with negative results. -A TB skin test dated 5/2/15 with negative results. -No documentation of TB skin test upon rehire 5/21/07. Interview with the Facilities' Manager on 3/31/16 at 8:55am revealed: -The facility had "lost" Staff D's original personnel file. -Staff D "had to go back and have a 2 step [TB test] when she [returned to work] from her second maternity leave" in May 2007. -He was unable to find a TB test for Staff D completed upon her rehire on 5/21/07. D. Review of Staff E's personnel record revealed: -Staff E was hired on 9/25/14 as an SIC. -A TB skin test dated 7/11/15 with negative results. -A TB skin test dated 8/14/15 with negative results. -No documentation of a TB skin test upon hire. Interview with the Facilities' Manager on 3/31/16 at 8:55am revealed: -He was unable to find any other TB tests in the personnel record for Staff E. -He was unsure why the TB test had not been completed upon hire. -He was mainly responsible for ensuring staff completed the required TB testing and the documentation was maintained in their personnel records. _____ The facility submitted a Plan of Protection on 3/30/16 as follows: -The facility will ensure that upon hire the individual will be required to have a TB test or	C 140		

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C 140	Continued From page 3 chest x-ray completed to screen for TB. -If a chest x-ray is performed, it will include a report specifically read by a physician to screen for the presence of active TB. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 19, 2016.	C 140		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure 2 of 3 sampled residents (Resident #1 and #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: A. Review of Resident #1's record revealed: -Resident #1 was admitted to the facility on	C 202		

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C 202	Continued From page 4 3/1/16. -A TB skin test was documented as placed on 3/1/16. -No documentation the TB skin test placed 3/1/16 was read. Refer to interview with the Facilities' Manager on 3/30/16 at 4:00pm. Refer to telephone interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 4/4/16 at 11:55am. Refer to telephone interview with the Administrator on 4/4/16 at 4:00pm. B. Review of Resident #3's record revealed: -Resident #3 was admitted to the facility on 10/13/15. -A TB skin test placed 11/12/15 was read negative. -A TB skin test placed 11/26/15 was read negative on 11/28/16. -No documentation of a TB skin test upon admission to the facility or a documented prior two step TB test prior to admission. Refer to interview with the Facilities' Manager on 3/30/16 at 4:00pm. Refer to telephone interview with the LHPS RN on 4/4/16 at 11:55am. Refer to telephone interview with the Administrator on 4/4/16 at 4:00pm. _____ Interview with the Facilities' Manager on 3/30/16 at 4:00pm revealed: -"I was not aware we had to have the TB test	C 202		

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C 202	Continued From page 5 done before [the resident] was admitted" to the facility. -"What happens when a hospital wants to discharge someone to here. They won't place the TB test." -"We were getting [the TB tests] done when [the LHPS Nurse's name] was here to place them the next time she was here." Telephone interview with the LHPS RN on 4/4/16 at 11:55am revealed she was in the facility one day a week every week to provide services the facility required. Telephone interview with the Administrator on 4/4/16 at 4:00pm revealed he thought he had 7 days to obtain a TB test for a newly admitted resident. _____ The facility submitted a plan of protection on 3/30/16 as follows: -We will ensure that Residents have a TB test performed before admission or upon admission (day of admission). -Resident #1 will get an immediate TB test. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 19, 2016.	C 202		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in	C 243		

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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 observation, interview, and record review, the facility failed to provide supervision for 1 of 3 sampled residents (Resident #3) with a wrist fracture, contusion of the right ribs and shoulder, and a broken nose due to falls.

The findings are:

Review of Resident #3's current FL2 dated 2/10/16 revealed:
-Diagnoses included advanced dementia, hypothyroidism, gastroesophageal reflux disease, hemorrhoids, and constipation.
-Resident #3 was documented constantly disoriented, semi-ambulatory, and occasionally incontinent of bladder and bowel.
-A physician's order for oxygen 2 liters continuously at night.

Review of Resident #3's Resident Register revealed an admission date of 10/13/15.

Review of Resident #3's Care Plan dated 12/10/15 revealed:
-The resident was documented as a wanderer and ambulatory with a walker or in a wheelchair.
-The resident was documented as sometimes disoriented with significant memory loss.
-The resident was documented as requiring limited staff assistance with transfers.
-The resident was documented as requiring extensive staff assistance with toileting and ambulation/locomotion.
-The resident was documented as totally

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C 243	Continued From page 7 dependent on staff for bathing, dressing, grooming, and personal hygiene. Observation of Resident #3 on 3/30/16 at 8:45am revealed: -The resident was sitting in a wheelchair and was wearing a properly applied Posey belt. -The resident had two purple areas 1/2 inch wide by 1" long under each eye with some swelling and greenish areas of discoloration on both sides of her nose. Interview with Staff A, Supervisor-In-Charge (SIC), on 3/30/16 at 8:45am revealed: -She had worked in the facility for 9 years. -She had worked the 11pm-7am shift on 3/29/16 and was just getting ready to leave. -Resident #3 had fallen during her shift on 3/29/16 and had just returned from being evaluated at the local hospital. -"I was in the kitchen and I heard a loud noise. Then about 35 minutes later the other girl that was here (I was training her last night) saw [Resident #3] sitting in the floor by her door." -Resident #3 "was looking up at us with blood all over her hands and [her] nose was bleeding." -"I think she tripped over her oxygen cord." -"The new [oxygen] cord we got for her is not as long." -"It's hard to tell, she may have slid out of bed." -Resident #3 had been sent out to the local hospital for evaluation and "she came right back." -"Just had a little broken nose and pride. That's about it." -"They will probably end up getting a hospital bed for her. She still has that big bed" in her room. -Resident #3 had fallen before this incident, but "she's been doing really well." Interview with Resident #3 on 3/30/16 at 8:50am	C 243		

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revealed:
-"I fell."
-"I'm kinda washed out."

Review of Resident #3's Emergency Room (ER) discharge summary dated 3/30/16 revealed:
-Resident #3 "presents with facial injury after fall in which she slipped and fell while getting out of bed."
-"She has had [nose bleed]. No known loss of consciousness."
-The resident's initial blood pressure was 182/64.
-A CT of the head was performed and showed "no evidence of acute traumatic brain injury."
-A CT of the cervical spine was performed with "no cervical spine fracture identified."
-The resident's diagnosis was contusion of nose and mild nose bleed.
-"Nose may be broken. Avoid reinjury and falls."

Review of Resident #3's Accident Reports and Nurses Notes concerning fall occurrences from 11/9/15 to 12/10/16 revealed:
-On 11/9/15 at 7:30pm, the resident "appeared to have been trying to use walker and cane at the same time" when "she fell in her bedroom." The resident's range of motion and vitals were checked and "both were fine and no visible markings from the fall were seen..." The Supervisor-On-Call (SOC) was notified. The resident was not sent out for evaluation.
-A nurses note dated 11/29/15 documented "at around" 3pm, "resident was playing with walker and fell on her bottom." SOC notified. "Resident got up and said she was fine and she did not hit her head or anywhere else just her bottom."
-On 12/7/15, the resident was sitting in a chair in the facility dining room and "...got up and tried to move chair and fell back and hit her head on door frame." The SOC was notified. The resident was

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immediately sent out for evaluation.
-On 12/8/15 at 8:30pm, the resident "got out of bed and fell" and staff found her "laying on the ground by her closet." There were no apparent injuries. The resident's blood pressure was 128/57, heart rate=79, and O2sat=98%. The Power of Attorney (POA) was notified and "said there was no need for her to go to the hospital." The resident was not sent out for evaluation.
-A nurses note dated 12/8/15, "Ativan has been [discontinued] and we now have order for [as needed] wheelchair and belt."
-On 12/9/15, staff gave the resident a glass of tea and "when she went to pick it up and I noticed her wrist was really red and swollen." The POA was notified and "he said to make her a doctor's appointment for the next morning." The resident "can move her wrist and said it doesn't hurt unless she moves it."
-A nurse's note dated 12/10/15 at 4:30pm, Resident #3 was "taken to [emergency room for reason of] swelling, bruising, and pain [in] right wrist."
-A nurse's note dated 12/10/15 3pm to 11pm, Resident #3 was taken to the emergency room "X-rays of wrist (broken/fractures) came back around 6:30[pm] with cast on wrist and in sling..."

Review of Resident #3's ER discharge summary dated 12/10/15 revealed:
-Resident #3 presented to the ER with "right wrist pain [times] 3 days."
-"Patient lives at [facility name] and fell 3 days ago."
-"Patient was assessed in the ED with negative CT of the head."
-Resident #3's "...primary reason for visit is right wrist pain, swelling, and influenza."
-The resident was diagnosed with a closed fracture of the right wrist.

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C 243	Continued From page 10 Review of Resident #3's Restraint Assessment and Care Plan dated 12/10/15 revealed: -The medical reason for the restraint was "unsteady balance." -The type of restraint to be used was wheelchair and pelvic belt. -The time period the restraint was to be used was as needed "when unsteady." Review of Resident #3's Request for Physician's Order to Use and/or Purchase Medical Equipment dated 12/10/15 revealed: -Wheelchair was selected due to "Resident high risk for falls, insufficient balance/stability to ambulate. -Posey Belt was selected and defined as "Used to secure resident in Geriatric chair or wheelchair to prevent resident from exiting without assistance, therefore preventing falls or injury..." -Walker to be used at all times when the resident is transferring and walking to assist with balance / avoid falls. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 12/17/15 revealed: -"Resident has experienced a significant change since last review" on 11/12/15. -The resident's "Gait became increasingly unsteady and residents' confusion increased." -"Resident has been placed in a [wheelchair] with pelvic restraint for safety. Staff checks every 30 minutes and releases and exercises every 2 hours." -"Resident experienced a fall 12/7/15. The POA refused to send the resident to the hospital on that date. Resident's right wrist began to swell and resident was sent to the [emergency department]."	C 243		

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-"Resident received a closed fracture to the distal radius. Resident to wear a splint to the hand but continuously refuses to wear it. Due to mental status, resident is unable to understand the significance of wearing the brace and will remove the brace when staff applies."
-"Requires staff assist with ambulation and stand-by assist with transfers."
-"PT to [evaluate] and [treat] if indicated."
-No recommended changes in caring for Resident #3.

Review of Resident #3's physician' visit note dated 1/5/16 revealed:
-The resident problem was a fracture of the right wrist.
-An X-ray was performed through the cast and showed no further loss of position with no healing yet. Re-x-ray one month unless there is a problem with the cast.

Continued review of Resident #3's Accident Reports and Nurse's Notes concerning fall occurrences from 12/21/15 to 1/15/16 revealed:
-On 12/21/15, the resident after having been removed from her restraint was sitting on the couch then "fell on the floor by the couch." There were no apparent injuries. The resident's blood pressure was 159/83, heart rate=92, and O2sat=98%. The POA was notified and he did not want her sent out for evaluation.
-On 1/8/16, staff found Resident #3 in her room "sitting on floor." There were no apparent injuries. The resident's blood pressure was 138/79 and heart rate was 103. The SOC was notified. The resident was not sent out for evaluation.
-On 1/15/16, Resident #3 was helped to bed by staff at 9:30pm and "went to give another resident a shower and I heard a thump and went out and [Resident #3's name] was sitting in the middle of

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the hallway." "I asked did she fall and she said yes. I checked her over and took her vitals" BP=159/83, heart rate=67, and O2sat 95%. The SOC was notified. The resident was not sent out for evaluation.

Review of Resident #3's ER discharge summary dated 1/26/16 revealed the resident was evaluated for a contusion of the rib on the right side, a contusion of the right shoulder, and a fall.

Continued review of Resident #3's Accident Reports and Nurses Notes concerning fall occurrences from 1/28/15 to 3/30/16 revealed:
-On 1/28/16, Resident #3 was in her room and the staff was in the kitchen and the staff "heard a loud thump" and went in and found the resident "laying on the ground with wheelchair and belt still attached.""Looks like she tipped the wheelchair on its side." There were no apparent injuries. The resident's blood pressure was 144/79, heart rate=74, and O2sat=96%. SOC was notified.
-On 1/28/16, "Doing shift change heard a big thump." Staff went to the Resident #3's room and found her "laying in the floor." SOC notified. There were no apparent injuries. The resident's blood pressure was 134/64 and heart rate=80.
-A nurse's note dated 2/16/16 11pm to 7am, Resident #3 "Fell at 12:40am while trying to get out of bed. Did [range of motion and] all seems ok, although she did complain of some right shoulder pain." SOC was notified. As needed pain medication was administered to the resident.
-On 2/17/16, "I was in the kitchen when I heard a loud noise. As I went down the hall, I saw [Resident #3's name] sitting on the floor beside her bed. She had one sock on and one off. I asked her if she was ok she complained of some pain on her [right] shoulder. [Range of motion] was ok. At the time, there were no bruises noted."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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The resident's blood pressure was 152/134, heart rate was 68, and o2sat was 98%. "No apparent head injuries noted." SOC was notified. Norco 5/325mg was given to the resident. Resident "rested well rest of the shift."
-On 3/12/16, Resident #3 "was out of her wheelchair. She had gotten out of the gate [sic] belt, taken off her pants, shoes and socks. She came out of [another resident's room] wearing nothing but her shirt and underwear. I got her to sit in a chair. I went to look for her wheelchair and bring it to her. While I was getting her chair she got up and was walking and fell near [a resident's room]. I looked her over very good didn't see any skin tears or broken bones. I ask her was she hurting anywhere, she said no. She appears to be fine at this time." SOC notified.
-On 3/29/16, Staff "heard noise went in each room and all residents were in their beds. [Another staff member's name] was returning from smoke break and found [Resident #3] on the floor next to her door. Blood was everywhere. [SOC's name] was notified and [emergency medical service] was called and transported [Resident #3] to [local hospital name]. [Resident #3] returned around 3:30am. We put her to bed and in 5 minutes she was back up. Has fractured nose and eyes are black." Vitals were taken and the resident's blood pressure was 158/52, heart rate was 70. Resident #3 "denied any pain-although SOC told me to give her Tylenol along with her regular meds." Resident #3's "appetite was normal and she was going strong when I left."

Review of Resident #3's LHPS evaluation dated 3/16/16 revealed:
-"Resident [continues] to be in a [wheelchair] with a pelvic restraint seat belt for safety. Restraint observed to be applied correctly. Staff checks

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every 30 minutes and releases and exercises every 2 hours."
-"Resident no longer required to wear wrist splint."
-"Requires staff assist with ambulation and stand-by-assist transfers."
-"Resident observed to be up in [wheelchair] propelling self in facility with her feet."
-No documentation regarding Resident #3's frequent falls since last LHPS evaluation.

Review of Resident #3's Physical Therapy (PT) notes revealed:
-PT "resumption of care" on 10/26/15. "Plan to perform PT trial for [two times a week] for 4 weeks for balance and gait training. Progress is guarded at this time due to severe dementia."
-On 10/28/15, PT visit "to work on increasing balance with stability training and dynamic balance work."
-On 11/2/15, PT visit "working on gait training to increase step length and decrease shuffle steps. Extreme exit seeking behavior today that was very distracting to PT session."
-On 11/4/15, PT visit "to increase dynamic balance."
-On 11/10/15, PT visit "working on dynamic balance activities and strengthening."
-On 11/13/15, PT visit "[Resident #3] showed some increased confusion today and inability to respond to verbal cues or demonstration."
On 11/16/15, PT visit "working on increased balance with directional changes while walking and balance on uneven surfaces."
-On 11/18/15, PT visit "to address balance-worked on using the [front wheeled walker] for use in the house as [patient] is very unsteady on her feet."
-On 11/27/15, PT reassessment visit "[Patient] is not showing good education carry over or

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retention. Plan to [discharge] from PT next week due to difficulty [with retention]. Staff instructed to remind [patient] to use [front wheeled walker] at all times as she is safer using the [front wheeled walker] than without."
-On 12/3/15, PT discharge visit "as [patient] is not retaining any information provided by PT and is unable to follow directions or mimic demonstration for balance or gait training. [Patient] is at max potential right now due to cognitive restraints."

Review of Resident #3's Speech Therapy (ST) notes revealed:
-On 10/28/15, ST visit for "resumption of care" for cognitive linguistic deficits."
-From 10/28/15 to 12/2/15, Resident #3 received twice weekly visits from ST for "cognitive linguistic deficits" and increasing "safety awareness."
-On 12/2/15, Resident #3 was discharged from ST due to "[Patient] is not retaining info /strategies from ST. [Patient] is maximum functioning level [at] this time..."

Interview with the SOC on 3/30/16 at 10:55am revealed "If a resident hits their head there's no choice [the resident] has to go to the [emergency room]" for evaluation.

Interview with Staff A, SIC, on 3/31/16 at 8:30am revealed:
-"We just keep [Resident #3] in her wheelchair close to us."
-"She's done better with falls, since we got the wheelchair for her."
-On the night of 3/29/16, "she just somehow got out of bed..."
-"Used to she would lean forward and try to walk too fast which was making her unsteady."
-Resident #3's falls occurred on "all shifts."

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C 243	Continued From page 16 Interview with Staff E, Supervisor, on 3/31/16 at 10:05am revealed: -She usually worked the 3pm to 11pm shift. -Resident #3 "has not fallen on my shift." -"I keep the Posey belt on her. [It] helps to keep her from taking her clothes off and from falling." -Resident #3 was "able to stand on her own-very brave to try to walk to bathroom." Interview with the SOC on 3/31/16 at 10:11am revealed: -The wheelchair and Posey belt had been the main interventions tried at the facility to prevent Resident #3 from falling. -The "main issue we battle is her getting out of bed." -Resident #3 "attempts to get into the wheelchair on her own or take herself to the bathroom" which staff believed were the cause of the resident's falls. -"We tried to keep her in the living room and kitchen to be right with her." -"We have decided to put her mattress and boxspring's on the floor" to help prevent falls, because the resident "won't have the strength" to get up from the bed being on the floor. -Resident #3's physician is aware of the falls and he received a copy of all of the Accident Reports." -Resident #3's physician had not made any other recommendations on how to prevent the resident from falling. -Resident #3's POA was made aware of the falls. Interview with the SOC on 3/31/16 at 11:20am revealed: -She was not aware if the facility had a fall policy. -Routine staffing in the facility was one SIC. -The SOC was always on call for any questions or concerns staff might have.	C 243		

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-There was a "float" staff that was available 8am to 7pm 7 days a week which could be utilized by the SIC for residents requiring 2 person assist transfers and for bathing assistance.
-The Activities Director was in and out of the facility 4 hours out of 8 hours on Mondays, Wednesday, and Fridays and was also available after lunchtime on Tuesdays and Thursdays.

Interview with the Facilities' Manager on 3/31/16 at 11:25am revealed:
-"I don't know if there's anything written" in regards to the facility's policy on falls.
-When a resident fell "we get the physician involved, the [emergency room] involved, and the families involved."
-"We try to get [float staff position] to work [SIC] position when there's an absence, etc."

Telephone interview with Staff F, SIC, on 4/1/16 at 7:00am revealed:
-She had recently been hired at the facility and was still training on 11pm to 7am shift.
-She had worked the 11pm to 7am shift on 3/29/16 and was there when Resident #3 had fallen.
-"We did rounds and everyone was in bed."
-"I had taken a smoke break and as I came through the back door [Resident #3's name] was sitting in the floor with blood all over her face, hands, and nightgown.."
-There was "so much blood, we had a hard time figuring out where all the blood was coming from."
-Staff got the resident into the bathroom and started getting the resident cleaned up and "that is when we saw her nose."
-"I went over and started changing her bed and that's when I saw a blood clot (the size of a half dollar) in a puddle of blood. That's where we think

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she hit the floor. Think she fell out face first. There was blood on her oxygen tubing thing that goes in her nose."
-"She keeps her [oxygen] on pretty much."
-"She did get something-medicine because she had gotten up twice. Then she settled down, we got her in the bed. Then about an hour and a half later this happened."
-To maintain Resident #3's safety, staff on the 11pm to 7a shift did more frequent checks on Resident #3 and used the wheelchair and Posey belt for the resident.
-The resident's bed had been put on the floor and Resident #3 "did not try to get up last night [3/31/16]..."

Telephone interview with Resident #3's POA on 4/1/16 at 1:25pm revealed:
-The facility had notified him after each fall occurrence Resident #3 had experienced.
-Facility staff had "taped the towel rack up in the bathroom" to prevent Resident #3 from trying to hold onto it to prevent falls.
-"I thought they were doing the best they could" to prevent Resident #3 from falling.
-"She was falling at home, before we took her [to the facility]. That's why we took her to [name of the facility]."
-Resident #3 had received "one on one" care at home, but she had "become belligerent with [the in home staff]. Felt [facility's name] was better place."
-"I think they are doing an excellent job."
-"[Facility's Manager's name] calls me anytime anything happens."

Telephone interview with the Facilities' Manager on 4/1/16 at 1:50pm revealed there was not a facility falls policy, however "we are putting one together."

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C 243	Continued From page 19 Telephone interview with the LHPS Nurse on 4/4/16 at 11:55am revealed: -"I'm in [the facility] one day a week." -It was very hard to "redirect" Resident #3. -"[Staff] try to keep [Resident #3] with them ...give her stuff to do like coloring and folding wash clothes." -"We can tell when she rolls wheelchair to her room she needs toileting." -"The Ativan played a direct role with her [the fall and the wrist fracture]." -"I did not know anything about the fall on 1/26/16 and the rib contusion." -She was unaware Resident #3 had multiple fall occurrences after her LHPS visit on 12/17/15. -"I didn't know anything about those falls. They didn't tell me. Maybe because there were no injuries and no required evaluation." Telephone interview with Resident #3's physician's office triage nurse on 4/4/16 at 12:55pm revealed: -Facility staff had been in "constant contact" with Resident #3's physician "about her falls." -The facility had started "contacting us more frequently over the past couple weeks asking for more orders." -Orders "over the past couple weeks" requested by the facility staff to implement for Resident #3 included putting her bed on the floor, a personal alarm, and a bed alarm. -The physician was going to see Resident #3 "tomorrow" and extra time had been allotted for the appointment for the physician to see if there were any other recommendations to be made. Telephone interview with the Administrator on 4/4/16 at 4:00pm revealed: -The Posey belt used for Resident #3 was not a	C 243		

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C 243	Continued From page 20 restraint, but an "enabler" because the resident still had freedom of movement throughout the facility by using her arms and legs in the wheelchair. -"We have shown due diligence in everything we have done" to prevent Resident #3's falls. -"We would have to chemically or physically restrain her, because one on one staff with her is unreasonable. It is cost prohibitive to put one on one staff on a resident." -Moving Resident #3 to a higher level of care "is not going to give [the resident] better care." -"We have taken appropriate steps to reduce her fall risks." Confidential interviews with two residents revealed: -"They ought to hire more staff. The staff here are running all the time." -"...They could use more staff on the floor. When only one person is here and two people need help, it can get hectic." _____ A Plan of Protection was provided on 3/31/16 as follows: -Resident #3's bed mattress will be put on the floor to eliminate the possibility of falling out of bed. -Primary Care Provider will be contacted to determine measures that can be implemented to prevent falls. _____ CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 4, 2016.	C 243		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support	C 254		

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C 254	Continued From page 21 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure Licensed Health Professional Support (LHPS) recommendations for changes in care related to frequent falls for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 2/10/16 revealed: -Diagnoses included advanced dementia, hypothyroidism, gastroesophageal reflux disease, hemorrhoids, and constipation.	C 254		

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C 254	Continued From page 22 -Resident #3 was documented constantly disoriented, semi-ambulatory, and occasionally incontinent of bladder and bowel. Review of Resident #3's Resident Register revealed an admission date of 10/13/15. Review of Resident #3's Care Plan dated 12/10/15 revealed: -The resident was documented as a wanderer and ambulatory with a walker or in a wheelchair. -The resident was documented as sometimes disoriented with significant memory loss. -The resident was documented as requiring limited staff assistance with transfers. -The resident was documented as requiring extensive staff assistance with toileting and ambulation/locomotion. -The resident was documented as totally dependent on staff for bathing, dressing, grooming, and personal hygiene. Review of Resident #3's Request for Physician's Order to Use and/or Purchase Medical Equipment dated 12/10/15 revealed: -Wheelchair was selected due to "Resident high risk for falls, insufficient balance/stability to ambulate. -Posey Belt was selected and defined as "Used to secure resident in Geriatric chair or wheelchair to prevent resident from exiting without assistance, therefore preventing falls or injury..." -Walker to be used at all times when the resident is transferring and walking to assist with balance / avoid falls. Review of Resident #3's LHPS evaluation dated 12/17/15 revealed: -"Resident has experienced a significant change since last review" on 11/12/15.	C 254		

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C 254	Continued From page 23 -The resident's "Gait became increasingly unsteady and residents' confusion increased." -"Resident has been placed in a [wheelchair] with pelvic restraint for safety. Staff checks every 30 minutes and releases and exercises every 2 hours." -"Resident experienced a fall 12/7/15. The POA refused to send the resident to the hospital on that date. Residents right wrist began to swell and resident was sent to the [emergency department]." -"Resident received a closed fracture to the distal radius. Resident to wear a splint to the hand, but continuously refuses to wear it. Due to mental status, resident is unable to understand the significance of wearing the brace and will remove the brace when staff applies." -"Requires staff assist with ambulation and stand-by assist with transfers." -"PT to [evaluate] and [treat] if indicated." -No recommended changes in caring for Resident #3. Review of Resident #3's Accident Reports and Nurse's Notes concerning fall occurrences from 12/21/15 to 1/15/16 revealed: -On 12/21/15, the resident after having been removed from her restraint was sitting on the couch then "fell on the floor by the couch." There were no apparent injuries. The resident's blood pressure was 159/83, heart rate=92, and O2sat=98%. The POA was notified and he did not want her sent out for evaluation. -On 1/8/16, staff found Resident #3 in her room "sitting on floor." There were no apparent injuries. The resident's blood pressure was 138/79 and heart rate was 103. The SOC was notified. The resident was not sent out for evaluation. -On 1/15/16, Resident #3 was helped to bed by staff at 9:30pm and "went to give another resident	C 254		

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a shower and I heard a thump and went out and [Resident #3's name] was sitting in the middle of the hallway." "I asked did she fall and she said yes. I checked her over and took her vitals" BP=159/83, heart rate=67, and O2sat 95%. The SOC was notified. The resident was not sent out for evaluation.

Review of Resident #3's hospital discharge summary dated 1/26/16 revealed the resident was evaluated for and diagnosed with a contusion of ribs right side and right shoulder.

Review of Resident #3's Accident Reports and Nurses Notes concerning fall occurrences from 1/28/15 to 3/12/16 revealed:
-On 1/28/16, Resident #3 was in her room and the staff was in the kitchen and the staff "heard a loud thump" and went in and found the resident "laying on the ground with wheelchair and belt still attached.""Looks like she tipped the wheelchair on its side." There were no apparent injuries. The resident's blood pressure was 144/79, heart rate=74, and O2sat=96%. SOC was notified.
-On 1/28/16, "Doing shift change heard a big thump." Staff went to the Resident #3's room and found her "laying in the floor." SOC notified. There were no apparent injuries. The resident's blood pressure was 134/64 and heart rate=80.
-A nurse's note dated 2/16/16 11pm to 7am, Resident #3 "Fell at 12:40am while trying to get out of bed. Did [range of motion and] all seems ok, although she did complain of some right shoulder pain." SOC was notified. As needed pain medication was administered to the resident.
-On 2/17/16, "I was in the kitchen when I heard a loud noise. As I went down the hall, I saw [Resident #3's name] sitting on the floor beside her bed. She had one sock on and one off. I asked her if she was ok she complained of some

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pain on her [right] shoulder. [Range of motion] was ok. At the time, there were no bruises noted." The resident's blood pressure was 152/134, heart rate was 68, and o2sat was 98%. "No apparent head injuries noted." SOC was notified. Norco 5/325mg was given to the resident. Resident "rested well rest of the shift."
-On 3/12/16, Resident #3 "was out of her wheelchair. She had gotten out of the gate [sic] belt, taken off her pants, shoes and socks. She came out of [another resident's room] wearing nothing but her shirt and underwear. I got her to sit in a chair. I went to look for her wheelchair and bring it to her. While I was getting her chair she got up and was walking and fell near [a resident's room]. I looked her over very good didn't see any skin tears or broken bones. I ask her was she hurting anywhere, she said no. She appears to be fine at this time." SOC notified.

Review of Resident #3's LHPS evaluation dated 3/16/16 revealed:
-"Resident [continues] to be in a [wheelchair] with a pelvic restraint seat belt for safety. Restraint observed to be applied correctly. Staff checks every 30 minutes and releases and exercises every 2 hours."
-"Resident no longer required to wear wrist splint."
-"Requires staff assist with ambulation and stand-by-assist transfers."
-"Resident observed to be up in [wheelchair] propelling self in facility with her feet."
-No recommendations documented.

Interview with the SOC on 3/31/16 at 10:11am revealed:
-The wheelchair and Posey belt had been the main interventions tried at the facility to prevent Resident #3 from falling.

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C 254	Continued From page 26 -The "main issue we battle is her getting out of bed." -Resident #3 "attempts to get into the wheelchair on her own or take herself to the bathroom" which staff believed were the cause of the resident's falls. -"We tried to keep her in the living room and kitchen to be right with her." -"We have decided to put her mattress and boxspring's on the floor" to help prevent falls, because the resident "won't have the strength" to get up from the bed being on the floor. -Resident #3's physician is aware of the falls and he received a copy of all of the Accident Reports." -Resident #3's physician had not made any other recommendations on how to prevent the resident from falling. -Resident #3's POA was made aware of the falls. Telephone interview with the Licensed Health Professional Support (LHPS) Nurse on 4/4/16 at 11:55am revealed: -"I'm in [the facility] one day a week." -It was very hard to "redirect" Resident #3. -"[Staff] try to keep [Resident #3] with them ...give her stuff to do like coloring and folding wash clothes." -"We can tell when she rolls wheelchair to her room she needs toileting." -"The Ativan played a direct role with her [the fall and the wrist fracture]." -"I did not know anything about the fall on 1/26/16 and the rib contusion." -She was unaware Resident #3 had multiple fall occurrences after her LHPS visit on 12/17/15. -"I didn't know anything about those falls. They didn't tell me. Maybe because there were no injuries and no required evaluation."	C 254		

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C 347	Continued From page 27	C 347		
C 347	10A NCAC 13G .1004 (o) Medication Administration 10A NCAC 13G .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and that the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure that medications were not being shared except for emergencies for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 2/10/16 revealed: -Diagnoses included advanced dementia, constipation, and hemorrhoids. -A physicians order for Miralax (used to soften the stool and increases the number of bowel movements) 17gm daily at bedtime. Review of a prescription for Resident #3 dated 10/16/15 revealed: -Miralax one powder daily at bedtime. -The prescription provided a 12 month supply of the medication for the resident. Observation of Resident #3's available medications in the facility on 3/30/16 at 11:55am revealed there was no Miralax powder available	C 347		

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C 347	Continued From page 28 on the medication cart. Telephone interview with the facility pharmacy on 3/30/16 at 2:50pm revealed: -They had received two orders for Resident #3 for Miralax. -The first order was dated 10/16/15 and was written for Miralax one powder daily at bedtime with a 12 month supply. -The pharmacy had interpreted the physician's order as Miralax 17gm daily at bedtime. -The Miralax order had been renewed on the FL2 dated 2/10/16 for Miralax 17gm to be given daily at bedtime. -The first dispense of Miralax powder for Resident #3 had occurred once from their pharmacy on 11/27/15. -The dispense on 11/27/15 had been a 527gm size bottle which was enough to last the resident 30 days. -They were "filling it again today." Review of Resident #3's November 2015 Medication Administration Record (MAR) revealed: -A handwritten entry for Miralax 17gm with 8oz. liquid daily at bedtime. -The Miralax was documented as administered for 27 occurrences out of 30 opportunities. -On 11/25/15, 11/26/15, and 11/27/15, initials were circled indication the medication had not been administered. -On 11/25/15, a handwritten entry on the back of the MAR documented "Med not here to administer." -On 11/26/15, a handwritten entry on the back of the MAR documented "Med not in med cart. Pharmacy notified." -On 11/27/15, a handwritten entry on the back of the MAR documented "Medication not	C 347		

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C 347	Continued From page 29 administered." Review of Resident #3's December 2015 MAR revealed: -A computer generated entry for Miralax 17gm in 8oz of liquid daily at bedtime. -The Miralax was documented as administered for 29 occurrences out of 31 opportunities. -On 12/7/15, a handwritten entry on the back of the MAR documented "Resident was unresponsive when meds were due to be given." Review of Resident #3's January and February 2016 MARs revealed: -Computer generated entries for Miralax 17 gm in 8oz. of liquid daily at bedtime. -The Miralax was documented as administered for 58 occurrences out of 59 opportunities. -On 2/8/16, a handwritten entry on the back of the MAR documented "Refused drink and Miralax." Review of Resident #3's March 2016 MAR revealed: -A computer generated entry for Miralax 17gm in 8oz of liquid daily at bedtime. -The Miralax was documented as administered for 27 occurrences out of 29 opportunities. -On 3/8/16, a handwritten entry on the back of the MAR documented "Med hasn't come from pharmacy yet." Review of Resident #3's Bowel Movement logs for November 2015 through March 2016 revealed: -Staff documented bowel movements for the resident for first, second, and third shift. -Frequent bowel movements were documented by staff for Resident #3 for November 2015 through March 2016.	C 347		

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Review of Resident #3's Medication Review dated 12/17/15 revealed there were no recommendations made to the facility.

Review of Resident #3's Medication Review dated 2/10/16 revealed there were no recommendations made to the facility.

Interview with the Supervisor-On-Call (SOC) on 3/30/16 at 2:50pm and 3:19pm revealed:
-The Miralax had been documented as administered for Resident #3 at 8pm on 3/29/16, but "I can't find any on the cart for [Resident #3]."
-She had texted the staff who documented the administration on 3/29/16 at 8pm and the staff had replied she had given the medication to the resident.
-Resident #1 was the only other resident in the facility that had orders for Miralax and the order was for as needed.
-Staff may have been administering the Miralax that belonged to Resident #1.
-Or perhaps, "If [Resident #3 is] refusing [the Miralax, the staff] aren't documenting the refusals."

Observation of Resident #1's Miralax supply on the medication cart on 3/30/16 at 3:22pm revealed there was 1/3 left of the 527gm bottle dispensed from the pharmacy on 3/1/16.

Review of Resident #1's documentation sheet for as needed doses of Miralax revealed there were no documented administered doses since the medication was dispensed to the resident on 3/1/16.

Telephone interview with the facility pharmacy on 3/30/16 at 3:23pm revealed there had been only one bottle of Miralax (a 30 day supply) dispensed

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C 347	Continued From page 31 to Resident #1, and it had been dispensed on 3/1/16. Interview with the Facilities Manager on 3/31/15 at 9:47am revealed: -The pharmacy sent over preprinted Medication Administration Records (MARs) every month. -Either the Supervisor-On-Call or the Supervisor in the home checks the preprinted MARs for accuracy with all new orders for each resident. -The staff "probably checks for the meds on the cart at this time." Interview with a Medication Aide on 3/31/16 at 10:05am revealed: -She routinely worked 3pm to 11pm shift. -"I gave [Resident #3] Miralax on every shift that I work." -"We had been using [Resident #1's name's Miralax] because [Resident #3's name] bottle was empty." -"That's the first time" she had ever borrowed another resident's medication to give to another resident. -"We don't borrow meds. I just thought that was her Miralax." Interview with the SOC on 3/31/16 at 10:11am revealed she relied upon staff to let her know when a medication like Miralax needed to be reordered from the pharmacy. Telephone interview with the SOC on 4/4/16 at 4:04pm revealed: -The Miralax was administer to Resident #3 as was documented on the MARs. -Staff had used left over Miralax from one resident who had passed away to administer to Resident #3.	C 347		

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C 347	Continued From page 32 Telephone interview with the Administrator on 4/4/16 at 4:05pm revealed: -"I don't want staff to throw away useable medication." -"We are trying to save our customers money." -The pharmacy would not issue a credit to the family for an open bottle of Miralax.	C 347		
C 456	10A NCAC 13G .1301(d) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be	C 456		

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made within 24 hours and documented in the resident's record.
(6) The restraint order shall be kept in the resident ' s record.

This Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to obtain an updated restraint order every 3 months for 1 of 2 sampled residents (Resident #3) with orders for restraints.

The findings are:

Review of Resident #3's current FL2 dated 2/10/16 revealed:
-Diagnoses included: advanced dementia, hypothyroidism, hemorrhoids, and gastroesophageal reflux disease.
-Resident #3 was documented constantly disoriented, semi-ambulatory, and occasionally incontinent of bladder and bowel.

Review of Resident #3's Resident Register revealed an admission date of 10/13/15.

Observation of Resident #3 on 3/30/16 at 12:22pm revealed:
-Resident #3 was sitting in a wheelchair in the dining room wearing a Posey belt that was secured in a quick release tie behind her wheelchair.
-Resident #3 was appropriately positioned in the wheelchair with no evidence of any acute distress.

Review of Resident #3's Licensed Health Professional Support (LHPS) review dated 12/17/15 revealed:
-"Resident has experienced a significant change

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since last review" completed 11/12/15.
-"Gait became increasingly unsteady and resident's confusion increased."
-"Resident has been placed in a [wheelchair] with a pelvic restraint for safety."
-"Staff checks every 30 minutes and releases and exercises every 2 hours."

Review of Resident #3's Restraint Assessment and Care Plan dated 12/10/15 revealed:
-The benefits and risk associated with the use of a restraint were listed at the top of the form.
-The medical reason for the restraint was "unsteady balance."
-The type of restraint to be used was wheelchair and pelvic belt.
-The time period the restraint was to be used was as needed "when unsteady."
-The restraint was to be checked every 30 minutes and "loosened every 2 hours."
-The form was signed by a physician.

Review of Resident #3's Request for Physician's Order to Use and/or Purchase Medical Equipment dated 12/10/15 revealed:
-Wheelchair was selected due to "Resident high risk for falls, insufficient balance/stability to ambulate.
-Posey Belt was selected.
-Description of Posey belt documented "Used to secure resident in Geriatric chair or wheelchair to prevent resident from exiting without assistance, therefore preventing falls or injury...."
-Walker to be used at all times when the resident is transferring and walking to assist with balance / avoid falls.
-The form was not signed by a physician.

Review of Resident #3's record revealed there were no physician updated restraint orders after

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C 456	Continued From page 35 12/10/15. Interview with the Supervisor-On-Call (SOC) on 3/30/16 at 11:25am revealed: -The restraint order dated 12/10/15 for Resident #3 was "..the most recent restraint order" the facility had for the resident. -"I was under the impression the [restraint] order needed to be renewed every 6 months." Interview with the SOC on 3/31/16 at 9:30am revealed: -Resident #3 "went into the wheelchair when she returned from the hospital from the fall where she fell and broke her wrist." -The wheelchair was implemented somewhere between 12/7/15 and 12/10/15. Interview with the SOC on 3/31/16 at 10:11am revealed: -The Supervisors were responsible for sending all the residents FL2s, care plans, restraint orders, standing orders, and activity reviews to their physicians every 6 months for renewal.	C 456		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 and interviews, the facility failed to assure residents received care and services that were adequate, appropriate, and in	C 912		

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C 912	Continued From page 36 compliance with federal and state laws and rules and regulations related to testing for tuberculosis. The findings are: A. Based on interview and record review, the facility failed to assure 4 of 5 sampled staff (Staff A, B, D, and E) were tested upon employment for tuberculosis (TB) in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 140, 10A NCAC 13G .0405(a)(b) Test for Tuberculosis (Type B Violation)]. B. Based on interview and record review, the facility failed to assure 2 of 3 sampled residents (Resident #1 and #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 202, 10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility neglected to provide supervison to prevent falls for 1 of 3 sampled residents (Resident #3). The findings are: Based on observation, interview, and record review, the facility failed to provide supervision for	C 914		

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C 914	Continued From page 37 1 of 3 sampled residents (Resident #3) with a wrist fracture, contusion of the right ribs and shoulder, and a broken nose due to falls. [Refer to tag 243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type A2 Violation).]	C 914		