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	HAL096001	A. BUILDING: _____ B. WING _____	05/17/2016

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LAGRANGE GARDENS ASSISTED LIVING	167 FUSSELL ROAD LA GRANGE, NC 28551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 17, 2016.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility neglected to provide preventative measures and interventions for 1 of 2 residents sampled (Resident #4) with multiple falls that required medical attention. The findings are: Review of Resident #4's current FL-2 dated 10/9/15 revealed: -Diagnoses included dementia, hypertension, urinary tract infection, stroke, and depression. -The resident was semi-ambulatory and intermittently disoriented. Review of Resident #4's Resident Register revealed: -She was admitted to the facility on 8/5/15. -She required assistance with dressing, bathing and ambulation. -She was oriented to time and place. -She utilized a walker for ambulation. -The Resident Register was signed by the Administrator and Resident #4's responsible party	D 338		

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D 338	Continued From page 1 on 8/5/15. Review of Resident #4's current Care Plan dated 8/14/15 revealed: -The Care Plan was completed by the Resident Care Coordinator (RCC) on 8/5/15 with documentation as follows: -The resident was sometimes disoriented and had periods of forgetfulness, needed reminders. -The resident was independent with eating, toileting, ambulation, dressing, grooming and transferring. -The resident required extensive assistance with bathing. -Documentation of personal care tasks of assistance with activities of daily living and medication administration. Interview with the RCC on 5/17/16 at 1:00 PM revealed she had completed a significant change care plan today (5/17/16) and would submit it to the primary care provider for review. Review of Resident #4's Licensed Health Profession Support (LHPS) quarterly assessment dated 1/25/16 revealed: -The LHPS tasks staff were to provide was assistance with ambulation with walker. -The recommendation made by the Registered LHPS Nurse for the facility to follow up included a notation that the " floor in her room is very slick" . Review of Resident #4's Licensed Health Profession Support (LHPS) quarterly assessment dated 4/25/16 revealed: -The LHPS tasks staff were to provide was assistance with ambulation with walker. -There was a notation made by the LHPS, "PT eval for 5 falls since 2/4/16?", questioning if there should be a physical therapy evaluation	D 338		

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performed due to the resident's frequent falls.

Review of the facility's falls policy revealed:
-There were no interventions for the prevention of falls.
-The policy included assessment of the resident after a fall, notifications of others and completion of an incident/accident report.
-Observations were to be documented in the record each shift for 72 hours after a fall to include the resident's condition and behaviors following the fall.

Review of Resident #4's Accident/Incident Reports related to falls revealed:
-On 3/12/16 at 4:40 PM, the resident got her foot caught under the chair and fell on her back after eating. The resident stated, "she was okay".
-On 3/30/16 at 12:00 AM, the resident slipped while trying to pick up her breathing treatment off the floor, "no bruises", and the resident refused to go to the emergency room.
-On 4/6/16 at 3:25 PM, the resident was found on the ground outside on the back porch and stated "she was not hurt".
-On 4/6/16 at 8:50 PM, the resident was found on the floor in her room, beside her bed. The resident stated "she was not hurt and did not want to go to the doctor".
-On 4/11/16 at 8:25 PM, the resident was heard yelling and staff found the resident on the floor with the walker in front of her. The resident was sent the emergency room for evaluation.
-On 4/29/16 at 5:00 PM, the resident was found on the back porch, on the ground. The resident stated "she fell and hurt her hip and elbow". The resident refused to go to the emergency room.
-On 5/11/16 at 6:40 PM, the resident was attempting to get out of the chair and lost her balance. The resident stated "she hurt her right

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shoulder and buttocks". The facility's Nurse assessed the resident. The resident refused to go to the emergency room.

Review of Resident #4's nurse's notes revealed:
-The resident had falls on 3/12/16, 3/30/16, 4/5/16, 4/6/16, 4/11/16, 4/29/16, and 5/11/16.
-She went to the emergency room for the 4/11/16 fall and returned with orders to follow up with her primary care provider.
-She saw her primary care provider on 4/13/16 and had X-ray and lab work performed with no new orders.

Review of physical therapy notes for Resident #4 revealed:
-The resident had not been seen since 2015.
-In October 2015, the resident was seen for gait training.

Interview with Resident #4's responsible party on 5/17/16 at 10:40 AM revealed:
-She lived in another state and last visited Resident #4 on May 8, 2016.
-The facility called her each time Resident #4 had a fall.
-Resident #4 was very weak and frail.
-She was concerned with all the falls and wondered what the facility had done to help.
-They only thing the facility had recommended was that a rug in Resident #4's room be removed, and that was done.
-She was concerned that Resident #4 would really hurt herself with one of the falls.

Interview with the Registered Nurse at the PCP's office on 5/17/16 at 10:52 AM and 1:00 PM revealed:
-Resident #4 was a patient of that practice.
-Resident #4 was last seen on 4/12/16 because

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of a fall at the facility.
-On 4/12/16 the PCP ordered an X-Ray of Resident #4's right hip to rule out a broken bone, the result showed no break.
-The PCP did not request that the facility notify him of falls without injury or not requiring medical attention.
-The PCP would expect to be notified of any fall with injury.
-The only fall the PCP's office was aware of was the 4/12/16 because of the emergency room visit.
-The facility would fax the accident/incident reports for Resident #4 to the PCP's office for his review if injury occurred.

Interview with the Administrator on 5/17/16 at 11:00 AM revealed:
-She was aware of Resident #4's falls.
-She was not aware Resident #4 had 7 falls since 3/12/16.
-The Corporate Nurse Consultant was there on 5/12/16 and they discussed Resident #4's falls.
-The RCC and the 7:00 AM-3:00 PM medication aide were responsible for following up on Resident #4's falls.

Interview with the Corporate Nurse Consultant on 5/17/16 at 11:02 AM revealed:
-She could not remember what she and the Administrator had talked about in the meeting on 5/12/16.
-She recalled they discussed Resident #4 but unsure what had been said.
-The facility had a falls policy that was a corporate policy.
-The facility did not have a policy to implement fall interventions.

Interview with the RCC on 5/17/16 at 11:02 AM revealed:

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D 338	Continued From page 5 -The staff were assisting Resident #4 with her transfers. -She had placed a note behind the Nurse's Station to inform staff that Resident #4 needed assistance when she was ambulating. -If a resident in the facility had a lot of falls (no amount specified) they would notify the PCP to see if they could order a physical therapy (PT) evaluation. -Resident #4 had not received PT since 2015. -She was not aware that Resident #4 had 7 falls since 3/12/16 to current date 5/17/16. -There had not been a Care Plan completed on Resident #4 since 8/14/15. -She would complete a change in condition Care Plan today (5/17/16) and send it to the PCP to indicate her increase in need for assistance with ambulation. -The facility had a falls policy in which the staff was to investigate the cause of the fall, complete an accident/incident report and monitor the resident and document each shift in the record for 72 hours after a fall. -They had not been documenting any observations of Resident #4's condition for 72 hours after a fall, but they had been observing her. -The accident/incident reports were given to her after the MA's completed them. -She would ensure the PCP was notified and an appointment made if a follow up with the PCP was recommended by the emergency room. -They had not put any interventions in place to prevent Resident #4 from falling other than to assist her when staff saw her trying to ambulate with her walker. Review of Resident #4's significant change Care Plan dated 5/17/16 revealed: -The Care Plan was completed by the RCC on	D 338		

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5/17/16 with written documentation as follows:
-The resident was independent when eating.
-The resident was sometimes disoriented and had periods of forgetfulness, needed reminders.
-The resident required limited assistance with toileting, ambulation, bathing, dressing, grooming and transferring.
-Documentation of personal care tasks of medication administration, assistance with activities of daily living and needs assistance with ambulation with a walker.

Observation on 5/17/16 at 12:20 PM revealed:
-Staff was walking with Resident #4.
-Resident #4 was using a rolling walker.

Interview with a Personal Care Aide (PCA) on 5/14/16 at 12:35 PM revealed:
-She checked on Resident #4 more frequently when she worked because of her falls.
-She had not been told to check on Resident #4 more often that every 2 hours.
-She would walk up and down the hall about every 15 minutes to check on all the residents.
-The RCC had informed the staff that they needed to assist Resident #4 when she was walking with her walker.
-Resident #4 would get up a lot by herself and not call for assistance.

Observation of the living room on 5/17/16 at 12:40 PM revealed:
-Resident #4 was sitting on the sofa watching TV with her walker in front of her.
-There was no staff present in the living room or within visual sight of the resident.

Interview with Resident #4 on 5/17/16 at 12:40 PM revealed:
-She was unsure exactly how long she had lived

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at the facility but she used to live with a family member.
-Her family member last visited on Mother's Day 2016.
-She had to live there because she had a stroke.
-She used a walker to help her walk and could not get around without it.
-She had fallen recently (unknown when) and hurt her hip, but it was not broken.
-She was lucky that she had not broken her hip with the falls.
-She had falls because she loses her balance and sometimes because she tripped over something.
-She did not call out for help before she got up without assistance.
-She did not know why she did not call out for help.
-She would call out for "help" if she was on the floor after a fall and staff would come.
-If she was up in the living room or dining room and was getting up, staff would come and help her.

Observation of the living room on 5/17/16 at 1:45 PM revealed:
-Resident #4 was sitting on the sofa watching TV with her walker in front of her.
-There was no staff present in the living room or within visual sight of the resident.

Interview with a MA on 5/17/16 at 2:45 PM revealed:
-She had worked at the facility since 2014.
-She worked 3:00 PM - 11:00 PM.
-She had been present and completed accident/incident reports on Resident #4 after the falls that occurred while she was working.
-She thought Resident #4 frequently lost her balance when she tried to get up without

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assistance.
-She had encouraged Resident #4 to call for assistance from staff prior to getting up by herself.
-All the staff had been informed to watch Resident #4 more frequently but there was nothing in place for how frequently.
-There was a note placed behind the Nurse's Station that the RCC wanted staff to assist Resident #4 if they saw her trying to walk.
-She would complete an accident/incident report for all residents' falls, with or without injury.
-After she completed the accident/incident report she would leave it for the RCC to file.

Interview with a second PCA on 5/17/16 at 2:55 PM revealed:
-She had only worked at the facility since February 2016.
-Resident #4 would never call for help until after she had fallen.
-The RCC had instructed staff to walk with Resident #4.
-The staff was required to check on Resident #4 every 2 hours.
-No one had instructed her to check on Resident #4 any more often than every 2 hours.

Interview with a second MA on 5/17/16 at 2:57 PM revealed:
-She worked 3:00 PM - 11:00 PM.
-Resident #4 was checked every 2 hours.
-She had not been instructed to check on Resident #4 any more often than every 2 hours.
-Staff was supposed to assist Resident #4 if they saw are ambulating.
-The RCC had instructed staff to assist Resident #4 if she was ambulating.
-If Resident #4 was in her room, staff would not know if she got up to ambulate.

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D 338	Continued From page 9 The facility provided a Plan of Protection on 5/17/16 as follows: -Records and Care Plans will immediately be assessed to determine individual's needs and will be updated by the RCC as needed. -The PCP will be made aware of any immediate needs and notified of all falls in the last six months and from this date on with or without injury. -Any changes identified by the RCC will to referred to the PCP and will increase monitoring or implement any interventions ordered. -All staff and new hires will be in-serviced on resident specific interventions to prevent falls. -Ongoing, the RCC will perform quarterly Care Plan assessments to determine any changes necessary. -The Administrator will oversee the RCC is completing the assessment's by monitoring weekly x 4 wk's then monthly thereafter. THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2016.	D 338		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents were free of neglect related to frequent falls.	D914		

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D914	Continued From page 10 The findings are: Based on observations, record reviews and interviews, the facility neglected to provide preventative measures and interventions for 1 of 2 residents sampled (Resident #4) with multiple falls that required medical attention. [Refer to Tag D0338, 10A NCAC 13F.0909 Resident Rights (Type A2 Violation)]	D914		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is	D992		

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D992	Continued From page 11 prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete an examination and screening for the presence of controlled substances prior to hire for 2 of 2 sampled staff members (Staff B and E) hired after October 1, 2013. The findings are: A. Review of Staff B's personnel record revealed: -A hire date of 02/24/16 as a Personal Care Aide. -No documentation of a controlled substance screening. Telephone interview with Staff B on 5/17/16 at 2:10 PM revealed: -She started working at the facility in February 2016. -She had not taken a controlled substance screening prior to her starting work at the facility. -She was not told she needed to complete a screening for controlled substances. Refer to interview with the Administrator on 5/17/16 at 2:10 PM. Refer to interview with the Resident Care Coordinator (RCC) on 5/17/16 at 5:10 PM.	D992		

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D992	Continued From page 12 B. Review of Staff E's personnel record revealed: -A hire date of 01/17/14 as a Personal Care Aide and Medication Aide. -No documentation of a controlled substance screening. Interview with Staff E on 5/17/16 at 5:10 PM revealed: -She started working at the facility in over a year ago. -She had not taken a controlled substance screening prior to her starting work at the facility. -She had not had a controlled substance screening performed since she had been employed at the facility. -She had not been told she had to have a controlled substance screening. Refer to interview with the Administrator on 5/17/16 at 2:10 PM. Refer to interview with the Resident Care Coordinator (RCC) on 5/17/16 at 5:10 PM. Interview with the Administrator on 5/17/16 at 2:10 PM revealed: -The facility did not perform controlled substances screenings on employees upon hire. -The corporate policy was to perform a controlled substance screening as needed on employees which were involved in an investigation. -She was not aware that all new hires after 10/1/13 were required to have a screening for controlled substances prior to starting work. -Any employee that was hired after 10/1/13 had not been tested for controlled substances. Interview with the RCC on 5/17/16 at 5:10 PM revealed:	D992		

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LAGRANGE GARDENS ASSISTED LIVING	167 FUSSELL ROAD LA GRANGE, NC 28551

(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
D992	Continued From page 13 -She maintained staffs personnel records. -She was not aware that employees that were hired after 10/1/13 were required to have a controlled substance screening. -None of the employees hired after 10/1/13 had been screened for controlled substances.	D992		