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D 000	Initial Comments The Adult Care Licensure Section and the Johnston County County Department of Social Services conducted a complaint investigation and a follow-up survey on 08/30/16 through 09/02/16 and 09/06/16 through 09/09/16.	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 maintain clean floors and walls as evidenced by dirty, sticky floors in the dining room; heavy dirt build up and urine stains on bathroom floors; and urine stains on bathroom walls in residents' rooms in the Memory Care Unit (MCU). The findings are: 1. Observations on 8/30/16 from 10:20am through 1:03pm and 8/31/16 between 9:15am and 9:30am revealed: -There was heavy dirt build up on the floor and urine stains on the floor and walls around the toilet in resident rooms #508, #601, #603 and #616. -There was heavy dirt build up on the bathroom floor in resident room #602. -There was heavy dirt build up on the floor and scuff marks and brown stains on the walls in the bathroom between resident rooms #617 and	D 074		

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D 074	Continued From page 1 #619. Interview with a family member on 9/1/16 at 11:00am revealed: -The family member visited the facility every few few weeks. -Sometimes when the family member came to visit, the floors did not look like they had been cleaned. Confidential interview with a family member revealed: -The family member visited the MCU frequently, a few times a week. -The bathrooms and toilets were dirty and needed cleaning. Interview with a housekeeper on 8/31/16 at 9:45am revealed: -Housekeepers were responsible for sweeping and mopping all floors, cleaning toilets and sinks, disinfecting everything and removing trash. -Supplies were adequate to complete assigned duties. -There was 1 housekeeper on duty daily for the MCU except 1 day per week when there were 2 housekeepers. -Housekeepers did deep cleaning when there were 2 housekeepers on duty. -Housekeepers were supervised by the Maintenance person. -All floors were cleaned daily and needed to be buffed to get stains out. -Regarding urine stains on floors and walls in bathrooms, the housekeeper reported not being on duty 8/30/16 and would sometimes find the bathrooms "this way" when she returned to work. -The housekeeper was in the process of cleaning resident rooms and bathrooms.	D 074		

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Confidential interview with a staff revealed:
-It was difficult to get housekeepers to clean the MCU.
-The housekeepers did not spend a full shift on the MCU.
-The bathrooms were not kept clean.
-The supervisors wanted personal care aides and medication aides to clean the MCU in addition to caring for the residents.
-Family members had reported unclean conditions of the bathrooms to the Supervisor and Resident Care Coordinator (RCC).

Interview with the Maintenance person on 8/30/16 at 12:15pm revealed:
-He was aware of the heavy build up on the floors.
-He was planning on stripping the floors a few resident rooms at a time beginning 8/30/16.

Telephone interview with the Resident Care Coordinator (RCC) on 9/8/16 at 7:02pm revealed:
-The cleanliness issues had not been brought forward until the current Administrator started on 6/20/16.
-The current Administrator did try to address the issues.

Interview with the former Administrator on 9/9/16 at 12:55pm revealed:
-The Administrator was not aware of any family complaints with the environment at the facility.
-The construction inspection completed in June 2016 made the Administrator aware of issues with the floors.
-The Administrator had developed a schedule with the maintenance person to strip and clean all the floors with a goal of completing 2 resident rooms per week.

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2. Observation of the dining room in the memory care unit (MCU) on 08/31/16 at 9:50 a.m. revealed:
-There were multiple patches of brownish black stains all over the dining room floor.
-There were some areas that had black streaks across the floor.
-The floor was sticky, causing shoes to stick to the floor in multiple areas.
-The floor was so sticky in one area near the back of the dining room, the surveyor's shoes stuck to the floor and the shoe pulled off the surveyor's foot when the surveyor tried to move.

Confidential interview with a family member revealed:
-The family member visited the facility frequently, a few times a week.
-The floors in the MCU, including the dining room, were dirty.

Interview with a personal care aide (PCA) in the MCU on 08/31/16 at 9:55 a.m. revealed:
-The housekeepers did not usually mop the dining room floor in the MCU.
-The PCAs on duty usually wiped the tables, swept the dining room floor, and mopped the dining room floor.
-The dining room floor was swept this morning but it would not be mopped until after lunch.
-The dining room floor was last mopped yesterday on first shift.

Interview with a housekeeper in the MCU on 08/31/16 at 10:24 a.m. revealed:
-She just started working at the facility about 2 weeks ago.
-The housekeepers usually mopped the dining room floor in the MCU every day after lunch.
-The PCAs were supposed to mop the dining

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D 074	Continued From page 4 room floor after snacks and other meals. -She thought the PCAs had just mopped the dining room floor after breakfast that morning. Interview with the Resident Care Coordinator (RCC) on 08/31/16 at 10:48 a.m. revealed: -There was currently no MCC in the MCU so she was trying to help out on both sides of the facility. -She did not know if there was a cleaning schedule for the facility. -The PCAs were supposed to sweep and mop the dining room floor in the MCU after each meal. Interview with the new corporation's Vice President of Quality Assurance and Regulatory Compliance on 08/31/16 at 3:45 p.m. revealed: -There had been a change of ownership at the facility and her corporation was scheduled to take over the facility tomorrow on 09/01/16. -She did a walk through the facility last Wednesday and noticed problems with the cleanliness of the floors. -She had already contacted some resources about getting the floor cleaned. Interview with the former Interim / Acting Administrator on 09/09/16 at 12:50 p.m. revealed: -The Administrator was working with housekeeping staff about the floors. -Facility staff had put air freshener in the mop water, causing the stickiness on the floors. -They were working on stripping and waxing the floors but started with the bathroom floors.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings	D 076		

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D 076	Continued From page 5 (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 25 of 25 blue cloth chairs in the dining room of the memory care unit (MCU) and 2 of 2 blue cloth chairs in the library / piano room of the MCU used by residents were clean. The findings are: Observation of the library / piano room in the memory care unit (MCU) on 08/30/16 at 1:15 p.m. revealed: -There were two chairs upholstered with blue cloth. -Both chairs had brownish black stains and dried food particles all over the seat and back of the chairs. Observation of the dining room in the MCU on 08/31/16 at 9:50 a.m. revealed: - There were 25 chairs at the dining room tables in the dining room. - All 25 of the dining room chairs were upholstered with a blue cloth material and had wooden frame and legs. - All 25 of the cloth chairs had multiple dark brown and black stains and dried food particles all over the seat and back cushions of the chairs. - All 25 of the cloth chairs had a brownish black build-up of dirt on the top of the back of the chair where one would grab the chair to pull it out or push it under the table. Interview with a personal care aide (PCA) in the MCU on 08/31/16 at 9:55 a.m. revealed:	D 076		

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-The dining room chairs had been stained for "some months".
-The PCA had tried to wipe the chairs down but she did not have anything to clean them with.
-The PCA had not observed any housekeepers cleaning the dining room chairs.

Interview with a housekeeper in the MCU on 08/31/16 at 10:24 a.m. revealed:
-She just started working at the facility about 2 weeks ago.
-The housekeepers did not clean the dining room chairs.
-She did not know who was supposed to clean the chairs.

Interview with the Resident Care Coordinator (RCC) on 08/31/16 at 10:48 a.m. revealed:
-She was the RCC and usually worked on the assisted living side of the facility.
-There was currently no Memory Care Coordinator (MCC) in the MCU so she was trying to help out on both sides of the facility.
-She did not know if there was a cleaning schedule for the facility.
-She was not sure who was responsible for cleaning the chairs in the dining room.

Interview with the new corporation's Vice President of Quality Assurance and Regulatory Compliance on 08/31/16 at 3:45 p.m. revealed:
-There had been a change of ownership at the facility and her corporation was scheduled to take over the facility tomorrow on 09/01/16.
-She would get the chairs replaced once their company took over the management of the facility.

Observation of the dining room in the MCU on 09/06/16 at 9:00 a.m. revealed:

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D 076	Continued From page 7 -All of the 25 soiled cloth dining room chairs had been replaced with clean vinyl upholstered chairs. -The two soiled cloth dining room chairs in the library had been removed. Interview with the former Interim / Acting Administrator on 09/09/16 at 12:50 p.m. revealed: -She had not noticed the stained dining room chairs in the MCU when their company managed the facility. -She did not know who was responsible for cleaning the chairs under their management.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free of hazards and obstructions as evidenced by broken and loose toilet paper holders and towel racks, 4 electrical outlets and 1 thermostat device left uncovered for approximately 1 week, and long standing toilet obstructions in the memory care unit (MCU). The findings are:	D 079		

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1. Observations on 8/30/16 from 10:20am through 1:03pm revealed:
-There was a broken toilet paper holder with sharp protruding edges in the bathrooms of resident rooms #606, #613 and #616.
-The toilet paper holder had been removed from the common shower room near resident room #608, leaving holes in the wall.
-There was a broken towel rack leaving sharp edges of the hanging brackets in the bathroom of resident room #611.
-There was a loose towel rack in the bathroom of resident room #613.

Observations on 8/31/16 between 9:15am and 9:30am revealed:
-The towel rack brackets in the bathroom in resident room #611 had been removed.
-The towel rack in the bathroom between resident rooms #613 and #615 remained loose.
-The broken toilet paper holders in the bathrooms of resident rooms #606, #613 and #616, were unchanged from 8/30/16.

Interview with a personal care aide (PCA) on 8/31/16 at 9:30am revealed:
-A resident had fell on the toilet paper holder in the shower room near resident room #611.
-The toilet paper holder had been removed to prevent anyone else from getting hurt.
-The PCA did know anything else about the incident.
-The PCA did not know if the broken toilet paper holders in resident rooms #606, #613 and #616 were going to be replaced also.

Interview with a housekeeper on 8/30/16 at 11:44am revealed:
-The housekeeper normally worked on the Assisted Living (AL) side and did not usually work

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in the Memory Care Unit (MCU).
-The housekeeper had not noticed the broken towel rack in resident room #611.

Interview with a second housekeeper on 8/31/16 at 9:45am revealed:
-Staff was expected to report housekeeping needs to the housekeeper or the Maintenance person.
-The broken toilet paper holders had been that way for more than 4-5 months.

Interview with the Maintenance person on 8/30/16 at 12:15pm revealed:
-He had worked at the facility for the last 4 years and had become the Maintenance person 3 months ago.
-He was not aware of the broken towel rack and toilet paper holders.
-Staff normally made the Maintenance person aware of repair issues and concerns.

Interview with the Maintenance Person on 9/1/16 at 8:55am revealed:
-He could not recall the details but he did remember being instructed to remove the toilet paper holder out of the shower room so no one else would get hurt.
-He could not remember who instructed him or which resident got hurt.
-He was instructed to remove the toilet paper holder and place a new one further back on the wall more than a month ago during the morning meeting.

Interview with the Resident Care Coordinator (RCC) on 9/1/16 at 2:00pm revealed:
-The RCC requested Maintenance remove the toilet paper holder and place a new one because Resident #15 was injured on the old toilet paper

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holder.
-Resident #15 was in the bathroom with the personal care aide (PCA) when she lost her balance and hit the toilet paper holder resulting in a skin tear to her arm.
-The RCC was not aware of any concern with the broken toilet paper holders in resident rooms #606, #611, #613 and #616.

2. Observations on 8/31/16 between at 9:56am revealed:
-There was 1 light switch and 4 electrical outlets without a protective cover in resident room #508.

Interview with the Maintenance Person on 8/31/16 at 4:45pm revealed:
-He was aware of the missing light switch and outlet covers in resident room #508.
-He was aware of the potential danger of exposed wiring.
-The covers were removed for insect extermination purposes last week (8/24/16).
-The Maintenance person had a number of ongoing repair issues he was attending to.

Observation on 9/2/16 at 3:15pm revealed:
-The light switch cover and 1 outlet cover had been replaced in resident room #508.
-There were 3 electrical outlets still without a cover in resident room #508.

Interview with the Maintenance Person on 9/2/16 at 4:51pm revealed:
-He was aware the outlet covers needed to be replaced in resident room #508.
-He had started replacing them and got pulled away for another repair.

3. Observations on 8/31/16 at 9:30am revealed:
-The toilet in resident room #612 had urine, stool

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and tissue in it.
-The common shower room near resident room #611 had an "out of order" sign on the door.

Observation on 9/1/16 at 5:28am revealed:
-The "out of order" sign remained posted on the common shower room near resident room #611.
-The door to the common bathroom was unlocked.
-There was a toilet lying on its side on the bathroom floor detached from the plumbing.

Observation on 9/2/16 at 4:51pm revealed the Maintenance Person was working on the toilet in the common bathroom near resident room #611.

Interview with a personal care aide (PCA) on 8/31/16 at 9:30am revealed:
-The PCA was not aware the toilet was obstructed with stool and tissue in resident room #612.
-The resident put things in the toilet "stopping it up all the time."

Interview with a second housekeeper on 8/31/16 at 9:45am revealed:
-The obstructed toilet in resident room #612 was not reported to housekeeping.
-Staff was expected to report housekeeping needs to the housekeeper or the Maintenance person.

Interview with a family member on 9/1/16 at 11am revealed:
-There were times when the toilet in the resident's toilet connected to her room was backed up.
-Staff would send the family member and the resident to another bathroom which would also be stopped up.
-The staff would then send the family member

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D 079	Continued From page 12 and resident to the end of the other hall to use another bathroom. Telephone interview with a second family member on 9/7/16 at 3:50pm revealed: -Toilets at the facility were stopped up all the time. -There was no housekeeping staff there on the weekend. -The family member had taken pictures 2-3 days in a row documenting the condition of the toilets was the same each day. -It had gotten so bad the family brought a plunger in to clear the toilet. -The family member had reported the condition of the toilet to staff and the Supervisor on duty and requested it to be cleaned. -The family member brought the plunger and took pictures after 3 days of asking staff to fix and clean the toilets. Interview with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm revealed the RCC would notify the Maintenance Person of any needed repairs identified while she was "walking around." Interview with the Maintenance Person on 8/31/16 at 4:45pm revealed: -The last Maintenance Person left and the position was vacant for approximately 2 months. -He had been working as a housekeeper and filled in on maintenance duties until becoming the Maintenance Person 3 months ago (June 2016). Interview with the former Administrator on 9/9/16 at 12:55pm revealed: -The Administrator was not aware of any complaints with the environment at the facility. -The construction inspection done in June 2016, brought the loose towel holders to the	D 079		

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D 079	Continued From page 13 Administrator's attention. -The Administrator was not aware of the electrical outlets, the frequent toilet obstructions nor the broken toilet paper holders. 4. Observation of Room #512 in the memory care unit (MCU) on 08/30/16 at 12:43 p.m. revealed: -There was a face plate for a thermostat device without a cover above the light switch. -There was red wiring connected to the middle of the face place. Interview with a resident in Room #512 on 08/30/16 at 12:45 p.m. revealed the resident was confused and unable to answer questions about the thermostat device. Interview with a personal care aide (PCA) on 08/30/16 at 12:49 p.m. revealed: -She was not aware the cover for the thermostat was missing. -She would check on it. Observation of Room #512 in the MCU on 08/30/16 at 12:43 p.m. revealed a cover had been placed over the face plate for the thermostat device.	D 079		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered	D 164		

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D 164	Continued From page 14 nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure 2 of 4 medication aides (F, G) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: 1. Review of Staff F's personnel file revealed: -Staff F was hired on 02/24/16 as a medication aide. -Staff F completed the medication aide clinical skills validation checklist on 03/10/16. -Staff passed the written medication aide exam on 07/22/03. -There was no documentation of any diabetes training completed for Staff F. Review of the facility's August 2016 medication	D 164		

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administration record (MAR) revealed Staff F administered insulin at least 18 out of 31 days from 08/01/16 - 08/31/16.

Interview with the former Interim / Acting Administrator on 09/08/16 at 3:10 p.m. revealed:
-Staff F completed the diabetes training during the medication administration training.
-She would check to see if she could find documentation of any diabetes training that Staff F may have completed.

No documentation of diabetes training for Staff F was provided.

2. Review of Staff G's personnel file revealed:
-Staff was hired on 12/07/15 as the resident care coordinator and she was responsible for supervision of the medication aides.
-Staff G completed the medication aide clinical skill validation checklist on 08/08/16.
-Staff G passed the written medication aide exam on 04/02/08.
-There was no documentation of any diabetes training completed for Staff G.

Review of the facility's August 2016 MARs revealed Staff G administered insulin on 08/23/16 and 08/24/16.

Interview with the former Interim / Acting Administrator on 09/08/16 at 3:10 p.m. revealed:
-Staff G does not administer medications.
-Staff G is the resident care coordinator.

No documentation of diabetes training for Staff G was provided.

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D 183	Continued From page 16	D 183		
D 183	10A NCAC 13F .0603(a) Management of Facilities with a Capacity or C 10A NCAC 13F .0603 Management of Facilities with a Capacity or Census of 81 or More Residents (a) An adult care home with a capacity or census of 81 or more residents shall be under the direct control of an administrator, who shall be responsible for the operation, administration, management and supervision of the facility on a full-time basis to assure that all care and services to residents are provided in accordance with all applicable local, state and federal regulations and codes. The administrator shall be on duty in the facility at least eight hours per day, five days per week and shall not serve simultaneously as a personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home except as follows. If there is more than one facility on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor in this campus setting. For staffing chart, see Rule .0606 of this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure all care and services were provided by management to residents in accordance with all applicable local, state, and federal regulations and codes.	D 183		

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D 183	Continued From page 17 The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance with transferring, ambulation, toileting, bathing and mouth care for 6 of 15 sampled residents (#1, #2, #4, #5, #11 and #15) resulting in a resident found with partially dried feces in her mouth, a high volume of unwitnessed falls in resident bathrooms and bedrooms with related injuries (broken bones, lacerations and hematomas), skin breakdown and residents with body odor, dirty nails and unclean clothing for several days at a time. [Refer to Tag 0269, 10A NCAC 13F 0901(a) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations, interviews and record reviews, the facility failed to provided minimally adequate supervision for 9 of 15 sampled residents resulting in 3 residents (#1, #5 and #11) consuming feces, 9 residents having numerous repeated falls resulting in serious physical injuries such as head lacerations and hematomas and broken hip, leg, arm and spine bones (#2, #3, #5, #6, #9, #11, #12 and #13), and 1 resident with combative and aggressive behaviors toward staff and other residents (#11). [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 3. Based on observations, interviews, and record reviews, the facility did not meet the health care needs of 9 of 15 residents sampled (#1, #2, #3, #5, #6, #9, #11, #13, #15) as related to the facility failed to notify the primary care provider (PCP) of falls with head injuries, obtain a hospital bed with rails, repair or replace a broken wheelchair and notify hospice of the broken wheelchair for a resident who had multiple falls with head injuries	D 183		

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D 183	Continued From page 18 (#3); failed to follow up with the PCP for a leg wound requiring stitches resulting in a hospitalization for cellulitis due to the stitches not being removed over 6 weeks after the stitches were placed (#6); failed to make a dermatology appointment for a resident with severely dry skin on legs and feet resulting in open leg wounds and a foul odor and failed to notify the psychiatric care provider of a resident's continued behaviors of verbal and physical aggression toward other residents (#11); failed to follow up with a medical provider for a resident with mental status changes (#1); failed to follow up with a medical provider for 3 residents with symptoms of pain, bruises and hematomas and from an injury after a fall (#5, #9 and #15); failed to contact a medical provider within a reasonable time for skin breakdown on 2 residents (#2 and #15); failed to notify a medical provider of a worsening ankle wound infection resulting in hospital admission for sepsis for a resident (#13); failed to follow up on referrals for skilled nursing care and home health services for 2 residents (#2 and #5); failed to follow up on orders for urinalysis for 2 residents (#5 and #13); and failed to administer prescribed laxatives for a resident (#15) resulting in fecal impaction. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).] 5. Based on observations and interviews, the facility failed to assure a care coordinator was on duty in the memory care unit (MCU) at least 8 hours a day, 5 days a week. [Refer to Tag 0466, 10A NCAC 13F .1308 Special Care Unit Staffing (Type B Violation).] _____ Review of the facilitiy's Plan of Protection	D 183		

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D 183	Continued From page 19 revealed: - A management company assumed responsibilty for daily operations on 9/1/16. - New licensee assigned qualified administrator effective 9/1/16 to oversee daily and clinical operations. - Facility structure and oversight re-organized and support team assigned to conduct a ful evaluation and assessment of operations to include but not limited to recruiting qualified personnel and department heads. - Administration will be on duty in the facility at least 8 hours a day/5 days per week and on call otherwise. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 9, 2016.	D 183		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide personal care assistance with transferring, ambulation, toileting, bathing and mouth care for 6 of 15 sampled	D 269		

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residents (#1, #2, #4, #5, #11 and #15) resulting in a resident found with partially dried feces in her mouth, a high volume of unwitnessed falls in resident bathrooms and bedrooms with related injuries (broken bones, lacerations and hematomas), skin breakdown and residents with body odor, dirty nails and unclean clothing for several days at a time.

The findings are:

Telephone interview with a family member of a resident on 9/6/16 at 4:01pm revealed:
-The family member observed there were residents who did not eat dinner frequently.
-Residents would sit at the table and not eat anything.
-Staff would ask the resident if they were going to eat and the resident would say no.
-Staff would just throw the food away without trying to encourage or assist the resident to eat.

Confidential interview with a staff revealed:
-Staff on all shifts did not do what they were supposed to do to care for residents and frequently left it for the next shift.
-Staff would start their shift and find residents' incontinence briefs were soaking wet; so you knew they had not been changed in a while.
-These concerns were reported to the Supervisor on duty and/or the Resident Care Coordinator (RCC).
-There was nothing to do about residents being soaking wet because the staff had already left and it would just be the same thing the next day.
-Staff in general were drained because they were forced to stay and work 12 and 16 hours a day to cover short shifts.
-The facility had a lot of falls which came from staff not taking care of and observing the

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residents.
-There was a pattern at the facility where so many residents had fallen and had not come back [died] from their injuries.

Interview with a personal care aide (PCA) on 9/1/16 at 6:32am revealed:
-The normal 3rd shift routine was to check residents every 2 hours.
-Residents were checked to make sure they were still breathing and they were not soaking wet.
-Residents were checked when the PCAs first came on duty at 11:00pm, then at midnight, 2:00am, 4:00am and 6:00am.
-Residents were showered according to the shower schedule.

Interview with a second PCA on 9/6/16 at 4:35pm revealed:
-The PCA would still attempt to provide care for any resident who may not like the PCA.
-If a coworker was having trouble with a resident, the PCA would help them with that resident and the coworker would help the PCA with one of their residents.
-Residents were checked every 30 minutes.
-The PCA offered toileting to residents, asked if they needed anything and if they had any pain.
-The PCA would stay with residents if they needed to use the bathroom.
-The PCA would report any pain issues to the medication aide.

1. Review of Resident #1's current FL-2 dated 12/02/15 revealed:
-Diagnoses included vascular dementia with altered mental status.
-The resident was constantly disoriented and wandered.

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Review of Resident #1's care plan dated 4/12/16 revealed:
-The resident wandered at times.
-The resident required extensive assistance with bathing, grooming, toileting and personal hygiene.

Confidential staff interview revealed:
-About 7 months ago (not sure of exact date) Resident #1 was found with feces packed in her mouth.
-The feces had been in her mouth for a long time because the nursing staff had to scrape dried feces out of her mouth.
-The resident walk back and forth in the memory care unit and her clothes were always dirty with dried food on the front of her clothes and brown feces under her nails.

Observation on 8/30/16 at 1:03pm revealed:
-Resident #1 was walking in the hallway.
-Her nails were approximately ¼ inch in length with thick brown matter under all nails on both hands.
-There were food particles and smudges on her shirt and pants.

Observation made on 8/30/16 on memory care unit at 3:40pm revealed:
-Resident #1 wandering up and down hallway with dried food particles on the front of shirt.
-Brown substance was under the resident's fingernails (right and left hands).

Observation on 8/31/16 at 9:38am revealed:
-Resident #1 was walking in the hallway.
-She had on clean clothes.
-Her nails remained approximately ¼ inch in length with thick brown matter under all nails on

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D 269	Continued From page 23 both hands. Review of documentation on facility "Nursing Assistant Notes" revealed: -On 1/14/16 (7-3 shift), " [Resident #1] was observed sitting at table with BM [bowel movement] on her lips, in her mouth, packed in her cheek. MCD [Memory Care Director] was notified and instructed staff to do what was possible to get it out. MT [medication aide] called SIC [Supervisor] to assist her and other staff. Resident had a lot of BM that was removed from her mouth by [SIC]. Interview with a medication aide (MA) on 8/31/16 at 10:15am revealed: -Resident nails were supposed to be checked daily with bathing. -The activity director also did nail care with residents on nail days. Interview with a former staff member on 8/31/16 at 7:40pm revealed: -She worked 3rd shift on the MCU and was working on the morning of 1/14/16. -Resident #1 smelled of feces during 3rd shift, but when the resident's underwear was checked, she had no BM. -She assisted the resident with bathing (a shower) but the resident continued to smell bad. -She did not provide mouth care to the resident. -When she left at 7:00am, the resident was drooling from her mouth. -When she came back to work (3rd shift) staff reported 1st shift staff member had to scrape feces from Resident #1's mouth which was impacted in her mouth. -The resident required assistance with personal	D 269		

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care which included bathing, mouth care and assistance cleaning after bowel movement.

Interview with Resident #1's family member on 9/01/16 at 3:15pm revealed:
-In January 2016 (unsure of exact date), when she was driving home around 7:30am, she received a call from a 1st shift staff member.
-She was informed Resident #1 was found with feces in her mouth and the resident was eating the feces.
-The staff member informed her even though emergency medical service (EMS) was called and came to the facility and checked the resident, the resident was not transported to the local emergency room.
-The resident was ambulatory and could walk to bathroom without assistance. The resident required assistance with cleaning self after having bowel movements, bathing and mouth care.
-The family provided items for mouth care (toothpaste, tooth brushes and mouth wash), but the items were never used and usually the resident's mouth had a foul odor hours after eating meals.
- When the family member visited the resident at the facility, the resident's nails remained dirty and untrimmed and only occasionally were trimmed and polished (about every few weeks).
-The staff never changed the resident's clothes after meals and she spilled food on the front of her clothes at meals and the dirty clothes remained on throughout the day.

Interview with former staff member on 9/02/16 at 11:00am revealed:
- In January 2016, Resident #1 was sitting at the dining room table with other residents in the MCU eating breakfast.
- The staff members smelled feces, but the

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resident had not had bowel movement.
- The former staff member noticed the resident had something in her mouth and when she checked, noted a large amount of feces in the resident's mouth.
- The feces had to be scraped out of the resident's mouth due to some of the feces had dried.
- The resident required assistance with personal care which included assisting with bathroom use and cleaning after use.

Interview with the facility's Memory Care Coordinator (MCC) on 9/01/16 at 11:45am revealed:
- The MCC did not know anything about Resident #1 being found with feces packed in her mouth because she was not the MCC in January, 2016.
- The incident should be documented in the resident's record.
- Resident #1 required assistance with her personal care which included bathing, dressing, assistance with bathroom use, and mouth care.

2. Review of Resident #4's FL-2 dated 7/25/16 revealed:
- Diagnoses which included Alzheimer's dementia and alcoholism.
- The resident was disoriented constantly and was a wanderer.
- The resident was incontinent of bowel and bladder.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 1/14/16.

Review of Resident #4's care plan dated 1/14/16 revealed:
- The resident required assistance of 1 staff with

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bathing/grooming and personal hygiene.
- The resident required assistance of 1 staff with dressing.

Interview with a family member on 9/06/16 at 10:05am revealed:
- The resident was admitted to the facility's MCU on 1/14/16 and discharged from the facility on 8/25/16.
- The resident was partially blind and confused and required assistance with all of his personal care and needed assistance with toileting.
- The family member visited the resident 2 to 4 times a week and always found the resident dirty and nasty.
- The resident's clothes were always dirty with dried food on the front of his shirt and pants.
- The staff never provided mouth care or shaved the resident.
- Whenever family came on Sunday to take the resident to church, the family had to bathe, shave and provide mouth care.
- The family member always had to change the resident's clothes if the family took him out of the facility during the week.
- The resident had to toilet himself without assistance and because he was partially blind and confused, he would make a mess in the bathroom.
- The family member had talked to the current MCC, the Administrator and other staff members about the resident's personal care multiple times during his stay at the facility, but nothing was ever changed.
- The family member expected the resident to be kept clean and expected better hygiene while the resident was living in the facility.
- Every time the family member visited the resident, the staff in the MCU was sitting and watching television instead of caring for the

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residents.
- The family member took the resident home on 8/25/16 because all his family decided he would get better care at home.

Interview with 2nd shift PCA on 9/1/16 at 11:30am revealed:
- Resident #4 did not want anyone to do anything for him, including assisting with baths, dressing, changing his clothes when soiled or assisting to the bathroom.
- The resident fed himself and dropped food on clothing, but would not let anyone change his clothes.
- The resident was mean at times and "cursed" and threatened the staff.
- The Memory Care Coordinator (MCC) was aware of the resident's behavior, but nothing was ever done.

Interview with the facility's MCC on 9/01/16 at 11:30am revealed:
- She was not aware of any problems with the resident's personal care.
- The staff assisted the resident with his bathing and dressing.
- The staff followed his care plan and assisted with bathing, dressing and grooming.
- She was not aware the family was dissatisfied with the care provided to the resident.

Interview with 3rd shift medication aide on 9/7/16 at 2:30pm revealed:
- The resident did curse at staff when care was provided.
- The resident did not want staff in his room.
- Third shift staff did not bathe or dress the resident, staff only changed his adult brief when needed.

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D 269	Continued From page 28 3. Review of Resident #11's most current FL-2 dated 11/30/15 revealed: -The resident's diagnoses included advanced dementia, fall, hypertension, acute on chronic stroke versus recurrent stroke, and constipation. -The resident was constantly disoriented and noted to wander, verbally abusive, and injurious to others. -The resident was ambulatory and incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #11's Resident Register revealed: -Resident #11 was admitted to the facility on 011/14/14. -The resident required assistance with dressing, bathing, nail care, shaving, toileting, and orientation to time and place. -The section regarding the resident's memory was blank. Review of Resident #11's current assessment and care plan dated 08/18/15 revealed: -The resident was noted to be wandering at times, verbally and physically abusive, and injurious to others. -The resident was receiving medications for mental illness / behaviors. -The resident required redirection and had behaviors. -The resident was not easily redirected and had prn (as needed) medications for behaviors. -The resident was ambulatory but his gait was unsteady. -The resident was incontinent of bowel and bladder. -The resident declined assistance and wore adult	D 269		

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incontinence briefs.
-The resident required extensive assistance with bathing, dressing, toileting, grooming, and personal hygiene.
-The resident could feed himself but was noted to require limited assistance with eating.
-The resident's ambulation was limited due to fall risk and unsteady gait.
-The resident's skin was noted to be normal.
-The resident was always disoriented and had significant memory loss and must be redirected.

Review of facility progress notes for Resident #11 revealed:
-10/11/15 (7-3 shift): Resident refused personal care from staff. Resident was given prn (as needed) medication for aggressive behavior with staff. Third attempt to toilet the resident was unsuccessful.
-11/13/15 (7-3 shift): Resident was trying to fight in the shower room. Resident said he would "knock the h--- " out of staff if they sprayed him with water.
-02/19/16 (11-7 shift): Resident was fighting the personal care aide (PCA) and refused to be assisted. Resident stayed up until 3:00 a.m.
-04/10/16 (7-3 shift): Resident was trying to hit PCAs when they were trying to change him. It took 3 PCAs and the medication aide to get resident changed.

Review of a visit form with Resident #11's psychiatric Nurse Practitioner (NP) dated 03/23/16 revealed:
-Resident with advanced dementia, agitation, and inability to fall asleep.
-This was a routine follow-up visit.
-Staff reported the resident's behavior was now under control and he was eating and sleeping well.

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D 269	Continued From page 30 -The medications seemed to be controlling evening agitation. -No medication changes needed today. Review of the April 2016 personal care task schedule for Resident #11 revealed: -Staff documented the resident had a sponge bath, skin care, and mouth care in 04/2016. -Staff documented the resident was also assisted with ambulation, toileting, dressing, and eating during 04/2016. Interview with a medication aide (MA) in the Memory Care Unit (MCU) on 09/02/16 at 4:55 p.m. revealed: -The resident usually ambulated independently with no device. -The resident would get upset or agitated mostly in the evenings and at night. -The resident was combative with care but he was put on some medications that seemed to help. Interview with a second MA in the MCU on 09/02/16 at 5:12 p.m. revealed: -Resident #11 usually walked independently without a device and he was "pretty steady". -The resident was combative with staff and residents only once in a while. Telephone interview with Resident #11's family member on 09/07/16 at 7:30 p.m. revealed: -The resident usually walked independently without a walker or wheelchair. -She visited the resident "constantly" to check on him. -Staff was not bathing the resident properly. -He was getting sores up and down his legs with blood and pus coming out of them. -She had taken cream for staff to put on his legs	D 269		

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but they were "neglecting" him.
-The resident would scratch his legs at night because they were so dry.
-The resident would wander late at night and he would miss breakfast in the mornings because staff would not get him up.
-Staff told her the resident was hard to get up in the mornings.
-She would have to bring snacks for the resident because he said he was hungry.
-Staff had lost the resident's belt one day and staff had tied plastic trash bags to his belt loops instead of finding his belt.
-Sometimes when she came to the facility staff did not even know where the resident was located because they were not paying any attention to him.
-The resident was a fall risk and staff was not watching him.
-Staff were not keeping him clean.
-She could smell body odor on the resident and his clothes were soiled.
-The resident would walk around with his nose running and dripping everywhere.
-Staff would not clean the resident after he used the bathroom so the resident would try to clean himself.
-A few times she visited, there was feces in the resident's room smeared on the floor, on the bed, and in a drawer and the feces was on the resident's hands, face, and in his mouth.
-On one of the occasions, she asked the housekeeper to clean it up; at other times, she would take paper towels and clean it herself.
-The resident would go several days without being shaved.
-She would have to shave the resident at times.
-The resident's fingernails were always dirty with stuff underneath them.
-She talked with a former Memory Care

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Coordinator (MCC) about her concerns and the MCC changed his bathing schedule to a different shift. She did not notice a difference, so they switched his bathing schedule back to first shift. The MCC started checking to make sure staff was doing it.
-It got better, but the MCC left around December 2015 and it started all over again.
-The resident was no longer at the facility as he had a fall and bleeding on the brain on 04/26/16 and died a few days later.

Interview with a PCA in the MCU on 09/08/16 at 10:35 a.m. revealed:
-Resident #11 would get verbally aggressive and he would resist care and swing at staff.
-Both of Resident #11's feet and legs were very dry and had open areas.
-They tried baby oil on them and a cream the physician ordered but it was not helping.

Interview with a second PCA in the MCU on 09/09/16 at 9:25 a.m. revealed:
-Resident #11 would occasionally take his feces out of his pants because he did not like it on him.
-Resident #11 had smeared it on his bed and thrown it in the trash can and got it on his hands.
-Resident #11 was incontinent and wore adult incontinence briefs.
-Resident #11 could toilet himself but he needed reminders and supervision.

Interview with the psychiatric NP on 09/08/16 at 3:50 p.m. revealed:
-Resident #11's issue was agitation in the afternoon.
-When the NP saw the resident, he was usually around the nurses' station.
-The resident was sometimes soiled or wet and had dirty clothes.

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-During her last visit with Resident #11 on 03/23/16, staff reported no concerns and staff reported the resident's behavior was under control.

Refer to interview with the former Administrator on 09/09/16 at 12:55 p.m.

4. Review of Resident #15's current FL-2 dated 4/14/16 revealed:
-Diagnoses included Alzheimer's Dementia without Behaviors, Hypertension, Atrial Fibrillation, Dysphagia and Osteoarthritis.
-Resident #15 was constantly disoriented, needed bathing, feeding and dressing assistance, was semi-ambulatory and used a wheelchair.

Review of Resident #15's Resident Register revealed the resident was admitted to the facility on 4/4/16.

Review of Resident #15's Care Plan dated 4/13/16 revealed:
-Resident #15 was non-ambulatory, had limited upper extremity strength, bowel and bladder incontinence, was always disoriented and needed to be directed.
-Resident #15 required extensive assistance with bathing, grooming and personal hygiene (there was no notation for which days).
-Resident #15 required extensive assistance with dressing, mobility, ambulation, transfers and toileting daily.
-The Care Plan was signed by the Resident Care Coordinator (RCC), Resident #15's Responsible Party and the Primary Care Provider on 4/14/16.

Review of the Licensed Health Professional Support (LHPS) review and evaluation dated 4/28/16 for Resident #15 revealed:

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D 269	Continued From page 34 -Personal care tasks included ambulation using assistive devices and transferring semi-(or) non-ambulatory residents. -Resident #15 used a wheelchair for mobility and transfers, was evaluated but not appropriate for physical therapy and staff denied falls since admission (4/4/16). -Recommendations were to continue to monitor for falls. Telephone interview with a family member of Resident #15's on 9/7/16 at 3:50pm revealed: -The family member had a problem with Resident #15 wearing soiled incontinence briefs. -The family member would ask staff for assistance in changing and cleaning Resident #15. -Resident #15 needed at least 2 people to assist with incontinence care. -Staff would respond saying they were too busy to deal with it right now. -The family member would wait one to one and one half hours before changing the incontinence brief without assistance from staff. Review a Nursing Assistant Note dated 5/24/16 for Resident #15 revealed: -On 5/24/16 for the 7am - 3pm shift, a PCA noted a family member requested assistance with incontinence care for the resident. -The PCA asked the family member to give staff a second because staff was assisting another resident. -When the PCA returned, she heard the family member telling other family members, staff would not change the resident. -The PCA reported the incidient to the Supervisor on duty. Interview with a personal care aide (PCA) on	D 269		

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9/7/16 at 5:40pm revealed:
-Resident #15 needed assistance with getting up, bathing and sometimes dressing.
-If Resident #15 sat too long, she would become stiff.
-Every time the PCA checked Resident #15, a red spot was noted on her buttocks.
-The PCA had not reported the red spot, and did not know if the red spot had been reported or if anything was done about it.

Telephone interview with a Medication Aide (MA)/Supervisor on 9/7/16 at 3:03pm revealed:
-Resident #15 should not have been at the facility.
-Although the MA was not sure of the dates, Resident #15 was falling within the first couple of days after she was admitted to the facility.
-Resident #15 needed skilled nursing care.
-Resident #15 required 2 staff to assist with getting out of the bed, transferring and bathing.
-The MA worked 3rd shift and Resident #15 would always be in the bed during the MA's shift.
-Staff would assist Resident #15 with getting up and going to the bathroom on 3rd shift.

Review of Nursing Assistant Notes dated from 4/10/16 through 6/6/16 for Resident #15 revealed:
-There were 5 entries documenting skin breakdown for Resident #15.
-On 4/10/16 at 2:41pm a PCA noted the resident's bottom was irritated.
-On 5/5/16 for the 11pm -7am shift staff noted the resident's bottom was a little raw.
-On 5/17/16 for the 7am - 3pm shift a Supervisor noted staff reported breakdown on the resident's left thigh.
-On 5/20/16 for the 11pm - 7am shift a PCA noted the resident had a sore on her left hip.
-On 5/31/16 for the 3pm - 11pm shift a MA noted

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D 269	Continued From page 36 that fanny cream was applied to her skin irritation. Interview with a second PCA on 9/7/16 at 4:50pm revealed: -Resident #15's family was at the facility all the time helping her. -The resident stayed in the bed all the time. -The PCA did not remember the resident having any skin breakdown. Interviews with 5 staff of the Memory Care Unit between 9/6/16 and 9/9/16 revealed: -Staff could not remember specific incidents with Resident #15. Review of Emergency Room (ER) record dated 5/30/16 for Resident #15 revealed: -Resident #15 presented to the emergency room with a soiled diaper. -Hospital staff documented just before completion of changing the incontinence brief she urinated. -ER staff documented Resident #15 had an ulceration on her left hip and right ankle. Review of the facilities "Discharge Note" dated 6/22/16 for Resident #15 revealed: -Resident #15 was sent to the hospital (5/31/16) due to constant pain, was admitted for thoracic and cervical fractures and then discharged to Hospice. -The resident was discharged from the facility on 6/6/16. Telephone interview with a family member on 9/8/16 at 11:00am revealed: -Resident #15 died at Hospice on 6/15/16. Refer to interview with the Administrator on 9/9/16 at 12:55pm.	D 269		

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D 269	Continued From page 37 5. Review of Resident #5's current FL-2 dated 12/16/15 revealed: -Diagnoses included Vascular Dementia, Hyperlipidemia, Sub-secular Mass/Brain Tumor, Type II Diabetes Mellitus, Arthritis, Cataracts, Constipation, Dry Skin, Diabetic Retinopathy, Alcohol Dependence and Schizoaffective Disorder. -Resident #5 was intermittently disoriented, verbally abusive, injurious to others and wandered. -Resident #5 had bladder and bowel incontinence, needed bathing, feeding and dressing assistance, was non-ambulatory and used a wheelchair. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 3/23/12. Review of Resident #5's Care Plan dated 1/20/16 revealed: -Resident #5 was non-ambulatory and used a wheelchair, had limited upper extremity range of motion, daily bowel and bladder incontinence, was sometimes disoriented and needed reminders. -Resident #5 required extensive assistance from 1 person with bathing, grooming and personal hygiene on Monday's and Thursday's and staff did all care. -Resident #5 required extensive assistance from 1 person with dressing daily and staff did all care. -Resident #5 required extensive assistance with mobility, ambulation and transfers daily with staff assistance at all times. -Resident #5 required supervision or prompting with eating from staff at times. -Resident #5 was totally dependent on staff with toileting and staff provided all incontinence care.	D 269		

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D 269	Continued From page 38 -The Care Plan was signed by the Resident Care Coordinator (RCC), Resident #5 and the Primary Care Provider (PCP) on 1/27/16. Review of the Licensed Health Professional Support (LHPS) review and evaluation dated 4/27/16 for Resident #5 revealed: -Personal care tasks included ambulation using assistive devices and collecting/testing of finger stick blood samples. -Resident #5 used a wheelchair with a wedge cushion for mobility with staff transferring and propelling. -The resident had three falls in the last quarter and was seen in the Emergency Room (ER) for two. -All recommendations were related to diabetic care. Telephone interview with a family member of Resident #5 on 9/5/16 at 4:05pm revealed: -Staff reported to the family member that Resident #5 fell in the bathroom across the hall from her room at the facility on 7/11/16. -Resident #5 was probably trying to use the bathroom. -On arrival to the emergency room Resident #5's body temperature was 88 degrees Fahrenheit on 7/12/16. -Hospital staff reported to the family member that Resident #5's wheel chair was on top of her when staff found her. -Resident #5's wheelchair was "a rickety one where one side locked and the other did not." -The family member did not know how long Resident #5 had been on the floor. -While visiting at the facility the family witnessed other residents fall and take off their clothes in common areas. -Residents falling and removing their clothing	D 269		

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seemed like a daily occurrence and people got used to seeing it.
-The family member was not able to visit as often as desired.
-On one occasion while visiting, Resident #5 was dirty and the family member had to bathe her.
-The family member was concerned for how staff treated Resident #5 because she could be combative.
-Resident #5 seemed fearful of being touched on her last visits (May/June 2016) at the facility and likened the behavior to someone who had been abused.
-The family member did not know of any specific staff or incidents regarding abuse and could not remember details related to all of what happended and dates of events.
-Resident #5 died 7/25/16.

Telephone interview with a medication aide (MA)/Supervisor on 9/7/16 at 2:38pm revealed:
-The MA was on duty on 7/11/16 when Resident #5 fell at 11:45pm.
-Staff had just finished their rounds on all residents when the MA/Supervisor heard Resident #5 holler out from her room.
-Resident #5 fell trying to get out of her bed.
-The MA checked Resident #5 for injury and found a knot on her head.
-Something was "off" about Resident #5 after she fell because she was acting different.
-The wheelchair was turned over but not on top of Resident #5.
-Regarding the knot documented on Resident #5's head, the MA could not remember if the knot was on the front or the back of Resident #5's head.
-The knot started small and grew bigger and bigger to the size of an orange.
-Resident #5's eyes were also glossy.

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-Resident #5 was sent to the Emergency Room (ER) on 7/11/16.
-Resident #5 was combative and would swing at, spit at, cuss at people and try to run people over with her wheelchair.
-Resident #5 needed more assistance in the last month or so, with bathing and dressing than she had before.
-Resident #5 was able to stand and take a few steps but not walk.
-Staff checked residents every 2 hours on 3rd shift for toileting and to make sure the residents were in the bed.

Interview with a personal care aide (PCA) on 9/2/16 at 3:00pm and 4:57pm revealed:
-Resident #5 had been her "normal self" in the days before she left the facility.
-Resident #5 needed assistance with bathing and toileting.
-Resident #5 could get up and down by herself but would lose her balance.
-Her care needs had changed towards the end (June and July 2016).
-Resident #5 used to be able to wash herself after being handed the wash cloth.
-She needed more assistance like being washed.

Telephone interview with a family member of a resident on 9/6/16 at 4:01pm revealed:
-The family member visited the facility every day.
-The family member observed that Resident #5 did not get dinner frequently.
-Staff would say if Resident #5 was sleeping not to wake her because she could be difficult.

Interview with a medication aide (MA) on 9/6/16 at 5:25pm revealed:
-Resident #5 was aggressive and combative at times.

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-The MA would step back and allow Resident #5 to calm down when she was agitated.
-It was possible staff did not wake Resident #5 for meals if she was sleeping.
-It was hard to get staff to take care of the residents.

Telephone interview with the previous Primary Care Provider (PCP) on 9/9/16 at 10:07am revealed:
-Resident #5 needed total care and guidance with activities of daily living.

Refer to interview with the Administrator on 9/9/16 at 12:55pm.

6. Review of Resident #2's current FL-2 dated 7/18/16 revealed:
-Diagnoses included Alzheimer's Dementia, Osteoporosis, Hypertension, Hyperlipidemia, Emphysema, Hypothyroidism, Bipolar Disorder and Glaucoma.
-Resident #2 was constantly disoriented, had bladder and bowel incontinence, needed bathing and dressing assistance, was semi-ambulatory and used a wheelchair.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/7/07.

Review of Resident #2's Care Plan dated 5/9/16 revealed:
-Resident #2 was non-ambulatory and used a wheelchair, had limited upper extremity strength, was sometimes disoriented and needed reminders.
-Resident #2 required extensive assistance with bathing, grooming and personal hygiene on Monday's and Friday's.

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-Resident #2 required limited assistance with dressing, mobility, ambulation, transfers, eating and toileting daily.
-The Care Plan was signed by the Resident Care Coordinator (RCC), Resident #2 and the Primary Care Provider (PCP) on 5/9/16.

Review of the Licensed Health Professional Support (LHPS) review and evaluation dated 7/19/16 for Resident #2 revealed:
-Personal care tasks included ambulation using assistive devices and transferring semi-(or) non-ambulatory residents.
-Resident #2 used a wheelchair for mobility, had a walker and used it with staff assistance; staff assisted with mobility and transfers; and the resident had several falls in the last quarter.
-The recommendation was to continue to monitor for falls.

Review of a Nursing Assistant Note dated 3/11/16 at 9:00am for Resident #2 revealed staff documented a family member had spoken to Resident #2 on several occasions about ringing her call bell for assistance.

Telephone interview with a family member on 9/5/16 at 3:58pm revealed:
-The family member talked to Resident #2 about using the call bell a hundred times.
-Resident #2 would not use the call bell.
-Resident #2 would not ask for help.
-Resident #2 would just get up by herself.
-Staff at the facility had found Resident #2 on the floor quite a few times.

Interview with the Primary Care Provider (PCP) on 9/1/16 at 2:47pm revealed:
-Resident #2 needed assistance with transfers.
-Resident #2 was independent and would decline

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assistance.
-Resident #2 was alert, oriented and able to retain information.

Interview with the Psychotherapist on 9/1/16 at 2:47pm revealed:
-The therapist had observed Resident #2 attempt transfers and ambulation in her room.
-Resident #2's safety awareness was a concern.
- "I've seen her step over her wheelchair and it scares me."

Observation on 8/30/16 at 1:05pm revealed:
-Resident #2 got up from the bed standing with an unsteady gait.
-She grabbed the arm of the unlocked wheelchair to stabilize herself.
-She had difficulty stepping over the foot pedals on the wheelchair nearly tripping.
-Resident #2 walked to the bathroom, hunched with a slow unsteady gait using objects in her path such as the dresser and walls to steady herself.
-Resident #2 had a hospital gown on which had fallen away from her back revealing significant redness to both buttocks and a raw area at the gluteal fold.
-Resident #2 vomited in the bathroom toilet in her room.
-When the call bell was activated, there was no audible sound to alert staff that assistance was needed.
-The Resident Care Coordinator (RCC) was in the hallway talking to staff and responded with signaling "just a minute" with her hand when alerted that Resident #2 needed assistance.

a. Observations on 8/31/16 between 2:58pm and 3:20pm revealed:
-Resident #2 was in the bathroom in her room.

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D 269	Continued From page 44 -There was no staff present in the room. -At 3pm staff was gathering residents for snack in the common area. -The Resident Care Coordinator (RCC) went into Resident #2's room asking about snack at 3:19pm. -The RCC instructed Resident #2 to get in her wheelchair and the RCC would come back and get her for snack as she left the room. Interview with Resident #2 on 8/31/16 at 3:30pm revealed: -She used to pull the call bell for staff assistance getting out of bed to her wheelchair/walker and getting to the bathroom. -She stopped using the call bell because staff did not respond to it. -Staff did not assist her to the bathroom. -Staff did not like doing anything for her. Review of Nursing Assistant Notes for Resident #2 revealed: -There were 14 entries which documented a slips, trips and falls with 5 documented incidents where Resident #2 was found in the bathroom or fell transferring to or from her wheelchair. -A note for 6:00am on 1/28/16 documented Resident #2 was found on the floor by the door of her room with no injury. -A note for 4:45am on 3/11/16 documented Resident #2 was found on the floor by the bathroom, trying to go to the bathroom, with her wheelchair turned over and complained of right hip and right leg pain. -A note for 9:00am on 3/11/16 documented that Resident #2 was admitted to the hospital for a broken hip. -A note for 5:30pm on 4/29/16 documented Resident #2 fell in the bathroom on her buttocks and sent to the hospital.	D 269		

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D 269	Continued From page 45 -A note for 3pm-11pm on 5/30/16 documented Resident #2 slipped to the floor trying to get out of her wheelchair to her bed with no injury. -A note for 3pm-11pm on 6/2/16 documented Resident #2 tried to get out of her wheelchair and slipped out of the wheelchair to the floor with no documented injury. -A note for 7am-3pm on 6/4/16 documented Resident #2 stated she slipped onto the floor with no injury. -A note for 3pm-11pm on 6/4/16 documented Resident #2 was found on the floor by staff and sent to the hospital. -A note for 4:50pm on 7/8/16 documented Resident #2 slipped out of her wheelchair with no injury. -A note for 6am on 7/12/16 documented Resident #2 was observed on the floor and reported trying to get in her wheelchair with no injury. -A note for 3pm-11pm on 7/13/16 documented Resident #2 slid out of the wheelchair to the floor trying to get in the wheelchair which was not locked with no injury. -A note for 1:30am on 7/16/16 documented Resident #2 was observed on the bathroom floor in her room with her arm bent behind her back and sent to the hospital. -A note for 1:40am on 7/17/16 documented Resident #2 was found on the floor sitting on top of her legs in front her wheelchair trying to go to the bathroom resulting in a skin tear to her right hand. Review of a "Physician Notification of Resident Fall" form for Resident #2 revealed: -A hand written entry following interventions implemented to reduce the risk of future falls included "Resident needs to ring the bell for help" signed by a Medication Aide (MA) and Primary Care Provider dated 7/16/16.	D 269		

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D 269	Continued From page 46 -A hand written entry following interventions implemented to reduce the risk of future falls included "Resident needs to ring the bell for help" signed by a Medication Aide (MA) and Primary Care Provider dated 7/17/16. Interview with a Personal Care Aide (PCA) on 9/2/16 at 4:57pm revealed: -Resident #2 needed assistance with bathing and with pushing her wheelchair to and from her room. -Resident #2 did not need assistance with going to the toilet. -Resident #2 could get to the bathroom and use the toilet by herself. Observation on 8/30/16 at 1:12pm revealed: -The call bell monitor was dark. -The RCC turned the monitor on revealing blinking notifications of call bells. -The RCC turned up the volume on a speaker next to the monitor revealing an electric doorbell alert. Confidential staff interview revealed: -The staff had noticed on average of twice weekly the volume on the call bells would be turned down. -Staff turned it down so they would not have to hear the call bell. -Staff had heard other staff saying they were turning the volume down so they did not have to hear it. -Resident #2 pulled the call bell at times for assistance. Interview with the RCC on 8/30/16 at 1:19pm revealed: -Staff were not supposed to touch the monitor or volume on the speaker.	D 269		

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D 269	Continued From page 47 -Staff had access and the ability to disable the call bell system by turning the monitor off and turning the volume down on the speaker. Interview with a second PCA on 8/31/16 at 2:45pm revealed: -Resident #2 used to use her call bell. -Resident #2 started coming out of her room to the hallway to let staff know when she needed assistance. -There were 4 other residents who regularly used the call bell to request assistance. Interview with a medication aide (MA) on 8/30/16 at 6:10pm revealed: -The MA had never heard of anyone turning off the monitor or turning down the volume for the call bells on 1st or 2nd shift. -The MA did not know what happened on 3rd shift. Interview with a second MA on 8/31/16 at 3:35pm revealed: -Resident #2 regularly used her call bell to request staff assistance. -There were 4 additional residents who also regularly used their call bells to request assistance from staff. Interview with the Administrator on 8/31/16 at 6:31pm revealed: -The Administrator had heard of the call bell speaker being turned down once on the Assisted Living side. -The Administrator was informed on 8/30/16 by the RCC the call bell speaker had been turned down on the MCU. Interview with Resident #2 on 9/7/16 at 10:30am revealed there was a button clipped to her clothes	D 269		

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D 269	Continued From page 48 to remind her to ask staff for assistance before getting out of her wheelchair. b. Interview with Resident #2 on 8/30/16 at 1:05pm and 1:14pm revealed: -She had not been feeling well since having her shower in the morning on 8/30/16. -She had informed staff that she was not feeling well and could not wash. -She reported staff yelled at her and made her wash herself anyway. -She reported asking staff for assistance in cleaning the raw area on her bottom and they refused. -The area on her bottom was painful and burned. -Staff had not checked on her since she bathed at approximately 7:30am on 8/30/16. -She had not had anything to eat or drink because she could not keep it down. Interview with Resident #2 on 8/30/16 at 6:10pm revealed: -Staff had given her medication to help her stomach. -She was feeling better and had drank some water. Interview with a medication aide (MA) on 8/30/16 at 6:10pm revealed the MA did not know that Resident #2 had not been feeling well on 1st shift on 8/30/16. Observation on 8/30/16 at 1:23pm, 8/31/16 at 3:20pm and 9/1/16 at 7:40am revealed Resident #2 was dressed in a blue cowl neck sweater, red pants and dark jacket. Observations on 9/2/16 at 9:00am revealed: -Resident #2 was dressed in a blue cowl neck sweater, red pants and dark jacket.	D 269		

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-Resident #2 had urine and body odor detectable from approximately 2-3 feet away.

Interview with Resident #2 on 9/2/16 at 9:00am revealed:
-Resident #2 stated, "I'm in bad need of a bath."
-She had not had a shower or sponge bath since 8/30/16.
-Staff did not help her.
-Staff would tell her to do it herself.

Interview with a personal care aide (PCA) on 9/2/16 at 3:10pm revealed:
-The PCA was assigned to care for Resident #2 for the 2nd shift on 9/2/16.
-The MA would have to assist in observing skin breakdown on Resident #2's buttocks because Resident #2 did not let the PCA come in her room.
-Resident #2 would yell at the PCA and would not let the PCA help her.

Interview with the MA/Supervisor on 9/2/16 at 3:10pm revealed Resident #2 would probably not let anyone look at her bottom because residents were about to have snack.

Interview with Resident #2 on 9/2/16 at 3:10pm revealed she stated "Oh yes, please look at it" [skin breakdown on buttocks].

Observation on 9/2/16 at 3:14pm revealed:
-Resident #2 had increased redness to the sacral and buttocks area with increased rawness to the gluteal fold since observation on 8/30/16 at 1:05pm.
-There was a new dime sized area of rawness to the right upper buttock.

Interview with Resident #2 on 9/7/16 at 10:30am

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revealed:
-She was feeling better.
-Staff had assisted her with bathing since 9/2/16 and the clothes she had on were clean.
-Staff had applied a new cream to her bottom which felt better.

Interview with a PCA on 9/2/16 at 4:57pm revealed:
-Resident #2 needed assistance with bathing and with pushing her wheelchair to and from her room.
-Resident #2 did not need assistance with going to the toilet.
-Resident #2 could get to the bathroom and use the toilet by herself.

Interview with a second MA/Supervisor on 9/7/16 at 2:38pm revealed:
-Resident #2 would constantly get up to the bathroom by herself.
-She would ambulate holding onto the back of her wheelchair.
-She could dress and feed herself.
-She could use the help but refuse it.
-She would not let anyone help her.
-She was not like that with all staff.
-She liked the MA and would let the MA help her with stockings but not to the bathroom.

Refer to interview with the Administrator on 9/9/16 at 12:55pm.

Interview with the Administrator on 9/9/16 at 12:55pm revealed:
-The Administrator was not aware of any issues or concerns with personal care in the Memory Care Unit.
-There was a complaint a while back with a family

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D 269	Continued From page 51 member who complained of wet linens and clothing for a resident. -The Administrator set time and date the resident was to be cleaned and dated and timed incontinence briefs which resolved the problem. -The Administrator expected staff to assure residents were clean and dry and bathed according to the shower schedule. _____ Review of the facility's Plan of Protection dated 9/2/16 revealed: -New managment company assumed responsibilty for daily operations on 9/1/16. - Body evaluations and assessments will be completed on all residents and supervised by licensed nurses. - Training will be provided on personal hygiene, dignity and respect conducted bt experienced licensed professionals. - All nursing staff will be competency revalidated relating to personal care by new licensee personnel. - Routine visual checks will be conducted by onsite management personnel. - Declaration of Resident Rights will be reviewed with all staff. - Shower assessments will be implemented and reviewed by the care manager and/or executive director. - Routine monitoring will be conducted during facility walk throughs by the executive director, clinical support team, QA nurses and coorperate personnel. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 9, 2016.	D 269		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 6 of 15 sampled residents resulting in 6 residents having numerous repeated falls resulting in serious physical injuries such as head lacerations, hematomas and broken hip, leg, arm and spine bones (#2, #3, #5, #6, #12 and #13). The findings are: Confidential interview with a staff revealed: -Staff in general were drained because they were forced to stay and work 12 and 16 hours a day to cover short shifts. -The facility had a lot of falls which came from staff not taking care of and observing the residents. -There was a pattern at the facility where so many residents had fallen and not come back [died] from their injuries. -Concerns were reported the Supervisor on duty and/or the RCC. Interview with a family member on 9/1/16 at 11:00am revealed:	D 270		

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D 270	Continued From page 53 -The family member observed a resident sitting in the dining room moving from table to table in a wheel chair picking up pieces of food off the floor and eating it. -The family member reported the observation to staff. -Staff informed the family member the resident did that all the time and that was part of his dementia. Interview with a Personal Care Aide (PCA) on 9/6/16 at 4:35pm revealed: -After a resident fell, staff would check there blood pressure. -Staff did not change care or monitoring after a resident fell. 1. Review of Resident #2's current FL-2 dated 7/18/16 revealed: -Diagnoses included Alzheimer's Dementia, Osteoporosis, Hypertension, Hyperlipidemia, Emphysema, Hypothyroidism, Bipolar Disorder and Glaucoma. -Resident #2 was constantly disoriented, had bladder and bowel incontinence, needed bathing and dressing assistance, was semi-ambulatory and used a wheelchair. Review of Resident #2's Care Plan dated 5/9/16 revealed: -Resident #2 was non-ambulatory, used a wheelchair, had limited upper extremity strength, was sometimes disoriented and needed reminders. -Resident #2 required limited assistance with dressing, mobility, ambulation, transfers, eating and toileting. -The Care Plan was signed by the Resident Care Coordinator (RCC), Resident #2 and the Primary Care Provider (PCP) on 5/9/16.	D 270		

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D 270	Continued From page 54 Interview with Resident #2 on 8/30/16 at 1:05pm and 1:14pm revealed staff had not checked on her since she bathed before breakfast on 8/30/16. Observation on 8/30/16 at 1:05pm revealed: -Resident #2 got up from the bed standing with an unsteady gait. -She grabbed the arm of the unlocked wheelchair to stabilize herself. -She had difficulty stepping over the foot pedals on the wheelchair nearly tripping. -Resident #2 walked to the bathroom, hunched with a slow unsteady gait using objects in her path such as the dresser and walls to steady herself. Observations on 8/31/16 between 2:58pm and 3:20pm revealed: -Resident #2 was in the bathroom in her room. -There was no staff present in the room. -At 3pm staff were gathering residents for snack in the common area. -The Resident Care Coordinator (RCC) went into Resident #2's room asking about snack at 3:19pm. -The RCC instructed Resident #2 to get in her wheelchair and the RCC would come back to get her for snack. Interview with Resident #2 on 8/31/16 at 3:40pm revealed: -She preferred to stay in her room. -Staff did not regularly check on her. -When she returned from the hospital after having surgery on her hip in March 2016, staff did not check her any more often than their usual routine.	D 270		

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D 270	Continued From page 55 Review of Nursing Assistant Notes for Resident #2 revealed: -There were 14 entries which documented slips, trips and falls with 6 documented injuries, 5 trips to the emergency room and 1 hospitalization with a broken hip for Resident #2 from 1/28/16 through 7/17/16. -For 7am-3pm on 2/9/16, Resident #2 was sent to the Emergency Room (ER) after she fell hitting the left side of her face while trying to get another resident out of her room. -At 4:45am on 3/11/16, Resident #2 was found on the floor by the bathroom, trying to go to the bathroom, with her wheelchair turned over and complained of right hip and right leg pain. -At 9:00am on 3/11/16, Resident #2 was admitted to the hospital for a broken hip. -At 5:30pm on 4/29/16, Resident #2 fell in the bathroom on her buttocks and was sent to the hospital. -For 3pm-11pm on 6/4/16, Resident #2 was found on the floor by staff and sent to the hospital. -At 1:30am on 7/16/16, Resident #2 was observed on the bathroom floor in her room with her arm bent behind her back and sent to the hospital. -At 1:40am on 7/17/16, Resident #2 was found on the floor sitting on top of her legs in front her wheelchair trying to go to the bathroom resulting in a skin tear to her right hand. Interview with Resident #2 on 8/31/16 at 3:20pm revealed: -Regarding the fall on 3/11/16 where she broke her hip, Resident #2 reported her foot slipped while she was trying to get to the bathroom. -She fell on the night shift. -Following the fall, she yelled out for staff to help her.	D 270		

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Telephone interview with a medication aide (MA)/Supervisor on 9/7/16 at 3:03pm revealed:
-Resident #2 went to the bathroom on 3/11/16.
-"Maybe her wheelchair slipped from under her."
-Resident #2 was constantly getting up and going to the bathroom by herself.
-Resident #2 would not let staff help her.
-Resident #2 needed assistance with getting up and getting to the bathroom, but would refuse.
-Resident #2 would yell at some of the staff and tell them to get out of her room.

Review of the facility's Risk Management Fall Report for Resident #2 revealed:
-A note following a fall on 5/30/16 for staff to be one on one with Resident #2 and to keep fall risk residents in view while up and active.
-A note following a fall on 6/4/16 to request order for personal alarm.
-A note following a fall on 7/16/16 documenting chair alarm ordered.
-A note following a fall on 7/17/16 documenting the Resident Care Coordinator (RCC) was to order a chair alarm.

Interview with Resident #2 on 9/2/16 at 3:14pm revealed she had never had a chair alarm.

Telephone interview with a family member on 9/5/16 at 3:58pm revealed:
-Resident #2 never had a chair alarm at the facility.
-Resident #2 did have a chair alarm at the rehabilitation center following her hip surgery in March 2016.

Interview with a personal care aide (PCA) on 9/6/16 at 4:35pm revealed Resident #2 never had a chair alarm.

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D 270	Continued From page 57 Interview with a second MA/Supervisor on 9/2/16 at 3:14pm revealed the MA was not aware of Resident #2 ever having a chair alarm. Interview with the RCC on 9/2/16 at 3:29pm revealed: -The previous Administrator advised the RCC the facility did not do one to one staffing. -The RCC ordered a chair alarm for Resident #2 after the incident on 7/16/16. -Resident #2 did not have a chair alarm from 6/4/16 through 7/16/16. -The RCC was trying to get an order from the physician who was only at the facility once per week. -The RCC did not know she did not need an order for the personal alarm. -Resident #2 was kept in the common area so she would be seen by staff as they walked around doing their rounds. Interview with a third PCA on 9/6/16 at 6:10pm revealed Resident #2 was in the hospital since 9/5/16. Interview with the Psychotherapist on 9/1/16 at 2:47pm revealed: -The therapist had observed Resident #2 attempt transfers and ambulation in her room. -Resident #2's safety awareness was a concern. -"I've seen her step over her wheelchair and it scares me." Interview with Resident #2 on 9/7/16 at 10:30am revealed: -There was a button clipped to her clothes to remind her to ask staff for assistance before getting out of her wheelchair. -There was a new management company that wanted to work with her to decrease her falls.	D 270		

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D 270	Continued From page 58 -It was a lot of change, but she did not want to fall anymore. Refer to interview with the Primary Care Provider (PCP) on 9/1/16 at 2:33pm. Refer to interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am. Refer to interview with a Medication Aide (MA) on 8/31/16 at 3:35pm. Refer to interviews with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm, 9/2/16 at 3:29pm and 9/8/16 at 7:02pm. Refer to interviews with the former Interim / Acting Administrator on 8/31/16 at 5:15 p.m., 6:31pm, 9/2/16 at 9:02am and 9/9/16 at 12:55pm. 2. Review of Resident #13's FL-2 dated 7/11/16 revealed: -Diagnoses included Vascular Dementia, Hypertension and Allergic Rhinitis. -Resident #13 was constantly disoriented, ambulatory, needed bathing, feeding and dressing assistance, and had bladder incontinence. Review of Resident #13's Care Plan dated 6/24/16 revealed: Resident #13 was ambulatory, had limited upper extremity strength, bladder incontinence, was always disoriented and needed to be directed. -Resident #13 required extensive assistance with dressing and toileting. -Resident #13 required limited assistance with mobility, ambulation, transfer and eating daily. -The Care Plan was signed by the Resident Care Coordinator (RCC), Resident #13's Power of	D 270		

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D 270	Continued From page 59 Attorney and the Primary Care Provider (PCP) by 6/27/16. Telephone interview with a family member of Resident #13 on 9/6/16 at 4:57pm revealed: -Resident #13 was at the facility for 4 months. -The family member was notified by staff that Resident #13 was trying to pull away from staff and fell and hit her head in the bathroom or the bedroom (6/29/16). -Staff would not really tell the family member much. -The family member was notified by staff that Resident #13 fell from her wheelchair, hit the floor and broke her elbow (7/12/16). -Resident #13 was unable to say what happened. -Resident #13 had hit a few of the staff, especially when they tried to move her away from the exit door when the family member was leaving. -Most of the staff were good, but there were a few on the 1st shift that treated residents "ill" whom the family member did not know their names. -Resident #13 left the facility on 8/9/16 and died 8/23/16. Review of Nursing Assistant Notes for Resident #13 revealed: -There were 3 entries which documented Resident #13 having bruises with no documented accident or injury which caused the bruising. -For 11pm-7am on 4/11/16, Resident #13 had a bruise on her left buttock. -For 7am-3pm on 4/30/26, Resident #13 had 2 bruises on her left arm and hand reported to the Medication Aide (MA). -For 7am-3pm on 6/15/16, Resident #13 had a bruise on the left side of her hand reported to the MA. -For 11pm-7am on 6/29/16, Resident #13 pulled away from staff, fell and hit her head on the floor	D 270		

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resulting in bleeding from her head.
-For 3pm-11pm on 7/2/2016, Resident #13 was making faces while holding her right hand.
-For 7am-3pm on 7/3/16, Resident #13 would not eat, was shaking and crying; and Emergency Medical Services (EMS) was called.
-At 12:30pm on 7/3/16, Resident #13 returned from the Emergency Room (ER) with a wrist sprain.
-At 1:00pm on 7/3/16, Resident #13's right knee was swollen.
-For 7am-3pm on 7/9/16, Resident #13 had an old appearing bruise on her butt and the MA was notified.
-For 3pm-11pm on 8/9/16, Resident #13 was found cold with a temperature of 89.9 degrees Fahrenheit and EMS was called.

Review of Caregiver Visual Skin Check forms for Resident #13 revealed:
-Documentation on 4/30/16 by a Personal Care Aide (PCA) that Resident #13 had a bruise on her left hand and arm reported to the Medication Aide (MA).
-Documentation on 5/21/16 by a PCA that Resident #13 had a bruise on her right arm reported to the MA.

Review of facility incident reports for Resident #13 revealed:
-On 6/19/16 at 1:00pm Resident #13 was pulled by another resident resulting in a bruise to her right arm.
-On 6/29/16 at 6:35am Resident #13 pulled away from staff in the hallway and fell and hit her head on the floor resulting in a laceration above her right eye.
-On 7/12/16 at 7:30am Resident #13 slid out of her wheelchair while her arm was caught in the hole of the arm rest resulting in her elbow "not

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looking right."
-There were no other incident reports for Resident #13.

Review of hospital records for Resident #13 revealed:
-Resident #13 was seen in the ER on 6/29/16 for a fall with head injury where ER staff documented the resident was walking with another resident and tripped and fell.
-EMS reported to hospital staff "story not corroborating from staff."
-On 8/9/16 the resident was admitted with severe septic shock and her physical exam noted she appeared toxic, sickly, ill and distressed.

Interview with a personal care aide (PCA) on 9/8/16 at 11:20am:
-The PCA documented the bruises she saw on Resident #13.
-No falls had been reported for Resident #13.
-The bruises on Resident #13 were reported to the MA on duty.

Interview with a second PCA on 9/2/16 at 3:00pm revealed:
-Resident #13 did not talk.
-She did like to walk until she fell (6/29/16).
-The PCA would assist Resident #13 to bed and Resident #13 would get up and fall.
-The PCA would spend more one on one time with the resident and monitor her more by checking on her "every so often."
-Resident #13 may have fallen because of her medications or dementia.

Interview with a third PCA on 9/6/16 at 4:35pm revealed:
-The PCA knew that Resident #13 had hurt her arm (7/12/16).

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D 270	Continued From page 62 -The PCA heard that Resident #13 had fell out of the bed on 3rd shift. -The PCA could not remember when it was that the resident fell out of the bed. Telephone interview with a MA/Supervisor on 9/7/16 at 3:03pm revealed: -Resident #13 was doing really well at the facility until she fell and hurt her head (6/29/16). -Resident #13 went downhill after that fall. -The MA was not sure but thought Resident #13 remained at the facility for 1 month after the fall in which she hurt her head. Interview with the Primary Care Provider (PCP) on 9/1/16 at 3:18pm revealed: -Resident #13 was initially ambulatory (on admission) and had a rapid decline moving to the use of a wheelchair for ambulation (following the fall 6/29/16). -Resident #13 was a high fall risk and needed assistance with transfers and ambulation. -Resident #13 had a hospital bed and fall mat for preventative measures. Telephone interview with the former PCP on 9/9/16 at 10:07am revealed: -Resident #13 fell on 6/29/16 and staff noticed injury to her left hand on 7/1/16. -An x-ray was ordered on 7/1/16 and the PCP received results which were initially normal. -Resident #13 fell again on 7/3/16 and was sent to the Emergency Room (ER). -Resident #13 fractured her right arm and was referred to an orthopedic physician by the ER. -If a resident fell at the facility, the PCP expected staff to complete a fall form (a form facility staff used to communicate falls to the medical provider) and keep the resident in an area where staff could watch them.	D 270		

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D 270	Continued From page 63 Refer to interview with the Primary Care Provider (PCP) on 9/1/16 at 2:33pm. Refer to interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am. Refer to interview with a Medication Aide (MA) on 8/31/16 at 3:35pm. Refer to interviews with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm, 9/2/16 at 3:29pm and 9/8/16 at 7:02pm. Refer to interviews with the former Interim / Acting Administrator on 8/31/16 at 5:15 p.m., 6:31pm, 9/2/16 at 9:02am and 9/9/16 at 12:55pm. 3. Review of Resident #5's current FL-2 dated 12/16/15 revealed: -Diagnoses included Vascular Dementia, Hyperlipidemia, Sub-secular Mass/Brain Tumor, Type II Diabetes Mellitus, Arthritis, Cataracts, Constipation, Dry Skin, Diabetic Retinopathy, Alcohol Dependence and Schizoaffective Disorder. -Resident #5 was intermittently disoriented, noted to be a wanderer and verbally abusive and injurious to others. -Resident #5 was non-ambulatory and used a wheelchair for mobility, had bladder and bowel incontinence and needed bathing, feeding and dressing assistance. Review of Resident #5's Care Plan dated 1/20/16 revealed: -Resident #5 was non-ambulatory, used a wheelchair, had limited upper extremity range of motion, daily bowel and bladder incontinence, was sometimes disoriented and needed	D 270		

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reminders.
-Resident #5 required extensive assistance with mobility, ambulation and transfers from staff at all times.
-Resident #5 required supervision or prompting with eating daily with staff supervision at times.
-Resident #5 was totally dependent on staff with toileting and staff assisted with all incontinence care.
-The Care Plan was signed by the Memory Care Coordinator (MCC), Resident #5 and the Physician on 1/27/16.

Telephone interview with a family member of Resident #5 on 9/5/16 at 4:05pm revealed:
-Facility staff reported to the family member that Resident #5 fell in the bathroom across the hall from her room at the facility.
-Hospital staff reported to the family member that Resident #5's wheel chair was on top of her when staff found her.
-Resident #5's wheelchair was "a rickety one where one side locked and the other did not."
-The family member did not know how long Resident #5 had been on the floor.
-On arrival to the emergency room, Resident #5's body temperature was 88 degrees Fahrenheit on 7/12/16.
-Resident #5 had a "gash" on the back of her head, some type of injury on her back that was covered with a bandage and her knees were "messed up" from the fall.
-Resident #5 had a lot of falls at the facility.
-Before Resident #5 died, she was not herself and had not been eating much.
-While visiting at the facility, the family witnessed other residents fall and take off their clothes in common areas.
-Residents falling and removing their clothing seemed like a daily occurrence and people got

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used to seeing it.
-It seemed like staff did not keep a good eye on the residents or maybe there was not enough staff.
-The nursing staff at the hospital informed the family member that Resident #5 had Escherichia Coli (a bacteria found in feces) in her mouth.
-Resident #5 died 7/25/16.

Review of a Physician Notification of Resident Fall dated 12/19/15 for Resident #5 revealed:
-Interventions implemented to reduce the risk of future falls were to make sure wheels were locked, assist resident to be safe while standing and staff to be observant of resident while standing or walking with her chair.
-The form was signed by the Memory Care Coordinator (MCC) and the Physician.

The MCC who completed the form was no longer available for interview.

Review of Nursing Assistant Notes for Resident #5 revealed:
-There were 18 entries which documented slips, trips, falls and being found on the floor with 8 documented injuries and 5 trips to the emergency room for Resident #5 from 1/6/16 through 7/11/16.
-For 11pm-7am on 1/6/16, Resident #5 was being assisted by staff when she fell off the bed, hit her head resulting in a laceration on top of her left eye and was sent to the Emergency Room (ER).
-For 3pm-11pm on 1/19/16, Resident #5 was found on the floor in her room beside her wheelchair, hurting all over and was sent to the ER.
-At 12:00pm on 3/1/16, Resident #5 was observed laying on the floor, was seen by staff hit the floor (staff witnessed the fall), hit the right side

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of her head and was sent to the ER.
-At 9:04pm on 4/5/16, Resident #5 slipped out of her wheelchair to the floor trying to hit another resident, complained of arm pain, Emergency Medical Services (EMS) was called and Resident #5 refused to go to the ER.
-For 3pm-11pm on 5/16/16, Resident #5 slipped out of her wheelchair resulting in a small cut to her right hand.
-For 7am-3pm on 6/3/16, Resident #5 fell hitting her head on the floor trying to turn and hit staff while pulling her wheelchair and was sent to the ER.
-For 3pm-11pm on 7/1/16, Resident #5 slipped out of her wheelchair 3 times.
-For 7am-3pm on 7/10/16, that documented Resident #5 had a black and blue knot on her left eye and the Medication Aide (MA) was notified.
-For 11pm-7am on 7/11/16, Resident #5 was observed on the floor in her room by the dresser with a knot on the top of her head.

Review of a Physician Notification of Resident Fall dated 6/3/16 for Resident #5 revealed:
-Interventions implemented to reduce the risk of future falls were resident won't sit in her wheelchair and she was unable to keep her balance.
-The form was signed by a MA.

The MA who completed the form was no longer available for interview.

Review of the facility's Incident Reports for Resident #5 revealed:
-On 6/23/16 at 2:13am, Resident #5 fell against the door of another resident's room on her "butt" without injury.
-On 6/23/16 day shift, Resident #5 had swelling to her face and left eye with redness to her left eye

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related to slipping out of her wheelchair early in the morning.
-On 6/30/16 at 2:15am, Resident #5 fell on her "butt" while attempting to stand and wheelchair was not locked.

Review of the facility's Risk Management Fall Report for Resident #5 revealed:
-A note following a fall on 3/21/16 inquiring if staff check Resident #5 hourly or every 30 minutes.
-A note following a fall on 5/16/16 for Resident #5 not to be placed in her room alone without staff present and should be placed directly into bed.

Interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm revealed:
-The RCC was responsible for informing staff of recommendations from Risk Management.
-The RCC had instructed staff after the 5/16/16 incident to keep resident s in sight until they were sleepy and then put residents in their beds for safety.
-On 5/16/16, Resdient #5 fell forward out of her wheelchair because she frequently leaned forward while sleeping in the wheelchair.
-Resident #5 could actually get up by herself.
-The RCC could not remember the time or exactly what happened on 7/10/16 and 7/11/16.

Telephone interview with a Medication Aide (MA) on 8/31/16 at 10:15am revealed:
-Resident #5 had fallen in her room at change of shift from 2nd to 3rd shift on 7/11/16.
-Staff heard the loud bump as Resident #5 hit the floor.
-Resident #5 was sent out by 3rd shift staff for being unresponsive.

Telephone interview with a medication aide (MA)/Supervisor on 9/7/16 at 2:38pm revealed:

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D 270	Continued From page 68 -The MA was on duty on 7/11/16 when Resident #5 fell. -Staff had just finished their rounds on all residents when the MA heard Resident #5 holler out. -Resident #5 fell trying to get out of her bed. -The MA checked Resident #5 for injury and found the knot on her head. -Something was "off" about Resident #5 after she fell because she was acting different. -Resident #5 was able to stand and take a few steps but not walk. -The wheelchair was turned over but not on top of Resident #5. -The MA was not aware of any problems with Resident #5's wheelchair. -Resident #5 was combative and would swing at, spit at, cuss at people and try to run people over with her wheelchair. -When a resident fell, staff would check them for injury, ask about any head injury, check vital signs, notify the RCC and family and send the resident out to the emergency room. -The RCC was responsible for any needed follow up for a resident after a fall. -Sometimes staff did 15 or 30 minute watch after a resident fell and there was a check list that had been done for a couple of other residents. -Resident #5 had not been on 15 or 30 minute checks. -Staff checked residents every 2 hours on 3rd shift for toileting and to make sure the residents were in the bed. -Regarding the knot documented on Resident #5's head, the MA could not remember if the knot was on the front or the back of Resident #5's head. -The knot started small and grew bigger and bigger to the size of an orange. -Resident #5's eyes were also glossy.	D 270		

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D 270	Continued From page 69 Interview with a Personal Care Aide (PCA) on 9/6/16 at 4:35pm revealed: -The PCA could not remember all the details about Resident #5. -Staff did not do anything different as far as care or monitoring after a resident fell as frequently as Resident #5. -Staff checked the residents blood pressure and made sure there was no injury after a fall. Interview with a second PCA on 9/2/16 at 3:00pm and 4:57pm revealed: -Resident #5 had been her "normal self" in the days before she left the facility. -Over time, her care needs had changed. -Resident #5 could get up and down but would lose her balance. -Resident #5 had a chair alarm when the PCA started working at the facility in 2014. -The chair alarm "just went missing." Interview with a MA on 9/6/16 at 5:25pm revealed: -Resident #5 required a lot of redirection so she wouldn't fall. -Resident #5 would not stay in her wheelchair. Interview with the Psychotherapist on 9/1/16 at 3:18pm revealed: -Resident #5 had poor safety awareness. -The therapist worked with staff to promote safety. -Resident #5 used a wheelchair for ambulation. -She could transfer but her gait was very unsteady. -Resident #5 fell from trying to ambulate unassisted. -Resident #5 was combative with spitting, kicking and hitting behaviors.	D 270		

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D 270	Continued From page 70 -The therapist worked with staff on redirection skills. Interview with the Primary Care Provider (PCP) on 9/1/16 at 3:18pm revealed: -The PCP had only seen Resident #5 once. -Resident #5 used a wheelchair. Telephone interview with the previous PCP on 9/9/16 at 10:07am revealed: -Resident #5 needed total care and guidance with activities of daily living. -The PCP was not aware Resident #5 had 29 documented falls from 1/6/16 through 7/11/16. Refer to interview with the Primary Care Provider (PCP) on 9/1/16 at 2:33pm. Refer to interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am. Refer to interview with a Medication Aide (MA) on 8/31/16 at 3:35pm. Refer to interviews with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm, 9/2/16 at 3:29pm and 9/8/16 at 7:02pm. Refer to interviews with the former Interim / Acting Administrator on 8/31/16 at 5:15 p.m., 6:31pm, 9/2/16 at 9:02am and 9/9/16 at 12:55pm. 4. Review of Resident #12's FL2 dated 12/26/14 revealed: -Diagnoses included dementia, major depression with psychosis, hypertension and coronary artery disease -Resident #12 was semi-ambulatory with device. -Resident #12 used walker and wheelchair for ambulating.	D 270		

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D 270	Continued From page 71 -Resident was constantly disoriented. Review of Resident #12's assessment and care plan dated 12/21/15 revealed: -Resident #12 required limited assistance with bathing, dressing, ambulation, toileting, eating and transferring. -Resident #12 was a wanderer. Review of facility's incident and accident reports revealed: -Resident had 5 incidents from 6/22/16 to 8/19/16. -6/22/16: (11:00am) Staff noticed resident #12 had bruising and a hematoma over right eye; resident sent to emergency room (ER). -6/23/16: (2:45pm) Staff notified by Resident #12's roommate of a skin tear of unknown origin; no other documentation noted. -8/2/16: (7:38am) Resident observed on the floor in his room; laceration above right eye; sent to ER. -8/3/16: (1:55am) Resident found on the floor in front of the bathroom with right hip pain; sent to ER. -8/19/16: (6:00pm) Resident found on the floor with heavy breathing; sent to ER. Interview with medication aide on 9/2/16 at 12:15pm revealed: -Resident #12 seemed to have trouble with his balance. -Most of the time, staff did not know resident had fallen until staff rounds were made. -Staff would leave resident's room door open and check on him more often. Interview with the Resident Care Coordinator (RCC) on 9/2/16 at 1:30pm revealed: -Resident #12 was very proud and liked his	D 270		

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independence.
-Staff would leave resident's room door open and check on him more often.
-Notification of falls are sent to the physician to sign then filed in the resident's record.

Interview with family member on 9/2/16 at 3:15pm revealed:
-Resident #12 had a history of falls and poor balance prior to going to the facility.
-Resident needed help getting to the bathroom.
-Staff would notify family of resident's falls.
-Resident had shortness of breath and fell on 8/19/16.
-Resident died at the hospital on 8/20/16.

When administrator was asked for a copy of the facility's fall policy on 9/2/16, she presented a copy of the facility's fall management program and stated "this is all I could find on falls."

Review of facility's fall management program revealed residents are to be monitored and identified for fall risk; recognize falls trends, and determine a way to reduce falls.

Refer to interview with the Primary Care Provider (PCP) on 9/1/16 at 2:33pm.

Refer to interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am.

Refer to interview with a Medication Aide (MA) on 8/31/16 at 3:35pm.

Refer to interviews with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm, 9/2/16 at 3:29pm and 9/8/16 at 7:02pm.

Refer to interviews with the former Interim /

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D 270	Continued From page 73 Acting Administrator on 8/31/16 at 5:15 p.m., 6:31pm, 9/2/16 at 9:02am and 9/9/16 at 12:55pm. 5. Review of Resident #3's current FL-2 dated 07/18/16 revealed: -The resident's diagnoses included Alzheimer's dementia, epilepsy, hypertension, hypothyroidism, and constipation. -The resident was constantly disoriented and noted to wander. -The resident was semi-ambulatory with wheelchair and incontinent of bowel and bladder. -The resident required assistance with bathing, dressing, and feeding. Review of Resident #3's Resident Register revealed: -Resident #3 was admitted to the facility on 05/26/11. -The resident required assistance with dressing, bathing, nail care, toileting, hair/grooming, skin care, mouth care, feeding, scheduling appointments, and orientation to time and place. -The resident was forgetful and needed reminders. Review of Resident #3's current assessment and care plan dated 09/02/15 revealed: -The resident was confused and must be redirected at all times. -The resident had significant memory loss and was disoriented at all times. -The resident was noted to be wandering at times. -The resident was non-verbal and babbles. -The resident was ambulatory but her gait was very unsteady and the resident was a fall risk. -The resident required extensive assistance with mobility, ambulation and transfers. -The resident was totally dependent with bathing,	D 270		

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grooming, personal hygiene, and dressing.
-The resident was incontinent of bowel and bladder and required extensive assistance with toileting.
-The resident required limited assistance with eating.

Review of the special care unit progressive profile for Resident #3 revealed:
-On 09/15/15, the resident was noted to ambulate unassisted at times and to fall frequently.
-On 08/11/16, the resident was noted to require a wheelchair for ambulation and assistance with ambulation.

Review of an emergency medical services (EMS) report dated 01/05/16 for Resident #3 revealed:
-The dispatch call was received at 9:30 a.m. and EMS arrived on scene at the resident at 9:37 a.m.
-The resident was lying prone on the floor beside her bed with blood under her head.
-The resident was alert but did not speak which was normal for her per facility staff.
-Facility staff stated they did not know how long she had been on the floor or if she had lost consciousness.
-The chief complaint was hematoma with laceration on head from fall from bed.
-The resident had a small ½ inch laceration on the top right of her head with bleeding and mild swelling at the site.
-The resident was transported to the hospital.

Review of the incident log sheet for all residents from January 2016 - September 2016 revealed:
-On 01/05/16, Resident #3 was observed lying face down and there was blood on the floor.
-The resident was not moved to prevent any further injury until EMS arrived.
-The resident was transported to the emergency

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D 270	Continued From page 75 room (ER) and returned with staples to her wound. Review of a physician's order dated 01/27/16 for Resident #3 revealed: -The resident had increased and frequent falls. -The physician ordered a hospital bed with rails. Review of facility progress notes for Resident #3 revealed: -02/17/16 (1:00 p.m.): Physical therapy (PT) evaluation was done and the resident was found to have poor rehab potential due to the resident's cognitive impairment, inability to communicate and follow instructions. The resident was not admitted to PT services. -04/18/16 (6:00 p.m.): The resident had a good evening. The resident got up and started walking. Staff helped the resident down the hallway. -06/13/16 (3 - 11 shift): A nurse came from hospice to meet with the resident's family. Review of an EMS report dated 06/30/16 for Resident #3 revealed: -The dispatch call was received at 9:06 a.m. and EMS arrived on scene at the resident at 9:14 a.m. -The resident was lying on the floor with staff by her. -The resident was unable to move or talk which facility staff reported was normal for the resident. -Staff stated the resident was sitting on the couch and fell over onto the floor and hit the right side of her forehead on the floor. -The resident had a small hematoma with minor bleeding and pressure was applied. -The chief complaint was laceration due to fall. -The resident was transported to the hospital. Review of an incident / accident report for	D 270		

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D 270	Continued From page 76 Resident #3 dated 06/30/16 at 9:00 a.m. revealed: -The resident was observed on the floor by staff in the library. -The medication aide assessed the resident and noticed bleeding coming from the right side of the temple area. -EMS was called and the resident was sent to the ER for evaluation. -The resident returned from the hospital with no new orders. -The resident had bruising above the right eye along with a small cut. -Hospice was to follow and the physician was to see on 07/01/16. Review of facility progress notes for Resident #3 revealed on 06/30/16 (3 - 11 shift), the resident was starting to bruise around her right eye due to a fall on first shift. Review of a hospice plan of care dated 07/05/16 for Resident #3 revealed: -The resident required maximum assistance with transferring. -The resident had increased lethargy. -The resident recently fell and was transported to the emergency room. Review of a hospice nursing visit note report for Resident #3 dated 07/11/16 revealed: -The resident was in bed and lethargic. -The resident's bruise to the right eye was almost completely healed. -The resident was unable to sit up independently. Review of facility progress notes for Resident #3 revealed on 07/15/16 (7 - 3 shift), the resident had a bruise on the top middle of the forehead and the medication aide was notified.	D 270		

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D 270	Continued From page 77 Review of a hospice nursing visit note report for Resident #3 dated 07/18/16 revealed the resident had a bruise to her right hand and forehead. Review of facility progress notes for Resident #3 revealed: -08/12/16 (9:00 a.m.): The resident was sitting at the dining room table in her wheelchair. The medication aide heard "a thump" and saw the resident laying on the floor on her right side. A quarter size bump started to form in the middle of her forehead. The medication aide contacted hospice nurse who will come to the facility to see the resident. POA and RCC were notified. -08/12/16 (3 - 11 shift): The resident was in the wheelchair and started jerking movement. The resident's face was swollen. Hospice was made aware and nurse will come back to check on resident. Review of a hospice nursing visit note report for Resident #3 dated 08/12/16 revealed: -The resident required assistance with all activities of daily living. -The resident was unable to sit up independently. -The nurse was called for a prn (as needed) visit due to a fall. -The nurse completed an assessment and the resident had a large mass to forehead. -The nurse reviewed fall precautions with facility staff. -The nurse would continue to monitor for fall prevention compliance. -Facility staff was instructed to call with any concerns or questions. Review of a hospice nursing visit note report for Resident #3 dated 08/15/16 revealed: -The resident was in bed and alert but nonverbal.	D 270		

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D 270	Continued From page 78 -The resident fell last week and had bruising to face and large lump to forehead. -The resident had redness on sacrum and staff was instructed to apply barrier cream and assure resident was being turned. -The nurse would continue to monitor for fall prevention efforts. Review of a hospice nursing visit note report for Resident #3 dated 08/22/16 revealed: -The resident was in bed and lethargic. -The resident had a history of falls and had facial bruising that had improved since last visit. -The nurse would continue to monitor for fall prevention efforts. Review of facility progress notes for Resident #3 revealed: -08/28/16 (7 - 3 shift): The medication aide noticed a knot on the resident's forehead and bruise around her eye and did not know if it was coming from healing from a fall. Hospice nurse was called and will check the resident tomorrow. Review of a hospice nursing visit note report for Resident #3 dated 08/29/16 revealed: -The resident was in bed and lethargic. -The resident had bruise to forehead with swelling. -The resident was unable to sit up without assistance. -The nurse would continue to monitor for fall prevention efforts. Telephone interview with the hospice nurse (HN) for Resident #3 on 09/02/16 at 1:30 p.m. revealed: -Facility staff called the HN around 9:53 a.m. on 08/12/16 and reported the resident had fallen and hit her forehead.	D 270		

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D 270	Continued From page 79 -Facility staff reported the resident was sitting in a wheelchair at a dining room table when she fell and hit her face on the table. -The HN went to the facility on 08/12/16 to assess the resident and the resident had "a pretty good little goose egg" on her forehead. -The HN spoke with the resident's spouse and he did not want the resident sent out to the hospital. -Facility staff called the HN back during the afternoon of 08/12/16 and reported the resident was bruising and shaking and they thought the resident may have had a seizure. -The HN went back to the facility on 08/12/16 to check the resident again. -The HN spoke with the family again and they did not want her sent to the ER. -The HN went over with staff on duty that Resident #3 could not sit up by herself in the wheelchair or other chair because she would lean forward. -Facility staff called the HN on 08/29/16 and reported bruising to the resident but when the HN checked, it appeared to be old bruising. Review of a hospice physician's note for Resident #3 dated 09/01/16 revealed: -The resident was lethargic and nonverbal. -The resident was unable to bathe, dress, groom, or transfer without assistance. -The resident was wheelchair bound and incontinent of bowel and bladder. -The resident had two prn hospice nurse visits due to fall with significant bruising to face. Observation of Resident #3 on 08/30/16 at 1:10 p.m. revealed: -Resident #3 was sitting on the couch in the library alone. -The resident's wheelchair was sitting in front of the couch touching her right leg.	D 270		

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D 270	Continued From page 80 -The resident had a large black and purple bruise under and above her left eye and a greenish purple bruise under her right eye. -The resident had a large protruding knot near the middle and toward the left side of her forehead. -The resident did not speak when spoken to. -The resident was leaning forward on the couch with no staff near the resident. Interview with a medication aide (MA) in the MCU on 08/30/16 at 1:20 p.m. revealed: -The bruising and the knot on Resident #3's face came from a fall a few weeks ago. -The MA was not working when the resident fell but she was told the resident leaned forward in the wheelchair and fell on her face. -Staff were supposed to watch Resident #3 when she was sitting up because she leaned forward when sitting up. -Resident #3 could stand with assistance but she could not walk and she could not transfer herself. Interview with the hospice aide on 08/30/16 at 6:40 p.m. revealed: -She usually came to the facility two days a week to give Resident #3 a shower and wash the resident's hair. -It was not unusual for Resident #3 to lean forward in the wheelchair. Interview with a family member of Resident #3 on 08/30/16 at 6:48 p.m. revealed: -Resident #3 just started receiving hospice services in June 2016. -Resident #3 cannot stand up on her own. -Resident #3 had a bad fall about 2 weeks ago. -A medication aide reported she was about 10 feet from the resident and heard "a loud boom" and saw the resident on the floor with the wheelchair on top of her.	D 270		

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-The facility called the hospice nurse who came right away that day to check the resident.
-The resident's eyes were swollen shut for 2 days.
-Resident #3 got tired and started to lean when left sitting up in the wheelchair.
-The family had told the staff to put the resident in bed when she got tired.
-Resident #3 had also fallen off the couch in the front area of the facility and had to go to the hospital sometime in June 2016.
-The family had asked for a bed rail because the resident had fallen off the bed.
-A former MCC told the family she was working on getting a bedrail but the paperwork did not go through.
-They never heard anything else about the bedrail.
-The family had been trying to prop up the resident with pillows while in bed.

Observation of Resident #3 on 08/31/16 at 9:35 a.m. revealed:
-The resident was lying in bed asleep.
-There was a straight back chair and the resident's wheelchair pushed up against one side of the bed and the other side of the bed was against the wall.
-The right side of the wheelchair was locked; the left side was not locked and moved when touched.

Interview with a personal care aide (PCA) on 08/31/16 at 9:40 a.m. revealed:
-The PCA had worked at the facility for about a month.
-The resident's family had requested staff to put chairs beside the bed to keep the resident from rolling out of the bed.
-Each time she had observed the resident in bed,

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the chairs had been pushed against the bed.
-The resident could not stand up by herself and staff have to turn her.
-The resident was a two person assist for transfers because her body "locks up".

Interview with a second PCA on 08/31/16 at 9:58 a.m. revealed:
-She had worked at the facility about 4 years and usually worked on first shift.
-The chairs were sometimes put against Resident #3's bed because the PCA was afraid the resident might roll out of bed.
-She thought the resident had some falls but could not recall when or how often.
-The resident was "real stiff" and the PCA was not sure if the resident was capable of turning herself in bed because staff usually turned her.
-If the resident was left sitting up in a chair, she would lean forward and fall.
-The PCA tried to sit the resident all the way back in the chair.
-The PCA checked on the resident during routine 2 hour incontinence care checks.
-The resident was a two person assist because the resident was so stiff but the PCA could assist the resident by herself.
-The resident used to be able to walk around by herself but had not done that in about a year.

Observation of Resident #3 on 08/31/16 at 10:22 a.m. revealed:
-The resident was still lying in bed.
-Both chairs were still pushed up against the resident's bed.

Interview with the Resident Care Coordinator (RCC) on 08/31/16 at 11:10 a.m. revealed:
-She was not aware staff was using a chair and Resident #3's wheelchair to push against the

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resident's bed to keep her from falling out of the bed.
-The facility was a restraint free facility and staff should not be doing that.
-Staff were supposed to come to her with any concerns about residents since the MCC position was vacant.
-She would check with hospice about possibly getting a concave mattress for the resident.
-She would notify staff to stop pushing the chairs against the bed.

Observation of Resident #3 on 08/31/16 at 2:50 p.m. revealed:
-Two personal care aides came out of the resident's room into the hallway.
-The resident was lying in bed on her left side.
-There was a straight back chair and the resident's wheelchair pushed up against one side of the bed and the other side of the bed was against the wall.
-The right side of the wheelchair was locked the left side was not locked and moved when touched.

Observation of Resident #3 on 08/31/16 at 3:07 p.m. revealed:
-Two personal care aides came out of the resident's room into the hallway.
-The resident was lying in bed on her left side.
-There was a straight back chair pushed up against one side of the bed and the other side of the bed was against the wall.
-The wheelchair had been moved away from the bed.

Observation of Resident #3 on 09/01/16 at 6:20 a.m. revealed:
-The resident was lying in bed asleep.
-There were no chairs pushed against the

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D 270	Continued From page 84 resident's bed. Interview with a third PCA in the MCU on 09/01/16 at 6:25 a.m. revealed: -She had worked at the facility for about 3 years usually on third shift. -Resident #3 was total care. -She was not on duty when Resident #3 fell recently. -Resident #3 had frequent falls with head injuries. -The resident usually fell when she was sitting up because the resident would lean forward. -Staff would push the resident's wheelchair closer to the table because of her leaning forward. -The resident could not stand up by herself and she had not walked in about a year. -The resident's family wanted staff to put a chair and her wheelchair close to the bed while the resident was in bed. -The PCA had not observed the resident rolling or turning herself in bed. -Staff did routine 2 hours checks on Resident #3. -Staff were instructed to do 30 minute checks on Resident #3 in the last day or so. Interview with a second MA in the MCU on 09/02/16 at 4:35 p.m. revealed: -He had worked at the facility previously and was rehired about 7 months ago. -Resident #3 was total care and required assistance with all activities of daily living. -Resident #3 could not bear weight and had to be pushed by staff in the wheelchair. -The resident always rocked and leaned forward when sitting in the wheelchair or other chair and sofa. -He was not working when the resident fell on 08/12/16 because it happened on first shift. -It was reported that Resident #3 was in the dining room and staff had stepped out of the	D 270		

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dining room.
-The resident was sitting in the wheelchair and fell face first.
-The resident had a hematoma on her forehead and both eyes were swollen and black and blue.
-The hospice nurse came and checked the resident after the fall and called the family.
-The family did not want the resident sent to the ER.
-Later that day on second shift, the MA noticed the resident was jerking her body so they laid her down.
-The MA called the hospice nurse and the nurse came back to the facility and checked the resident.
-Staff were not supposed to leave Resident #3 sitting up in the chair alone because she would get sleepy and lean forward.
-The MA usually put pillows between the bed and the resident's body for safety.

Interview with a third MA in the MCU on 09/02/16 at 5:12 p.m. revealed:
-She was working on first shift on 08/12/16 when Resident #3 fell.
-Resident #3 was still sitting at the dining room table in her wheelchair with the wheelchair locked after breakfast.
-The resident was rocking her body back and forth.
-The MA was passing medications at the medication cart near the dining room.
-The MA's back was turned away from the dining room as the MA was talking to another resident.
-There was no staff in the dining room with the resident because they were assisting other residents.
-The MA heard a "bam" and turned around and saw Resident #3 lying on the floor under the table.

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D 270	Continued From page 86 -The wheelchair was still near the table but one side of the chair was turned outwards. -The resident was lying on her right side and she was moving and awake. -After staff got the resident back in her chair, the MA moved her hair back and saw the resident had a knot above her left eye toward the middle of her forehead. -The knot was about the size of a nickel and was a little purple. -Staff called the hospice nurse and she was coming to assess the resident. -The knot started getting bigger about 30 minutes after the fall. -The hospice nurse looked at it and told staff if the resident started vomiting or sleeping a lot to call the nurse back. -The resident had a few previous falls as well. -The family wanted staff to put a chair and the wheelchair against the resident's bed so she would not roll off the bed. Interview with a fourth PCA in the MCU on 09/06/16 at 9:25 a.m. revealed: -She had worked at the facility for about a month. -The resident required a two person assistance. -Hospice staff had told facility staff to lay the resident down because of the resident's rocking and leaning in the chair. -The PCA was working when Resident #3 had her last fall. -Resident #3 was sitting in her wheelchair, pushed up to the dining room table. -The medication aide was giving medications; a PCA was sweeping; a second PCA was changing a resident; and a third PCA was taking a tray to the kitchen. -She was wiping a table when she heard a "loud boom" and then she saw Resident #3 on the floor lying in a fetal position on her side.	D 270		

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D 270	Continued From page 87 -Staff moved the table and she saw a knot on the resident's head. -The medication aide called the hospice nurse. -The resident's wound got worse and the resident's eyes swelled shut. Interview with a fifth PCA in the MCU on 09/06/16 at 9:50 a.m. revealed: -She had worked at the facility for about 2 months. -Resident #3 fell sometime around July 2016 in the dining room. -The resident was sitting in her wheelchair at a table in the dining room. -Staff left the resident at the table alone. -The resident needed someone with her when she was sitting up in a chair. -The resident liked to play with her feet. -She did not see the resident fall but she saw the resident lying on the floor. -The left side of the wheelchair had pushed back away from the table. -Staff called the hospice nurse who came to the facility to check the resident. -She thought Resident #3 had another fall sometime around the end of August 2016 that was not reported because it looked like the resident had fresh bruising and a "goose egg". Interview with a fourth MA in the MCU on 09/06/16 at 2:50 p.m. revealed: -Sometime around May or June 2016, Resident #3 was sitting on the couch in the library / piano room. -Another resident let staff know that Resident #3 had fallen. -Resident #3 had a knot on the side of her head. -The MA thought the resident was sent to the ER. Observation of Resident #3 on 09/06/16 at 3:05	D 270		

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p.m. revealed:
-Resident #3 was sitting in a chair in the living room / television (tv) room.
-The resident was leaning forward in the chair.
-There was a PCA standing in the common area between the nurses' station and the tv room who could see the residents sitting in the tv room, including Resident #3.

Telephone interview with Resident #3's family member / power of attorney (POA) on 09/07/16 at 11:40 a.m. revealed:
-Facility staff notified him immediately about the resident's fall on 08/12/16.
-Staff reported the resident was pushed up to the table in her wheelchair and fell and hit her head first and then hit the floor.
-Both of the resident's eyes were black and blue from the fall.
-The HN came to the facility and checked the resident.
-The HN reported the resident had a knot on her head but the HN did not advise the resident needed to go to the ER so the resident was not sent out.
-There had been other times when the resident had fallen but he could not recall specific times or what may have contributed to the falls.

Telephone interview with a Nurse Practitioner (NP) from the current provider group on 09/09/16 at 10:00 a.m. revealed:
-She worked with the current provider group but she no longer provided care for residents at this facility.
-She last saw Resident #3 in June 2016.
-Resident #3 would lean forward while sitting up in a chair and she had some falls.
-Resident #3 needed supervision while sitting up in a chair because of her risk for falls.

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D 270	Continued From page 89 Refer to interview with the Nurse Practitioner (NP) on 9/1/16 at 2:33pm. Refer to interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am. Refer to interview with a Medication Aide (MA) on 8/31/16 at 3:35pm. Refer to interviews with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm, 9/2/16 at 3:29pm and 9/8/16 at 7:02pm. Refer to interviews with the former Interim / Acting Administrator on 8/31/16 at 5:15 p.m., 6:31pm, 9/2/16 at 9:02am and 9/9/16 at 12:55pm. 6. Review of Resident #6's most current FL-2 dated 07/11/16 revealed: -The resident's diagnoses included vascular dementia, anxiety disorder, insomnia, hypothyroidism, chronic kidney disease, dysphagia, and gastroesophageal reflux disease. -The resident was intermittently disoriented and noted to wander. -The resident was hard of hearing. -The resident was semi-ambulatory with wheelchair and incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #6's pre-admission assessment dated 06/23/15 revealed: -The resident was non-ambulatory, had a wheelchair, and required standby assistance by one person for mobility. -The resident required assistance with transferring, toileting, and turning and repositioning.	D 270		

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D 270	Continued From page 90 -The resident had a history of falls and would attempt to get out of wheelchair and ambulate without assistance. Review of Resident #6's Resident Register revealed: -The resident was admitted to the facility on 07/29/15. -The resident required assistance with dressing, bathing, nail care, correspondence, getting in and out of bed, toileting, grooming, skin care, mouth care, scheduling appointments, and orientation to time and place. Review of the family intervention discussion agreement for Resident #6 signed and dated 07/24/15 and 08/10/15 revealed: -The resident was at risk for falls. -There was no interventions checked off to minimize the resident's fall risk. Review of Resident #6's current assessment and care plan dated 08/12/15 revealed: -The resident was non-ambulatory, had a wheelchair and staff were to assist. -The resident had limited range of motion in upper extremities. -The resident was incontinent of bowel and bladder and staff had to assist with incontinence care. -The resident complains of pain and inability to stand up. -The resident required extensive assistance with bathing, dressing, toileting, grooming, personal hygiene, and ambulation (staff assists with wheelchair). -The resident's ambulation was limited ability due to fall risk and unsteady gait. -The resident was always disoriented and had significant memory loss and must be redirected.	D 270		

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D 270	Continued From page 91 Review of the special care unit progressive profile for Resident #6 revealed: -On 08/11/15, the resident was noted to have a history of falls. -On 05/25/16 and 08/11/16, the resident was noted to fall frequently. Review of facility progress notes for Resident #6 revealed: -08/24/16 (11 - 7 shift): The resident was observed on the floor by her bed. The resident's right hip was turned outwards. Vital signs were unable to be taken. The family and physician were notified. Emergency Medical Services (EMS) was called and the resident was taken to the hospital. -08/24/16 (1:00 p.m.): The nurse at the hospital called the Resident Care Coordinator (RCC) regarding the resident. The resident was a candidate for surgery due to right broken leg. The RCC voiced that the resident transferred self from bed to chair and from chair to chair as nurse asked about ambulation. Review of an incident / accident report for Resident #6 dated 08/24/16 at 5:00 a.m. revealed: -The resident was found on the floor on her back in her room. -Staff noted the resident leg was hurting. -The part injured was documented as the right hip and right leg. -The resident's blood pressure was 153/79 and her pulse was 81. -The resident was sent to the ER and admitted to the hospital for broken right leg. Surgery was to be done. Interview with a personal care aide (PCA) in the	D 270		

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D 270	Continued From page 92 MCU on 09/01/16 at 6:25 a.m. revealed: -She had worked at the facility for about 3 years usually on third shift. -Resident #6 did not fall very often to her knowledge. -Resident #6 used a wheelchair and she would sometimes get up by herself but she needed assistance. -The PCA was on duty on 08/24/16 when the resident fell. -Between 3:30 a.m. and 4:00 a.m., staff heard Resident #6 holler. -The PCA and the medication aide went into the resident's room. -The resident was lying on her back on the floor. -It appeared the resident had been coming out of the bathroom. -The resident was conscious and said she had fallen. -The resident said her leg was hurting. -The upper part of the resident's leg was sticking out and did not look right. -The MA called 911. -Staff did 2 hour routine checks on the residents in the MCU. -It had been about 30 to 40 minutes from the last routine check when Resident #6 hollered out. Interview with a medication aide (MA) in the MCU on 09/02/16 at 4:43 p.m. revealed: -He was not working on 08/24/16 when Resident #6 fell as it happened on third shift. -He thought a lot of falls happened on third shift. -Staff reported Resident #6 got up by herself to go to the bathroom. -Resident #6 needed a one person assist to go to the bathroom. -The resident hollered out when she fell and her leg was broken. -The resident went to the hospital and later died.	D 270		

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-Resident #6 was not a frequent faller and she could transfer herself.
-Staff were supposed to toilet the resident and check on her every 2 hours.
-He did not think staff was checking on the resident every 2 hours because there was so many falls.
-The resident could tell you when she needed to go to the bathroom.

Interview with a second MA in the MCU on 09/02/16 at 5:12 p.m. revealed:
-She came into work about 2 and ½ hours after Resident #6 fell on 08/24/16.
-Staff reported the resident was checked on at 5:00 a.m. and the resident was found lying on her back on the floor.
-Staff reported she was lying on the floor away from the bed, near the bathroom.
-Staff reported they did not know how long the resident had been lying on the floor.
-Resident #6 had a tendency to go to the bathroom by herself.
-The resident had a wheelchair and could transfer herself but staff usually toileted the resident about every 1 to 2 hours.
-The resident could tell staff when she needed to go to the bathroom.

Telephone interview with Resident #6's family member on 09/06/16 at 4:30 p.m. revealed:
-He was notified the resident was taken to the hospital on 08/24/16 because the resident was found out of bed.
-They did not say it was a fall just that they found her.
-He finally reached the Administrator and found out the resident was found between the bed and the nightstand.
-The resident had a broken femur, had surgery,

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D 270	Continued From page 94 and passed away. Telephone interview with a former MA in the MCU on 09/07/16 at 3:10 p.m. revealed: -She had worked at the facility from March 2015 until 08/30/16. -Resident #6 could not walk but was able to transfer from the bed to the wheelchair and then self-propel the wheelchair to the common living room. -The resident would fall sometimes and get skin tears. -She was on duty as the MA in the MCU on third shift when Resident #6 fell. -Resident #6 had been up and down all night. -The resident had been having a lot of bowel movements for about 4 days and the RCC had been notified. -The MA could not recall if she had documented this in the resident's record and she did not know if the RCC had checked on the resident. -Staff heard the resident holler out and they found her on the floor. -The resident was lying on her back and her leg was straight forward but her knee was twisted. -The resident's wheelchair was facing the bed and it looked like the resident had tried to get up out of bed. -The resident had just been checked 30 minutes prior to this and the resident was lying in bed. Review of an Emergency Medical Services (EMS) report dated 08/24/16 for Resident #6 revealed: -The dispatch call was received at 4:40 a.m. and EMS arrived on scene at the resident at 4:45 a.m. -The chief complaint was possible hip dislocation / fracture and the secondary complaint was a fall. -No report or resident information was given to EMS staff upon arrival. -EMS staff noted upon arrival to the facility, they	D 270		

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D 270	Continued From page 95 found the resident in her room on the floor with door closed and no staff with the resident. -The resident had a right hip deformity with right leg shortened and rotated out. -The resident had dementia but was oriented to person and place. -The resident had pinpoint pupils and was not complaining of pain and wanted to sleep. -It was unknown how long the resident had been on the floor or how much pain medication was given to the resident. -After EMS staff got the resident on the stretcher, staff from the front of the facility brought paperwork for the resident. -As EMS staff were leaving, they noticed a facility staff member sitting in the dayroom watching television. Refer to interview with the Nurse Practitioner (NP) on 9/1/16 at 2:33pm. Refer to interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am. Refer to interview with a Medication Aide (MA) on 8/31/16 at 3:35pm. Refer to interviews with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm, 9/2/16 at 3:29pm and 9/8/16 at 7:02pm. Refer to interviews with the former Interim / Acting Administrator on 8/31/16 at 5:15 p.m., 6:31pm, 9/2/16 at 9:02am and 9/9/16 at 12:55pm. _____ Interview with the Nurse Practitioner (NP) on 9/1/16 at 2:33pm revealed: -The NP came to the facility twice each week to see residents. -Fall prevention measures included use of	D 270		

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wheelchairs, keep closer eye on resident and follow up on any concerns by sending resident to the hospital as needed.
-Other interventions included chair and bed alarms, fall mats, hospital beds and physical therapy referrals.
-The NP expected all residents to be sent to the emergency room following a fall unless the family did not want the resident sent.

Interview with a Personal Care Aide (PCA) on 9/1/16 at 6:32am revealed:
-The normal 3rd shift routine was to check residents every 2 hours on the MCU.
-Residents were checked to make sure they were still breathing and they were not soaking wet.
-Residents were checked when the PCAs first came on duty at 11:00pm, then at midnight, 2:00am, 4:00am and 6:00am.

Interview with a Medication Aide (MA) on 8/31/16 at 3:35pm revealed:
-Residents were checked every 2 hours.
-If the resident was a" heavy wetter" they were checked every hour.
-When residents returned from the hospital they were checked every 30 minutes.
-Every 30 minute checks meant keeping an eye on the resident whenever staff went by that resident.
-Staff did not document 30 minute checks.
-There were no residents "technically" on 30 minute checks.

Interview with the Resident Care Coordinator (RCC) on 8/31/16 at 4:50pm revealed:
-The RCC would follow up on any discharge instructions when a resident returned from the hospital after a fall.
-The RCC would ask the physician if the resident

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might be a candidate for physical therapy.
-The RCC would ask the physician about the resident getting a chair alarm.
-The RCC was not aware of increased level of concern from management regarding the number of falls at the facility resulting in serious injuries to residents.
-The facility put measures into place to prevent fall, but falls were going to happen.

Second interview with the RCC on 9/2/16 at 3:29pm revealed:
-Residents were kept in sight until they were sleepy.
-Once in the bed staff checked each resident every hour.
-When residents returned from the hospital after a fall staff were expected to document any reoccurrence of falls and any known injuries.
-Staff were also expected to keep the resident where they could be seen by staff at all times for 24 hours.
-The RCC was responsible for informing staff of fall prevention interventions recommended by the Risk Management RN on the Quality Assurance Report.

Interviews with the Interim / Acting Administrator on 8/31/16 at 5:15 p.m. and 6:31 p.m. revealed:
-The facility's policy and procedure for managing and preventing falls was no longer available in the facility.
-The bottom of the incident / accident reports had a list of interventions and the staff were supposed to document the interventions on that form.
-Staff do not always document like they were supposed to.
-They also have a family intervention discussion agreement that was completed upon admission for all residents.

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-All staff at the facility [Assisted Living and Memory Care] were expected to check residents at least every 2 hours.
-The MCU staff to resident ratio was 1:8, so they were expected to always know where the residents were.
-If a resident was a fall risk, staff was supposed to be doing 30 minute checks and documenting.
-There was always 1 supervisor on duty for the entire facility [Assisted Living and Memory Care].
-The Supervisor was responsible for making sure staff knew what to do and that they were doing it.

Interview with the former Interim / Acting Administrator on 9/2/16 at 9:02am revealed:
-Facility incident reports were sent to the Registered Nurse (RN) in charge of Risk Management at the headquarter offices.
-The incident reports were entered into a computer system along with any intervention recommended by the Risk Management RN.
-If the intervention was documented in capital letters that indicated the Risk Management RN contacted the facility by phone to discuss.
-The Risk Management RN, Administrator and Resident Care Coordinator (RCC) conducted a meeting each month to review incident reports and recommended interventions.

Interview with the former Interim / Acting Administrator on 9/9/16 at 12:55pm revealed:
-The Administrator would do a walk through in the MCU at least daily and if any concerns were observed, the Administrator would address it at that time.
-The Administrator had concerns about the residents in the MCU being in the common areas with no supervision while staff was in residents' rooms performing resident care.
-The Administrator expected staff to supervise

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D 270	Continued From page 99 residents in the MCU in the common areas at all times. -She addressed this concern with staff in the MCU at least once or twice. -The Administrator was not aware of the number of falls and serious outcomes from January 2016 through June 2016. -The Administrator was only aware of the incidents which occurred after she started working at the facility 6/20/16. -The Administrator became aware of the total number of falls when printing the Risk Management report on 8/31/16. -Staff were expected to document all falls, complete an incident report and notify the family. _____ Review of the facility's Plan of Protection dated 8/31/16 revealed: - Supervision will increase to every 30 minutes for memory care residents effective 8/31/16. -Fall management program will be implemented to include and not limited to: - Fall risk assessments by nurse on all memory care residents. - Employee education on increased supervision. - Fall prevention awareness and prevention techniques - Hot box charting. - Incident reporting - 72 hour follow-up on resident falls to include Hot Box Charting. - Symbol for identified fall risk "falling leaves" will be visible beside name plates. - "Who I Am" will be completed on all memory care residents and posted in closet to assure employees are informed of needs. - Employees will be trained on preventive measures, interventions, possible contributing environmental and medical factors.	D 270		

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D 270	Continued From page 100 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 9, 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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility did not meet the health care needs of 9 of 15 residents sampled (#1, #2, #3, #5, #6, #9, #11, #13, #15) as related to the facility failed to notify the primary care provider (PCP) of falls with head injuries, obtain a hospital bed with rails, repair or replace a broken wheelchair and notify hospice of the broken wheelchair for a resident who had multiple falls with head injuries (#3); failed to follow up with the PCP for a leg wound requiring stitches resulting in a hospitalization for cellulitis due to the stitches not being removed over 6 weeks after the stitches were placed (#6); failed to make a dermatology appointment for a resident with severely dry skin on legs and feet resulting in open leg wounds and a foul odor and failed to notify the psychiatric care provider of a resident's continued behaviors of verbal and physical aggression toward other residents (#11); failed to follow up with a medical provider for a resident with mental status changes (#1); failed to follow up with a medical provider for 3 residents with symptoms of pain, bruises and	D 273		

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hematomas and from an injury after a fall (#5, #9 and #15); failed to contact a medical provider within a reasonable time for skin breakdown on 2 residents (#2 and #15); failed to notify a medical provider of a worsening ankle wound infection resulting in hospital admission for sepsis for a resident (#13); failed to follow up on referrals for skilled nursing care and home health services for 2 residents (#2 and #5); failed to follow up on orders for urinalysis for 2 residents (#5 and #13); and failed to administer prescribed laxatives for a resident (#15) resulting in fecal impaction.

The findings are:

1. Review of Resident #1's current FL-2 dated 12/02/15 revealed:
- Diagnoses which included vascular dementia with altered mental status.
- The resident was constantly disoriented wandered.

Review of Resident #1's care plan dated 4/12/16 revealed:
- The resident wandered at times.
- The resident required extensive assistance with bathing, grooming, toileting and personal hygiene.

Interview with Resident #1's family member on 9/1/16 at 10:20am revealed:
- The family member had visited the resident the weekend before July 4th and noticed the resident was weaker and unsteady when walking.
- The family member informed the medication aide (MA). Something was going on and the MA checked the resident's blood pressure and stated the resident was fine.
- The facility had called the family member one time (during the week) before the next weekend and informed her the resident had fallen asleep in

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a chair and slid onto the floor, but no injuries.
- On 7/9/16, the family member visited the resident at the facility around 11:15am.
- The resident was in bed and the family member could not fully awaken the resident and could not get her to focus.
- A staff member informed the family member the resident may just be sleepy.
- The family member walked to nurse's station in memory care unit (MCU) and was talking to the medication aide about the resident changes and observed staff members "dragging" the resident down the hall and to the dining room.
- The staff attempted to get the resident to eat without success.
- The family member instructed the staff to call EMS to transport the resident to the local hospital for evaluation.
- The facility's Resident Care Coordinator (RCC) was not at the facility but came to the facility to evaluate the resident.
- The RCC refused to call EMS and stated the resident must have a urinary infection.
- The family member "argued" with the RCC and insisted she send the resident to the hospital.
- The RCC called for non-emergency medical transport, which took over 30 minutes to arrive.
- The RCC informed the medical transport personnel "she (the family member) wanted us to call to transport the resident to the hospital".
- The resident was admitted to the hospital on July 9th and was discharged on July 15th.
- The resident was placed in intensive care unit on admission and treated for hypothermia and dehydration. The resident was critically ill.

Review of Resident #1's hospital admission records (admission date 2/27/16 and discharge date 3/2/16) revealed:
- The resident was brought in unresponsive. The

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ECG showed bradycardia (slow heart beat).
- The resident diagnosed with hypothermia (rectal temperature of 90.5 Farheinheit), hypotension (blood pressure of 93/40) and altered mental status.
- The resident was bolused with 3 liters of normal saline and placed in a blanket warmer.
- The resident was admitted into CCU (critical care unit) for further management.
- The resident was believed to have severe septic shock and treated with intervenous (IV)Vancomycin.
- The resident's ammonia level was elevated from 36 to 42 (normal ammonia levels 11-35) and was treated with a dose of Lactulose 30 grams.
- The resident was stabilized and discharged back to the facility on 7/15/16.

Interview with the facility's RCC on 9/1/16 at 11:45am revealed:
- She was not aware of any changes in the resident's status until July 9, 2016 and the resident's family member insisted she was transported to the hospital.
- If a resident has any changes, the RCC or MA were responsible for contacting the medical provider immediately and reporting the changes.

Interview with a MA (2nd shift) on 9/7/16 at 2:30pm revealed:
- Resident #1 was hospitalized in July, 2015 (uncertain of date).
- The resident was "spaced out" for about a week before hospitalization.
- The resident did not recognize her name and slept a lot during the day (the resident was usually up and wandering through the memory care unit all day).
- The resident did not eat much.
- The changes were reported to the memory care

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D 273	Continued From page 104 coordinator/resident care coordinator (MCC/RCC), but did not know whether the resident's primary physician was informed of the changes. - The MCC/RCC was responsible for informing the residents' medical provider of changes. - She did not know if the MCC/RCC contacted the resident's physician, - The resident ' s family member was at the facility and found the resident sick and " made " the MCC/RCC send the resident to hospital. - The resident was septic and was in the hospital for several days. Review of the resident's record revealed no documentation of the resident's changes. 2. Review of Resident #9's FL-2 dated 12/23/15 revealed: - Diagnoses included dementia and insomnia. - The resident was intermittently disoriented and required a wheelchair for ambulation. Review of the resident's care plan dated 6/16/15 revealed: - The resident wandered at times - The resident was non-ambulatory and required use of a walker and wheelchair. - The resident required limited assistance with mobility, ambulation and transfers. Confidential staff interview revealed: - About 6 months ago (did not remember date), observed Resident #9 in bed for several days screaming for help/complaining of pain. - No one at the facility helped her for 2-3 days. - The resident was sent to the hospital and passed away. - The staff member did not talk to the	D 273		

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D 273	Continued From page 105 Administrator or RCC about the resident. - The resident had fallen out of her wheelchair and was not taken to the hospital to be checked. Interview with a family member on 9/2/16 at 12:20pm revealed: - The family member was informed by a staff member on 2/24/16, the resident was sitting in her wheel chair in the front TV room and the staff was not watching her. - The resident "supposedly" fell from her wheelchair (in the morning) and was found on the floor by staff. - The RCC performed range of motion to extremities and the resident was put back in her wheelchair by staff and was taken to lunch. - A staff member from the facility (did not remember the staff's name) contacted the family member later in the evening (around 6:00pm) and informed her the resident was complaining of arm pain. - X-rays were taken that night at the facility and the resident was transported to the local hospital the next morning and diagnosed with a fractured elbow on 2/25/16. - On 2/27/16, the resident was transported to 0 an out of county hospital due to complaint of severe pain and was diagnosed with multiple fractures. The resident was discharged home on 3/2/16 and passed away 3 days later at home. - After the resident had passed away, the family went to the facility and asked for a copy of the accident report and a copy of the progress notes concerning the resident's fall, but the documents were not available. Review of a mobile x-ray report revealed: - On 2/24/16, an x-ray was completed on Resident #9's right elbow due to complaint of pain to touch.	D 273		

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D 273	Continued From page 106 - The impression results (dated 2/25/16) was communicated acute fracture of distal humerus. Review of Resident #9's hospital admission and discharge records revealed: - The resident was admitted to an out of county hospital on 2/27/16 with diagnoses of closed nondisplaced fracture of acetabulum (hip), closed supracondylar fracture of humerus (upper arm) and right closed pelvis fracture and acute renal failure and discharged on 3/2/16. - The resident was seen by orthopedics and due to advanced age medical management was advised. Since admission, the resident needed sedation to assist with care. - Resident developed advanced dementia and cachexia (weight loss, muscle wasting, fatigue, loss of apetite, a positve risk factor for death) multiple decubitus ulcers and showed little interest in food during hospital stay. - Palliative care was consulted and arrangements made for resident to return home with family and hospice care. Interview with a former staff member on 8/31/16 3:30pm revealed: - Resident #9 was sitting in the front TV room in the assisted living unit on 2/24/16. - The resident fell out of her wheel chair and another resident called staff to let them know Resident #9 had fallen out of the wheelchair. - A portable x-ray was done at the facility and the resident was diagnosed with a fractured elbow the next day. - The resident was transported to the hospital 3 days later and was diagnosed with several fractures including her arm and hip. - The resident passed away a few days later. - If the staff were watching the resident closer, she would not have fallen.	D 273		

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- The RCC instructed the staff not to send the resident to the emergency room for evaluation after she assessed the resident after the fall on 2/24/16.
- The fall was documented on progress notes and on an accident report, but neither were available when resident's family member requested to see them.

Interview with 1st shift Supervisor (assisted living unit), on 9/7/16 at 3:10pm revealed:
- On 2/24/16, before lunch, Resident #9 was sitting in the front TV room and another resident yelled to staff, the resident was on the floor.
- The resident was found on the floor against a recliner.
- The resident stated she was trying to transfer self from recliner to wheelchair without assistance.
- The resident could not transfer self and could not ambulate and require 1 to 2 person assistance with all transfers.
- The facility's Resident Care Coordinator checked the resident and the resident was picked up from floor and placed in wheelchair.
- The resident was assisted to the dining room and ate lunch.
- The personal care staff reported the resident continuously complained of pain when they moved her and would holler out in pain when they tried to get her out of bed.
- The resident's family member was at the facility 3 days later and was concerned about the resident's severe pain.
- The family member insisted the facility transfer the resident to the local hospital for evaluation.
- The resident passed away in an out of county hospital a few days later.
- An incident report was completed by the RCC and documentation was done in progress notes

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but the documentation concerning the fall and resident's complaint of pain was not found the resident's record after the resident was hospitalized.

Interview with the 3rd shift medication aide on 9/7/16 at 2:30pm revealed:
- About the last week of February, Resident #9 fell out of a chair on the assisted living unit (front TV room).
- The RCC and supervisor assessed the resident but did not send her to local emergency room.
- The resident complained of pain for several days. The Resident was hollering when staff attempted to perform personal care.
- The resident's family member came to the facility a few days later and was upset because the resident was in pain and nobody could tell her why.
- The resident was transported to an out of county hospital and passed away a few days later.

Interview with the RCC on 9/1/16 at 11:45am revealed:
- She did not remember Resident #9's fall in February 2016.
- She did not know what happened to the documentation regarding a fall, including incident report and progress notes.

Interview with the facility's former Administrator on 9/7/16 revealed:
- She was not working at the facility in February 2016 and was not aware of Resident #9 and of any falls or injuries.
- There should be documentation of any accidents, follow-ups and assessments in the resident's records.

Interview with Resident #9's primary medical

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provider's medical assistant on 9/9/16 at 11:25am revealed:
- The resident was last seen by the physician on 2/1/16.
- There was an orthopedic note in the resident record from a orthopedic provider (out of county hospital) dated 2/29/16 which documented information regarding hospitalization due to multiple fractures.
- The last note from the facility was dated 2/24/16, the resident fell out of a recliner and hurt elbow. An order was written for x-ray.
- The facility's RCC had contacted the medical provider and reported fall, but did not give details of fall or date of fall.

Review of Residnet #9's records revealed no nurses notes after 2/5/16 and no incident reports for February, 2016.

3. Review of Resident #3's current FL-2 dated 07/18/16 revealed:
-The resident's diagnoses included Alzheimer's dementia, epilepsy, hypertension, hypothyroidism, and constipation.
-The resident was constantly disoriented and noted to be a wanderer.
-The resident was semi-ambulatory with wheelchair and incontinent of bowel and bladder.
-The resident required assistance with bathing, dressing, and feeding.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 05/26/11.

Review of the family intervention discussion agreement for Resident #3 signed and dated 05/26/11 revealed the resident was not noted to be at risk for falls or to have a history of falls.

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D 273	Continued From page 110 Review of Resident #3's current assessment and care plan dated 09/02/15 revealed: -The resident was confused and must be redirected at all times. -The resident had significant memory loss and was disoriented at all times. -The resident was noted to be wandering at times. -The resident was non-verbal and babbles. -The resident was ambulatory but her gait was very unsteady and the resident was a fall risk. -The resident required extensive assistance with mobility, ambulation and transfers. -The resident was totally dependent with bathing, grooming, personal hygiene, and dressing. -The resident was incontinent of bowel and bladder and required extensive assistance with toileting. -The resident required limited assistance with eating. Review of the special care unit progressive profile for Resident #3 revealed: -On 09/15/15, the resident was noted to ambulate unassisted at time and to fall frequently. -On 08/11/16, the resident was noted to require a device for ambulation and assistance with ambulation. Review of facility progress notes for Resident #3 revealed: -04/30/15: The resident fell today around 4:30 p.m. and was sent to the emergency room (ER). The resident had no injuries and per hospital, a seizure caused the fall. -08/20/15: The resident slipped out of a chair in the television (tv) room and had no injuries. Review of an emergency medical services (EMS)	D 273		

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report dated 01/05/16 for Resident #3 revealed:
-The dispatch call was received at 9:30 a.m. and EMS arrived on scene at 9:37 a.m.
-The resident was lying prone on the floor beside her bed with blood under her head.
-The resident was alert but did not speak which was normal for her per facility staff.
-Facility staff stated they did not know how long she had been on the floor or if she had lost consciousness.
-The chief complaint was hematoma with laceration on head from fall from bed.
-The resident had a small ½ inch laceration on the top right of her head with bleeding and mild swelling at the site.
-The resident was transported to the hospital.

Review of the incident log sheet for all residents from January 2016 - September 2016 revealed:
-On 01/05/16, Resident #3 was observed lying face down and there was blood on the floor.
-The resident was transported to ER and returned with staples to her wound.

Review of a physician's order dated 01/27/16 for Resident #3 revealed:
-The resident had increased and frequent falls.
-The physician ordered a hospital bed with rails.

Review of facility progress notes for Resident #3 revealed:
-01/28/16 ((7 - 3 shift): The resident received order for hospital bed.
-01/29/16 (7 - 3 shift): A medical supply company was called for clarification on reason why the resident needed bed. The physician was called and the nurse stated for the medical supply company to fax the form for them to sign.

Review of a physician's order request form for

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Resident #3 dated 02/01/16 revealed:
-The Memory Care Coordinator (MCC) faxed the form dated 02/01/16 to the physician.
-The medical supply company needed reason why the resident needed a hospital bed.
-The MCC instructed the physician to document the reason the resident would be receiving a hospital bed.
-The physician's office responded and noted for the facility to have the medical supply company to fax the paperwork to the physician with the fax number included.

Review of facility progress notes for Resident #3 revealed:
-02/17/16 (1:00 p.m.): Physical therapy (PT) evaluation was done and the resident had poor rehab potential due to cognitive impairment, inability to communicate and follow instructions. The resident was not admitted to PT services.
-06/30/16 (3 - 11 shift): The resident was starting to bruise around her right eye due to a fall on first shift.

Review of an EMS report dated 06/30/16 for Resident #3 revealed:
-The dispatch call was received at 9:06 a.m. and EMS arrived on scene at 9:14 a.m.
-The resident was lying on the floor with staff by her.
-The resident was unable to move or talk which facility staff reported was normal for the resident.
-Staff stated the resident was sitting on the couch and fell over onto the floor and hit the right side of her forehead on the floor.
-The resident had a small hematoma with minor bleeding and pressure was applied.
-The chief complaint was laceration due to fall and the resident was transported to the hospital.

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Review of an incident / accident report for Resident #3 dated 06/30/16 at 9:00 a.m. revealed:
-The resident was observed on the floor by staff in the library.
-The medication aide assessed the resident and noticed bleeding coming from the right side of the temple area.
-EMS was called and the resident was sent to the ER for evaluation.
-The resident returned from the hospital with no new orders.
-The resident had bruising above the right eye along with a small cut.
-Hospice was to follow and the physician was to see on 07/01/16.

Review of a hospice plan of care update dated 07/05/16 for Resident #3 revealed:
-The resident required maximum assistance with transferring.
-The resident had increased lethargy.
-The resident recently fell and was transported to the ER (06/30/16).

Review of a hospice nursing visit note report for Resident #3 dated 07/11/16 revealed:
-The resident was in bed and lethargic.
-The resident's bruise to the right eye was almost completely healed.
-The resident was unable to sit up independently.

Review of facility progress notes for Resident #3 revealed:
-08/12/16 (9:00 a.m.): The resident was sitting at the dining room table in her wheelchair. The medication aide heard "a thump" and saw the resident laying on the floor on her right side. A quarter size bump started to form in the middle of her forehead. The medication aide contacted

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hospice nurse who will come to the facility to see the resident. POA and RCC were notified.
-08/12/16 (3 - 11 shift): The resident was in the wheelchair and started jerking movement. The resident's face was swollen. Hospice was made aware and nurse will come back to check on resident.

Review of a hospice nursing visit note report for Resident #3 dated 08/12/16 revealed:
-The resident required assistance with all activities of daily living.
-The resident was unable to sit up independently.
-The nurse was called for a prn (as needed) visit due to a fall.
-The nurse completed an assessment and the resident had a large mass to forehead.
-The nurse reviewed fall precautions with facility staff.
-The nurse would continue to monitor for fall prevention compliance.
-Facility staff was instructed to call with any concerns or questions.

Observation of Resident #3 on 08/30/16 at 6:48 p.m. revealed:
-The resident was lying in a standard twin size bed.
-The resident did not have a hospital bed or bed rails.

Interview with a family member of Resident #3 on 08/30/16 at 6:48 p.m. revealed:
-Resident #3 just started receiving hospice services in June 2016.
-Resident #3 cannot stand up on her own and she had a bad fall about 2 weeks ago.
-A medication aide (MA) reported she was about 10 feet from the resident and heard "loud boom" and saw the resident on the floor with the

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wheelchair on top of her.
-The facility called the hospice nurse who came right away that day to check the resident.
-The resident's eyes were swollen shut for 2 days.
-Resident #3 got tired and started to lean when left sitting up in the wheelchair.
-The family had told the staff to put the resident in bed when she got tired.
-Resident #3 had also fallen off the couch in the front area of the facility and had to go to the hospital.
-The family had also asked for a bed rail because the resident had fallen off the bed also.
-A former MCC told the family she was working on getting a bedrail but the paperwork did not go through.
-They never heard anything else about the bedrail.
-The family had been trying to prop up the resident with pillows while in bed.

Observation of Resident #3 on 08/31/16 at 9:35 a.m. revealed:
-The resident was lying in bed asleep.
-There was a straight back chair and the resident's wheelchair pushed up against one side of the bed and the other side of the bed was against the wall.
-The right side of the wheelchair was locked the left side was not locked and moved when touched.

Interview with a personal care aide (PCA) on 08/31/16 at 9:40 a.m. revealed:
-The PCA had worked at the facility for about a month.
-The resident's family had requested staff to put chairs beside the bed to keep the resident from rolling out of the bed.

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D 273	Continued From page 116 -Each time she had observed the resident in bed, the chairs had been pushed against the bed. Interview with a second PCA on 08/31/16 at 9:58 a.m. revealed: -She had worked at the facility about 4 years and usually worked on first shift. -The chairs were sometimes put against Resident #3's bed because the PCA was afraid the resident might roll out of bed. -She thought the resident had some falls but could not recall when or how often. -The resident was "real stiff" and the PCA was not sure if the resident was capable of turning herself in bed because staff usually turned her. -The resident did not have a hospital bed or bed rails. Observation of Resident #3 on 08/31/16 at 10:22 a.m. revealed: -The resident was still lying in bed. -Both chairs were still pushed up against the resident's bed. Interview with the Resident Care Coordinator (RCC) on 08/31/16 at 11:10 a.m. revealed: -She was not aware staff was using a chair and Resident #3's wheelchair to push against the resident's bed to keep her from falling out of the bed. -The facility was a restraint free facility and staff should not be doing that. -Staff were supposed to come to her with any concerns about residents since the MCC position was vacant. -She was not aware of the 01/27/16 order for hospital bed with rails. -She did not know if the facility had made any attempts to get a hospital bed for the resident. -The MCC at the time the order was received was	D 273		

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no longer employed at the facility.
-She would check with hospice about possibly getting a concave mattress for the resident.
-She would notify staff to stop pushing the chairs against the bed.

Observation of Resident #3 on 08/31/16 at 2:50 p.m. revealed:
-Two PCAs came out of the resident's room into the hallway.
-The resident was lying in bed on her left side.
-There was a straight back chair and the resident's wheelchair pushed up against one side of the bed and the other side of the bed was against the wall.
-The right side of the wheelchair was locked the left side was not locked and moved when touched.

Observation of Resident #3 on 08/31/16 at 3:07 p.m. revealed:
-Two PCAs came out of the resident's room into the hallway.
-The resident was lying in bed on her left side.
-There was a straight back chair pushed up against one side of the bed and the other side of the bed was against the wall.
-The wheelchair had been moved away from the bed.

Observation of Resident #3 on 09/01/16 at 6:20 a.m. revealed:
-The resident was lying in bed asleep.
-There were no chairs pushed against the resident's bed.

Interview with a third PCA in the MCU on 09/01/16 at 6:25 a.m. revealed:
-She had worked at the facility for about 3 years usually on third shift.

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-Resident #3 was total care.
-She was not on duty when Resident #3 fell recently.
-Resident #3 had frequent falls with head injuries.
-The resident's family wanted staff to put a chair and her wheelchair close to the bed while the resident was in bed.
-The PCA had not observed the resident rolling or turning herself in bed.
-Resident #3 never had a hospital bed or bed rails to her knowledge.

Interview with the current primary Nurse Practitioner (NP) on 09/01/16 at 3:05 p.m. revealed:
-She first started seeing residents at the facility about 1 and ½ months ago.
-She saw Resident #3 for the first time today, 09/01/16.
-She was last seen by another NP in their practice on 07/25/16.
-They were not notified of Resident #3's recent fall on 08/12/16.
-Resident #3 had a hematoma on her forehead when she saw her today.
-The facility staff should notify her of falls when they occur.
-She checked the computer files and there was no record of the facility contacting them regarding Resident #3's most current fall with injury on 08/12/16.

Observation of Resident #3 on 09/02/16 at 11:20 a.m. revealed:
-Resident #3 was lying in a hospital bed with ½ rail up on one side of bed and other side of bed was against the wall with no rail.
-The ½ rail had a padded cushion attached to it.

Review of a restraint care planning form for

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D 273	Continued From page 119 Resident #3 dated 09/02/16 revealed the facility completed an assessment and care plan for the use of a hospital bed with siderail. Telephone interview with the hospice nurse (HN) for Resident #3 on 09/02/16 at 1:30 p.m. revealed: -Facility staff called the HN around 9:53 a.m. on 08/12/16 and reported the resident had fallen and hit her forehead. -The HN went to the facility on 08/12/16 to assess the resident and the resident had "a pretty good little goose egg" on her forehead. -The HN spoke with the resident's spouse and he did not want the resident sent out to the ER. -Facility staff called the HN back during the afternoon of 08/12/16 and reported the resident was bruising and shaking and they thought the resident may have had a seizure. -The HN went back to the facility on 08/12/16 to check the resident again. -The HN spoke with the family again and they did not want her sent to the ER. Interview with a medication aide (MA) in the MCU on 09/02/16 at 4:35 p.m. revealed: -He had worked at the facility previously and was rehired about 7 months ago. -Resident #3 was total care and required assistance with all activities of daily living. -Resident #3 could not bear weight and had to be pushed by staff in the wheelchair. -The resident always rocked and leaned forward when sitting in the wheelchair or other chair or sofa. -He was not working when the resident fell on 08/12/16 because it happened on first shift. -The facility's policy was to send a resident to the ER if they hit their head unless it was a hospice resident.	D 273		

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-If a hospice resident resident fell and hit their head, the facility's policy was to call the hospice nurse first and follow the nurse's instructions.
-The MA recalled hearing something about getting a hospital bed for the resident in the past but he could not recall why she never got one.
-The RCC was supposed to be working on getting a hospital bed for the resident.
-The MA usually put pillows between the bed and the resident's body for safety.

Interview with a second MA in the MCU on 09/02/16 at 5:12 p.m. revealed:
-She was working on first shift on 08/12/16 when Resident #3 fell.
-Resident #3 was still sitting at the dining room table in her wheelchair with the wheelchair locked after breakfast.
-The resident was rocking her body back and forth.
-The MA was passing medications at the medication cart near the dining room.
-The MA's back was turned away from the dining room as the MA was talking to another resident.
-There was no staff in the dining room with the resident because they were assisting other residents.
-The MA heard a "bam" and turned around and saw Resident #3 lying on the floor under the table.
-The wheelchair was still near the table but one side of the chair was turned outwards.
-The resident was lying on her right side and she was moving and awake.
-After staff got the resident back in her chair, the MA moved her hair back and saw the resident had a knot above her left eye toward the middle of her forehead.
-The knot was about the size of a nickel and was a little purple.

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-Staff called the hospice nurse and she was coming to assess the resident.
-The resident had a few previous falls as well.
-The resident had never had a hospital bed to her knowledge.
-The family wanted staff to put a chair and the wheelchair against the resident's bed so she would not roll off the bed.

Interview with a fourth PCA in the MCU on 09/06/16 at 9:25 a.m. revealed:
-She had worked at the facility for about a month.
-The left side of Resident #3's wheelchair did not lock.
-She was not sure if the wheelchair was supposed to be repaired.
-The PCA was working when Resident #3 had her last fall.
-Resident #3 was sitting in her wheelchair, pushed up to the dining room table.
-The MA was giving medications, a PCA was sweeping, a second PCA was changing a resident, and a third PCA was taking a tray to the kitchen.
-She was wiping a table when she heard a "loud boom" and then she saw Resident #3 on the floor lying in a fetal position on her side.
-Staff moved the table and she saw a knot on the resident's head.
-The MA called the hospice nurse.
-The resident's wound got worse and the resident's eyes swelled shut.

Interview with a fifth PCA in the MCU on 09/06/16 at 9:50 a.m. revealed:
-She had worked at the facility for about 2 months.
-Resident #3 fell sometime around July 2016 in the dining room.
-The resident was sitting in her wheelchair at a

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table in the dining room.
-The left side of the wheelchair had pushed back away from the table.
-Staff called the hospice nurse who came to the facility to check the resident.
-She had reported to the RCC that Resident #3's wheelchair was broken and would not lock on one side.
-She thought the RCC had spoken to the hospice nurse about the wheelchair about 2 weeks ago.

Attempt to contact the RCC via telephone on 09/06/16 at 4:16 p.m. was not successful.

Observation of Resident #3's wheelchair with the new corporation's MCC on 09/06/16 at 10:05 a.m. revealed the left side of Resident #3's wheelchair would not lock.

Interview with the new corporation's MCC on 09/06/16 at 10:05 a.m. revealed:
-She was not aware Resident #3's wheelchair was broken.
-She would check with hospice about getting it repaired or getting a new wheelchair.

Interview with the Vice President of Quality Assurance and Regulatory Compliance for the new corporation on 09/06/16 at 11:20 a.m. revealed:
-Resident #3 now had a new wheelchair.
-They would check all equipment for all residents for any repair or replacement needs.

Interview with a MA in the MCU on 09/06/16 at 6:20 p.m. revealed:
-Resident #3's wheelchair had not locked on one side for "a long time" (could not specify timeframe).
-Resident #3's family had told staff if the

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wheelchair was not locked, the resident would fall out.
-The MA had not reported the broken wheelchair to anyone because he thought everyone already knew about it.

Telephone interview with Resident #3's family member / power of attorney (POA) on 09/07/16 at 11:40 a.m. revealed:
-Facility staff notified him immediately about the resident's fall on 08/12/16.
-Staff reported the resident was pushed up to the table in her wheelchair and fell and hit her head first and then hit the floor.
-Both of the resident's eyes were black and blue from the fall.
-There had been other times when the resident had fallen but he could not recall specific times or what may have contributed to the falls.
-He recalled talking a while ago (could not recall specific timeframe) to a staff person who used to be in charge in the MCU about getting a hospital bed for Resident #3.
-That staff person was checking into getting a hospital bed but then she was let go by the facility and he never heard anything else about the hospital bed.
-The family was told the resident could not have a rail on the bed because it was a restraint.
-One of the wheels on the resident's wheelchair did not lock properly.
-He did not know if there had been any efforts by the facility to get the wheelchair repaired.

Telephone interview with the nurse for Resident #3's former primary care provider (PCP) on 09/07/16 at 11:45 a.m. revealed:
-The facility transitioned to another primary practice for the residents during the first part of 2016.

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-The last visit they had with Resident #3 was on 01/27/16 for a follow-up regarding seizures and a hospital bed with rails was ordered.
-They were not notified about the resident's fall on 01/05/16.
-The medical equipment company normally wanted paperwork filled out for any medical equipment ordered.
-They were not contacted by the facility or the medical supply company about paperwork for a hospital bed for Resident #3.

Telephone interview with the hospice nurse (HN) for Resident #3 on 09/07/16 at 12:16 p.m. revealed:
-Resident #3 had never had a hospital bed to her knowledge.
-She was not aware of an order for a hospital bed in January 2016 because the resident did not start hospice services until around the middle of June 2016.
-She was not aware Resident #3's wheelchair was broken and would not lock on one side until she was called by facility staff yesterday on 09/06/16.
-Another wheelchair was ordered and obtained for the resident yesterday on 09/06/16.

Telephone interview with Resident #3's former PCP on 09/08/16 at 12:15 p.m. revealed:
-He last saw Resident #3 on 01/27/16.
-The resident was total care and she was having frequent falls.
-He ordered a hospital bed for the resident.
-He was not aware the resident never got the hospital bed.

Telephone interview with a representative from the medical supply company on 09/08/16 at 2:45 p.m. revealed:

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-They received an order for Resident #3 for a hospital bed with rails on 01/29/16.
-The order was incomplete so they called the facility and told facility staff that they needed more paperwork to process the order.
-They never heard anything back from the facility.

4. Review of Resident #6's most current FL-2 dated 07/11/16 revealed:
-The resident's diagnoses included vascular dementia, anxiety disorder, insomnia, hypothyroidism, chronic kidney disease, dysphagia, and gastroesophageal reflux disease.
-The resident was intermittently disoriented and noted to be a wanderer.
-The resident was hard of hearing.
-The resident was semi-ambulatory with wheelchair and incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 07/29/15.

Review of Resident #6's current assessment and care plan dated 08/12/15 revealed:
-The resident was noted to be pleasantly confused and wandering at times.
-The resident was receiving medications for mental illness / behaviors.
-The resident was readmitted from a skilled nursing facility.
-The resident was non-ambulatory, had a wheelchair and staff were to assist.
-The resident had limited range of motion in upper extremities.
-The resident had thin skin and no breakdown with skin intact.
-The resident was incontinent of bowel and

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bladder and required assistance with incontinence care.
-The resident complains of pain and inability to stand up.
-The resident required extensive assistance with bathing, dressing, toileting, grooming, personal hygiene, and ambulation (staff assists with wheelchair).
-The resident required limited assistance with eating.
-The resident's ambulation was limited ability due to fall risk and unsteady gait.
-The resident was always disoriented and had significant memory loss and must be redirected.

Review of a hospital emergency room (ER) form dated 02/19/16 for Resident #6 revealed:
-The resident was seen for laceration of the leg.
-The resident was to follow-up with the primary care physician (PCP) in 2 - 3 days.

Review of Resident #6's record revealed no documentation of a follow-up with the PCP in 2 to 3 days for the ER visit on 02/19/16.

Review of the incident log sheet for all residents from January 2016 - September 2016 revealed:
-On 02/19/16, Resident #6 was observed on the dining room floor. She was trying to transfer to a dining room chair and slipped and hit her face on the table and her right leg was scratched in the fall.
-The resident was transported to ER and returned with hematoma to right side of eye.

Review of a routine visit note for Resident #6 with the PCP on 02/24/16 revealed:
-The resident had no complaints and the PCP noted the resident was stable.
-There was no documentation in the note

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regarding Resident #6's ER visit on 02/19/16 or leg wound.

Review of facility progress notes for Resident #6 revealed:
-03/23/16 (3 - 11 shift): The resident slept most of the shift. The resident's legs were swollen and red and warm to the touch. Medication aide (MA) was notified.

Review of a routine visit note for Resident #6 with the PCP on 03/24/16 revealed:
-The resident had no complaints and the PCP noted the resident was stable.
-There was no documentation in the note regarding Resident #6's legs.

Review of facility progress notes for Resident #6 revealed:
-03/28/16 (3 - 11 shift): The resident was complaining of left leg. Her leg was red and swollen and warm to the touch. MA was notified.
-03/28/16 (11:00 p.m.): The resident's left leg was red and swollen. Memory Care Coordinator (MCC) was called. The resident's temperature was 95.3 degrees F and MCC would follow-up in the morning. The resident was talking and alert.

Review of a physician order request form for Resident #6 dated 03/29/16 revealed:
-The MCC on 03/29/16 faxed a request to Resident #6's physician.
-The resident's leg was red, warm to touch, and swollen.
-The resident had "stitches from a previous fall x 1 month".
-The PCP responded by ordering an antibiotic on 03/29/16.

Review of facility progress notes for Resident #6

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revealed:
-04/02/16 (7 - 3 shift): The resident was sent out to the ER due to swelling in the left leg. The POA, MCC and NP were called. The resident was admitted to the hospital for cellulitis in the left leg.

Review of a hospital discharge report for Resident #6 dated 04/02/16 revealed:
-The resident was admitted to the hospital on 04/02/16 for left lower extremity (LLE) cellulitis.
-The resident presented with LLE erythema, warmth, and swelling.
-The resident was quite demented and unable to tell her name so history was obtained from chart and ER attending (physician).
-The facility was called to obtain further history but hospital staff was left on hold by the facility.
-The resident apparently had sutures placed in February 2016 and those sutures had not been removed so the resident now presented with erythema, swelling, warmth of the lower aspect of the extremity almost up to the left knee.
-The sutures were removed by the ER attending and she had intravenous antibiotics.
-The resident was discharged on 04/05/16.

Review of facility progress notes for Resident #6 revealed:
-04/07/16 (11:00 p.m.): The resident transferred herself from the wheelchair to her bed and received a skin tear to her left leg.
-04/07/16 (11 - 7 shift): The resident returned from the hospital at 2:00 a.m. with a skin avulsion (torn skin) on left leg. Resident was in bed resting. The resident was to follow-up with physician in 2 days. Physician was faxed.

Review of a hospital ER form dated 04/07/16 for Resident #6 revealed:
-The resident was seen for a skin avulsion.

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D 273	Continued From page 129 -The resident was to follow-up with the PCP in 2 days. Review of an incident / accident report for Resident #6 dated 04/07/16 at 10:50 p.m. revealed: -Staff noticed the resident's left leg was bleeding from a skin tear. -Staff applied pressure and EMS came and the resident was taken to the ER. -The resident returned to the facility and the resident was to follow-up with PCP in 2 days. Review of Resident #6's record revealed there was no documentation of follow-up with the PCP in 2 days from the ER visit on 04/07/16. Review of facility progress notes for Resident #6 revealed: -04/08/16 (9:00 p.m.): The resident's left lower leg had a small bruise and red area from swollen leg. -04/12/16 (9:00 p.m.): The resident was given a bath tonight by staff. Staff informed the medication aide about the resident. The bandage on the resident's left leg where the stitches were taken out had to be changed. The bandage was soiled red and a small odor was coming from her left leg. A small area was found on the same leg. The dressing was taken off and cleaned. -04/13/16 (4:00 p.m.): The physician came today and the resident would be put on antibiotics and home health would be ordered to do the dressing. Review of a visit note for Resident #6 with the PCP on 04/13/16 revealed: -The resident had a grade I ulcer on LLE and cellulitis. -The PCP ordered for home health to evaluate and treat. -The PCP noted antibiotics would be given.	D 273		

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Review of a physician's order request form for Resident #6 dated 04/13/16 revealed:
-The physician noted the resident had cellulitis in left lower extremity and grade I ulcer.
-There was an order for home health to evaluate and treat.
-The physician ordered two different antibiotics.

Review of facility progress notes for Resident #6 revealed:
-04/15/16 (no time): Skilled Nursing Visit (SNV) by home health. The resident was admitted to home health for LLE wound care.

Interview with a medication aide (MA) in the MCU on 09/02/16 at 4:43 p.m. revealed:
-Both of the resident's legs were swollen and home health had to come in and treat them.
-He did not recall seeing the stitches in the resident's leg.
-He did not know why the stitches were not taken out.
-The MCC would be responsible for making sure the stitches were taken out.

Telephone interview with Resident #6's family member on 09/06/16 at 4:30 p.m. revealed:
-Facility staff called him about a leg wound the resident had and apparently they had to take the resident back to the hospital.
-He could not get a straight answer from staff.
-He was notified of a fall a while back.
-He was notified the resident was taken to the hospital on 08/24/16 because the resident was found out of bed.
-The resident had a broken femur, had surgery, and passed away.

Review of a hospital death summary report for

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D 273	Continued From page 131 Resident #6 revealed: - The resident was taken to the operating room on 08/24/16 to have surgery for a right hip fracture. - The resident had postoperative blood loss anemia and her kidney function declined. - The resident's date of death was 08/25/16 and most likely cause of death was myocardial infarction (heart attack) or fat embolism (causes blockage of blood flow). Telephone interview with the nurse for Resident #6's former PCP on 09/07/16 at 11:45 a.m. revealed: -The facility transitioned to another primary practice for the residents during the first part of 2016. -They saw Resident #6 for a routine visit at the facility on 02/24/16. -Facility staff did not notify them that Resident #6 had fallen and had been to the ER and got leg sutures on 02/19/16. -The physician would have physically assessed the resident's wound during the routine visit if he had known. -They did not do complete body assessments during routine visits unless staff notified them of a concern or change in condition. -They had no idea the resident had sutures and they usually removed sutures 10 to 12 days after they were placed. -The facility did not notify the PCP that the resident was admitted to the hospital for cellulitis on 04/02/16. -The PCP found out about it after their office received a copy of the discharge paperwork from the hospital. -The facility did not notify them of another skin tear on the resident's leg until a routine visit on 04/13/16 when the PCP ordered home health.	D 273		

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Telephone interview with a former MA in the MCU on 09/07/16 at 3:10 p.m. revealed:
-She had worked at the facility from March 2015 until 08/30/16.
-Resident #6 had kept telling the MA that the stitches in her leg needed to come out.
-The MA did not know the resident had stitches in her leg until the resident told the MA.
-The MA could not recall when the resident told her about the stitches.
-The MA had told a previous MCC that the stitches in Resident #6's legs had been there a while and they needed to come out.
-The previous MCC told the MA that she would take care of it.

Telephone interview with Resident #6's former PCP on 09/08/16 at 12:15 p.m. revealed:
-Facility staff never told the PCP that Resident #6 had any stitches.
-He would have taken the stitches out if he had known.
-He found out about the resident's leg after he got a report from the hospital.

5. Record review of Resident #11's most current FL-2 dated 11/30/15 revealed:
-The resident's diagnoses included advanced dementia, fall, hypertension, acute on chronic stroke versus recurrent stroke, and constipation.
-The resident was constantly disoriented and noted to be a wanderer, verbally abusive, and injurious to others.
-The resident was ambulatory and incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

Review of Resident #11's Resident Register

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revealed the resident was admitted to the facility on 11/14/14.

A. Review of Resident #11's admission assessment dated 11/13/14 revealed:
-The resident was ambulatory and a wanderer.
-The resident had a history of combativeness.

Review of Resident #11's current assessment and care plan dated 08/18/15 revealed:
-The resident was noted to be wandering at times, verbally and physically abusive, and injurious to others.
-The resident was receiving medications for mental illness / behaviors.
-The resident required redirection and had behaviors.
-The resident was not easily redirected and had prn (as needed) medications for behaviors.
-The resident declined assistance and wore adult incontinence briefs.
-The resident was always disoriented and had significant memory loss and must be redirected.

Review of facility progress notes dated 06/30/15 - 11/20/15 for Resident #11 revealed:
-Resident #11 physically assaulted other residents on at least 5 occasions.
-Resident #11 verbally threatened residents on at least 3 occasions and staff on at least 4 occasions.
-Resident #11 was physically aggressive and combative with staff on at least 5 occasions.

Review of a visit form with Resident #11's primary Nurse Practitioner (NP) dated 11/30/15 revealed:
-The resident was seen for chronic care follow-up.
-The resident had severe dementia without reported behavioral changes noted by staff.

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D 273	Continued From page 134 -Continue to work with staff on environmental safety issues, appropriate activities, and appropriate redirection when behavior intervention was needed. -There was an order for a psych consult for diagnosis of dementia. Review of a visit form with Resident #11's psychiatric Nurse Practitioner (NP) dated 12/02/15 revealed: -Resident with advanced dementia, agitation, and inability to fall asleep. -The resident would be agitated if another resident would stumble over his feet but the resident would deliberately stretch his legs per staff. -The resident would walk up and down the hall until about 1am - 2am and would sleep late and took naps during the day. -There was an order to increase Zoloft to help with agitation and add Melatonin to help with sleep. Review of facility progress notes for Resident #11 revealed: -12/03/15 (7 - 3 shift): Resident was very combative towards staff. Resident hit 2 staff with closed fist. Resident tried to kick staff and tried to grab a mop and hit a male staff. Housekeeper tried to push carts in closet while staff tried to redirect resident. Resident then hit female staff with a closed fist. Male staff tried to redirect resident by talking with him and then resident began to make a lot of threats. Family, MCC, and 911 were called. -12/03/15 (3 - 11 shift): Resident returned from the emergency room (ER) and was diagnosed with dementia and to follow up with physician in 2 to 3 days.	D 273		

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Review of a hospital ER form dated 12/03/15 for Resident #11 revealed the resident was seen for dementia and was to follow up with physician in 2 to 3 days.

Review of facility progress notes for Resident #11 revealed:
-12/07/15 (7 - 3 shift): Resident was aggravating another resident when medication aide (MA) asked him to step away. Resident made threats to the MA and stated he would "knock the h--- out of her". Another staff redirected the resident to another area.

Review of a visit form with Resident #11's psychiatric Nurse Practitioner (NP) dated 12/16/15 revealed:
-This was a follow-up visit after Zoloft and Melatonin were started.
-Staff reported the resident had been pretty good for the most part with some increased agitation starting at 5pm and prn Ativan was used.
-Staff reported the resident was sleeping well and staff thought he would benefit with scheduled Ativan in the afternoon.
-Staff reported the Zoloft seemed to decrease the agitation and combativeness.
-He now slept good and did not wander around until late.
-There was an order to start Ativan 0.25mg daily at 4:00 p.m.

Review of facility progress notes for Resident #11 revealed:
-12/23/15 (9:20 p.m.): Resident "swung on" medication aide because he was asked to move out of the way of another resident.

Review of a visit form with Resident #11's psychiatric NP dated 12/30/15 revealed:

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-The NP was asked to see the resident per facility request due to increased agitation after dinner time.
-Scheduled Ativan dose at 4pm during last visit did not seem to be helping as staff stated he could get agitated in seconds.
-There was an order to increase Ativan to 0.5mg daily at 4:00 p.m.

Review of facility progress notes for Resident #11 revealed:
-01/07/16 (7 -3 shift): Resident told another resident to "shut her d--- mouth". Resident was redirected to another area.
-01/13/16 (3 - 11 shift): Resident kept grabbing and feeling another resident. Staff had to keep redirecting him from the female resident. Resident started to get agitated around 7pm, fussing staff out. He would not listen to staff so "we just let him walk up and down hall" until he calmed down.

Review of a visit form with Resident #11's psychiatric NP dated 01/13/16 revealed:
-This was a follow-up visit after Ativan was increased due to aggressive behavior in the afternoon and evening.
-Staff reported he became aggressive around 5pm and he was still combative even after Ativan was increased.
-There was an order to add low dose Seroquel 25mg at noon to control afternoon behavior.

Review of a visit form with Resident #11's psychiatric NP dated 01/27/16 revealed:
-This was a follow-up visit after low dose Seroquel was added at noon due to increased aggressiveness and combativeness in the afternoon.
-Staff reported better behavior overall.

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-The resident seemed to be well controlled and behaved.
-No medication changes needed today.

Review of facility progress notes for Resident #11 revealed:
-02/01/16 (8:00 a.m.): Resident had a rough start this morning as he was making threats toward another resident. Staff redirected him to another area.
-02/01/16 (10:20 a.m.): Resident still making threats, offered prn medication, but he refused.
-02/06/16 (7 - 3 shift): Resident made threats towards other residents and staff. Resident stated he would "knock the h--- out of her". Resident also stated if he had his gun he would shoot the MA.

Review of a visit form with Resident #11's primary FNP dated 02/08/16 revealed:
-The resident was seen for annual wellness visit for 2016.
-The examination included vital signs and basic vision and hearing screening.
-The resident's past medical history noted the resident was at high risk for falls and had a small subarachnoid hemorrhage due to a fall in 11/2014.
-The FNP rated the resident's fall risk as low and the resident was not a good rehab candidate.
-The FNP noted the resident's gait was fair and the resident did not have a walking device.
-The resident's overall cognitive function was poor and he was only oriented to person.

Review of facility progress notes for Resident #11 revealed:
-02/16/16 (12:00 p.m.): Resident got a bit agitated when told not to put his hands on the dinner glasses. He knocked over a glass of tea and was

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directed out of the dining area to the library for calmness. Resident calmed down at this moment.
-02/19/16 (11 - 7 shift): Resident was fighting the PCA, refused to be assisted, and stayed up until 3:00 a.m.

Review of a visit form with Resident #11's psychiatric NP dated 02/24/16 revealed:
-This was a routine follow-up visit.
-Staff reported the resident's behavior was now under control and the resident was sleeping and eating well.
-The medications seem to be controlling evening agitation.
-No medication changes needed today.

Review of facility progress notes for Resident #11 revealed:
-03/01/16 (3 - 11 shift): Resident had been unzipping his pants and showing his penis. Resident had been observed holding hands with another resident. Staff redirected.

Review of a visit form with Resident #11's primary Family Nurse Practitioner (FNP) dated 03/07/16 revealed:
-The resident was seen for dry irritated skin on his lower legs and feet and a cream was ordered.
-There was no documentation related to the resident's behaviors.

Review of facility progress notes for Resident #11 revealed:
-03/10/16 (7 - 3 shift): Resident hit a female staff twice. Staff informed resident that he could not hit other residents.

Review of a visit form with Resident #11's psychiatric NP dated 03/23/16 revealed:

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-This was a routine follow-up visit.
-Staff reported the resident's behavior was now under control and he was eating and sleeping well.
-The medications seemed to be controlling evening agitation.
-No medication changes needed today.

Review of facility progress notes for Resident #11 revealed:
-04/06/16 (7 - 3 shift): Resident had been told multiple times to "stop touching on a female resident". Female resident was removed from his reach and he followed her and continued to try to touch her.
-04/10/16 (7 - 3 shift): Resident was trying to hit PCAs when they were trying to change him. It took 3 PCAs and the MA to get resident changed.

Interview with a medication aide (MA) in the MCU on 09/02/16 at 4:55 p.m. revealed:
-The resident would get upset or agitated mostly in the evenings and at night.
-The resident was combative with care but he was put on some medications that seemed to help.
-The resident was combative with staff and other residents especially if someone got in his space.
-Staff would redirect the resident by talking to him.

Interview with a second MA in the MCU on 09/02/16 at 5:12 p.m. revealed Resident #11 was combative with staff and residents once in a while but did not hurt anyone to her knowledge.

Telephone interview with the nurse for Resident #11's former primary care provider (PCP) on 09/07/16 at 11:45 a.m. revealed:
-The facility transitioned to another primary

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practice for the residents during the first part of 2016.
-They first saw Resident #3 in March 2015.
-The facility had notified the PCP a couple of times about the resident being agitated and combative in 2015.
-They saw the resident in January 2016 and he seemed okay but staff stated Resident #11 was verbally aggressive and combative so they changed some of his medications.
-They last saw the resident in March 2016 and staff reported no complaints about the resident.
-They were not aware of the resident having any behavior issues from January 2016 until their last visit with the resident in March 2016.

Telephone interview with a former MA in the MCU on 09/07/16 at 3:10 p.m. revealed:
-Resident #11 was "flirty" and would make you laugh.
-If you made Resident #11 mad, he would cuss you out and he might draw his arm back like he was going to hit you.
-Resident #11 would get mad if he was told to do something.

Interview with a personal care aide (PCA) in the MCU on 09/08/16 at 10:35 a.m. revealed:
-Resident #11 did not like it when another male messed with a female, like if a male yelled at any female.
-Resident #11 would get verbally aggressive and he would resist care and swing at staff.

Interview with a second PCA in the MCU on 09/09/16 at 9:25 a.m. revealed:
-Resident #11 would wander throughout the MCU and he would hold hands with a female resident and he would try to touch the female resident.
-Staff would try to watch him and keep him apart

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D 273	Continued From page 141 from the female resident. Interview with the psychiatric NP on 09/08/16 at 3:50 p.m. revealed: -Resident #11's issue was agitation in the afternoon. -When the NP saw the resident, he was usually around the nurses' station. -She was not getting consistent reports from staff about the resident's behavior. -During visit with Resident #11 on 12/16/15, she added Ativan for his agitation. -During visit with Resident #11 on 12/30/15, she increased Ativan for continued agitation. -During visit with Resident #11 on 01/13/16, she added Seroquel for his combativeness. -During visit with Resident #11 on 01/27/16, staff reported his behaviors were better so no changes were made. -During visit with Resident #11 on 02/24/16, staff reported the resident's behavior was under control so no changes were made. -During her last visit with Resident #11 on 03/23/16, staff again reported no concerns and the resident's behavior was under control. -Staff never reported any behavior issues during the visits on 01/27/16, 02/24/16, 03/23/16 or afterwards otherwise she would have documented it and made medication changes. -Facility staff had the NP's phone number and should have called to report any concerns or behaviors. -Resident #11 was due to be seen again one month after the visit on 03/23/16 or sooner if any behaviors had been reported. B. Review of Resident #11's current assessment and care plan dated 08/18/15 revealed: -The resident required extensive assistance with bathing, dressing, toileting, grooming, and	D 273		

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personal hygiene.
-The resident's skin was noted to be normal.
-The resident was always disoriented and had significant memory loss and must be redirected.

Review of facility progress notes for Resident #11 revealed:
-08/12/15 (7:30 p.m.): While putting on the resident's bedtime clothes, the PCA discovered cracks on the resident's ankles that were bleeding. The medication aide was notified.
-01/22/16 (3 - 11 shift): Resident received new order for Eucerin cream apply to dry irritated skin bilateral lower legs and feet daily. Order was faxed to pharmacy.

Review of a visit form with Resident #11's primary Nurse Practitioner (NP) dated 01/22/16 revealed:
-The resident had dry irritated skin on his lower legs and feet.
-There was an order for a steroid / emollient cream to be applied to his lower legs and feet daily.

Review of a visit form with Resident #11's primary NP dated 03/07/16 revealed:
-The resident had dry irritated skin on his lower legs and feet.
-There was an order to continue the steroid / emollient cream to be applied to his lower legs and feet daily.

Review of a visit form with Resident #11's primary NP dated 04/18/16 revealed:
-There was an order for Eucerin intensive repair cream apply to bilateral lower extremities for dry skin.
-There was an order to refer to dermatology for management of dermatitis bilateral lower extremities / xerosis (a condition of rough, dry

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D 273	Continued From page 143 skin with fine scaling of skin and occasionally with small cracks in the skin.) Telephone interview with Resident #11's family member on 09/07/16 at 7:30 p.m. revealed: -He was getting sores ups and down his legs with blood and pus coming out of them. -She had taken cream for staff to put on his legs but they were "neglecting" him and not putting the cream on his legs. -The resident would scratch his legs at night because they were so dry. -Staff eventually got some cream from the physician but it was not working because staff was not applying it like they were supposed to. -The resident was transported to the hospital due to a fall on 04/26/16, then transferred to hospice, and did not return to the facility. Interview with a personal care aide (PCA) in the MCU on 09/08/16 at 10:35 a.m. revealed: -Both of Resident #11's feet and legs were very dry and had open areas. -They tried baby oil on them and a cream the physician ordered but it was not helping. Interview with a medication aide (MA) in the MCU on 09/08/16 at 10:35 a.m. revealed: -Resident #11's legs were "real scaly" and they were applying cream that the physician had ordered. -The cream was not helping and there was an order for the resident to see a dermatologist. -The Resident Care Coordinator (RCC) would forward any referrals to the transporter who would make the appointment. -Resident #11 never went to a dermatologist and his legs never got better. Interview with the facility's transporter on 09/08/16	D 273		

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at 11:05 a.m. revealed:
-She had made a dermatology appointment for Resident #11 but the resident passed away.
-She was not sure which dermatologist office she called to make the appointment.
-There were only two dermatology offices that they used for the residents.
-It should have been documented in the appointment book but she could not find documentation of a dermatology appointment for Resident #11.

Telephone interview with the receptionist from a local dermatology office on 09/08/16 at 11:17 a.m. revealed:
-There was no record of Resident #11 having an appointment with their office.
-They had never seen the resident.

Telephone interview with the receptionist from a second local dermatology office on 09/08/16 at 11:22 a.m. revealed:
-There was no record of Resident #11 having an appointment with their office.
-They had never seen the resident.

Interview with the facility's transporter on 09/08/16 at 11:25 a.m. revealed:
-She was unsure why the dermatology appointment was not made for Resident #11.
-She could have sworn she made the appointment.

Telephone interview with a Nurse Practitioner (NP) from the current provider group on 09/09/16 at 10:00 a.m. revealed:
-She worked with the current provider group but she no longer provided care for residents at this facility.
-She last saw Resident #11 on 04/18/16 and she

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made a referral to dermatology for the management of his dermatitis.
-Resident #11 had chronic, severely dry skin.
-It got better then it got worse again.
-She did not recall any open areas but it was severely dry the last she saw the resident's skin.

Review of a hospital admission form dated 04/26/16 for Resident #11 revealed:
-Resident #11 was admitted to the hospital on 04/26/16 after a fall.
-Physical exam notes indicated the resident's left lower extremity had areas of open skin, hyperpigmentation, appearance of old wounds, and a foul odor.

6. Review of Resident #5's FL-2 dated 12/16/15 revealed diagnoses of Vascular Dementia, Hyperlipidemia, Sub secular Mass/Brain Tumor, Type II Diabetes Mellitus, Arthritis, Cataracts, Constipation, Dry Skin, Diabetic Retinopathy, Alcohol Dependence and Schizoaffective Disorder.

a. Telephone interview with a family member of Resident #5 on 9/5/16 at 4:05pm revealed:
-Staff reported to the family member that Resident #5 fell in the bathroom across the hall from her room at the facility on 7/11/16.
-Hospital staff reported to the family member that Resident #5's wheel chair was on top of her when staff found her.
-Resident #5's wheelchair was "a rickety one where one side locked and the other did not."
-The family member did not know how long Resident #5 had been on the floor.
-On arrival to the emergency room Resident #5's body temperature was 88 degrees Fahrenheit on 7/12/16.
-Resident #5 had a "gash" on the back of her

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head, some type of injury on her back that was covered with a bandage and her knees were "messed up" from the fall.
-Resident #5 had a lot of falls at the facility.
-The family member could not remember the details.
-The family member did not recall staff reporting an injury or accident on 7/10/16.
-Resident #5 died 7/25/16 following admission to the hospital on 7/12/16 and then to Hospice.

Telephone interview with a medication aide (MA) on 8/31/16 at 10:15am revealed:
-Resident #5 had fallen in her room at change of shift from 2nd to 3rd shift (11pm) on 7/11/16.
-Staff heard the loud bump as Resident #5 hit the floor.
-Resident #5 was sent out by 3rd shift staff for being unresponsive.

Review of Nursing Assistant Notes for Resident #5 revealed:
-A note for 7am-3pm on 7/10/16 which documented Resident #5 had a black and blue knot on the left eye, reported to the MA.
-The next entry was for 11pm-7am on 7/11/16 which documented Resident #5 was observed on the floor in her room with a knot on the top of head.
-The final entry was for 3pm-11pm on 7/12/16 which documented that Resident #5 was in the hospital.

Interview with a personal care aide (PCA) on 9/2/16 at 8:52am revealed:
-The PCA wrote the nursing assistant note dated 7/10/16 for Resident #5.
-No fall had been reported for Resident #5.
-It was like a knot on Resident #5's head above her eye.

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-The PCA reported the injury to the medication aide on duty.
-The PCA could not remember who the MA was.
-Resident #5 was "her usual self" on 7/10/16.

Review of facility incident reports for Resident #5 revealed:
-There was no incident report dated for 7/9/16 or 7/10/16.
-An incident report for 11:45pm on 7/11/16 completed by the MA and signed by the Resident Care Coordinator (RCC) and Administrator.
-Documentation that Resident #5 was found on the floor with a knot on top of her head, a blood pressure and heart rate were done and Resident #5 was sent to the Emergency Room (ER).
-Resident #5 was admitted to the hospital.

Interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm revealed she did not remember a knot on Resident #5's left eye documented on 7/10/16.

There was no documentation that Resident #5 received any follow up for the knot on her left eye documented on 7/10/16.

Interview with the Nurse Practitioner (NP) on 9/9/16 at 10:07am revealed:
-The NP was not aware of the knot on Resident #5's eye.
-There was poor notification of falls in June and July 2016 from facility staff to NP.

Review of hospital records for Resident revealed:
-Resident #5 was admitted to the hospital on 7/12/16 for possible Sepsis due to Nosocomial Pneumonia.
-The hospital staff documented it was unknown how long Resident #5 was "down", her rectal

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temperature was 88 degrees Fahrenheit and her right hand was swollen with a blister on the right pinky finger.
-Head imaging study done on 7/12/16 documented a left frontal scalp hematoma and a right parietal scalp hematoma.

The facility policy and procedure for fall management and prevention was not available for review.

Review of the facility's Risk Management Fall Report for Resident #5 revealed a note following a fall on 3/21/16, to have Resident #5 evaluated for a skilled nursing facility due to the number of recurrent falls.

Interview with the Administrator on 9/2/16 at 9:02am revealed facility incident reports were sent to the Risk Management Registered Nurse (RN) who reviewed them and made recommendations which were reviewed with facility staff monthly.

Interview with the RCC on 9/2/16 at 3:29pm revealed:
-The RCC was responsible for informing staff and follow up of fall prevention interventions recommended by the Risk Management RN.
-The RCC was not aware of a skilled nursing care evaluation for Resident #5 being done.

Review of a facility incident report for Resident #5 dated 6/9/16 revealed documentation a urinalysis was ordered by the physician.

Review of the facility's Risk Management Fall Report for Resident #5 revealed a note following an altercation on 6/9/16, "order received for urinalysis" for Resident #5.

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D 273	Continued From page 149 Record review for Resident #15 revealed there were no urinalysis or urine culture results. Interview with the Divisional Care Manager (New Company) on 9/7/16 at 2016 revealed the lab company was contacted and there were no results for a urinalysis for Resident #5 for 2016. Interview with a Personal Care Aide (PCA) on 9/9/16 at 11:11am revealed: -When a resident needed a urine specimen, staff would be given a catcher by the medication aide (MA). -The PCA would put the catcher in the toilet to catch the urine. -The PCA would then give the urine specimen to the MA. -Resident #5 never had to have a urine specimen done. Interview with a medication aide (MA)/Supervisor on 9/9/16 at 11:32am revealed: -When a urinalysis was ordered for a resident, the specimen was obtained and the lab was contacted to pick up the specimen. -The results were faxed to the facility. -Staff put the lab result in a folder for the physician. Telephone interview with the previous Nurse Practitioner (NP) on 9/9/16 at 10:07am revealed the NP did not have any results for the urinalysis ordered 6/9/16 for Resident #5. 7. Review of Resident #15's FL-2 dated 4/14/16 revealed diagnoses included Alzheimer's Dementia without Behaviors, Hypertension, Atrial Fibrillation, Dysphagia and Osteoarthritis.	D 273		

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a. Telephone interview with a family member of Resident #15 on 9/6/16 at 4:01pm revealed:
-The family member visited daily to apply a dressing to Resident #15's right arm which had stiches from a fall on 5/23/16.
-The family member wanted to make sure the dressing was done right each day.
-On Sunday 5/29/16 the family member observed that Resident #15 was not her usual self and knew something was not right.
-On Monday 5/30/16 the family member visited and observed that Resident #15 was in so much pain she could not be touched.
-The family member insisted Resident #15 be sent to the emergency room.
-At the emergency room the family member found that Resident #15 had bandages to her left arm and shoulder and Resident #15 was "all bruised up."
-The family member asked facility staff what happened and no one knew anything.
-The family member felt that someone at the facility knew what happened because someone applied the bandages to Resident #15's left arm.

Review of the facility's Risk Management Fall Report for Resident #15 revealed:
-A note following an incident titled "other" dated 5/28/16 that Resident #15 "was sent to the ER at the request of the family on 6/1/16 because the resident was unable to hold her head up as previously noted."
-Resident #15 was admitted to the hospital for vertebral fracture.

Second telephone interview with a family member of Resident #15 on 9/8/16 at 11:00am revealed:
-Resident #15 went to the emergency room (ER) on 5/29/16.
-The ER sent Resident #15 back to the facility the

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same day.
-The ER called the facility on 5/30/16 saying Resident #15 had 2 broken vertebrae.
-Resident #15 did not return to the facility after 5/30/16.
-Resident #15 was in the hospital for 5 days, went to hospice and died on 6/15/16.

Review of Nursing Assistant Notes for Resident #15 revealed:
-The next entry was for 5pm-11pm on 5/30/16 which documented Resident #15 returned from the hospital with a fracture to her neck.
-The next entry was for 3pm-11pm on 5/31/16 which documented Resident #15 had a good day.
-The next entry was for 3pm-11pm on 6/1/16 which documented Resident #15 was "still out of the facility at the hospital."
-The next entry was for 7am-3pm on 6/1/16 which documented that it was a late entry and Resident #15 was sent out at the request of the Power of Attorney (POA) for a lot of pain.

Interview with a MA on 9/6/16 at 5:25pm revealed:
-Resident #15's family member took the resident to the hospital on 5/30/16.
-Other staff had reported Resident #15 had a fractured neck.
-Resident #15 had been left sitting by staff with her head drooped down for a prolonged period of time.
-When the family member came to visit, they knew right away something was not right.
-Whatever happened, happened on 2nd shift and the family member came the next day.

Telephone interview with a second MA on 9/9/16 at 9:35am revealed the MA did not remember noticing anything different about Resident #15,

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D 273	Continued From page 152 5/28/16 -5/30/16. Telephone interview with the physician on 9/9/16 at 11:45am revealed: -Resident #15 presented for her appointments with the physician with bruises on her face and body. -The bruises were "reportedly from falls." -The physician had concerns about the bruises and how the resident obtained them. -Resident #15's last physician's office visit was on 5/5/16. -The incident on 5/23/16 was not reported. -Notification of the neck fracture came from the hospital on 6/2/16. Telephone interview with the Resident Care Coordinator (RCC) on 9/8/16 at 7:02pm revealed: -The family of Resident #15 reported to the RCC that Resident #15's neck was in an awkward position. -An incident report was completed and sent to the Risk Management RN and the Department of Social Services. Review of the facility incident reports for Resident #15 revealed there was no incident report dated 5/28/16, 5/29/16, 5/30/16, 5/31/16 or 6/1/16. Review of hospital record for Resident #15 revealed: -Resident #15 presented to the ER on 5/30/16 with family members who were concerned she may have fell the night of 5/29/16. -Resident #15 complained of neck pain the evening of 5/29/16 and the morning of 5/30/16. -ER staff removed a bandage from Resident #15's left elbow and noted black and green discharge from 2 skin tears and deformity to the elbow.	D 273		

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D 273	Continued From page 153 -ER staff documented Resident #15 had tenderness to the left elbow and was reluctant to move it. -ER staff documented abrasions to both of Resident #15's upper extremities and a yellow green bruise on the right buttock. -Final diagnoses was documented as Compression Fractures of the C-Spine and Thoracic Vertebrae. b. Review of the Nursing Assistant Notes for Resident #15 revealed: -A note at 9:00am on 4/15/16 which documented Resident #15 was having trouble having a bowel movement and the Medication Aide (MA) was notified. -A note at 7:30pm on 4/19/16 which documented Resident #15's Power of Attorney (POA) was concerned about Resident #15's stomach. -A note at 7pm on 4/22/16 that Resident #15 was given a PRN (as needed) medication for her stomach. -A note on 4/23/16 documented PCA was looking down to see if Resident #15 was backed up when Resident #15 fell back on the toilet and cut her arm. -A note for 7am-3pm on 4/26/16 which documented that Resident #15's "bowel was backed up," the MA was notified and Resident #15 needed something to help her go to the bathroom. -A note for 7am-3pm on 4/28/16 which documented Resident #15 had a bowel movement, please try to help keep her hydrated on all shifts. Review of hospital notes for Resident #15 revealed: -Resident #15 was seen in the Emergency Room (ER) on 5/23/16 for evaluation of a laceration.	D 273		

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-ER staff documented Resident #15 was being disimpacted when she jumped forward and struck her forearm on the toilet paper holder.
-ER staff documented Resident #15 requested to be disimpacted in the ER which was done.

Interview with a Personal Care Aide (PCA) on 9/7/16 at 5:40pm revealed:
-Resident #15 had a hard time moving her bowels.
-The Medication Aides (MAs) would give Resident #15 Miralax and it would help.(Miralax is a laxative used to treat constipation.)

Interview with a MA on 9/6/16 at 5:25pm revealed:
-Resident #15 had issues with constipation.
-Miralax had been ordered daily as needed by the physician.
-The PCA would notify MA if Resident #15 was constipated and the MA would give a laxative.
-The MAs usually referred physician requests to the Memory Care Coordinator (MCC)and the MCC contacted the physician.
-The physician would come to the facility and see the resident and then write an order.

Telephone interview with a second MA on 9/9/16 at 9:35am revealed the MA did not remember Resident #15 having any problems with constipation and needing dis-impaction.

Interview with a medication aide (MA)/Supervisor on 9/7/16 at 5:00pm revealed:
-The facility had standing orders for Milk of Magnesia for constipation.
-Once the resident had signed (by the physician) standing orders, the MAs could give the Milk of Magnesia without further orders.
-The MAs could have notified the physician/NP

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themselves but the RCC wanted to do that herself.

Review of Standing Orders for Resident #15 revealed orders included Milk of Magnesia 30ml daily as needed for constipation signed by the physician on 4/7/16.

Telephone interview with the Resident Care Coordinator (RCC) on 9/8/16 at 7:02pm revealed:
-Resident #15 had standing orders which were initiated on admission to the facility.
-Standing orders included an order for Milk of Magnesia daily as needed for constipation.

Review of Resident #15's April and May 2016 eMARs revealed there was no Milk of Magnesia administered.

Review of a Physician's orders dated 4/21/16 for Resident #15 revealed an order for Miralax 17grams in 8 ounces of fluid daily as needed for constipation.

Review of Resident #15's electronic medication record (eMAR) for April 2016 revealed:
-An entry for Miralax 17gms in 8 ounces of water once daily as needed for constipation.
-The Miralax was documented as administered on 4/22/16 at 5:25pm, 4/26/16 at 12:29pm and 4/27/16 at 7:47pm.

Review of Resident #15's electronic eMAR for April 2016 revealed:
-An entry for Miralax 17gms in 8 ounces of water once daily as needed for constipation.
-The Miralax was documented as administered on 4/29/16 at 4:38pm.

Second interview with a MA on 9/8/16 at 2:47pm

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revealed:
-The MA did not consider administering Milk of Magnesia from the standing orders for Resident #15.
-Whenever the PCA reported Resident #15 was constipated the MA administered the Miralax once Resident #15 had an order for it.

In summary, Resident #15 had severe constipation requiring frequent disimpaction and went without a laxative being administered from 4/15/16 until 4/22/16 and again from 4/30/16 until 5/23/16 when she was disimpacted in the ER.

Telephone interview with the physician on 9/9/16 at 11:45am revealed:
-Resident #15 did not have issues with constipation requiring disimpaction prior to her admission to the facility.
-The physician was not aware that Resident #15 was experiencing severe constipation requiring disimpaction while she was at the facilitiy.
-Staff had not reported Resident #15 needing disimpaction.
-Resident #15's last physician's office visit was on 5/5/16.

c. Review of Nursing Assistant Notes for Resident #15 revealed:
-A note at 2:41pm on 4/10/16 which documented Resident #15's bottom "very irritated," needed cream and the Medication Aide (MA) was notified.
-A note at 9:00pm on 4/10/16 which documented the physician was contacted and would call back on 4/11/16 with orders.
-A note for 7am-3pm on 4/26/16 which documented Resident #15's bottom was irritated and the MA was notified.
-A note for 11pm-7am on 5/5/16 which documented Resident #15's bottom is a little raw

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signed by a staff.
-A note for 7am-3pm on 5/17/16 which documented the Supervisor was notified of skin breakdown on Resident #15's left thigh and notified the Resident Care Coordinator (RCC).
-A note for 11pm-7am on 5/20/16 which documented Resident #15 had a sore on her left hip signed by a PCA.

Interview with a PCA on 9/7/16 at 5:40pm revealed:
-Every time the PCA provided incontinence care for Resident #15 she noticed there was always a red spot on Resident #15's bottom.
-The PCA did not know if the redness had been reported or if anything was being done for the redness.

Interview with a medication aide (MA) on 9/6/16 at 5:25pm revealed:
-Resident #15 did have some skin breakdown on her bottom.
-The MA was waiting on an order from the doctor for Resident #15's bottom.
-The MAs usually referred physician requests to the Memory Care Coordinator and they contacted the physician.
-The physician would come to the facility and see the resident and then write an order.

Telephone interview with the physician on 9/9/16 at 11:45am revealed:
-There was no skin breakdown reported.
-Resident #15's last physician's office visit was on 5/5/16.

8. Review of Resident #2's FL-2 dated 7/18/16 revealed diagnoses included Alzheimer's Dementia, Osteoporosis, Hypertension, Hyperlipidemia, Emphysema, Hypothyroidism,

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D 273	Continued From page 158 Bipolar Disorder and Glaucoma. Observation on 8/30/16 at 1:05pm revealed Resident #2 had a hospital gown on which had fallen away from her back side revealing significant redness to both buttocks and a raw area at the gluteal fold. Observation on 9/2/16 at 3:14pm revealed: -Resident #2 had increased redness to the sacral and buttocks area with increased rawness to the gluteal fold since 8/30/16. -There was a new dime sized area of rawness to the right upper buttock that was not present on 8/30/16. Review of Nursing Assistant Notes for Resident #2 revealed: -A note at 2:30pm on 7/17/16 documenting that Resident #2 had reddened buttocks with no breakdown signed by the Resident Care Coordinator (RCC). -There was no further documentation related to the redness on Resident #2's buttocks. Review of the Nurse Practitioner's (NP) facility visit note dated 8/18/16 for Resident #2 revealed: -An order for Home Health services to monitor the sacral wound. -An order for an occlusive padding like dressing to sacral wound daily. Interview with the RCC on 9/1/16 at 2:00pm revealed: -The RCC observed the skin breakdown on Resident #2's buttocks the day it was brought to the RCC's attention on 7/17/16. -The RCC instructed Resident #2 to leave her incontinence brief off to allow the area to get some air.	D 273		

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D 273	Continued From page 159 -The RCC notified the physician when he came to the facility. -Resident #2 continued with the incontinence brief off and the ordered cream for 2 weeks. Interviews with the NP on 9/1/16 at 2:33pm, 9/7/16 at 11:47am and 9/8/16 at 11:35am revealed: -The NP was initially notified by staff over the phone about Resident #2's skin breakdown on 8/17/16. -The NP placed an order with the pharmacy that day. -The NP saw Resident #2 at the facility the following day (8/18/16) and changed the orders. -The NP ordered Home Health and dressing changes after seeing Resident #2 on 8/18/16. -The NP ordered Home Health to evaluate and treat the area and padded dressings to decrease pressure to the area. -The NP put orders into the computer system and then faxed to facility. -Urgent orders were sent the same day and non-urgent orders were sent the next day. -The NP checked in with the RCC on arrival and again before leaving the facility. -The NP communicated any plans or changes to orders prior to leaving the facility. Telephone interview with Home Health agency staff on 9/2/16 at 4:18pm revealed: -There was a skilled nurse evaluation on 6/21/16 for Resident #2. -There were no other home health services for Resident #2. Interview with Resident #2 on 8/30/16 at 1:23pm revealed staff applied a cream to her buttocks twice a day in the morning and at night.	D 273		

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Telephone interview with a family member of Resident #2 on 8/31/16 at 4:23pm revealed:
-The family member was aware of the skin breakdown on Resident #2's bottom.
-It had started approximately 1 week ago [8/24/16].
-Staff at the facility were applying cream to the area.

Interview with a personal care aide (PCA) on 9/2/16 at 8:52am revealed:
-The PCA noticed Resident #2 had skin breakdown on her buttocks last week [8/25/16].
-The Medication Aides (MA) started applying cream to Resident #5's buttocks last week [8/25/16].

Interview with a MA on 8/30/16 at 1:12pm and 8/31/16 at 10:02am revealed:
-Resident #2 had an area of breakdown on her buttocks a while ago.
-The area had since "technically healed" and was almost gone.
-Resident #2 had a cream applied to her buttocks twice daily.
-The MAs were responsible for applying the ointment.

Telephone interview with a second MA on 8/31/16 at 10:15am revealed:
-Resident #2 had skin breakdown on her buttocks for approximately one month.
-The MAs were responsible for applying ointment to the area twice daily so the MAs observed the area twice a day, every day.

Interview with a medication aide (MA)/Supervisor on 9/7/16 at 5:00pm revealed:
-The physician or NP faxed the order to the facility.

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-Facility staff faxed the order to the pharmacy.
-One copy was given to the RCC and another copy was placed in the resident's record.
-Orders were received from the physician/NP within a day or two following the physician/NP visit to the facility.
-The only orders received the same day were orders the staff wrote down and asked the physician/NP to sign.
-PCAs reported concerns to the MAs.
-The MAs checked the resident and discussed with the RCC about letting the physician/NP know and getting orders.

Interview with the RCC on 9/8/16 at 7:02pm revealed:
-There was no system in place to review and assure physician orders were accurately entered and followed up on.
-The RCC had more access to orders on the Assisted Living (AL) side than in the Memory Care Unit (MCU).

9. Review of Resident #13's FL-2 dated 7/11/16 revealed diagnoses included Vascular Dementia, Hypertension and Allergic Rhinitis.

a. Review of Nursing Assistant Notes for Resident #13 revealed a note for 3pm-11pm on 7/19/16 which documented that Resident #13 had pus draining from her foot, a dressing was put on it and signed by a Medication Aide (MA).

Interview with the MA on 9/6/16 at 5:56pm revealed:
-The MA observed pus draining from Resident #13's right ankle on 7/19/16.
-The MA documented what was observed and reported it to the oncoming MA (3rd shift).
-The 3rd shift MA was supposed to report it to the

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Resident Care Coordinator (RCC).
-The MA did not know if that was done.
-The MA did not report it directly to the RCC.

Telephone interview with the RCC on 9/8/16 at 7:02pm:
-Resident #13 had an area on the both sides of her right ankle.
-The RCC could not recall exactly what the area looked like but there were no signs of infection.
-Resident #13 did not have a fever in the days before leaving the facility on 8/9/16.
-The wounds came from Resident #13 wearing "slippy" socks instead of shoes.
-The wounds were evaluated by Home Health and did eventually get better.

Interview with a personal care aide (PCA) on 9/7/16 at 5:40pm revealed the PCA did not know anything about pus draining from Resident #13's ankle wound.

Telephone interview with the former Nurse Practitioner (NP) on 9/9/16 at 10:07am revealed:
-The NP saw Resident #13 on 7/21/16 and noted an ankle wound that had gotten worse.
-Resident #13 was noncompliant with wearing foot protection.
-The antibiotic used to empirically treat for the urinary tract infection (7/12/16 Emergency Room visit), would have covered any wound infection.

Interview with the Nurse Practitioner (NP) on 9/1/16 at 3:18pm revealed:
-The NP had seen Resident #13 prior to her hospital admission on 8/9/16, for minor right foot wounds.
-Home health had been ordered to monitor the wound.

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Review of Home Health (HH) note dated 7/26/16 revealed:
-Resident #13 was seen by a Registered Nurse (RN) on 7/26/16 for HH Services admission.
-Documentation of a skin tear on Resident #13's right heel with slight redness and no drainage.
-Documentation that caregiver was instructed to get a foot stand for Resident #13's wheelchair related to Resident #13 constantly dragging her right foot with resistance when being pushed in the chair.
-There were no further HH notes in the resident's record.

The HH RN was not available for interview.

Interviews with 5 staff on the Memory Care Unit from 9/6/17 through 9/9/16 revealed:
-Staff could not remember the details regarding Resident #13.
-Staff were not working at the facility when Resident #13 was there.

Record review for Resident #13 revealed:
-There were no further staff entries regarding the right foot wound.
-There were no further HH notes.
-There was a Nursing Assistant Note for 3pm-11pm on 8/9/16 which documented that Resident #13 was found cold, temperature was 89.9 degrees Fahrenheit and Emergency Medical Services was called signed by a MA.

Review of facility incident report dated 8/9/16 for Resident #13 revealed Resident #13 was in the common room when she was found cold at 8:30pm.

Review of hospital records for Resident #13 revealed:

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D 273	Continued From page 164 -Resident #13 arrived in the Emergency Room on 8/9/16 with body temperature of 89.2 degrees Fahrenheit and a blood pressure of 56/34. -Hospital physician documented there was evidence of septic shock possibly due to ulceration on Resident #13's right foot versus aspiration pneumonia. -Hospital physician noted there was skin breakdown on the gluteal area and an ulcerated area involving the right heel with some drainage and necrosis. b. Review of physician visit notes for Resident #13 revealed: -A visit note dated 7/11/16 with an order to obtain a urine specimen for urinalysis and culture signed by the former Nurse Practitioner. -A visit note dated 7/18/16 with an order to obtain a urine specimen for urinalysis and culture signed by the former Nurse Practitioner. Record review for Resident #13 revealed there were no urinalysis or urine culture results for 7/11/16 or 7/18/16. Interview with the Interim Administrator (New Company) on 9/7/16 at 2:10pm revealed the lab company did not have urinalysis results for Resident #13 for July 2016. Telephone interview with the former NP on 9/9/16 at 10:07am revealed: -A urinalysis was ordered on 7/11/16 to check for a urinary tract infection (UTI) because Resident #13 had increased confusion. -Resident #13 was sent to the ER on 7/12/16 and the ER usually would just treat for a UTI which is why the urinalysis was not done on 7/11/16. -Resident #13 was treated empirically for UTI's because staff was unable to get a urine sample.	D 273		

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D 273	Continued From page 165 -The NP spoke to the Resident Care Coordinator (RCC) about the urine specimen on 7/18/16. Telephone interview with the Resident Care Coordinator on 9/8/16 at 7:02pm revealed the urinalysis for 7/18/16 should have been in Resident #13's record. _____ Review of the facility's Plan of Correction dated 9/2/16 revealed: - Resident charts from previous licensee will be re-developed, then audited by th clinical support team in coordination with quality assurance nurses. - Primary care providers (PCP) will review and verify exisiting orders. - PCPs will be consulted to address any concerns identified from the audit. - Training will be provided on "New Order Tracking System", 24 hour communication log, documentation, notification of PCP, family members and other health care providers. - Daily stand up meetings will be conducted to improve communication among staff and management. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 10/9/16.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 4 residents (#2, #3) sampled including errors with medication for anxiety (#3), a topical antifungal medication (#2), and a topical medication for inflammation and itching (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 07/18/16 revealed:
-The resident's diagnoses included Alzheimer's dementia, epilepsy, hypertension, hypothyroidism, and constipation.
-There was an order for Clonazepam 0.5mg take ½ tablet at bedtime. (Clonazepam is a controlled substance used to treat anxiety.)

Review of the August 2016 and September 2016 medication administration records (MARs) revealed:
-Clonazepam 0.5mg ½ tablet at bedtime was scheduled to be administered at 6:00 p.m.
-Clonazepam was not documented as administered from 08/30/16 - 09/05/16 due to the medication being unavailable / waiting on pharmacy.

Review of the controlled substance (CS) records for Resident #3's Clonazepam revealed:
-There was a CS record for the supply of 16 Clonazepam 0.5mg tablets (31 day supply) that were dispensed on 07/12/16.

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D 358	Continued From page 167 -Staff documented they started using this supply on 07/29/16 at 6:00 p.m. and the last tablet from this supply was administered on 08/29/16 at 6:00 p.m. -There were no CS logs for Clonazepam after this supply. Review of pharmacy dispensing records dated 01/01/16 - 09/06/16 revealed: -16 Clonazepam 0.5mg tablets (31 day supply) were dispensed on 01/12/16. -15 Clonazepam 0.5mg tablets (30 day supply) were dispensed on 02/15/16. -16 Clonazepam 0.5mg tablets (31 day supply) were dispensed on 03/15/16. -16 Clonazepam 0.5mg tablets (31 day supply) were dispensed on 04/15/16. -16 Clonazepam 0.5mg tablets (31 day supply) were dispensed on 05/15/16. -15 Clonazepam 0.5mg tablets (30 day supply) were dispensed on 06/15/16. -16 Clonazepam 0.5mg tablets (31 day supply) were dispensed on 07/12/16. -No Clonazepam was dispensed after 07/12/16. Observation of the 6:00 p.m. medication pass on 09/06/16 revealed Resident #3 was administered medications scheduled for 6:00 p.m. at 6:16 p.m. except for Clonazepam. Interview with the medication aide (MA) on 09/06/16 at 6:20 p.m. revealed: -Resident #3's Clonazepam was currently being prepared at the pharmacy and the facility staff was going to pick it up as soon as it was ready. -The Clonazepam required a hard script since it was a controlled substance. -The MAs were supposed to notify the Memory Care Coordinator (MCC) when a 5 day supply was left so the MCC could get a new prescription.	D 358		

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D 358	Continued From page 168 -They did not have a MCC in the memory care unit currently so they had been notifying the Resident Care Coordinator (RCC). -Resident #3 ran out of Clonazepam on 08/29/16. -The RCC was notified prior to 08/29/16 about the Clonazepam. -The RCC was supposed to call the physician to get a prescription. -The MA did not know if that was done by the RCC. -The MA had not noticed any difference in Resident #3's behavior since she had not been receiving the Clonazepam. -The MA had not notified the physician that the resident was not receiving the Clonazepam as the RCC was supposed to do that. Interview with the Vice President of Quality Assurance and Regulatory Compliance for the new corporation on 09/06/16 at 4:45 p.m. revealed: -She questioned a medication aide (MA) about the omissions on Resident #3's MARs for the Clonazepam today. -The MA reported the RCC handled all prescriptions with the psych provider. -The new corporation had contacted the pharmacy and the psych provider and were in the process of getting the Clonazepam for Resident #3. Review of resident care notes for Resident #3 dated 09/06/16 revealed: -New facility management team contacted the psych provider and the pharmacy regarding Resident #3's Clonazepam. -The pharmacy provided a 30 day emergency supply on 07/12/16 and notified the previous facility management about the need for a hard script.	D 358		

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-Medication error reports were completed.
-New facility management received a call back from the psych Nurse Practitioner (NP) who was going to call in a prescription to the pharmacy so the facility could get the Clonazepam from the back up pharmacy.
-The NP wanted the facility to restart the Clonazepam 0.5mg ½ tablet at bedtime on 09/06/16 upon receipt of the medication.

Telephone interview with the psychiatric Nurse Practitioner (NP) on 09/09/16 at 10:55 a.m. revealed:
-She made visits with residents at the facility at least once a week.
-Facility staff were supposed to call her office prior to a resident running out of a medication.
-If they needed a hard script prescription, the medication aide should call when 4 pills remain so the NP could get a prescription to the pharmacy.
-The MA could also let her know during her on-site weekly visits at the facility.
-The MA could notify the pharmacy as well.
-No one had notified her that Resident #3 was out of the Clonazepam and had missed the medication for a week until they called her on 09/06/16.
-The NP wrote a new prescription for the Clonazepam on 09/06/16.

Interview with the new corporation's Interim Administrator / Clinical Support Specialist on 09/07/16 at 11:15 a.m. revealed:
-They got Clonazepam from the back up pharmacy last night on 09/06/16.
-The Clonazepam was administered to the resident on 09/06/16 at 9:30 p.m.

Review of medications on hand on 09/07/16

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revealed there was a supply of Clonazepam 0.5mg dispensed on 09/06/16.

2. Review of Resident #2's FL-2 dated 7/18/16 revealed diagnoses included Alzheimer's Dementia, Osteoporosis, Hypertension, Hyperlipidemia, Emphysema, Hypothyroidism, Bipolar Disorder and Glaucoma.

a. Review of the electronic pharmacy prescription dated 8/17/16 revealed an order for Ketoconazole 2% cream apply to affected skin twice daily. (Ketoconazole is an antifungal used to treat fungal infections.)

Review of the Nurse Practitioner's (NP) facility visit note dated 8/18/16 for Resident #2 revealed an order to discontinue the Ketoconazole 2% cream.

Observation on 9/2/16 at 3:22pm revealed:
-A tube of Ketoconazole 2% cream on the medication cart with a pharmacy label for Resident #2 instructing administration to the skin twice daily with dressing changes and a dispense date of 8/29/16.

Review of Resident #2's August 2016 electronic treatment administration record (eTAR) revealed:
-An entry for Ketoconazole 2% cream apply to the skin twice daily.
-The entry was initialed as administered twice daily at 8am and 8pm starting 8/18/16, at 8pm through 8/31/16, at 8pm except on 8/23/16, at 8am and 8/27/16, at 8am.
-There was a notation that on 8/23/16 at 8am Resident #2 refused the Ketoconazole cream.

Resident #2's September 1 - 2, 2016 eTAR revealed:

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D 358	Continued From page 171 -An entry for Ketoconazole 2% cream apply to the skin twice daily. -The entry was initialed as administered twice daily at 8am and 8pm on 91/16 at 8am and 8pm; and on 9/2/16 at 8am. Telephone interview with the Pharmacist on 9/8/16 at 12:35pm revealed: -The pharmacy received an order for Ketoconazole cream on 8/17/16. -The pharmacy dispensed Ketoconazole cream on 8/17/16 and 8/29/16. -The pharmacy did not receive a discontinue order for the Ketoconazole. b. Observation on 8/31/16 at 10:02am revealed: -The electronic medication administration record on the medication cart computer monitor screen indicated that Resident #2 was receiving Hydrocortisone 1% ointment applied to skin daily with dressing changes. (Hydrocortisone is used to treat inflammation and itching.) -A tube of Hydrocortisone 1% cream on the medication cart with a pharmacy label for Resident #2 instructing administration to the skin daily with dressing changes and a dispense date of 8/29/16. Review of the Nurse Practitioner's (NP) facility visit note dated 8/18/16 for Resident #2 revealed an order to start Prednisone-Aloe Vera 1% oinment daily to sacral wound with dressing changes. (Prednisone and Aloe Vera are used to treat inflammation and itching.) Review of the electronic pharmacy prescription dated 8/18/16 revealed an order for Hydrocortisone 1% cream apply on the skin once daily with dressing changes.	D 358		

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D 358	Continued From page 172 Review of Resident #2's August 2016 electronic medication administration record (eMAR) revealed: -An entry for Hydrocortisone 1% cream apply to skin every day with dressing changes. -The entry was initialed as administered once daily at 8am 8/24/16 through 8/31/16. -There was no documentation the Hydrocortisone was administered 8/18/16 through 8/23/16. Resident #2's September 1 - 2, 2016 eMAR revealed: -An entry for Hydrocortisone 1% cream apply to skin every day with dressing changes. -The entry was initialed as administered once daily at 8am on 9/1/16 and 9/2/16. Telephone interview with the Pharmacist on 9/8/16 at 12:35pm revealed: -The pharmacy received the order for Hydrocortisone (Prednisone Aloe-Vera) cream on 8/18/16. -The pharmacy received a discontinue order for Hydrocortisone on 9/5/16. _____ Interview with a medication aide (MA) on 8/31/16 at 10:02am revealed: -Resident #2 had a cream applied to her buttocks twice daily. -The wording on the medication administration record for dressing change meant when her incontinence brief was changed. -The MAs were responsible for applying the ointment. Interview with the Nurse Practitioner (NP) on 9/8/16 at 11:35am revealed: -The NP spoke with the MA/Supervisor (name) specifically about changing the Ketoconazole to	D 358		

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D 358	Continued From page 173 Hydrocortisone ointment. -The NP put orders into the computer system and then faxed to facility. -Urgent orders were sent the same day and non-urgent orders were sent the next day. -Medication changes were sent directly to the pharmacy and the facility. -The NP checked in with the RCC on arrival and again before leaving the facility. -The NP communicated any plans or changes to orders prior to leaving the facility. Interview with the Resident Care Coordinator (RCC) on 8/31/16 at 2:55pm and 9/8/16 at 7:02pm revealed: -Hydrocortisone was the only ointment being administered to Resident #2. -The wording of dressing on the eMAR meant Resident #2's incontinence brief. -There was no system in place to review physician orders were accurately entered and followed up on. -The RCC had more access to orders on the Assisted Living (AL) side than in the Memory Care Unit (MCU). Interview with a medication aide (MA)/Supervisor on 9/7/16 at 5:00pm revealed: -The physician or NP faxed the order to the facility. -Facility staff faxed the order to the pharmacy. -One copy was given to the RCC and another copy was placed in the resident's record. -Orders were received from the physician/NP within a day or 2 following the physician/NP visit to the facility. -The only orders received the same day were orders the staff wrote down and asked the physician/NP to sign.	D 358		

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D 358	Continued From page 174 Telephone interview with the Pharmacist on 9/8/16 at 12:35pm revealed: -The pharmacy normally received orders by fax from the facility. -The physician would send electronic prescriptions directly to the pharmacy. -The pharmacy would provide a copy of electronic prescriptions to the facility when they filled the medication. Interview with the Administrator on 9/9/16 at 12:55pm revealed: -MAs were expected to process physician orders each day. -The RCC was responsible for checking all orders from the previous day. -Sometimes the orders went from the MA to the Supervisor then to the RCC. -Once per month a medication audit was conducted by the corporate nurses on a sample of residents. -The audit had been completed once or twice since June 2016. -Any findings were discussed with the Administrator.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to notify the county department of social sevices of incidents requiring referral for emergency medical evaluation for 5 of 10 sampled residents (#3, 5, 6, 9 and 15).

The findings are:

1. Review of Resident #9's FL-2 dated 12/23/15 revealed:
- Diagnoses included dementia and insomnia.
- The resident was intermittently disoriented and required a wheelchair for ambulation.

Confidential staff interview revealed:
- About 6 months ago (did not remember date), Resident #9 was observed in bed for several days screaming for help/complaining of pain.
- No one at the facility helped her for 2-3 days.
- The resident was sent to the hospital and passed away.
- The resident had fallen out of her wheelchair and was not taken to the hospital to be checked.

Interview with a family member on 9/2/16 at 12:20pm revealed:
- On 2/24/16, the resident was sitting in her wheel chair in the front TV room and the staff was not watching her.
- The resident "supposedly" fell from her wheelchair (in the morning) and was found on the floor by staff.
- The resident care coordinator (RCC) performed range of motion to extremities. The resident was put back in her wheelchair by staff and was taken to lunch.
- The facility contacted the family member later in the evening (around 6:00pm) and informed her the resident was complaining of arm pain.

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- X-rays were taken that night (2/24/16) at the facility and the resident was transported to the local hospital the next morning and diagnosed with a fractured elbow on 2/25/16.
- On 2/27/16, the resident was transported an out of county hospital due to complaint of severe pain and was diagnosed with multiple fractures. The resident was discharge home on 3/2/16 and passed away 3 days later at home.
- After the resident had passed away, the family went to the facility and asked for a copy of the accident report and a copy of the progress notes concerning the resident's fall, but was told by a staff member (family member did not know staff's name) someone removed the notes and the accident report.

Interview with 1st shift Supervisor (assisted living unit), on 9/7/16 at 3:10pm revealed:
- On 2/24/16, before lunch, Resident #9 was sitting in the front TV room and another resident yelled to staff, the resident was on the floor.
- The resident was found on the floor against a recliner.
- The resident stated she was trying to transfer self from the recliner to wheelchair without assistance.
- The facility's Resident Care Coordinator checked the resident and the resident was picked up from the floor and placed in the wheelchair.
- The personal care staff reported the resident continuously complained of pain when they moved her and would holler out in pain when they tried to get her out of bed.
- The resident's family member was at the facility 3 days later and was concerned about the resident's severe pain.
- The family member insisted the facility transfer the resident to the local hospital for evaluation.
- The resident passed away in an out of county

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hospital a few days later.
- A incident report was completed by the RCC and documentation was done in progress notes but all documentation concerning the fall and the resident's complaint of pain was removed from the resident's record after the resident was hospitalized.

Interview with the RCC on 9/1/16 at 11:45am revealed:
- She did not remember Resident #9's fall in February 2016.
- She did not know what happened to the documentation regarding a fall, including incident report and progress notes.

Interview with the facility's former Administrator on 9/7/16 revealed:
- There should be documentation of any accidents, follow-ups and assessments in the resident's records.
- Any accidents which require the resident to be sent to the ER should be reported to the county department of social services.

Refer to interview with a personal care aide (PCA) on 9/2/16 at 8:45am.

Refer to interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm.

Refer to interview with the Administrator on 9/2/16 at 9:02am.

Refer to interview with the Administrator on 9/9/16 at 12:55pm.

2. Review of Resident #15's FL-2 dated 4/14/16 revealed diagnoses included Alzheimer's Dementia without Behaviors, Hypertension, Atrial

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D 451	Continued From page 178 Fibrillation, Dysphagia and Osteoarthritis. Telephone interview with a family member of Resident #15 on 9/6/16 at 4:01pm revealed: -The family member visited daily to apply a dressing to Resident #15's right arm. -On Sunday 5/29/16 the family member observed that Resident #15 was not her usual self and knew something was not right. -There was something wrong with her neck. -On Monday 5/30/16 the family member visited and observed that Resident #15 was in so much pain she could not be touched. -The family member called Emergency Medical Services (EMS) for Resident #15 to be evaluated at the Emergency Room (ER). -At the ER, the family member found that Resident #15 had bandages to her left arm and shoulder and Resident #15 was "all bruised up." -The family member asked facility staff what happened and no one knew anything. -The family member asked for an incident report and there was none. -The facility never reported to the family member what happened to Resident #15. -The family member felt that someone at the facility knew what happened because someone applied the bandages to Resident #15's left arm. Telephone interview with the physician on 9/9/16 at 11:45am revealed: -Resident #15 presented for her appointments with the physician with bruises on her face and body. -The bruises were "reportedly from falls." -The physician had concerns about the bruises and how the resident obtained them. -Resident #15's last physician's office visit was on 5/5/16. -Notification of the neck fracture came from the	D 451		

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D 451	Continued From page 179 hospital on 6/2/16. Review of hospital record for Resident #15 revealed: -Resident #15 presented to the ER on 5/30/16 with family members who were concerned she may have fell the night of 5/29/16. -Resident #15 complained of neck pain the evening of 5/29/16 and the morning of 5/30/16. -ER staff removed a bandage from Resident #15's left elbow and noted black and green discharge from 2 skin tears and deformity to the elbow. -ER staff documented Resident #15 had tenderness to the left elbow and was reluctant to move it. -ER staff documented abrasions to both of Resident #15's upper extremities and a yellow green bruise on the right buttock. -Final diagnoses was documented as Compression Fractures of the C-Spine and Thoracic Vertebrae. Telephone interview with a Medication Aide (MA)/Supervisor on 9/7/16 at 3:03pm revealed: -Resident #15 should not have been at the facility. -Resident #15 was falling within the first couple of days after she was admitted to the facility. -Resident #15 needed skilled nursing care. -Resident #15 required 2 staff to assist with getting out of the bed, transferring and bathing. -The MA was not sure of the dates of the falls. -The MA worked 3rd shift and Resident #15 would always be in the bed during the MA shift. Review of Nursing Assistant Notes dated from 4/6/16 through 6/6/16 revealed: -There were 2 entries documenting falls for Resident #15.	D 451		

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-On 4/11/16 at 6:45pm the resident was found sitting on the floor at the foot of her bed.
-On 5/23/16 the resident fell backwards on the toilet while being assisted by staff.
-On 5/24/16 for the 7am - 3pm shift a PCA noted a family member requested assistance with incontinence care for the resident.
-The PCA asked the family member to give staff a second because staff was assisting another resident.
-When the PCA returned, she heard the family member telling other family members staff would not change the resident.
-The PCA reported the incidient to the Supervisor on duty.
-On 5/30/16 for the 3pm - 11pm shift the resident returned from the ER with a fracture to her neck.
-On 5/31/16 for the 3pm - 11pm the resident had a good day.
-On 6/1/16 for the 3pm - 11pm shift the resident was out of the facility at the hospital.
-A second entry dated for 6/1/16 noted as a late entry documenting Resident #15 was sent out at the request of her Power of Attorney (POA).

Review of the facility's incident reports revealed:
-There were 2 incident reports for Resident #15.
-On 4/11/16 at 6:45am the resident was found on the floor at the foot of her bed.
-On 5/23/16 at 1:00pm the resident fell back on the toilet injurying her right arm.
-There was no incident report dated for 5/28/16, 5/29/16, 5/30/16 or 5/31/16 for Resident #15.

Review of Resident #15's record revealed there was no documentation of an incident, accident or observed injury for Resident #15 on 5/28/16, 5/29/16, 5/30/16 or 5/31/16.

Telephone interview with the Resident Care

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D 451	Continued From page 181 Coordinator (RCC) on 9/8/16 at 7:02pm revealed: -The family of Resident #15 reported to the RCC that Resident #15's neck was in an awkward position. -An incident report was completed and sent to the Risk Management RN and the Department of Social Services. Interview with the Adult Home Specialist (AHS) from the County Department of Social Services (DSS) on 9/6/16 at 6:00pm revealed the AHS had not received an incident report for Resident #15 dated 5/29/16, 5/30/16/ 5/31/16 or 6/1/16. Refer to interview with a personal care aide (PCA) on 9/2/16 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm. Refer to interview with the former Administrator on 9/2/16 at 9:02am. Refer to interview with the former Administrator on 9/9/16 at 12:55pm. 3. Review of Resident #5's FL-2 dated 12/16/15 revealed diagnoses included Vascular Dementia, Hyperlipidemia, Sub secular Mass/Brain Tumor, Type II Diabetes Mellitus, Arthritis, Cataracts, Constipation, Dry Skin, Diabetic Retinopathy, Alcohol Dependence and Schizoaffective Disorder. Review of Nursing Assistant Notes dated 1/6/16 for Resident #5 revealed: -Resident #5 was assisted to sit on the edge of the bed by the Personal Care Aide (PCA). -Resident #5 fell off the bed and hit her head on the side of the night stand.	D 451		

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D 451	Continued From page 182 -Resident #5 had a laceration on the top of her left eye. The staff that documented the incident was no longer available for interview. Review of Nursing Assistant Notes dated 7/10/16 for Resident #5 revealed: -Resident #5 had a knot on the left eye. -The knot was black and blue. -The Medication Aide was notified about the knot. Interview with the Personal Care Aide (PCA) on 9/2/16 at 8:52am revealed: -The PCA had documented what she saw on Resident #5. -No fall had been reported to the PCA. -The PCA reported the knot on Resident #5 to the Medication Aide (MA) on duty. -The PCA could not remember who the MA was that she reported to. Review of the facility's incident reports revealed there was no incident report dated 1/6/16 or 7/10/16 for Resident #5. Interview with the Adult Home Specialist (AHS) from the County Department of Social Services (DSS) on 9/6/16 at 6:00pm revealed the AHS had not received an incident report for Resident #5 dated for 1/6/16 or 7/10/16. Refer to interview with a personal care aide (PCA) on 9/2/16 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm. Refer to interview with the former Administrator on 9/2/16 at 9:02am.	D 451		

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D 451	Continued From page 183 Refer to interview with the former Administrator on 9/9/16 at 12:55pm. 4. Review of Resident #3's current FL-2 dated 07/18/16 revealed: -The resident's diagnoses included Alzheimer's dementia, epilepsy, hypertension, hypothyroidism, and constipation. -The resident was constantly disoriented and wandered. -The resident was semi-ambulatory with wheelchair and incontinent of bowel and bladder. -The resident required assistance with bathing, dressing, and feeding. Review of the family intervention discussion agreement for Resident #3 signed and dated 05/26/11 revealed the resident was not noted to be at risk for falls or to have a history of falls. Review of Resident #3's current assessment and care plan dated 09/02/15 revealed: -The resident had significant memory loss and was disoriented at all times. -The resident was ambulatory but her gait was very unsteady and the resident was a fall risk. -The resident required extensive assistance with mobility, ambulation and transfers. Review of the special care unit progressive profile for Resident #3 revealed: -On 09/15/15, the resident was noted to ambulate unassisted at time and to fall frequently. -On 08/11/16, the resident was noted to require a device for ambulation and assistance with ambulation. Review of an emergency medical services (EMS) report dated 01/05/16 for Resident #3 revealed:	D 451		

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-The dispatch call was received at 9:30 a.m. and EMS arrived on scene at the resident at 9:37 a.m.
-The resident was lying prone on the floor beside her bed with blood under her head.
-The resident was alert but did not speak which was normal for her per facility staff.
-Facility staff stated they did not know how long she had been on the floor or if she had lost consciousness.
-The chief complaint was hematoma with laceration on head from fall from bed.
-The resident had a small ½ inch laceration on the top right of her head with bleeding and mild swelling at the site.
-The resident was transported to the hospital.

Review of facility progress notes for Resident #3 revealed:
-08/12/16 (9:00 a.m.): The resident was sitting at the dining room table in her wheelchair. The medication aide heard "a thump" and saw the resident laying on the floor on her right side. A quarter size bump started to form in the middle of her forehead.
-The medication aide contacted hospice nurse who will come to the facility to see the resident.
-The family and the Resident Care Coordinator (RCC) were notified.

Review of Resident #3's incident/accident reports revealed no documentation of an incident/accident report for either fall on 01/05/16 or 08/12/16.

Interview with the former Interim / Acting Administrator on 09/02/16 at 9:05 a.m. revealed:
-When an incident / accident report was completed by facility staff, they were supposed to give it to the RCC and / or the Administrator.
-The reports then get forwarded to the corporate

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nurse to use as a quality assurance tool.
-If the corporate nurse noticed any significant concerns, the nurse would contact the facility for follow-up information.
-She could print a copy of the incident log sheet for all residents that was sent to the corporate nurse.
-If there was no record of an incident on the log sheet, then a report was not turned in.
-If there was a record of an incident listed on the log sheet, there was a report turned in at some point and there should be a copy on file at the facility.
-She was unsure why some incident reports were either not done or missing or why some reports were not sent to the local Department of Social Services (DSS).
-She could not locate the incident report for Resident #3 for the fall with ER visit on 01/05/16 but it was listed on the incident log sheet.
-She could not locate an incident report for Resident #3's fall on 01/05/16 or the fall on 08/12/16 and it was not listed on the incident log sheet.

Review of the incident log sheet for all residents from January 2016 - September 2016 revealed:
-On 01/05/16, Resident #3 was observed lying face down and there was blood on the floor.
-The resident was not moved to prevent any further injury until EMS arrived.
-The resident was transported to the emergency room (ER) and returned with staples to her wound.
-There was no listing for the fall on 08/12/16.

Interview with the RCC on 09/02/16 at 11:26 a.m. revealed:
-Staff on duty usually wrote the incident reports and forwarded to the RCC.

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D 451	Continued From page 186 -The RCC reviewed and signed the reports, sent a copy to their corporate nurse, faxed to DSS, forwarded to the Administrator, and then the report was filed in the incident report notebook. -She remembered staff writing an incident / accident report for Resident #3's fall on 08/12/16. -She recalled staff wrote "goose egg" instead of "knot" and she asked staff to correct it. -She could not recall which staff wrote the incident report. -The RCC reviewed and signed the incident report and faxed it to DSS the next day. -The RCC gave the report to the Interim / Acting Administrator. -She did not have confirmation of faxing it to DSS. -She could not locate the report and did not know where it could be. -She had checked the incident report notebook and it was empty. -They usually kept incident reports for the last 2 years in that book. -She would check to see if the Interim / Acting Administrator had the reports. Interview with an Adult Home Specialist (AHS) for the local Department of Social Services (DSS) on 09/08/16 at 3:25 p.m. revealed DSS had not received incident reports for Resident #3's falls on 01/05/16 and 8/12/16. Refer to interview with a personal care aide (PCA) on 9/2/16 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm. Refer to interview with the former Administrator on 9/2/16 at 9:02am.	D 451		

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D 451	Continued From page 187 Refer to interview with the former Administrator on 9/9/16 at 12:55pm. 5. Review of Resident #6's most current FL-2 dated 07/11/16 revealed: -The resident's diagnoses included vascular dementia, anxiety disorder, insomnia, hypothyroidism, chronic kidney disease, dysphagia, and gastroesophageal reflux disease. -The resident was intermittently disoriented and wandered. -The resident was hard of hearing. -The resident was semi-ambulatory with wheelchair and incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of the family intervention discussion agreement for Resident #6 signed and dated 07/24/15 and 08/10/15 revealed: -The resident was at risk for falls. -There was no interventions checked off to minimize the resident's fall risk. Review of Resident #6's current assessment and care plan dated 08/12/15 revealed: -The resident non-ambulatory, had a wheelchair and staff were to assist. -The resident had limited range of motion in upper extremities. -The resident complained of pain and inability to stand up. -The resident required extensive assistance with toileting and ambulation (staff assisted with wheelchair). -The resident's ambulation was limited due to fall risk and unsteady gait. -The resident was always disoriented and had significant memory loss and must be redirected.	D 451		

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Review of the special care unit progressive profile for Resident #6 revealed:
-On 08/11/15, the resident was noted to have a history of falls.
-On 05/25/16 and 08/11/16, the resident was noted to fall frequently.

Review of facility progress notes for Resident #6 revealed:
-08/24/16 (11 - 7 shift): The resident was observed on the floor by her bed. The resident's right hip was turned outwards. Vital signs were unable to be taken. The family and physician were notified. Emergency Medical Services (EMS) was called and the resident was taken to the hospital.
-08/24/16 (1:00 p.m.): The nurse at the hospital called Resident Care Coordinator (RCC) regarding the resident. The resident was a candidate for surgery due to right broken leg. The RCC voiced that the resident transferred self from bed to chair and from chair to chair as nurse asked about ambulation.

Review of an EMS report dated 08/24/16 for Resident #6 revealed:
-The dispatch call was received at 4:40 a.m. and EMS arrived on scene at 4:45 a.m.
-The chief complaint was possible hip dislocation / fracture and the secondary complaint was a fall.
-No report or resident information was given to EMS staff upon arrival.
-EMS staff noted upon arrival to the facility, they found the resident in her room on the floor with the door closed and no staff with the resident.
-The resident had a right hip deformity with right leg shortened and rotated out.
-The resident had dementia but was oriented to person and place.
-The resident had pinpoint pupils and was not

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complaining of pain and wanted to sleep.
-It was unknown how long the resident had been on the floor or how much pain medication was given to the resident.
-After EMS staff got the resident on the stretcher, staff from the front of the facility brought paperwork for the resident.
-As EMS staff were leaving, they noticed a facility staff member sitting in the dayroom watching television.

Review of an incident / accident report for Resident #6 dated 08/24/16 at 5:00 a.m. revealed:
-The resident was found on the floor on her back in her room.
-Staff noted the resident leg was hurting.
-The part injured was documented as the right hip and right leg.
-The resident's blood pressure was 153/79 and her pulse was 81.
-The resident was sent to the emergency room (ER) and admitted to the hospital for broken right leg. Surgery was to be done.
-The area on the report to document when the report was faxed to DSS was blank.

Review of the incident log sheet for all residents from January 2016 - September 2016 revealed there was no entry for an incident report for Resident #6's fall on 08/24/16.

Telephone interview with a former medication aide (MA) in the MCU on 09/07/16 at 3:10 p.m. revealed:
-She had worked at the facility from March 2015 until 08/30/16.
-She was on duty as the MA in the MCU on third shift when Resident #6 fell.
-Staff heard the resident holler out and they found

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D 451	Continued From page 190 her on the floor. -The resident was lying on her back and her leg was straight forward but her knee was twisted. -The resident's wheelchair was facing the bed and it looked like the resident had tried to get up out of bed. -The resident had just been checked 30 minutes prior to this and the resident was lying in bed. -The MA filled out an incident report for the fall and faxed it to the PCP office and called the family. -The MA put the incident report in the RCC's folder behind the desk, -The RCC was supposed to handle the incident report from that point. -The MA did not know if the RCC faxed the report to the Department of Social Services (DSS). Interview with an Adult Home Specialist (AHS) for the local DSS on 09/08/16 at 3:25 p.m. revealed DSS had not received an incident report for Resident #6's fall on 08/24/16. Refer to interview with a personal care aide (PCA) on 9/2/16 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm. Refer to interview with the former Administrator on 9/2/16 at 9:02am. Refer to interview with the former Administrator on 9/9/16 at 12:55pm. _____ Interview with a personal care aide (PCA) on 9/2/16 at 8:45am revealed: -The medication aides (MA) were responsible for completing incident reports.	D 451		

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D 451	Continued From page 191 -If the PCA witnessed the incident, they would write down what they saw on the incident report. -The MA would then write what they saw and complete the form. Interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm revealed: -Staff were expected to document incidents on incident report forms and in the nursing assistant notes in the resident record. -The RCC was responsible to review all incident reports, sign off on any interventions, follow up as needed and then forward the incident report to the Administrator. -The Administrator would fax them to Risk Management and the Department of Social Services. -Faxing the incident reports fell back on the RCC after when the Administrators changed in June 2016. Interview with the former Administrator on 9/2/16 at 9:02am revealed: -Facility incident reports were sent to the Registered Nurse (RN) in charge of Risk Management at the headquarter offices. -The incident reports were entered into a computer system along with any intervention recommended by the Risk Management RN. -Incident reports were supposed to be sent to the county Department of Social Services at the same time they were sent to the Risk Management RN. Interview with the former Administrator on 9/9/16 at 12:55pm revealed: -Staff were expected to document all falls, complete an incident report and notify the family. -The RCC reviewed the incident reports to make sure everything was done.	D 451		

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D 451	Continued From page 192 -The RCC then faxed a copy of the incident report to the Department of Social Services and Risk Management and then gave the Administrator the incident report to review.	D 451		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure a care coordinator was on duty in the memory care unit (MCU) at least 8 hours a day, 5 days a week. The findings are: Review of the facility's current census on 08/30/16 revealed the census in the memory care unit (MCU) was 32 residents. Interview with the Interim / Acting Administrator on 08/30/16 at 10:15 a.m. revealed: -She was currently working as the Interim / Acting Administrator for the facility. -She started working at the facility on 06/20/16. -The facility was about to undergo a change of ownership effective 09/01/16. -The Memory Care Coordinator (MCC) position was currently vacant and had been vacant for	D 466		

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about 8 weeks.
-The previous MCC was a medication aide who was promoted to the position of MCC.
-The previous MCC stepped down from the position after 2 days about 8 weeks ago and started back as a medication aide.
-The Resident Care Coordinator (RCC) was currently covering both the assisted living side of the facility and the MCU.

Interview with the Resident Care Coordinator (RCC) on 08/31/16 at 10:48 a.m. revealed:
-She was the RCC and usually worked on the assisted living side of the facility.
-There was currently no MCC in the MCU so she was trying to help out on both sides of the facility.
-The previous MCC stepped down from the position at the end of June 2016 or the first part of July 2016.
-No one had instructed the RCC to work in the MCU.
-The RCC took it upon herself to help supervise in the MCU after the previous MCC stepped down.
-The RCC would go to the MCU periodically during the day at different times.
-The RCC was usually in the MCU for a total of at least 1 and ½ hours a day each day Monday through Friday.
-When she was in the MCU, the RCC was mingling with the residents and making sure staff were doing their duties and taking care of the residents.

Interview with the RCC on 08/31/16 at 11:20 a.m. revealed:
-She had been trying to work in the memory care unit (MCU) some since the MCC position was vacant.
-She felt like staff in the MCU did not

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communicate as much with the residents in the MCU unless there was some oversight or management overseeing the staff.

Interview with the Vice President of Quality Assurance and Regulatory Compliance with the new corporation on 08/31/16 at 3:15 p.m. revealed:
-She had just sent the RCC from the AL side to the MCU to work as the MCC until the new corporation could hire a new MCC.
-The RCC was currently in the MCU working as the MCC.

Observation on 08/31/16 at 3:15 p.m. in the MCU revealed the RCC from the AL side of the facility was in the nurses' station in the MCU.

Additional interview with the former Interim / Acting Administrator on 09/01/16 at 8:15 a.m. revealed:
-The RCC was supposed to be working in the MCU 8 hours a day as the MCC until they could hire someone new.
-The RCC did not stay in the MCU like she was supposed to.
-They put ads in the newspaper recruiting for the position of MCC.
-They had 2 in-house staff to apply but no other responses to the ad.
-They had not done any interviews for the position because their corporation had sold the facility and there was going to be new owners as of today, 09/01/16.
-The Administrator had forwarded the applications to the new corporation.

Interview with the current primary Nurse Practitioner (NP) on 09/01/16 at 2:30 p.m. revealed:

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D 466	Continued From page 195 -She first started seeing residents at the facility about 1 and ½ months ago. -She usually came to the facility twice a week to see residents. -She would not get as much feedback from the staff in the MCU because there was no one in charge in the MCU. Confidential interview with a family member revealed: -There had been a lot of staff turnover in the MCU. -Staff in the MCU had been working double shifts. -There was not supervisor /coordinator to go to with concerns in the MCU. -There was no supervision of the staff in the MCU. Confidential interview with a second family member revealed: -The family member visited the facility frequently, a few times a week in the MCU. -There had not been any staff in charge in the MCU for a while. -There had been a lot of staff turnover. -The family had talked with the RCC from the front of the facility over the phone but had never seen the RCC actually working in the MCU. Confidential interview with a third family member revealed: -He had difficulty communicating with the facility. -He never could get an answer about a fall that occurred with a resident. -It was very frustrating. -The facility changed Administrators " like some people change underwear". -He had a hard time trying to find who was in charge and no voice mail was available.	D 466		

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D 466	Continued From page 196 Interview with the RCC on 09/02/16 at 11:26 a.m. revealed: -She was not instructed by the Interim / Acting Administrator from the previous corporation to be the MCC while the position was vacant. -She continued to work up front in the assisted living side of the building as the RCC but she took it upon herself to go to the MCU and help out occasionally. Telephone interview with the nurse for a former primary care provider (PCP) on 09/07/16 at 11:45 a.m. revealed: -The facility transitioned to another primary practice for the residents during the first part of 2016. -For the last 2 to 3 months that they serviced the residents in the facility, there was no one in charge in the MCU. -There was no one supervising in the MCU. -The RCC from the assisted living side of the facility would come to the MCU sometimes but she was new and she was working mostly on the AL side of the facility. -There was a lack of communication about the residents in the MCU because no one was in charge and it was difficult to get information from staff. -She observed staff in the MCU being verbally hostile to the residents. -If a resident came up and asked staff for something, staff would tell the residents to sit down in a loud, harsh tone. Telephone interview with a physician from a former primary care provider group with the facility on 09/08/16 at 12:15 p.m. revealed: -He provided services for some residents at the facility for about 2 years. -He usually went to the facility every Wednesday	D 466		

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D 466	Continued From page 197 until the facility cut down on the number of residents he was providing services to. -The facility eventually cut him down to 3 residents in the MCU and he was no longer able to continue to travel that far for a small number of residents and the facility staff was disrespectful to him and his staff. -He stopped servicing the facility around the first part of 2016. -There was a different staff in the MCU every 2 weeks. -There was no one in charge in the MCU. -Staff in the MCU would not report issues or concerns about the residents. Interview with a psychiatric NP on 09/08/16 at 3:50 p.m. revealed: -She made visits to the facility at least every other week to see some of the residents. -She had observed residents in the MCU were sometimes wet, soiled, and had dirty clothing. -Residents in the MCU would be screaming and yelling and staff would do nothing. -One of the previous MCC did not like her providers' group and would refuse to give reports about the residents to them. -When that MCC left the facility, they got another MCC that seemed to be very receptive. -Once that MCC left the facility, the RCC was supposed to supervise the MCU as well as the assisted living side of the facility. -The RCC was not usually in the MCU when the NP visited. -There was not a lot of supervision in the MCU. -Residents that were unsteady walking would get up and walk and there was no staff around to supervise them. -There had been many falls at the facility. -The NP would hold onto some of the unsteady residents herself.	D 466		

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-The medication aide in the mornings in the MCU would be very stressed out and the MA was always yelling.

Interview with the Interim / Acting Administrator on 8/30/16 at 10:25am revealed:
-The acting Administrator had been covering at the facility since 6/20/16.
-The Resident Care Coordinator (RCC) for the Assisted Living covered the Memory Care Unit.
-The last Memory Care Coordinator (MCC) stepped down and was working as a Medication Aide on the 2nd shift.
-The MCC position had been vacant for approximately 8 weeks.

Interview with the former MCC on 8/30/16 at 5:40pm revealed:
-The former MCC worked as the MCC for approximately 2 weeks.
-He returned to working as a medication aide where he felt more comfortable.
-The MCC position has remained unfilled for approximately 2 months.
-The RCC from the AL side covered the MCU.
-The RCC would come to MCU periodically during the day to check on things and check resident charts.

Interview with the Resident Care Coordinator (RCC) on 9/2/16 at 3:29pm revealed:
-The RCC started working at the facility 12/7/15 as the RCC on the Assisted Living side.

Telephone interview with the RCC on 9/8/16 at 7:02pm revealed:
-There were communication issues from AL to MCU and the RCC.
-The RCC covered 4 hours each day in the MCU and the Supervisor in Charge from AL would

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cover the remaining 4 hours in the MCU.
-The coverage for the MCU was put into place when the current Administrator started 6/20/16.
-The facility did not have an Administrator for a month and half in February and March 2016 and again for nearly a month in June 2016.
-The absence was covered by fill-in Administrators from other facilities and the Regional Director would "pop in twice a week for like 3 hours."
-The RCC would report to whomever was covering at the facility or contacted the Regional Director by phone.
-There was no management consistency.

Confidential staff interview revealed:
-MCU staff reported issues and concerns to the RCC.
-The RCC was supposed to be covering as the MCC also.
-The RCC would go the MCU and look around but did not stay long.

Interview with a personal care aide (PCA) on 9/1/16 at 5:42am revealed any concerns or issues were brought to the RCC when she came in.

Interview with a second PCA on 9/1/16 at 6:32am revealed any issues or concerns were reported to the MA on duty in the MCU or to the MA on duty on the AL side.

Interview with a medication aide (MA) on 9/1/16 at 7:53am revealed the MA reported any concerns or issues to the Supervisor in Charge (SIC) on duty.

Telephone interview with a MA on 9/8/16 at 7:40pm revealed:

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D 466	Continued From page 200 -The MA reported to the RCC "up front [AL]." -The RCC tried to take care of any issues. -There was no real Administrator because the covering Administrator was just covering from the corporate office. Telephone interview with a family member on 9/6/16 at 4:57pm revealed: -Staff would not tell the family much. -Staff would tell the family member to go up front [Assisted Living] and talk to the RCC. -Most of the time the RCC would try and take care of any concerns. Interview with the former former Administrator on 9/9/16 at 12:55pm revealed: -The RCC was directed to be in the MCU 4 hours per day. -The Supervisor from the AL side covered the remaining 4 hours each day. -The Administrator would have to redirect the RCC to actually stay in the MCU for the entire 4 hours each day. -The Administrator was aware that prior to her arrival there were covering Administrators for a few days per week. -The Administrator was not aware of what happened in the facility in February and March 2016. _____ Review of the facility's Plan of Protection dated 9/9/16 revealed: - The new management company assumed responsibilty for daily operations on 9/1/16. - Qualified memory care manager assigned by licensee on 9/1/16. - New licensee has assined an experienced memory care manager to manage memory care unit 8 hours per day/5 days per week at a	D 466		

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D 466	Continued From page 201 minimal. - New licensee will recruit permanent memory care manager and maintain required coverage until permanent manager is hired and trained. - Executive Director will ensure a qualified memory care manager is on duty as required per rules and monitor daily. - Support team will assist with on-site monitoring to assure required coverage when cobducting routine onsite monitoring. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2016.	D 466		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision	D 468		

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D 468	Continued From page 202 within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 4 of 8 sampled staff (A, E, F, G) who were responsible for personal care and supervision within the special care unit completed 6 hours of orientation within the first week of employment and 2 of 8 sampled staff (A, E) completed 20 hours of training specific to the population being served within 6 months of employment. The findings are: 1.Review of Staff A's personnel file revealed: -Staff A was hired on 03/02/15 as a medication aide. -Staff A received the 6 hours of special care unit (SCU) orientation training on 04/08/15, more than 1 week after hire. -There was no documentation of the 20 hour SCU training completed for Staff A. -There was no documentation of any additional SCU training specific to the population provided for Staff A. Refer to interview with the former Interim / Acting Administrator on 09/07/16 at 11:23 a.m.	D 468		

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D 468	Continued From page 203 2. Review of Staff E's personnel file revealed: -Staff E was hired on 09/21/15 as a personal care aide. -There was no documentation of the 6 hour SCU orientation training within the first week of employment. -There was no documentation of the 20 hour SCU training specific to the population completed for Staff E. -There was no documentation of any additional SCU training specific to the population provided for Staff E. Refer to interview with the former Interim / Acting Administrator on 09/07/16 at 11:23 a.m. 3. Review of Staff F's personnel file revealed: -Staff F was hired on 02/24/16 as a medication technician. -There was no documentation of the 6 hour SCU orientation training within the first week of employment. -Staff F completed the 20 hour SCU training on 07/21/16. Interview with Staff F on 09/08/16 at 2:43 p.m. revealed: -Staff F had received many trainings since being hired at the facility on 02/24/16. -Staff F was unable to indicate if the trainings consisted of the 6 hour SCU orientation training and 20 hour SCU trainings. Refer to interview with the former Interim / Acting Administrator on 09/07/16 at 11:23 a.m. 4. Review of Staff G's personnel file revealed: -Staff G was hired on 12/07/15 as the resident care coordinator. -There was no documentation of the 6 hour SCU	D 468		

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D 468	Continued From page 204 orientation training within the first week of employment. -Staff G completed the 20 hour SCU training on 07/21/16. Refer to interview with the former Interim / Acting Administrator on 09/07/16 at 11:23 a.m. _____ Interview with the former Interim / Acting Administrator on 09/07/16 at 11:23 a.m. revealed: -She was not aware that the 6 hour and 20 hour SCU training had not been completed. -There was a different Administrator at the facility when Staff A, E, F and G were hired.	D 468		
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 recieved care and services which were adequate, appropriate, and in compliance with relavent federal and state laws and rules and regulations regarding assuring a care coordinator was on duty in the memory care unit at least 8 hours a day, 5 days a week. The findings are: Based on observations and interviews, the facility	D912		

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D912	Continued From page 205 failed to assure a care coordinator was on duty in the memory care unit (MCU) at least 8 hours a day, 5 days a week. [Refer to Tag 0466, 10A NCAC 13F .1308 Special Care Unit Staffing (Type B Violation).]	D912		
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 observations, interviews and record reviews, the facility neglected to provide care based on the resident's assessed needs. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure all care and services were provided by management to residents in accordance with all applicable local, state, and federal regulations and codes. [Refer to Tag 183, 10A NCAC 13F .0603(a) Management of Facilitites with Capacity or Census of 81 or Greater Residents (Type A1 Violation).] 2.Based on observations, interviews and record reviews, the facility failed to provide personal care assistance with transferring, ambulation, toileting, bathing and mouth care for 6 of 15 sampled residents (#1, #2, #4, #5, #11 and #15) resulting in a resident found with partially dried feces in her mouth, a high volume of unwitnessed falls in resident bathrooms and bedrooms with related injuries (broken bones, lacerations and hematomas), skin breakdown and residents with	D914		

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D914	Continued From page 206 body odor, dirty nails and unclean clothing for several days at a time. [Refer to Tag 0269, 10A NCAC 13F 0901(a) Personal Care and Supervision (Type A1 Violation).] 3. Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 6 of 15 sampled residents resulting in 6 residents having numerous repeated falls resulting in serious physical injuries such as head lacerations, hematomas and broken hip, leg, arm and spine bones (#2, #3, #5, #6, #12 and #13). [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 4. Based on observations, interviews, and record reviews, the facility did not meet the health care needs of 9 of 15 residents sampled (#1, #2, #3, #5, #6, #9, #11, #13, #15) as related to the facility failed to notify the primary care provider (PCP) of falls with head injuries, obtain a hospital bed with rails, repair or replace a broken wheelchair and notify hospice of the broken wheelchair for a resident who had multiple falls with head injuries (#3); failed to follow up with the PCP for a leg wound requiring stitches resulting in a hospitalization for cellulitis due to the stitches not being removed over 6 weeks after the stitches were placed (#6); failed to make a dermatology appointment for a resident with severely dry skin on legs and feet resulting in open leg wounds and a foul odor and failed to notify the psychiatric care provider of a resident's continued behaviors of verbal and physical aggression toward other residents (#11); failed to follow up with a medical provider for a resident with mental status changes (#1); failed to follow up with a medical provider for 3 residents with symptoms of pain, bruises and hematomas and from an injury after a fall (#5, #9	D914		

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D914	Continued From page 207 and #15); failed to contact a medical provider within a reasonable time for skin breakdown on 2 residents (#2 and #15); failed to notify a medical provider of a worsening ankle wound infection resulting in hospital admission for sepsis for a resident (#13); failed to follow up on referrals for skilled nursing care and home health services for 2 residents (#2 and #5); failed to follow up on orders for urinalysis for 2 residents (#5 and #13); and failed to administer prescribed laxatives for a resident (#15) resulting in fecal impaction. [Refer to Tag 0273, 10A NCAC 13F 0902(b) Health Care (Type A1 Violation).]	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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D935	Continued From page 208 (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 3 of 4 medication aides (A, F, G) sampled who administered medications in the facility and were hired after 10/01/13 had completed the 5 hour, 10 hour, or the 15 hour state approved medication administration courses as required. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired on 03/02/15 as a medication aide. -Staff A completed the medication aide clinical skills checklist on 03/24/15. -Staff A passed the written medication aide exam	D935		

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	HAL051036	A. BUILDING: _____ B. WING _____	R 09/09/2016

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D935	Continued From page 209 on 02/03/11. -There was no medication aide employment verification for Staff A. -There was no documentation of the 5 hour, 10 hour, or 15 hour state approved medication administration courses for Staff A. Review of August 2016 medication administration record revealed Staff A administered medications at least 17 out of 31 days from 08/01/16 - 08/31/16. Refer to interview with the former Interim / Acting Administrator on 09/08/16 at 3:10 p.m. 2. Review of Staff F's personnel file revealed: -Staff F was hired on 2/24/16 as a medication aide. -Staff F completed the medication aide clinical skills checklist on 3/10/16. -Staff F passed the written medication aide exam on 7/22/03. -There was no medication employment verification for Staff F. -There was no documentation of the 5 hour, 10 hour or 15 hour state approved medication administration courses for Staff F. Review of August 2016 medication administration record revealed Staff F administered medication at least 18 out of 31 days from 08/01/16 - 08/31/16. Refer to interview with the former Interim / Acting Administrator on 09/08/16 at 3:10 p.m. 3. Review of Staff G's personnel file revealed: -Staff G was hired on 12/07/15 as a resident care coordinator. -Staff G completed the medication aide clinical	D935		

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D935	Continued From page 210 skills checklist on 08/18/16. -Staff G passed the written medication aide exam on 04/02/08. -There was no medication employment verification for Staff G. -There was no documentation of the 5 hour, 10 hour, or 15 hour state approved medication administration courses for Staff G. Review of August 2016 medication administration record revealed Staff G administered medications on 08/23/16 and 08/24/16. Refer to interview with the former Interim / Acting Administrator on 09/08/16 at 3:10 p.m. _____ Interview with the former Interim / Acting Administrator on 09/08/16 at 3:10 p.m. revealed: -Staff A, F, and G had not completed the 5 hour, 10 hour, or 15 hour medication aide state approved course. -She thought all of the medication aides had the medication aide employment verification forms on file which would exempt them from needing the 5 hour, 10 hour, or 15 hour training. -She did not realize there were no verification forms on file for Staff A, F, and G.	D935		
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	D992		

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D992	Continued From page 211 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 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 assure examination and screening for the presence of controlled substances were performed for 2 of 8 staff (C, E) who were hired after 10/01/13. The findings are:	D992		

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D992	Continued From page 212 1. Review of Staff C's record revealed: -Staff C was hired on 09/21/15. -Staff C was hired as an interim memory care coordinator. -There was a urine preliminary drug screening result form dated 09/21/15 by the Administrator, but there was no documentation of results. Refer to interview with former Interim / Acting Administrator on 09/07/16 at 2:45 p.m. 2. Review of Staff E's record revealed: -Staff E was hired on 09/21/15. -Staff E was hired as a personal care aide. -There was a urine preliminary drug screening result form dated 09/21/15 by the Administrator, but there was no documentation of results. Interview with former Interim / Acting Administrator on 09/07/16 at 2:45 p.m. revealed: -She was not sure why the results of the urine screening were not noted. -The Administrator and a witness were supposed to review the results together and document them on the form.	D992		