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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 12/20/16, 12/21/16 and 12/22/16.	D 000		
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 supervision for 1 of 5 sampled residents (Residents #1) who required assistance with transfers, and ambulation, with frequent falls in accordance with the residents' assessed needs and current symptoms which resulted in injuries including a fractured hip, fractured phalanges and a shoulder dislocation. The findings are: Review of Resident #1's current FL2 dated 2/01/16 revealed: -Diagnoses included dizziness, arthritis, supraventricular tachycardia, spinal stenosis of the lumbar, dementia, osteoporosis, and atrial fibrillation. -Ambulation status indicated Resident #1 is ambulatory. -There was no documentation about Resident's	D 270		

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D 270	Continued From page 1 #1 mental, cognitive or adult daily living activities status. Review of Resident #1's care plan dated 10/21/16 revealed: -Resident #1 was "alert and oriented, however some short term memory loss is noted". -The resident does not require bathroom assistance. -The resident was at risk for falling and had fallen in the past 12 months with emergency treatment/assessment. -The resident was independent going to and from the dining room or community activities. -Resident #1 is "very independent-minded" who does not always want to call for or to accept help. -Encourage the use of hip protectors, furniture corner protectors, scoop mattress, bedside fall cushion, and a high rise toilet seat. -The resident used a walker and a manual wheelchair as mobility aid devices. -The interventions to be implemented as of 10/21/16 included, to consider the involvement of the physician regarding changes and observations, labs and medication review, to encourage program participation as a means to increase observation, to encourage the resident to call for assistance with transfers, to use a gait belt with transfers, safety rounds routinely during the day and night and a personal alarm pendant. -The personal alarm was put into place in January 2016. -There was no documentation that the other documented interventions or increased supervision were implemented. Review of Resident #1's History and Physical/Progress Note dated 11/15/16 revealed after a review of systems, Resident #1 has weakness, depression, forgetfulness, and	D 270		

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D 270	Continued From page 2 dementia. Observation during the initial tour on 12/20/16 at 9:00 am revealed: -Resident #1 was sitting in the dining room, in her wheelchair, wearing a hospital gown visiting with her Power of Attorney (POA). -There was a large lump above her left eye and her left eye was swollen shut. -The left side of Resident #1's head had blood in her hair. Interview on 12/20/16 at 9:00 am with Resident #1 revealed: -She fell earlier this morning on 12/20/16. -She could not recall how she fell, but she was getting out of bed and going to the bathroom. -She was found on the floor by a Medication Aide (MA). -She complained of pain in her left wrist, left hip and the left side of her head. -She was sent to the emergency room to be checked out. Interview on 12/20/16 at 9:00 am with Resident #1's POA revealed: -He was called around 6:00 am this morning (12/20/16) and was told the resident had fallen and was being transported to the hospital. -He met Resident #1 at the hospital and was told that she had a head injury, contusion to the head, left hip and left wrist injury and nothing was broken. -Resident #1 had fallen more than "17 times this year alone and more than 14 times last year". -He was made aware of all Resident #1's previous falls by the facility. -Resident #1's falls have resulted in a broken hip, a fractured pelvis and injuries to her body. -He bought an alarm in January, for Resident #1	D 270		

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to wear around her neck to make it easier for her to get help when needed.

Review of Resident #1's Incident Reports revealed:
-Resident #1 had 18 falls between 01/05/16 and 12/20/16 with injuries including a fractured pelvis, head injury, broken toe, and arm injury.
-All falls documented were related to Resident #1 trying to perform activities of daily life without assistance.
-On 04/25/16, an unwitnessed fall in bathroom, from "missing toilet seat".
-On 05/16/16 an unwitnessed fall, which resulted in a fractured pelvis, from "resident was getting out of bed".
-A fall dated 9/24/16 at 5:30 am resulted from Resident #1 "misjudging where the toilet was".
-A fall dated 10/19/16 at 7:48 am resulted from Resident "walking to breakfast by self with walker".
-A fall dated 11/16/16 at 2:40 pm resulted from Resident #1 "missing a chair on the front porch".
-A fall dated 12/20/16 at 6:00 am resulted from Resident #1 "attempting to go to bathroom by self".

Review of Resident #1's Nursing Notes revealed:
-There was no documentation by staff of increased supervision more frequent than the routine 2 hour checks.
-Physical Therapy (PT) and Occupation Therapy (OT) were documented as implemented starting on 4/26/16 and off and on through 09/12/16.
-PT was started due to the fractured pelvis and discontinued due to completing the goal set by the Physical Therapist.

Review of Resident #1's Licensed Health Professional Support (LHPS) review dated

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12/09/16 revealed:
-The resident was alert and oriented, and had some short term memory loss/forgetfulness.
-The resident was a fall risk and had numerous falls.
-The resident wore a personal call bell pendant for emergencies.
-The resident required "a lot of encouragement to call for assistance and required assistance with Activities of Daily Living" .
-The resident had stress incontinence.
-The only LHPS task documented for Resident #1 was the application and removal of compression stockings.

Interview on 12/20/16 at 2:41 pm with a first shift Medication Aide (MA) revealed:
-She had been employed for 6 years as a MA, and "normally" worked on Resident #1's hall.
-She received verbal report from the third shift MA about Resident #1 falling around 6:00 am on 12/20/16.
-Resident #1 returned from the Emergency Room around 9:00 am on 12/20/16.
-Resident #1 was "notorious for not asking for assistance, "and would" forget to ask" and all of the falls she knew about were because Resident #1 did not ask for assistance.
-She reminded Resident #1 every day to call for help in getting out of bed, chair, and wheelchair, and when she needed to go to the rest room.
-The fall policy stated that "we are to check on the resident every 30 minutes for 24 hours after fall, then every hour for 24 hours and then back to every 2 hours after that."
-Resident #1 was to be checked on every 30 minutes since her fall on 12/20/16 and her record was placed into the "hotbox" to remind other MAs about her fall and increased checks.
-There was no documentation on the post fall

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D 270	Continued From page 5 checks. Interview on 12/21/16 at 10:51 am with a second first shift MA revealed: -She rarely worked on Resident #1's hall. -During the Stand Up meeting, this morning, (12/21/16) at 10:00 am, the Health and Wellness Director (HWD) asked us to implement Resident #1 receiving "extra rounds" and to be "escorted to meals by wheelchair" by staff because of falls. -Resident #1 got checked on every hour since her fall on 12/20/16. -After every fall, a resident would be followed up on for 72 hours and monitored. The fall policy states that "we are to check on the resident every 30 minutes for 24 hours after fall, then every hour for 24 hours and then back to every 2 hours after that." -There was no documentation on those "extra rounds, or every 30 minute, 1 hour checks, we just check on her". -Most of Resident #1's falls were in her room trying to do things in her room by herself (i.e. getting out of bed, going to the bathroom, etc.). -Floor mats, bed alarms and chair alarms were only used in the Special Care Unit. -Resident #1's record was in the "hotbox" area and at 10:00 am and 4:00 pm staff attended a "stand-up" to discuss falls and concerns about residents. -The hotbox was where all records were kept for residents who required a closer look due to falls, medication changes or change in status. They were removed from the hotbox after 3 days. -She was not aware of any other falls pertaining to Resident #1. -After every fall, the resident was assessed and sent to the hospital for evaluation if needed. An incident report was filled out and given to HWD for review and new care plan completed.	D 270		

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D 270	Continued From page 6 Interview on 12/21/16 at 9:30 am with a first shift Personal Care Aide (PCA) revealed: -She had worked at the facility for 8 years and was primarily on Resident #1's hall. -She assisted Resident #1 with getting up in the morning and helped her get dressed. -Resident #1 "usually" used a walker to help with ambulation but it had to be removed because the resident would try to ambulate without assistance and fell. -She checked on Resident #1 any time she went by the room. -Resident #1 was "unsteady" and required assistance with transfers". Resident #1 liked to stay in her room all of the time unless she was eating. Interview on 12/21/16 at 9:45 am with a second first shift PCA revealed: -She got Resident #1 up this morning and Resident #1 complained of dizziness. -She reported the dizziness to the first shift MA. -She took Resident #1 to breakfast in her wheelchair and then brought her back to her room after breakfast, "She liked to stay in her room a lot". -She did 2 hour checks on every resident on the Assisted Living Unit which was the facility's standard policy. -Resident #1 was monitored every hour because of her fall yesterday 12/20/16. -The staff was told to "take" Resident #1's bedside commode and wheelchair away from her to "make her call for assistance" back when she broke her hip (05/15/16). Observation on 12/20/16 at 10:30 am of Resident#1's room and location revealed: -Resident #1's room was an apartment style living	D 270		

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quarters included a living room with a kitchenette, a bathroom and a bedroom.
-The bedroom had a twin bed in the low position with a regular mattress.
-Resident #1's room did not have a high rise toilet seat, floor mat, protectors for the corners of the furniture or a bedside commode.
-Resident #1's room was located 100 ft. from the back entrance to the medication room.
-In order to get to Resident #1's room from the medication room, you could leave out the back door to the medication room turn right, walk to the end of the hall and turn right again and the room was the last room on the right.

Observation on 12/20/16 at 12:45 pm of Resident #1 revealed:
-She was sitting in her recliner, in her room watching TV.
-Her wheelchair was to the left of her recliner and not locked in place which increases the risk for accident and injury.

Observation and interview on 12/21/16 at 9:24 am with Resident #1 revealed:
-She was sitting in her recliner, in her room with her wheelchair to the left of the recliner and not locked in place.
-She like to return to her room after every meal to watch tv.
-When asked about her fall yesterday, she was unable to remember what happened, just that she "thinks she fell again because she is in pain" and had received something for the pain.
-When asked about why she thinks that she falls, she was unsure how it happened, "I just fall when I get up" and "No one is in here to help me."
-She considered herself "independent" and did not like to "bother" people.
-She had "a hard time remembering what

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D 270	Continued From page 8 happened just a few minutes ago." Observation of the hallway outside Resident #1's room on 12/21/16 from 9:55am to 11:30am revealed none of the facility staff went in to Resident #1's room and checked her for safety or offered assistance for activities of daily life. Observation on 12/22/16 at 11:11 am of Resident #1's wheelchair in her room revealed: -The wheelchair was not locked in place. -The seat cushion was in the floor. -The wheelchair back was at the end on the recliner facing away from the resident. Interview on 12/21/16 at 12:06 pm with Resident Care Coordinator (RCC) revealed: -She was responsible for ensuring that all care plans were updated with any changes in condition, and in compliance with facility's policy. -The HWD was responsible for the updated and assessment as well as the trackers for all care plans. Interview on 12/21/16 at 12:22 pm with HWD revealed: -All falls were reported to her through the Incident Reports. -The reports were evaluated and discussed during the daily "stand-up" meetings. -The Incident Reports were sent to the District Nurse who made recommendations based on the fall trends only, not the individual resident (i.e. shift adjustments, rounding times, ect). -All falls were identified on a new care plan with recommendations and all staff were educated on the new recommendations during the next stand-up meeting. -Resident #1 was a "homebody" and liked staying in her room.	D 270		

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-"We increased supervision from every 2 hours to every 15-30 minute checks but we don't have documentation noted in the chart pertaining to the every 15 and 30 minute checks or the increased supervision checks."
-The facility did not allow for bed, and chair alarms, "It's a dignity issue."
-The resident had a low bed and now a bed side commode. Floor mats were only allowed in the SCU.
-As far as hip protectors, "that is something that we can supply but the POA needs to purchase".
-The scoop mattress was considered a restraint by the Executive Director and District Nurse and was not used.
-A self-locking wheelchair was discussed in one of the meetings but it was an expense that Resident #1's POA would have to incur.
-It had not been discussed or thought of to place Resident #1 in the Special Care Unit for increased supervision, or decline in her cognitive abilities because of continued non-compliance with staff's efforts to assist with activities of daily life.

Telephone interview with Resident #1's Physician's Assistant on 12/21/16 at 4:35 pm revealed:
-The facility informed her office via fax anytime Resident #1 fell.
-A higher level of care had not been discussed with the facility or the responsible party.
-Resident #1 had been at risk for falls and would continue to be at risk for falls since she has not had a change in the level of care or supervision.
-Resident #1 may continue to be at risk for falls at a higher level of care.
-There was an order for physical therapy and a physician order for a gait belt to assist with transfers but she did not know if Resident #1 was

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still taking physical therapy or if she had been discharged.
-She expected any orders issued by herself or the physician be implemented by the facility.
-The facility had not requested any other interventions to prevent falls or reduce risk for injury.

Telephone interview on 12/21/16 at 4:36 pm with Resident #1's POA revealed:
-Resident #1 would not ask for help, "and was very independent but forgetful" and "I tried to get the facility to check on her more often."
-Resident #1 has "gone downhill drastically, more so with safety".
-Since Resident #1 had been in the facility, her falls have gotten worse.
-The more she is kept busy then the less she will fall. "She is just in the room all of the time".
-He was notified that Resident #1 fell again today trying to transfer from the recliner to her wheelchair by herself and the wheelchair was not locked and it slid out from under her.
-He feels that if the staff checked on Resident #1 more often than every 2 hours, then she would not fall.

Telephone interview on 12/22/16 at 11:26 with District Director of Clinical Services revealed:
-They meet with CCR on a monthly basis to discuss trends in the incident reports and "it is up to the facility to implement their own interventions".
-If a trend shows falls happening at certain times during the shifts, then assignment changes could be made.
-She would expect to see a referral for SCU if a resident had declined in the "memory department".
-She only received the trends, not the name that

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go with the falls.
-The trends showed an increase in falls during the month of November due to the time of day.

Interview on 12/22/16 at 1:00 pm with the Executive Director (ED) revealed:
-She was aware of Resident #1 frequent falls and felt everything had been done to prevent the falls.
-The HWD handled all of the Incident Reports and implements all of the interventions.
-Floor mats were only allowed in the SCU.
-The scoop mattress was considered a restraint.
-The hip protectors were a part of our policy but the resident's POA must purchase them.

Review of the facility's Fall Management Program revealed:
-The Fall Management Program included a recommendation for a sitter or increased family involvement, and increased frequency of monitoring (rounds, resident programs, and group activities ect.).
-An incident report was to be completed for all falls in the facilities ' incident reporting system and the responsible party and physician notified.
-The Health Wellness Director (HWD) was required to review all incident reports for content, accuracy and completeness.
-The HWD should determine any immediate interventions required, based on circumstances of fall.
-A post fall investigation was completed and individualized interventions (i.e. medication changes, removing rugs, night light, hip protectors, ect.) are included in his/her service plan.
-A review of the fall in the morning stand up meeting to verify that the post fall investigation is underway.
-A discussion of the resident fall(s) at the next

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D 270	Continued From page 12 Collaborative Care Review (CCR) meeting. -Additional interventions should be noted on the resident service plan if recurrent fall occur. -Falls are tracked and tendered as a clinical indicator for quality improvement opportunities. -Related documents/other manuals noted but not attached included: evaluation process policy, service plan process policy, change of condition policy, documentation policy, collaboration care review meeting policy, incident reporting policy, reportable events policy, reportable events grid, head injury policy, call 911 how to, assist with a fall how to, fall interventions clinical guidelines, orthopedic blood pressure how to, and hip protectors available upon request. The facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) with frequent falls in accordance with the residents' assessed needs and current symptoms. Resident #1 experienced 18 unwitnessed falls from 1/30/16 to 12/20/16. Documented fall injuries included a fractured pelvis, head injury, broken toe, and arm injury. There was no documentation of that staff increased supervision of the resident in response to the resident's falls. Upon observation there was no evidence that staff increased supervision of the resident in response to the resident's falls. She had diagnoses including dizziness, arthritis, superventricular tachycardia, spinal stenosis of the lumbar, dementia, osteoporosis, and atrial fibrillation and a medication for dizziness. Her falls were often related to transferring self from bed or recliner to wheelchair or to go to the bathroom. The failure of the facility to provide to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms resulted in injury to residents and constitutes a Type A1 Violation.	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 On 12/22/16, the ED submitted a Plan of Protection as follows: -A Risk Identification will be completed by the ED/HWD/RCC/Designee for anyone with 2 or more falls since March 2016. -Interventions will be reviewed for appropriateness for each individual resident's identified needs; i.e.; to include scoop mattress if appropriate, suggested room change, increased toileting, assignment acuity review, time patterns of falls, etc. and adjustments in interventions will be made accordingly. -Current associates will be made aware of residents at high risk for falls by the ED/HWD/Designee, at each day's Stand Up meeting with documentation to include added interventions. -Residents will be reviewed for continued appropriateness in regards to preventing falls. Those deemed inappropriate will be reviewed for a higher level of care by the MD/ED/HWD. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 26, 2017.	D 270		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	D 367		

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	HAL029006	A. BUILDING: _____ B. WING _____	12/22/2016

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D 367	Continued From page 14 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the accuracy of the Medication Administration Record for 1 of 7 residents (Resident #6) observed on the morning medication pass. The findings are: Review of Resident #6's current FL2 dated 12/02/16 revealed: -Diagnoses included heart failure, hypertension, edema and chronic kidney disease. -A physician's order for lisinopril 5mg once daily (a medication used to treat hypertension). Review of Resident #6's record revealed a physician's order dated 6/22/16 to discontinue lisinopril 7.5mg and start lisinopril 10mg. Observation of the medication pass on 12/21/16 at 9:48 am revealed: -The MA prepared Resident #6's morning medications which included Lisinopril 10 mg and 3 other oral medications. -The MA administered Resident #6's medications with a small amount of applesauce and water and	D 367		

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D 367	Continued From page 15 Resident #6 swallowed her medications without difficulty. Review of Resident #6's June 2016 paper MAR revealed: -An entry for lisinopril 7.5mg once daily at 9:00 am that was discontinued 6/22/16. -An entry for lisinopril 10mg once daily at 8:00 am that was started 6/23/16. Review of Resident #6's July 2016 paper MAR revealed: -An entry for lisinopril 7.5mg once daily at 8:00 am with documentation the medication was discontinued 6/22/16 (not documented as administered). -An entry for lisinopril 10mg once daily with documentation the medication was started 6/23/16 and administered daily until 7/06/16. Review of Resident #6's July 2016 eMAR revealed an entry for lisinopril 5mg, give 1 and 1/2 tablets (7.5mg) once daily at 9:00 am and documented as administered daily from 7/06/16 to 7/31/16. Review of Resident #6's August, September, November and December 2016 eMARs revealed: -An entry for lisinopril 5mg, give 1 and 1/2 tablets (7.5mg) once daily at 9:00 am and documented as administered daily. Review of Resident #6's documented blood pressures From July 2016 to December 2016 revealed a range from 128/68 to 146/92. Interview with the MA on 12/21/16 at 9:50 am revealed: -She did not know why the lisinopril order was not changed to 10mg on the eMAR.	D 367		

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D 367	Continued From page 16 -The MA or the nurse were responsible for entering the physician order's into the eMAR. -She had the Health and Wellness Director (HWD) call the physician to verify the lisinopril order and the physician verified the order was lisinopril 10mg once daily. -They had been giving the correct dose of lisinopril but documenting the 7.5 mg dose because that was what was on the eMAR. -She did not know why she or no other MA had noted the label on the medication they were administering did not match the eMAR entry. -She thought she and the other MAs must have been going too fast and just glanced at the medication name and not focused on the dosage. -If she had noticed it before today she would have called the physician for clarification. -She thought the HWD and/or the Resident Care Coordinator (RCC) compared the physician orders with the eMARs after the MAs entered them into the eMAR. -She thought the HWD and/or the Resident Care Coordinator (RCC) compared the eMARs from month to month to ensure accuracy of the entries. Interview with a second MA on 12/21/16 11:13 am revealed: -The MAs were responsible for entering the new orders on the eMAR. -The MAs audited the eMARs every shift to make sure all orders were entered correctly. -She did not know about the discrepancy between the lisinopril dose on the medication punch card as compared with the eMAR, but thought the MAs must have been going too fast and not paying enough attention. -They did use a new order tracking form for all new orders and this for was given to the RCC and/or HWD to review the eMAR entries to ensure they were entered correctly.	D 367		

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D 367	Continued From page 17 -If MA did not fill out a new order tracking form the RCC and the HWD may not know there was a new order they needed to check in the eMAR. -The MAs that administered the lisinopril should have observed the discrepancy during their medication pass and clarified the order with the physician. Interview with the HWD on 12/21/16 at 10:46 am revealed: -She had verified with the physician the dose of lisinopril was 10mg once daily for Resident #6 that morning. -The MAs were giving the correct medication. -The facility switched from paper MARs to electronic MARs in July 2016. -She and the RCC entered the medication orders into the eMARs in June 2016 and the order change must have occurred after they had already entered Resident #6's physician orders into the eMAR. -She would have expected that the MAs identify the discrepancy during the medication pass and expected the MAs to compare the medication label with the eMAR each time the medication was pulled. -She did not use the new order tracking forms when they were putting the entries into the eMARs and it must have been overlooked. -The MAs were likely going too fast when comparing the medication label to the computer and did not identified the dose discrepancy. Interview with a representative from the contracted pharmacy on 12/21/16 at 10:30 am revealed: -The facility staff were responsible for entering the new orders into the eMAR. -The pharmacy was responsible for updating the residents' profiles and filling the prescriptions	D 367		

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D 367	Continued From page 18 according to the physician orders. -She verified 30 tablets of lisinopril 10 mg was dispensed on 8/19/16, 9/17/16, 10/13/16, 11/10/16 and 12/14/16. -If there was a discrepancy between what the pharmacy supplied and what the facility entered into the eMAR she expected the facility to verify the order with the doctor and notify the pharmacy. Interview with the Administrator on 12/21/16 at 1:12 pm revealed: -She was unaware there was a discrepancy between Resident #6's lisinopril dose on the medication label compared with the eMAR. -She would have expected the MAs identify the discrepancy before today. -She did not know why the MAs did not identify the dose discrepancy. -She did expect the MAs to compare the medication label with the eMAR for each medication every time it was administered.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding supervision	D912		

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D912	Continued From page 19 of residents. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Residents #1) who required assistance with transfers, and ambulation, with frequent falls in accordance with the residents' assessed needs and current symptoms which resulted in injuries including a fractured hip, fractured phalanges and a shoulder dislocation. [Refer to tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]	D912		