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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 1-2, 2017 and February 6, 2017.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F.) to a maximum of 116 degrees F. for 12 of 20 sinks located in the residents' bathrooms and 3 of 4 sinks in the community spa rooms and community restrooms used by residents. The findings are: Observation during the initial tour of the facility on Halls D and E on 02/01/17 revealed the following hot water temperatures: - The hot water temperature at the sink in Room D1 was 126 degrees F. at 10:30 am. - The hot water temperature at the sink in Room	D 113		

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D2 was 128 degrees F. at 10:35 am.
- The hot water temperature at the sink in Room D3 was 124 degrees F. at 10:40 am.
- The hot water temperature at the sink in Room D4 was 128 degrees F. at 10:45 am
- The hot water temperature at the sink in Room D5 was 126 degrees F. at 10:50 am.
- The hot water temperature at the sink in Room D6 was 132 degrees F. at 10:55 am.
- The hot water temperature at the sink in Room D7 was 120 degrees F. at 11:00 am.
- The hot water temperature at the sink in Room E1 was 130 degrees F. at 11:07 am.
- The hot water temperature at the sink in Room E2 was 128 degrees F. at 11:10 am.
- The hot water temperature at the sink in Hall E restroom sink was 124 degrees F. at 11:12 am.
- The hot water temperature at the sink in Room E8 was 126 degrees F. at 11:15 am.

Observation during the initial tour of the facility on Halls A, B, and C on 02/01/17 revealed the following hot water temperatures:
- The hot water temperature at the community spa sink on Hall A was 120 degrees F. at 3:40 pm.
- The hot water temperature at the sink in Room A4 was 118 degrees F. at 3:44 pm.
- The hot water temperature at the sink in Room B1 was 118 degrees F. at 4:02 pm.
- The hot water temperature at the sink in Room C2 was 120 degrees F. at 4:08 pm.

Interview with the Maintenance staff and the Administrator-in-Training (AIT) at 11:45 am revealed:
- They were not aware the hot water temperatures were too high in some resident rooms.
- They were not aware the hot water

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temperatures were too high in in common spa bathrooms and restrooms.
- The Maintenance staff stated he would immediately adjust the mixing valves to lower the temperature.

Continued observation on 02/02/17 revealed the following hot water temperatures:
- The hot water temperature at the sink in the community spa on Hall A was 98 degrees F. at 2:30 pm.
- The hot water temperature at the sink in the Hall B/C connecting community spa sink was 94 degrees F. at 2:15 pm.
- The hot water temperature at the sink in Room B3 was 98 degrees F. at 2:18 pm.
- The hot water temperature at the sink in Room B7 was 98 degrees F. at 2:21 pm.
- The hot water temperature at the sink in Room C2 was 98 degrees F. at 2:24 pm.
- The hot water temperature at the sink in Room C5 was 98 degrees F. at 2:27 pm.
- The hot water temperature at the sink in Room D7 was 94 degrees F. at 2:15 pm.
- The hot water temperature at the sink in Room E1 was 96 degrees F. at 2:20 pm.
- The hot water temperature at the sink in Room E2 was 92 degrees F. at 2:25 pm.
- The hot water temperature at the sink in the Hall E restroom was 88 degrees F. at 2:30 pm.
- The hot water temperature at the sink in Room E6 was 96 degrees F. at 2:50 pm.
- The hot water temperature at the sink in Room E7 was 96 degrees F. at 2:55 pm.
- The hot water temperature at the sink in Room E8 was 96 degrees F. at 2:58 pm.

Review of facility water temperature logs revealed:
- The Maintenance Staff took weekly temperature

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readings in the community spa room and the Community restroom on Halls A, B, C, D, E, and F, plus one or two resident rooms.

- The range of temperatures for sampled hot water readings throughout the resident rooms and common areas accessible by residents were as follows during the following weeks:
- Sampled hot water readings ranged from 101.3 -117.7 degrees F. during the week of 10/6/16.
- Sampled hot water readings ranged from 118 - 127.2 degrees F. during the week of 10/26/16.
- Sampled hot water readings ranged from 105.4 - 127 degrees F. during the week of 11/2/16.
- Sampled hot water readings ranged from 101.7 - 118.2 degrees F. during the week of 11/21/16.
- Sampled hot water readings ranged from 97.7 - 117.7 degrees F. during the week of 12/13/16.
- Sampled hot water readings ranged from 105.4 - 117.3 degrees F. during the week of 01/03/17.
- Sampled hot water readings ranged from 100.4 - 118 degrees F. during the week of 01/16/17.
- Sampled hot water readings ranged from 106.9 - 118 degrees F. during the week of 01/26/17.
- Sampled hot water readings ranged from 89 - 130 degrees F. during the week of 02/04/17.
- Sampled hot water readings ranged from 90 - 119 degrees F. during the week of 02/05/17.

Interview with the resident in Room E8 at 11:15 am on 02/01/17 revealed:
- Personal care aides always assisted her when she showered or bathed.
- She was told to wait for staff to assist her with bathing/showering.
- The personal care aides always adjusted the water temperature so it was warm during the shower. They let it run a few minutes, then added cold water if needed to lower the temperature to "lukewarm".

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D 113	Continued From page 4 - She knew how to adjust the hot water in the sink in her bathroom by adding cold water. - She had never been burned by the hot water. Observation of a resident in Room E2 at 2:25 pm on 02/02/17 revealed: - She was unable to move herself in her reclining wheelchair or to use the bathroom sink independently. - She required assistance from facility staff and hospice staff for all activities of daily living, including transfers in and out of bed, transfers from her wheelchair, transfers to the toilet, and in bathing. Interview with a resident in Room E2 at 2:25 pm on 02/02/17 revealed: - Hospice staff and facility personal care aides adjusted water temperatures for her. - She preferred "warm, not hot" water for bathing and personal care. Interview with the Medication Aide located on D Hall on 02/01/17 at 11:20am revealed: - Facility policy required all residents to be assisted with bathing and showering, as all residents had diagnoses of dementia. - Personal care aides and hospice staff assisted all residents with showering and bathing. - Water temperatures in facility bathrooms, spas, and restrooms varied day by day, from steaming hot to barely warm. - Staff knew to report very hot water temperatures to their supervisor, so maintenance could adjust hot water temperatures for the facility. - Personal care aides were trained to check hot water temperatures by testing the hot water with their hands or forearm, and adding cold water as needed to make the water warm. - Showers were preferred over baths by most	D 113		

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residents.

Interview with a Personal Care Aide on 2/2/17 at 2:30 pm revealed:
- She only bathed residents in the community spa on B/C hall.
- That was a Jacuzzi style tub and it had a temperature setting on it.
- The temperature regulator would not allow the water to be too hot for a resident.
- The showers in all the community spas were utilized.
- She had not noticed the water being hot because she regulated the water herself by mixing the cold in with the hot.
- She always checked the temperature of the water with her hand and arm before putting a resident in the shower or bath.

Interview with the AIT at 11:06 am on 2/6/17 revealed:
- Corporate policy required a weekly check of water temperatures.
- Water temperatures in the "Common Hot Water Supply" (boiler room) of the kitchen and laundry areas were "a lot hotter" than those in resident rooms.
- The Maintenance staff checked water temperatures at least weekly in the Common Hot Water Supply and in the mixing valves, and kept logs of his readings. "The mixing valve is what water is going to resident rooms."

Interview with the Maintenance staff on 02/01/17 at 4:38 pm revealed:
- He had worked at the facility since March 2016.
- In the last few months, he had noticed some issues with the water temperature readings fluctuating too low and too high.
- He checked the water temperatures throughout

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the building, once a week.
- He documented the water temperatures in a log and gave the data to the AIT each week.
- If the temperature readings were not between 100 degrees F and 120 degrees F, he would make an adjustment.
- The company told him to keep the water temperatures between 100 degrees F and 120 degrees F.
- There had been mechanical issues at the facility off and on since he had worked there.

Interview with the Maintenance staff at 3:00 pm on 02/06/17 revealed:
- A local plumbing service company was contacted on 02/02/17.
- A local plumbing contractor came in to service the boiler room "over the weekend" [02/02/17 to 02/05/17].
- The plumbing contractor replaced three check valves, repaired six leaks, and added an additional check valve so the hot water return circulation loops would be plumbed correctly.

Documentation of hourly monitoring of both the Common Hot Water Supply Temperatures (CHWST) and the Mixing Valve Temperatures (VT) was provided on a log of Boiling Room Water Temperature Readings from 6:30 pm on 02/04/17 to 3:30 am on 02/06/17. Each reading had documentation of action taken to adjust the mixing valves and the circulation pumps to achieve recommended temperatures.

Comparison of readings of the facility's digital thermometer provided for the Maintenance staff and the surveyor's glass thermometer was conducted on 02/06/17 from 3:30 pm to 4:15 pm.
- The hot water temperature at the sink in Room B8 was 106 degrees F. on the surveyor's

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thermometer, and was 105.6 degrees on the digital facility thermometer at 3:30 pm.
- The hot water temperature at the sink in Room B4 was 110 degrees F. on the surveyor's thermometer, and was 106.5 degrees on the digital facility thermometer at 3:40 pm.
- The hot water temperature at the sink in Room C7 was 112 degrees F. on the surveyor's thermometer, and was 118 degrees on the digital facility thermometer at 3:50 pm.
- The hot water temperature at the sink in Room C3 was 108 degrees F. on the surveyor's thermometer, and was 117.9 degrees on the digital facility thermometer at 3:55 pm.
- The hot water temperature at the sink in Room D5 was 108 degrees F. on the surveyor's thermometer, and was 109 degrees on the digital facility thermometer at 4:00 pm.
- The hot water temperature at the sink in Room D1 was 102 degrees F. on the surveyor's thermometer, and was 103.8 degrees on the digital facility thermometer at 4:05 pm.
- The hot water temperature at the sink in Room E7 was 102 degrees F. on the surveyor's thermometer, and was 102.6 degrees on the digital facility thermometer at 4:07 pm.
- The hot water temperature at the sink in Room E3 was 102 degrees F. on the surveyor's thermometer, and was 105.8 degrees on the digital facility thermometer at 4:10 pm.
- The hot water temperature at the sink in Room F3 was 104 degrees F. on the surveyor's thermometer, and was 103.3 degrees on the digital facility thermometer at 4:13 pm.
- The hot water temperature at the community spa sink on the F Hall was 104 degrees F. on the surveyor's thermometer, and was 107.4 degrees on the digital facility thermometer at 4:17 pm.
- The hot water temperature at the sink in Room A2 was 102 degrees F. on the surveyor's

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D 113	Continued From page 8 thermometer, and was 102.4 degrees on the digital facility thermometer at 4:20 pm. - The hot water temperature at the sink in Room A4 was 102 degrees F. on the surveyor's thermometer, and was 104.5 degrees on the digital facility thermometer at 4:25 pm. The facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F.) to a maximum of 116 degrees F. for 12 of 20 sinks located in the residents' bathrooms and 3 of 4 sinks in the community spa rooms and restrooms used by residents. The Maintenance staff had documented the water temperature readings fluctuating during once weekly spot checks of water temperatures in resident rooms and resident accessible common areas. The failure of the facility to ensure the hot water temperatures were maintained at a safe temperature was detrimental to the health and safety of the residents, who were at risk of being burned or experiencing discomfort during personal care, and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 2/2/17 revealed: - Due to water temperature a plumbing company has been contacted for immediate assessment and repair. - Plumber will be on site on 2/2/17 with 3 hour estimated repair time to ensure water temperature range from 100-116 degrees Fahrenheit. - Emergency supplies for 2/2/17 evening meals obtained. - Showers and laundry halted during the 3 hour repair.	D 113		

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D 113	Continued From page 9 - Will monitor water temperature every hour following repair until assured consistency at range for 30 day period to March 2, 2017. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 23, 2017.	D 113		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #4) who required assistance with ambulation, with frequent falls in accordance with the residents' assessed needs and current symptoms. The findings are: Review of Resident #4's current FL-2 dated 3/10/16 revealed: -Diagnoses included coronary heart disease, high cholesterol, benign prostatic hyperplasia, hypertension, vascular dementia and dementia with agitation	D 270		

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D 270	Continued From page 10 -There was no documentation about Resident #4's cognitive, ambulatory or activities of daily living activities status. Review of Resident #4's Resident Register revealed the resident was admitted on 3/20/14. Review of Resident #4's Personal Service Plan (PSP) dated 5/20/16 revealed: -Resident #4 was not always oriented to place and time. -Resident #4 needed help to participate in community activities because of memory loss. -Resident #4 wandered and required redirection. -Resident #4 was able to use the bathroom independently at times, but often required assistance. -Resident #4 required assistance with bathing. -Resident #4 was "physically able to walk to and from the activities without assistance". -Resident #4 was part of the "fall management program", interventions included the use of hip protectors to reduce risk of injury, low bed, removal of sharp edged furniture, bedside fall cushion and high-rise toilet seat. -A handwritten addendum to Resident #4's PSP was made on 11/23/16; "resident encouraged to use wheelchair due to recent falls" and "the resident had been found sitting on the floor multiple times recently". Review of Resident #4's Licensed Health Professional Support dated 11/23/16 revealed: -Resident #4 required physical assistance with ambulation with an assistive device. -The Registered Nurse assessed Resident #4 as needing assistance with all activities of daily living. Review of Resident #4's incident reports from	D 270		

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D 270	Continued From page 11 10/1/16 - 2/6/17 revealed: -On 10/18/16 at 5:15 pm, the resident had an unwitnessed fall in the hallway with no apparent injury. -On 10/18/16 at 6:00 pm, the resident had an unwitnessed fall in the resident's bathroom with injury sustained with abrasion to the left knee and mouth. -On 10/20/16 at 2:00 pm, the resident had an unwitnessed fall in the resident's room with injury sustained with abrasion and swelling to the forehead. -On 10/23/16 at 6:30 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury. -On 10/24/16 at 11:00 am, the resident had an unwitnessed fall in the resident's bathroom with no apparent injury. -On 10/25/16 at 7:00 pm, the resident had an unwitnessed fall with no apparent injury. -On 10/30/16 at 10:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury. -On 11/3/16 at 2:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury. -On 11/6/16 at 6:00 pm, the resident had an unwitnessed fall in the hallway with no apparent injury. -On 11/7/16 at 10:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury. -On 11/8/16 at 6:00 pm, the resident had an unwitnessed fall in the resident's room and sustained an injury with a cut/abrasion to his finger and scalp. -On 11/16/16 at 7:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury. -On 11/17/16 at 3:00 pm, the resident had an	D 270		

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unwitnessed fall in the resident's room with no apparent injury.
-On 11/19/16 at 1:00 pm, the resident had an unwitnessed fall in the dining room with no apparent injury.
-On 11/20/16 at 9:00 am, the resident had an incident of unknown origin where bruising was discovered on his left buttock.
-On 11/26/16 at 4:45 pm, the resident had an unwitnessed fall in the common room with no apparent injury.
-On 11/27/16 at 10:30 am, the resident had a witnessed fall in the resident's room with no apparent injury.
-On 11/28/16 at 9:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury.
-On 12/2/16 at 3:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury.
-On 12/6/16 at 10:30 am, the resident had an unwitnessed fall in the resident's room with no apparent injury.
-On 12/16/16 at 10:30 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury.
-On 12/21/16 at 4:00 pm, the resident had an unwitnessed fall in the resident's room with no apparent injury.
-On 1/11/17 at 4:00 pm, the resident had an unwitnessed fall in the resident's room and sustained a skin tear on his right forearm.
-On 1/31/17 at 6:30 am, the resident had an unwitnessed fall in the resident's room that resulted in swelling and bruising of the left eye and required first aid.
-There were no staff interventions listed on the incident reports.

Review of Resident #4's Nursing Notes revealed

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there was no documentation by staff of increased supervision more frequent than the routine 2 hour checks.

Observation during the initial tour on 2/1/17 at 10:20 am revealed:
-Resident #4 was sitting in the common room, in his wheelchair.
-Resident #4 had purple bruising and swelling around his left eye.

Observation on 2/2/17 at 10:20 am of Resident#4's room revealed:
-Resident #4's room smelled of urine with stains on the carpet.
-Resident #4's room contained bedroom furniture, a rolling desk chair and a private bathroom with a sink and toilet.
-The bedroom had a standard twin bed and the height could not be adjusted.
-Resident #4's room did not have a high rise toilet seat, floor mat, protectors for the corners of the furniture or a bedside commode.
-The resident's bed was located on the side of the wall at the entrance of the room.
-The resident's call bell was located across the room on the left wall.

Based on observations, interviews and record reviews, Resident #4 was not interviewable.

Interview with a Personal Care Aide on 2/1/17 at 10:22 am revealed:
-She had worked at the facility about 7 months.
-She worked on first shift usually from 6:00 am - 2:00 pm.
-She had found Resident #4 on the floor in his room on 1/31/17 around 6:00 am.
-She notified the Medication Aide.
-She was not sure how long the resident had

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been on the floor.
-She thought he had hit his left eye on the corner of his bedside table.
-Resident #4 had a lot of falls over the past few months.
-She checked on all the residents every 2 hours.
-She had not been instructed to check on Resident #4 any more frequently than every 2 hours.
-She knew Resident #4 had a lot of falls.

Interview with the Home Health Care Transition Manager on 2/2/17 at 11:20 am revealed:
-Resident #4 was admitted into home health for physical therapy on 7/15/16 for assessment for gait training.
-Resident #4 received continuous physical therapy from 7/15/16 until discharged on 12/22/16.
-Resident #4 was discharged on 12/2216 due to admission to hospice care.
-On 11/11/16, the physical therapist recommended that Resident #4 be fitted for a wheelchair to decrease the risk of falls.
-On 11/17/16, the physical therapist rearranged Resident #4's room to increase mobility in the wheelchair.
-On 11/17/16, the physical therapist noted that Resident #4 was resistive to therapy due to "being upset" from a fall that day.
-On 11/17/16, the physical therapist instructed Resident #4 to utilize his wheelchair for mobility on his own, and receive assistance of caregivers with transfers and ambulation using a rolling walker.
-The physical therapist recommendations were discussed at a collaborative care meeting which usually included family, the Health and Wellness Director and the Executive Director.
-The facility would utilize the physical therapist

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reports to develop interventions for residents with frequent falls.

Telephone interview on 2/2/17 at 9:02 am with Resident #4's Power of Attorney revealed:
-He went to the facility to visit Resident #4 almost every day, usually in the evenings.
-He was made aware of all of Resident #4's previous falls by the facility.
-He did not realize that there were 24 total falls since October 2016 to the current day.
-The staff at the facility had discussed the falls with him, but had not put any interventions in place that he was aware of.
-He was not sure how often the facility checked on Resident #4.
-The facility had discussed a low bed for Resident #4, but nothing ever happened with it, and he still had a standard bed in his room.
-The staff at the facility tried to keep Resident #4 in the common areas to provide supervision but the resident preferred to be alone in his room.
-Resident #4 had always walked with an unsteady gait that had become worse in the last few months.
-He had seen Resident #4 get down on the floor when he became unsteady.
-He wasn't sure if the falls were related to Resident #4 trying to get to the bathroom.
-Resident #4 could have behaviors because he was independent until the dementia worsened and he was admitted into the facility in 2014.
-He knew the Primary Care Provider (PCP) had changed some of Resident #4's medications over the last 2-3 months to help with the behaviors.
-He thought the behavior medications could cause Resident #4 to be unsteady, but he needed them.
-He was not sure of what interventions the facility could implement to prevent or reduce the number

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of falls for Resident #4.
-He would discuss concerns with the staff at the facility.

Interview with the Primary Care Provider (PCP) on 2/2/17 at 11:00 am revealed:
-She was the PCP for Resident #4 and had been since he was admitted to the facility in 2014.
-There had been a decline in the health and ambulatory status of Resident #4 over the last 6 months.
-She was notified every time Resident #4 had a fall.
-She was aware that Resident #4 had a lot of falls recently.
-Resident #4's behaviors and ambulatory status changed daily.
-There were some days Resident #4 would use a wheelchair and other days he would try and walk.
-She had adjusted Resident #4's medications for behaviors a few times over the last 6 months to help with resistance to care.
-Resident #4 would not tolerate a sitter because he became agitated when someone was in his room.
-Increasing the frequency of checks more than every 2 hours could be beneficial if Resident #4's gait was unsteady that day.

Interview on 2/2/17 at 2:30 pm with a second Personal Care Aide (PCA) revealed:
-She had worked at the facility since Resident #4 was admitted.
-She did not typically work with Resident #4 but did on occasion.
-Resident #4 had a lot of falls recently.
-When Resident #4 was admitted, he could walk.
-In the last 6 months to a year, Resident #4 had become unsteady.
-Resident #4 now used a wheelchair to get

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around.
-Some days Resident #4 could walk, and some days he could not.
-Resident #4 was very unpredictable with his ambulation and behaviors.
-Resident #4 would not remember any instructions to call for assistance or how to use a call bell.
-All the residents in the facility were checked every 2 hours.
-There were no resident's in the facility that were checked more frequently than every 2 hours.

Interview on 2/2/17 at 12:00 pm with the Health and Wellness Director (HWD) revealed:
-She had worked at the facility for about 3 months.
-All falls were reported to her through the Incident Reports.
-There was a policy and procedure for residents with falls.
-Interventions implemented for residents with falls were listed on their personal service plan.
-The incident reports were evaluated and discussed during the daily "stand-up" meetings.
-She updated PSP's every 3 and 6 months, and annually.
-She updated Resident #4's PSP on 11/23/16 with information related to recent falls.
-If she had known of all the falls that Resident #4 had prior to her hire, she would have updated the entire PSP.
-The power of attorney and the primary care provider were notified of Resident #4's falls each time.
-It would be difficult to increase the frequency of monitoring/checks more than every 2 hours.
-If a resident at the facility required more frequent than every 2 hours checks, the resident should be evaluated for a higher level of care.

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D 270	Continued From page 18 Interview with the Executive Director (ED) on 2/2/17 at 10:42 am revealed: -She had worked at the facility since 8/2016. -The facility implemented interventions for residents with frequent falls. -All residents were on every 2 hour checks. -When residents were in their rooms, their call bell was kept within reach. -For residents with frequent falls, they were placed in visually monitored areas when possible. -If a resident utilized a walker, staff would assist them to and from activities and the dinning room. -There would be a discussion with a resident's responsible party to determine if a sitter may be beneficial. -She was aware of Resident #4's frequent falls. -Resident #4 had declined over the last 6 months and a lot since 12/2016. -The facility had implemented the interventions of keeping Resident #4 in a visually monitored area when possible. -The staff was checking on Resident #4 every 2 hours. -Resident #4's bed had been pushed against the wall. -The bedside table was moved away from the bed to prevent injury from the corners because that was what caused the injury in the last fall. -She would discuss other interventions with Resident #4's power of attorney. Interview with a Medication Aide (MA) on 2/6/17 at 10:15 am revealed: -When a resident had a fall the MA was responsible for checking the resident for injuries. -If the resident needed immediate treatment the facility would call 911. -The MA would notify the family or responsible party for the resident, notify the Primary Care	D 270		

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Provider, notify hospice if applicable and notify the Registered Nurse that worked at the facility.
-The Registered Nurse was also called the Health and Wellness Director, and they were responsible for completing the incident report in the computer.
-Resident #4 had been at the facility for about 2-3 years.
-Resident #4 had gone from walking, to ambulating with a walker to utilizing a wheelchair.
-Resident #4 had begun using the wheelchair in the last about 2 months.
-The staff checked on Resident #4 every 2 hours.
-The staff was not asked to check on Resident #4 more frequently than every 2 hours.
-The every 2 hours checks on Resident #4 were not documented.
-The staff was not required to document any activities of daily living or every 2 hour checks.
-The staff did try and keep Resident #4 in a visually monitored area when he was awake due to his frequent falls.
-Today (2/6/17), Resident #4 had a sitter in his room for the first time.

Interview with the Executive Director on 2/6/17 at 10:22 am revealed:
-The facility did not document any activities of daily living, toileting or every 2 hour checks for any residents.
-It was not the company policy to perform that documentation.
-Any information needed to be discussed was done in shift to shift report from MA to MA.
-The day shift MA would relay any information needed to the HWD.

Telephone interview with the Hospice Nurse on 2/6/17 at 10:41 am revealed:
-Resident #4 was assessed for admission to hospice on 10/28/16, but was denied admission.

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D 270	Continued From page 20 -Resident #4 was admitted to hospice care on 12/21/16. -Resident #4 had one fall on 1/31/17 since he was admitted into hospice. -She implemented interventions after Resident #4's fall on 1/31/17. -When hospice assumed care, Resident #4 was in a wheelchair. -Hospice worked with Resident #4 to teach him to propel the wheelchair with his feet. -She ordered a hospital bed for Resident #4 after the 1/31/17 fall, which would allow the bed to be adjusted to a low position. -Hospice did not recommend a bedside mat due to the mat being a trip hazard. -Resident #4's diagnosis of dementia was the primary reason for the history of frequent falls. -The facility could have implemented more frequent than every 2 hour checks to possibly prevent falls. Review of the facility's Fall Management Policy on 2/2/17 revealed: -"A fall is defined as any drop, collapse, or tumble. Any witnessed or reported unwitnessed fall with or without injury is reported in the reporting system. Residents who sustain a fall should have a post fall investigation completed with interventions identified to reduce the potential for future falls and injury". -The ED and HWD are responsible for verifying that associates have completed the training. -Resident falls are noted in the Resident Record and entered into the reporting system. -A post fall investigation was completed after a resident fall and individualized interventions are included in the service plan. -When a fall occurs, staff should assist the resident and provide first aid or call 911. -Notify the HWD/designee and ED.	D 270		

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D 270	Continued From page 21 -Notify the physician for evaluation, care and treatment. -Notify the family/responsible party and document in the record. -Document the resident fall/injuries, resident response and interventions taken in the resident record. -"Review the fall in the morning standup meeting to verify that the post fall investigation is underway". -Discuss resident falls at the next care review meeting. -"Additional interventions should be noted on the resident service plan if recurrent falls occur". Review of Resident #4's record on 2/2/17 revealed: -The facility could not provide documentation for post fall investigations completed for the identified 15 falls the resident had from 7/16/16 to 1/4/17. -Use of a wheelchair was the only documented addendum for falls intervention implemented on the personal service plan on 11/23/16. The facility failed to provide supervision for 1 of 5 sampled residents (Resident #4) with frequent falls. Resident #4 experienced 23 unwitnessed falls from 10/18/16 to 1/31/17. Documented fall injuries included bruises, skin tears, swelling and abrasions to the scalp. There was no documentation or observations that staff increased supervision of the resident in response to the resident's falls. Upon observation of Resident #4's room, the residents' call bell was not within reach while he was in bed. The failure of the facility to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms resulted in multiple injuries to the resident and constitutes a Type A2 Violation.	D 270		

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D 270	Continued From page 22 Review of the facility's Plan of Protection dated 2/2/17 revealed: -Resident's family members/responsible party will be contacted to discuss 1 on 1 supervision for residents with frequent falls and high risk for additional falls. -Residents with 1 or more falls in 30 days will be assessed for increased supervision needs and those assessed to need increased supervision; it will be implemented. -Increased supervision would include transporting the resident to common areas, hourly or every 30 minute checks and including the needed for 1 to 1 supervision. -If increased need, the personal service plan will be updated and interventions may include physical therapy/occupational therapy, medication reviews, and consults with other providers. -Following a fall, residents will be monitored every 30 minutes for 24 hours, every 1 hour for 24 hours and every 2 hours for 24 hours over a total of 72 hours. -Documentation of the 72 hour assessment will be made in the resident's record by the Medication Aides. -The Health and Wellness Director or designee will monitor the documentation daily to ensure it was completed. -Residents who continue to have falls or need increased supervision beyond the 72 hours or who continue to have falls will be assessed by the physician for a higher level of care. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 8, 2017.	D 270		

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D912	Continued From page 23	D912		
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 assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to other requirements. The findings are: Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F.) to a maximum of 116 degrees F. for 12 of 20 sinks located in the residents' bathrooms and 3 of 4 sinks in the community spa rooms and community restrooms used by residents. [Refer to Tag D113, 10A NCAC 13F .0311 (d) Other Requirements (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.	D914		

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D914	Continued From page 24 This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure all residents were free from neglect related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #4) who required assistance with ambulation, with frequent falls in accordance with the residents' assessed needs and current symptoms. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		