STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	C 03/23/2017

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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 000	Initial Comments 5/03/17 AMENDED STATEMENT OF DEFICIENCIES The Statement of Deficiencies dated 03/23/17 was amended as follows on 05/03/17: To remove one bullet/statement from Tag 74. To change the date from November 2017 to November 2016 on Tag 74. To remove one bullet/statement from Tag 76. To change the date from 09/25/17 to 09/25/16 on Tag 270. To remove one quote from Tag 270. To remove one quote from Tag 980. The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation from 03/15/17-03/17/17 and 03/21/17-03/23/17 with an exit conference conducted by telephone on 03/23/17.	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 assure the walls, floors, and ceiling air vents in the residents' bedrooms on the 100 and 200 hallways, on the Central Hallway, and the carpet in the private dining room were kept clean and in good repair.	D 074		

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D 074	Continued From page 1 The findings are: Observation of facility's wooden railings along both sides of the 100 Hall hallway, 200 Hallway and Central Hallway between 11:00am and 1:00pm on 3/15/17 revealed: -The top surfaces of the wooden railings were worn exposing the bare wood. -The crevice between the wooden railing and the wall contained various pieces of trash, dust, food particles and other unidentifiable clutter. -The handrails had a gray sticky film on the top surface and inside area between the wall and the handle-side. Observation of Resident Room #103 on 3/15/17 at 11:15am revealed: -There was a 3-foot section of peeling paint above the right side of the bed next to the wall outlet. -There was a 12-inch long paint scrape to the right of the window sill. Observation of Resident Room #104 on 3/15/17 at 11:25am revealed a 3-foot horizontal scrape on the bathroom door to the left of the door handle. Observation of Resident Room #107 on 3/15/17 at 11:30am revealed: -There were multiple brown splatter stains and drip marks on the wall above the bed. -The entry door had missing wood peeling from both sides of the exterior of the door, extending approximately 1 foot above and below the door handle. Observation of Resident Room #108 on 3/15/17 at 11:40am revealed there was brown grime on the light switch by the entry door.	D 074		

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D 074	Continued From page 2 Observation of Resident Room #114 on 3/15/17 at 11:44am revealed there was a 4-foot by 1-foot section of peeling paint to the right of the bathroom door. Observation of Resident Room #116 on 3/15/17 at 11:52am revealed there were three areas of torn peeling drywall above the headboard of the bed by the entry of the room. Observation of Resident Room #210 on 3/15/17 at 11:00am revealed an 18-inch curved black scrape mark the on floor extending from the footboard on the bed. Observation of Resident Room #211 on 3/15/17 at 11:35am revealed the closet had a 5-inch by 3-inch dent in the middle of the closet door at the site where the entry door handle made contact when fully opened. Observation of private dining room on the Central Hallway on 3/15/17 at 11:58am revealed the carpet was heavily stained in several areas around the dining room table by the entrance. Interview with 2 housekeeping staff on 3/15/17 at 2:00pm revealed: -Any identified repair needs discovered during their workday were verbally reported to the Administrator. -They did not document any repair needs discovered during their work day. -They could not recall when they informed the Administrator of any repair needs. Interview with 2 Personal Care Aides (PCAs) on 3/15/17 at 2:15pm revealed: -Any identified repairs noted during their workday were reported to the Administrator.	D 074		

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D 074	Continued From page 3 -They did not document any repair needs discovered during their work day. -They could not recall when they informed the Administrator of any repair needs. Interview with the Administrator on 3/16/17 at 1:05pm revealed: -The facility had an outside maintenance contractor for all as-needed repairs. -The staff were instructed to report any identified needed repairs to the senior staff on duty so the repair requests could be forwarded to the maintenance contractor as needed. -The maintenance contractor had not been utilized during the time of the previous administrator who had left in 10/2016 when there was a change in management. -The maintenance contractor would perform a full inspection on 3/16/17 and weekly thereafter for all maintenance needs of the facility. -She was unaware that several of the rooms were in need of wall and floor repairs. -She was unaware that the railings throughout the facility were in need of repair and deep cleaning. -There was a lack of cleaning enforcement during the time of the previous administrator who had left in 10/2016 leaving many areas in need of regular cleaning left unmonitored. Interview with the facility's maintenance contractor representative on 3/16/17 at 2:15pm revealed: -The maintenance company had been formerly contracted to clean the facility as of 10/2016. -The previous administrator had not requested any deep cleaning or maintenance. -The maintenance company would begin a weekly walk-through of the facility each week beginning 3/16/17 and identify all areas in need of cleaning.	D 074		

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D 074	Continued From page 4 -He could not explain why they had not been to the facility since November 2016 for regular cleaning needs. -He had instructions from the facility's corporate office to immediately walk through the entire facility and identify all areas in need of cleaning and maintenance. -There was a weekly schedule for cleaning of the railings, room entry handles, bathroom handles, toilets and faucets initiated on 3/16/17. Interview with the Vice President of Quality Assurance (VPQA) on 3/16/17 at 2:15pm revealed: -The facility had a contracted maintenance and cleaning company who would assess all areas in need of cleaning and repair. -The contractor was currently in the building assessing areas to be cleaned and repaired.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (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 the nightstands in 4 of the residents' bedrooms and 22 chairs in the dining room were kept clean and in good repair. The findings are: Observation of Resident Room #210 on 3/15/17	D 076		

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D 076	Continued From page 5 at 10:00am revealed the night stand had a missing knob on the lower drawer. Observation of Resident Room #103 on 3/15/17 at 10:20am revealed: -There were two missing drawers of the night stand by the window. -The nightstand by the door had a missing knob on the lower drawer. Observation of Resident Room #106 on 3/15/17 at 11:10am revealed: -There was a missing knob on the drawer of the nightstand by the bed by the entry. -The lampshade on the nightstand was dusty and had brown stains. Observation of Resident Room #114 on 3/15/17 at 11:18am revealed the night stand had two missing knobs on the drawers. Observation of Resident Room #116 on 3/15/17 at 11:24am revealed that both night stands each had two missing knobs on both drawers. Observation of 22 chairs in the dining room on 3/17/17 at 11:00am revealed: -There were dried food particles on the underside of both arms of all 22 chairs. -The underside of both chair arms were sticky of all 22 chairs. -Four of the chairs had a sticky substance at the top back center of the chair. Interview with the Administrator on 3/16/17 at 1:05pm revealed: -She was unaware of the missing knobs on any nightstands in any of the rooms. -The facility had an outside maintenance contractor for all as-needed repairs.	D 076		

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D 076	Continued From page 6	D 076		

-The staff were instructed to forward any identified needed repairs to the senior staff on duty so the repair requests could be forwarded to the maintenance contractor as needed.
-The maintenance contractor had not been notified since 10/2016 when there was a change in management.
-The maintenance contractor would be performing a full inspection today and weekly for all cleaning and maintenance needs of the facility beginning 3/16/17.
-She would remind all staff to notify the management on each shift of any needed cleaning or repairs.

Interview with the facility's maintenance contractor representative on 3/16/17 at 2:15pm revealed:
-The maintenance company had been formerly contracted to perform any maintenance the facility as of 10/2016.
-The previous administrator had not requested any maintenance.
-The maintenance company will begin a weekly walk-through of the facility each week beginning today and identify all areas in need of repair.
-He could not explain why they had not been to the facility since 10/2016.
-He had instructions from the facility's corporate office to immediately walk through the entire facility and identify all areas in need of repair.
-Staff would be reminded to report all maintenance needs to the administrator.

Interview with the Vice President of Quality Assurance (VPQA) on 3/16/17 at 2:15pm revealed:
-The facility had a contracted maintenance and cleaning company who would assess all areas in need of cleaning and repair.

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D 076	Continued From page 7 -The contractor was currently in the building assessing areas to be cleaned and repaired. Interview with the VPQA on 3/17/17 at 1:05pm revealed: -She had noticed the undersides of the dining room chair arms were dirty. -She had immediately instructed a nearby staff to clean the underside of the arms on all chairs in the dining area. -The contracted cleaning company already began a full inspection of the facility and was currently in the building assessing areas of need.	D 076		
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, record reviews, and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs and current symptoms for 4 of 7 residents sampled (#1, #2, #3 and #8) related to three residents with multiple falls resulting in serious physical injuries to include hip and humerus fractures (#1), multiple head injuries to include a head injury requiring staples (#3), and a knot on the back of the head and ear injury (#2) and for a resident with a docmented history of reoccurring	D 270		

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physical altercations with other residents at the facility (#8), resulting in a physical altercation with another resident causing Resident #8 to fall and sustain an atypical femoral fracture.

The findings are:

1. Review of the facility's policy Guidelines for Supervision of Residents who Exhibit Difficult Behaviors revealed:
-Management of behaviors began prior to admission by learning as much as possible about the resident and identifying at risk behavior.
-At risk behaviors included agitation, aggression, assaultive behavior and sexual inappropriate behavior (definitions were given for each).
-Possible Risk Evidence was listed (Criminal History, History of Aggression, Assault, Violence, History of Mental Illness etc.).
-Staff shall be trained in methods of recognizing and managing at risk behaviors as agitation, aggression, assaultive behavior, and inappropriate sexual behavior to include use of redirection, recognizing escalating behavior, maintaining safety, using activities, using the Intervention list, room change, or as needed (PRN) medication if appropriate and ordered by the physician.
-Upon observation of at-risk behavior, staff shall notify the Supervisor. The Supervisor shall assure the Care Manager is notified who is responsible for also notifying the Executive Director.
-Any resident at risk shall be placed on increased supervision with documentation included on the Medication Administration Record (MAR). The doctor, Guardian or Responsible Party is to be notified.
-A mental health referral shall be considered and discussed with the resident's physician.
-The Executive Director shall assure staff is made

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aware of any resident at risk in the community.
-The at-risk resident shall be added to the At-Risk Board in the staff lounge and medication room.
-At risk residents shall be discussed at community stand up and/or at risk meetings.
-A care planning meeting shall be held to discuss the resident's behavior, proposed interventions and ongoing plan to assure care and safety.
-The resident's care plan shall be updated to include the at-risk behavior and interventions.
-The Care planning team shall be at a minimum composed of the Executive Director, Care Manager, representative care staff, and Registered Nurse Consultant. The Responsible Party/Guardian shall be invited to participate. Care planning shall be documented.
-Any behavior which escalates to a threat to the resident or others shall require immediate intervention to assure safety as to move residents out of harm's way and call 911 (Emergency Medical Services/Authorities).
-Notification shall be made to the Supervisor, Care Manager, Executive Director, Regional Director of Operations, DSS (department of social services), physician, Mental Health Provider and Guardian/Responsible Party.
-Notice of immediate discharge with issuance of the discharge/transfer/appeal form shall be discussed.

Review of Resident #8's current FL-2 dated 03/07/17 revealed:
-Diagnoses included dementia, hypertension, femoral fracture, gastro-esophageal disease and anemia.
-The resident was constantly disoriented.
-The resident was ambulatory with assistance.

Review of Resident #8's Resident Register revealed an admission date of 05/07/15.

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D 270	Continued From page 10 Review of Resident #8's "Care Notes" revealed: -On 02/07/16 there was documentation that the resident got into a confrontation with "another resident". Resident #8 had some light scratches on the left side of the face but stated she was fine. The contact person was notified and the primary care provider was notified. -On 05/04/16, there was documentation that Resident #8 had a confrontation with "another resident" in the dining area. -On 07/25/16 at 7:00 p.m., Resident #8 got into an altercation with "another resident". The other resident was a female and she grabbed Resident #8's arm and tried to slap her. The staff person cleaned Resident #8's arm and applied a triple antibiotic ointment and applied a dressing. The staff member completed an incident report and gave the report to administration. -On 01/16/17, Resident #8 pushed "another resident" down. The resident's vital signs were taken. The primary care provider and the responsible party was notified. There was documentation on the side of the entry that an incident report was completed. -On 02/04/17 at 4:15 p.m., Resident #8 was observed laying on her back. The resident did not have any visible injuries at that time. The resident was sent to a local hospital and was complaining of hip pain. The resident's vital signs were taken. The primary care provider and the contact person was notified. At 9:10 p.m. a call was made to the local hospital by the staff member and the resident was transferred to another hospital for a "hip fracture". -On 03/03/17 at 1:00 p.m., there was documentation that Resident #8 would return to the facility the week of 02/05/17 and had been out of the facility with a femoral fracture. New orders had been received for a wheelchair with leg rests,	D 270		

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D 270	Continued From page 11 chair and bed alarms. Review of an admission record from a local rehabilitation center for Resident #8 revealed: -The resident was admitted to the rehabilitation center from a local hospital on 02/09/17. -The admitting diagnosis was an atypical femoral fracture. Interview with the Executive Director (ED) and the Clinical Support Specialist on 03/21/17 revealed they would provide incident reports for Resident #8 from December 2016 through March 21, 2017. Review of an Accident/Injury Report dated 02/04/17 for Resident #8 revealed: -The time of the incident occurred at 4:15 p.m. -The Business Office Manager (BOM) discovered the accident/incident. -The resident was observed on the floor laying on her back. -The resident was not alone. -There was a box checked none present for type of injury. -The resident was taken to the emergency room. -The responsible party/family member [named] and the primary care physician [named] was notified. -The Department of Social Services was notified by the ED on 02/06/17 by fax at 3:00 p.m. -There was documentation that the resident was admitted with a fractured right hip. -The form was prepared by a Medication Aide (MA) with the MA's signature and date of 02/04/17. -The ED signed the report on 02/05/17. Interview with the ED on 03/23/17 at 11:27 a.m. revealed there were no other incident reports for Resident #8 for March 2016 through December	D 270		

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D 270	Continued From page 12 2016 as requested on 03/23/17 other than the one incident report that had been submitted earlier in the week. Interview with a Medication Aide (MA) on 03/21/17 at 1:14 p.m. revealed: -The MAs were responsible for completing the residents' incident and accidents reports. -All completed resident incident and accident reports were given to the Care Manager (CM) but for the period of time when there was not a CM the Executive Director (ED) would have received the reports. Review of Resident #8's assessment and plan of care dated 03/14/17 revealed: -The resident was always disoriented with a significant memory loss requiring direction. -The resident was verbally abusive and resisted care. -The resident was not receiving any mental health services or medications for mental health behaviors. Review of Resident #8's previous assessment and plan of care dated 12/07/15 revealed: -The resident was sometimes disoriented and forgetful, needing reminders. -The resident was a wanderer, verbally and physically abusive. -The resident was not receiving any mental health services or medications for mental illness. -The resident needed to be redirected when she became verbally and physically aggressive. Review of Resident #8's special care unit Resident Profile and Care Plan Update Form dated 11/02/16 and 12/20/16 revealed: -The resident's behavioral pattern was documented as "N/A" (not applicable).	D 270		

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D 270	Continued From page 13 -There was no intervention documentation for the resident. Review of Resident #8's special care unit Resident Profile and Care Plan Update Form dated 03/20/17 revealed: -The resident's review was completed due to a significant change. -There was documentation that the resident had assessed behavioral pattern changes: "Resident seems to be more afraid of being alone. Wants someone in the room with her. Will do things to set the alarm off." -The resident's special management needs required bed and chair alarms at all times. -There was a section for the resident's cognitive impairments that documented the resident was much more confused and disoriented. The resident did not want to be alone. Review of a psychiatric initial visit on 10/05/15 for Resident #8 revealed: -The resident voiced no mental health complaints. -The resident had a flat affect, mood irritable and poor eye contact. -The resident's findings included depression unstable, anxiety unstable, dementia with behavior unstable. -Recommendations included to start Wellbutrin 75 mg every day and Depakote 125 mg every hour of sleep for dementia with behaviors. Review of a psychiatric follow up note dated 11/12/15 for Resident #8 revealed: -The resident was seen on 11/10/15 for a follow up visit. -The resident voiced no mental health complaints. -The resident had a flat affect, mood irritable and	D 270		

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poor eye contact.
-Staff reported no issues.
-The resident's findings included depression stable, anxiety stable, dementia with behavior stable and adjustment disorder unstable.
-Recommendations included to continue to monitor, no medication changes warranted at this time and follow up in 4 to 8 weeks.

Review of Resident #8's record revealed there was no documentation related to additional supervision, additional interventions implemented or psychiatric follow up appointments.

Based on observations, interviews and record review Resident #8 was not interviewable due to not engaging in conversation and a diagnosis of dementia.

Telephone interview with a former Medication Aide (MA) on 03/22/17 at 2:08 p.m. revealed:
- Resident #8 picked on another resident [named].
-The MA had worked at the facility on 02/04/17 and recalled Resident #8's fall that day.
-On 02/04/17, the other resident [named] shoved Resident #8 and Resident #8 fell.
-The MA did not actually see the incident between Resident #8 and the other resident [named] but did hear Resident #8 fall. It was a hard fall. The incident was not witnessed by staff but another resident saw the incident.
-The Business Office Manager and the MA "rolled back" the video surveillance footage and it was observed that Resident #8 pushed the other resident [named] and the other resident pushed Resident #8 back, but she was not pushed hard. Resident #8 fell to the floor.
-The MA called the primary care provider and was instructed to send Resident #8 out to the

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emergency room
-The MA called the family member prior to reviewing the video surveillance footage. The MA told the family member that the resident had lost her balance and had fallen. The MA told the ED that she only reported to the family member that the resident had fallen. The ED told the MA that was fine.

Confidential staff interview revealed:
-The Medication Aides (MAs), Care Manager (CM), and/or Executive Director were supposed to be notified of any residents exhibiting behaviors that could be harmful to themselves or others.
-When behaviors occurred, staff split up the residents and put them on 15 minute or 30 minute "watches"; the 15-30 minutes watches were not always documented.
-The MAs or CM notified the physician of any resident behaviors.
-Behaviors were documented in the records of all residents involved and on an incident report.

A second confidential staff interview revealed:
-Resident #8 would "slap" other residents "out of the blue" before she fell and broke her hip.
-Resident #8 slapped another resident; that resident pushed her, resulting in Resident #8 falling and breaking her hip.
-The staff member was not aware of any special interventions implemented for Resident #8's behaviors to keep other residents safe.

A third confidential staff interview revealed:
-The staff member received report from another staff member that Resident #8 had an altercation with another resident in which Resident #8 "messed up her hip" and needed surgery; the other resident had pushed Resident #8 after

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being first pushed by Resident #8.
-Prior to the surgery on her hip, Resident #8 would "fight" residents and staff.
-The staff was not aware of any increased supervision or interventions put in place to address Resident #8's behaviors.
-Resident #8 was "not herself," did not even look like herself, and could not walk since returning to the facility after surgery.

A fourth confidential staff interview revealed:
-Resident #8 had a history of "picking on" another (named) resident.
-One to two months ago, the staff received report from another staff that the resident got tired of being picked on so she pushed Resident #8 back; Resident #8 fell and broke her hip.

A fifth confidential interview with a staff member revealed the last staff meeting was held a couple of months ago and no behavioral interventions were reviewed for Resident #8 or any other residents.

A sixth confidential interview with a staff member revealed:
-Staff were expected to notify the primary care provider if a resident had behavioral issues and the primary care provider would refer the resident to mental health if needed.
-The staff member did not know of a policy or procedure the facility had for behaviors, "never had a need for it"
-"It had been a while, maybe middle of last year, June 2016" since the staff member had any training related to behaviors.

A seventh confidential interview with a staff member revealed:
-The staff member had worked at the facility for a

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couple of years.
-The facility did not have a behavioral policy or procedure that the staff member was aware of.
-Some of the residents said that Resident #8 got into another resident's face [named] and the other resident [named] pushed Resident #8 but this did not happen on first shift. Resident #8 left the facility after the altercation with the resident; "she must have broke her hip".
-Resident #8 and the other resident [named] did not have a history of any altercations.
-Resident #8 never put her hands on anyone; it was always a verbal altercation.
-Resident #8 stayed in her room, was territorial and did not like for other residents to touch her things.
-If any resident had an altercation with another resident, that resident would be placed automatically on 30 minute checks.

Confidential interview with 4 additional staff members revealed:
-Resident #8 and another resident [named] argued a lot.
-Resident #8 was very critical and picked on a resident [named].
-The resident [named] would argue or talk back with Resident #8, which made Resident #8 even more hostile.
-They were aware that the two residents had a physical fight, in which Resident #8 fell and broke her hip when the resident [named] shoved Resident #8.
-Two of the staff members did not know of any behavioral issues or interventions for Resident #8.

Confidential telephone interview with a former staff member revealed:
-Resident #8 and another resident [named] used

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to go at it like sisters fussing but it was just verbal between the two.
-The former staff member heard that someone pushed Resident #8 down and broke the resident's hip.
-The former staff member was never given any instructions from the facility related to handling resident behaviors but knew to distract and calm the resident down.
-There was no plan to increase supervision and the staff never told to report behaviors to the primary care provider.
-The former staff member was never alerted to any behavioral interventions for Resident #8.

A second confidential telephone interview with a former staff member revealed:
-Resident #8 would "nitpick" with other residents.
-Resident #8 sometimes would hit other residents when she thought no one was looking.
-Sometimes Resident #8 used an open or a closed fist to hit other residents.
-There was no increased supervision for Resident #8. It was common knowledge Resident #8 would slap other residents.
-Resident #8's behavior was never addressed. The staff member never saw any type of interventions put in place to stop the behavior.
-The facility did not put interventions in place to avoid incidents between residents. "They have favorites with who works and what happens; some things are hushed".
-The staff member was not aware of a behavior policy or steps to take when a resident displayed behaviors.
-The staff member never knew of a specific process of how to report behavior issues of residents as far as a policy but knew to document the information in the care notes, complete an incident and accident report and call the primary

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care provider.
-A call to the primary care provider and the family depended on how the altercation occurred but staff were never told to call the primary care provider and the family on every altercation.

A third confidential telephone interview with a former staff member revealed:
-Resident #8 got "very agitated" and would "swing at you" if "she didn't get her way."
-Resident #8's behaviors were directed mainly at other residents.
-When Resident #8 exhibited behaviors directed at others, staff separated the residents, tried to talk to Resident #8 to calm her down, and thought she was administered as needed medications for agitation.
-The former staff thought Resident #8's physician was aware of her behavior, but was not sure.

Interview with the Executive Director (ED) on 03/21/17 at 7:29pm revealed:
-The facility had a behavior policy that included a "whole list" of interventions for residents' who exhibited/ displayed behaviors that were harmful to themselves or others.
-Interventions included preadmission assessment, care plan with quarterly reviews, medications, mental health referrals, and physician notification.
-Verbal and written reports (shift reports) were used to communicate any resident behaviors to staff on all shifts.
-Staff and families were included in care plan meetings.
-Behaviors were also addressed at quarterly quality assurance (QA) meetings.
-Since arriving in the facility on 01/03/17, she had gotten mental health providers "very much involved" and they were in the facility weekly;

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primary care providers were also in the facility weekly.
-Physicians were notified of behaviors at weekly facility visits or could be called at any time, depending on the severity of the behavior.
-Behaviors and interventions were supposed to document in the "Care Notes."
-She expected the physician to be notified of behaviors as needed and expected documentation to be maintained.
-If a resident was having continual behaviors, interventions should have been implemented and documented.
-Resident #8 had left the facility 02/04/17 due to a fall and "broken hip" and returned 03/09/17.
-The ED got report from the Business Office Manager (BOM) that Resident #8 pushed another resident; that resident pushed her back, which resulted in Resident #8 falling and sustaining the hip fracture on 02/04/17.
-She reviewed the video surveillance footage of the 02/04/17 incident and observed the following: Resident #8 and the other resident were near the nurses' station; Resident #8 pushed the other resident; the resident pushed back; Resident #8 fell.
-Prior to 02/04/17, she had not been notified by any staff that Resident #8 had any behaviors or any other incidents between Resident #8 and the resident that pushed her.
-Prior to 02/04/17, there had not been any behaviors reported to her for Resident #8 so there had not been any interventions implemented.

Telephone Interview with Resident #8's family member on 03/22/17 at 12:25 p.m. revealed:
-There were good aides at the facility but there was not enough of them. This was nothing against the facility but the system.

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D 270	Continued From page 21 -The facility kept the family member informed concerning Resident #8. -The family member had never been involved or asked to attend a care plan meeting for Resident #8. -The family member recalled some type of altercation with another resident around the end of December 2016. -Resident #8 was never physical but could be blunt. -Resident #8 was a very independent person prior to the resident's illness and was used to being the boss and a leader. -Resident #8 had an unobserved fall on the first Saturday in February 2017. No one observed the fall when the resident broke her hip that she was aware of. The facility did not elude to what caused the fall. -"With what the facility had to deal with, the facility does all that it can; they have good aides there but not enough". The residents have to have their space and are subject to a "knock down drag out; nothing we can do about that". -Resident #8 did have some anxiety issues but had as needed medications for that. -The family member was not aware of any recent mental health services for Resident #8. Telephone Interview with the ED on 03/23/17 at 11:27 a.m. revealed: -The facility had no further documentation related to interventions for Resident #8. -The ED started at the facility in January 2017 and had not had time to review Resident #8's chart. -Prior to the conversation with the surveyor, the ED had no knowledge of Resident #8's altercations. -There was no documentation of any interventions for Resident #8's behavior.	D 270		

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D 270	Continued From page 22 -In general, the ED expected in general staff should use redirection and separating residents when incidences occurred. -The ED expected for the resident's physician to be notified and to notify mental health services or ask the primary care provider for a mental health referral. -If Resident #8's primary care provider was notified and interventions were put into place, it should be documented in the care notes. -The ED would have expected for interventions to have been put into pace to keep other residents safe from any other residents behavior. -All staff received training related to behaviors during orientation. Staff knew what they were supposed to be doing. -The ED expected family members to be notified of behaviors of both the aggressor and the receiver. -The ED expected increased supervision to be put into place. -As far as the ED knew, Resident #8's family member was notified and this was documented on the incident and accident report. Telephone interview with a Medical Assistant for Resident #8's primary care provider on 03/23/17 at 8:55 a.m. revealed: -The Medical Assistant did remember one time the facility called regarding an incident of an altercation with Resident #8 around the end of 2016. -There was documentation that Resident #8 was found on the floor on 02/04/17 but there was no information that there was an altercation with Resident #8 and another resident that caused the fall. -There was no notification of any behavioral issues regarding Resident #8, she was "calm with no issues".	D 270		

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D 270	Continued From page 23 -The primary care provider would expect increased supervision to be put into place for any resident exhibiting changes in behavior. -There had not been any notifications of any behavioral interventions for Resident #8. -The primary care provider would have expected to be notified of any behavioral issues including behavioral interventions put into place for Resident #8. -The primary care provider would have expected to be notified of any behaviors in order to treat the resident and to see what was going on with that resident. The behavior could be related to something as simple as a urinary tract infection. -She was not aware of any mental health services involved in Resident #8's care. 2. Review of the facility's "Fall Management Program" revealed: -The "Fall Risk Assessment Tool" was "completed for all residents admitted to determine factors that may contribute to possible falls." -"Staff completes an Incident Report in its entirety for any fall. Staff contacts family/responsible party, contact physician ... Executive Director &/or Care Manager should determine any immediate interventions required, based on circumstances of fall." -"Staff completes the 72 Hour Follow Up on resident fall to investigate possible circumstances contributing to the fall and documents observations for the period of 72 hours after the fall." -"For any fall, the resident must be placed on Hot Box/Alert Charting for 72 hours for follow up and monitoring." -"Falls Management Team Meeting: "Team will consist of the Executive Director, Care Manager, Med/Tech/SIC (supervisor in charge), Aide/Floor Staff and any other discipline as determined by the team. a. Falls Management Team Meeting QA	D 270		

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form is used for documentation. b. Team will review all resident falls from past month (Incident reports & charts for trends)."

A. Review of Resident #1's hospital generated FL-2 dated 09/19/16 revealed:
-Diagnoses included dementia.
-Resident #1 was ambulatory and intermittently disoriented.
-The "discharge plan" was documented as "memory care."

Review of Resident #1's Resident Register revealed:
-The admission date was documented as 09/20/16; the discharge date was documented as 09/27/16.
-"Memory" was documented as "significant loss-must be directed."
-"Special aids" included "walker."
-Resident #1 required assistance with bathing, dressing, shaving, toileting, orientation to time and place, positioning/turning, and ambulation.

Interview with the Business Office Manager (BOM) on 03/16/17 at 9:35am revealed:
-Resident #1 was admitted to the facility on 09/20/16 and discharged on 09/27/16.
-Resident #1 actually left the facility on 09/25/16 due to a "fall."

Review of the "Care Notes" dated 09/25/16 for Resident #1 revealed "Resident observed laying on the floor behind the door of his (resident) room. Sent resident to ER (emergency room) via EMS (emergency medical services) complained of hip and shoulder pain."

Review of an "Accident/Injury Report" dated 09/25/16 for Resident #1 revealed:

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D 270	Continued From page 25 -The time of the "accident/incident" was documented as 9:15am. -"Resident observed on the floor behind door on right side." -The "location of incident" was documented as "bedroom." -The "type of injury" was documented as "none present." -The "Accident/Injury Report" included documentation that Resident #1 was alone, "alert and oriented," no first aid was administered, and Resident #1 was taken to the emergency room (ER). Interview with a Nurse Aide/Medication Aide (NA/MA) on 03/16/17 at 10:02am revealed: -Resident #1 was "a nice, funny guy" who used a walker to assist with ambulation. -Resident #1 did not always use his walker because he would forget and said he did not need the walker. -The NA/MA was on duty when Resident #1 fractured his hip (the NA/MA could not recall the exact date this occurred). -The NA/MA recalled going to Resident #1's room (the last room on the right on the 200 hall) "around breakfast" time. -Resident #1's room door was closed; the NA/MA could not get the door to the room to open all of the way because Resident #1 was on the floor against the door. -The NA/MA "pushed the night stand over and squeezed into his room." -The NA/MA saw Resident #1 flat on his back with his head toward the bathroom. -Resident #1 "screamed in agony" when the NA/MA assessed/completed range of motion on his hip; (the NA/MA could not recall which hip). -The NA/MA immediately notified the (named) Medication Aide (MA) on duty. (That MA did not	D 270		

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work at the facility any longer).
-Resident #1 was sent to the hospital and did not return to the facility.

Interview with the Business Office Manager (BOM) on 03/16/17 at 09:35am revealed the MA who responded to Resident #1 on 09/25/16 no longer worked at the facility.

Attempted telephone interview on 03/17/17 at 9:06am with the MA who responded to Resident #1 and documented on the Care Notes for Resident #1 dated 09/25/16 and signed the "Accident/Injury Report" dated 09/25/16 for Resident #1 was unsuccessful.

Review of the "Emergency Department Encounter" dated 09/25/16 for Resident #1 revealed:
-The chief complaint was documented as "fall."
-The history of present illness included documentation that Resident #1 presented to the ER after an "unwitnessed fall...was found "wedged behind the door to his room."
-"He states he fell out of bed ...He said he was on the floor for approximately one half an hour."

Review of the "Emergency Department Provider Notes" dated 09/25/16 revealed Resident #1 sustained "a new right hip fracture" and a "displaced proximal humerus fracture." (The humerus is the only bone in the upper arm).

Review of the "Operative Note" for Resident #1 dated 09/26/16 revealed:
-The preoperative diagnosis was documented as hip fracture.
-The post-operative diagnosis was right hip hemiarthroplasty with right femur fracture. (The femur is the only bone in the upper leg.

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Hemiarthroplasty is a surgical procedure that replaces half of the hip joint with a prosthetic material).
-"Complications: Yes: right femur fracture."

Review of the "Physician Discharge Summary" for Resident #1 dated 09/29/16 revealed:
-The admission diagnoses included "right hip fracture" and "hip fracture requiring operative repair."
-The discharge diagnoses included right hip fracture, right femur fracture, and right humerus fracture.

Confidential staff interview revealed:
-Between his admission date of 09/20/16 and prior to 09/25/16, Resident #1 had fallen at least one other time.
-The staff recalled Resident #1 falling near the columns located in the common area across from the Business Office.
-The staff thought the fall occurred on "second shift" but could not recall the date of the fall (it was prior to the 09/25/16 fall).
-The staff recalled that Resident #1's glasses came off during the fall.
-The staff did not recall if Resident #1 was sent to the hospital for that fall.
-The staff did not recall if Resident #1's physician was notified of the fall that occurred prior to 09/25/16; but if was facility "protocol" to notify the physician.

Confidential interview with a second staff revealed:
-Prior to 09/25/16, Resident #1 "slipped" and fell near the Business Office "one to two days" prior to the 09/25/16 incident. (The staff could not recall the date or time of the fall).
-Resident #1 had his walker when he fell near the

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Business Office.
-Resident #1 told staff the "only thing hurt was his pride."
-Resident #1 was not injured, therefore, was not sent to the hospital.
-The only interventions the staff could recall being put in place after Resident #1's fall near the Business Office was "He would sit up front where he was visible for staff to watch."
-Falls were supposed to be documented in each resident's record on the "Nurse Notes," on an incident report, and on the shift report.
-The facility had a fall policy which included "72 hour checks after a fall" and notifying the family and physician.

Confidential interview with a third staff revealed:
-The staff received verbal report from another staff member that Resident #1 fell and "broke his hip." (Staff could not recall the date of the incident).
-The staff recalled that Resident #1 had at least one other fall before the incident on 09/25/16 when he broke his hip. (The staff could not recall the dates).
-The staff was not aware of any interventions being put in place for Resident #1 to prevent more falls from the times he first fell to the incident when his hip was fractured.

Interview with Resident #1's family member/Power of Attorney (POA) on 03/20/17 at 8:27am revealed:
-Resident #1 was admitted to the facility in September 2016 from the hospital.
-When Resident #1 moved into the facility, the POA was told by the former ED that "staff were trained to handle whatever may happen."
-On 09/25/16 at approximately 8:00 or 9:00am, the POA was contacted by the hospital that

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D 270	Continued From page 29 Resident #1 was "severely injured" at the facility and needed to be transferred to another hospital for treatment. -After talking with the hospital physician, the POA called the facility to inquire what happened. -The staff on duty told the POA "I went down to check his blood sugar and give him his medicine but he would not take his medicine." -The staff was "yelling and rude" to the POA so the POA hung up on the staff member. -The POA arrived at the hospital to see Resident #1 on the morning of 09/26/16, prior to his surgery. -Resident #1 kept telling the POA "they told me to say I fell." -The POA asked Resident #1 for more information but he was not able to give any more information because he was in pain and kept saying "I hurt." -Since the surgery (on 09/26/16), Resident #1 had not been able to answer any questions as to what happened on 09/25/16. -When the POA went to the facility to pick up Resident #1's belongings, she spoke with the Business Office Manager (BOM) and the Executive Director (the Executive Director is no longer employed by the facility) about the incident and was told by both that they did not know what happened (on 09/25/16) but Resident #1 "probably fell." -The POA was "very concerned" because the BOM and Executive Director would not acknowledge Resident #1 was injured and "nobody could tell me anything." -The POA requested to see the video surveillance footage of the hallway and was told "there is nothing for you to see." -Resident #1 was not able to walk, feed himself, or do anything for himself since "whatever happened in that room" (on 09/25/16).	D 270		

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D 270	Continued From page 30 -The POA had visited Resident #1 during the time he was admitted to the facility; during her visits, which lasted approximately 2 hours the POA did not observe staff monitor or check on Resident #1. -When visiting Resident #1, the POA recalled Resident #1 complaining of a "bruised hinny" due to a fall. (The POA could not recall the date). -The facility never notified the POA that Resident #1 had any falls; the POA expected to be notified. -The POA was notified of the 09/25/16 incident when the hospital contacted her. Telephone interview with the former Executive Director (ED) on 03/17/17 at 11:40am revealed: -The former ED thought Resident #1 only resided at the facility for less than one week before he fell and was sent to the hospital for a hip fracture (unsure of the date). -The former ED reviewed the video surveillance for the date of the incident when Resident #1 broke his hip. -The video showed Resident #1 walking into his room; he was alone in the room because his roommate was not there. (She did not recall why the roommate was not there). -The video showed a Medication Aide on the hall administering medications; the Nurse Aide (NA) went in to Resident #1's room (which was the last room on the right side of the 200 hall), then the MA and NA both responded to the room until Resident #1 was sent out to the hospital by EMS. -The former ED could not recall how long Resident #1 had been in his room before staff checked on him. -The former ED was not there at the time of the incident but recalled Resident #1 had been found on the floor; he was sent to the hospital per the facility protocol. -At the hospital, it was determined that Resident	D 270		

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#1 had a hip fracture; he never returned to the facility.
-The former ED recalled Resident #1 having a fall (unsure of the date) and the facility requesting an order for physical therapy (PT) from the physician; the former ED did not think the PT order was ever implemented because Resident #1 fell and did not return to the facility.

Review of a "Physician Order Request" for Resident #1 dated 09/21/16 revealed "may we have an order for PT and OT (occupational therapy): evaluate and treat. Please advise;" there was no physician response/signature on the order request.

Review of Resident #1's record revealed:
-There was no documentation of Resident #1 falling prior to 09/25/16 in the "Care Notes."
-There was no Fall Risk Assessment found in the record.
-There were no 72 hour charting forms or documentation of additional monitoring or other interventions found in the record.

Interview with the facility's Registered Nurse/Clinical Support Specialist (RN/CSS) on 03/16/167 at 10:47am revealed the only "Accident/Injury Report" found for Resident #1 was the one dated 09/25/16.

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 10:50am revealed she would expect all of Resident #1's falls to be documented, to include falls prior to 09/25/16.

Interview with the facility's RN/CSS on 03/16/17 at 11:27am revealed:
-If the fall management policy was followed for

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Resident #1, the documentation would be with his paperwork or in the "fall book."
-The RN/CSS would check the fall book for any documentation related to Resident #1's falls.

Telephone interview with the Medical Assistant at Resident #1's physician's office on 03/21/17 at 12:22pm revealed the Medical Assistant could not find any documentation of being notified by the facility of Resident #1 falling prior to 09/25/16; she would check with the physician.

A second telephone interview with the Medical Assistant at Resident #1's physician's office on 03/21/17 at 12:45pm revealed
-The Medical Assistant had spoken with the physician regarding Resident #1's falls.
-The physician did not recall receiving any notification from the facility regarding Resident #1 falling.
-The physician would expect to be notified of Resident #1 falling so he could evaluate Resident #1 in an effort to prevent any other falls.

Observation on 03/17/17 at 11:10am revealed the Vice President of Quality Assurance and Regulatory Compliance looked through the "fall book" and did not locate any documentation that the facility's fall policy interventions were implemented for Resident #1.

Interview with the Executive Director and Vice President of Quality Assurance and Regulatory Compliance on 03/17/17 at 11:10am revealed:
-The fall policy had "lapsed" after the former Executive Director was terminated and the Regional Director of Operations took over as the Executive Director/Administrator of the facility.
-The Vice President of Quality Assurance and Regulatory Compliance did not find any

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documentation in the fall book related to Resident #1's falls or fall policy implementation.

Refer to the confidential staff interviews.

Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 10:33am.

Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 11:47am.

Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/17/17 at 2:07pm

Refer to the interview with the Executive Director (ED) on 03/21/17 at 7:29pm.

B. Review of Resident #3's current FL-2 dated 11/30/16 revealed:
-Diagnoses included dementia with behavioral disturbance, Alzheimer's and atherosclerotic disease.
-The resident was intermittently oriented.
-The resident was semi-ambulatory.

Review of Resident #3's Resident Register revealed that the resident was admitted on 06/10/16.

Review of Resident #3's personal service plan dated 11/30/16 revealed:
-The resident required feeding assistance.
-The resident required assistance for toileting, bathing, dressing, and grooming.
-The resident required staff assistance when transfering and walking.

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D 270	Continued From page 34 Observation of Resident #3 on 03/15/17 at 10:30am revealed: -The resident was walking in Hallway 100 with staff assistance. -The resident had an approximately 4-inch diameter area of purple bruising over her right eye. -The resident had a shuffled gait. Observation of Resident #3's bedroom on 03/15/17 at 10:35am revealed there were two beds in the room with a night between the two beds. Interview with Resident #3 on 03/15/17 at 10:31am revealed: -The resident was unaware of the bruise over her eye. -The resident did not recall falling. -The resident was unable to provide any detailed information related to her daily activities at the facility. Confidential staff interview revealed: -Resident #3 often got up in the middle of the night to check on her roommate, stumbled into the nightstand and fell. -Staff would check on Resident #3 but it was impossible to prevent a fall unless Resident #3 was watched continuously. -Staff assisted Resident #3 with dressing, bathing, and feeding. -Resident #3 had fallen 3 days in a row last week. -Resident #3 had the same demeanor and alertness before and after her falls. Confidential interview with a second staff revealed: -Resident #3 required staff assistance for walking.	D 270		

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D 270	Continued From page 35 -Resident #3 would sometimes get up in the middle of the night without calling for staff and fall or be found on the floor. -Resident #3's falls were a result of the resident wanting to check on the roommate when she awoke in the morning or during the night. Confidential interview with a third staff member revealed: -Resident #3 had an unsteady gait so a wheelchair was often used for the resident's safety. -Resident #3 would occasionally fall in her bedroom around a night stand; the night stand was moved out of the room recently, but nothing had been rearranged in the bedroom prior to removing the night stand that the staff member knew of. Confidential interview with a fourth staff member revealed: -Resident #3 had a history of falling on 2nd and 3rd shifts. -She would get up to check on her family member. -Interventions the staff member implemented for Resident #3 included assisting her with ambulation and offering her a wheelchair. -Other interventions for Resident #3 included moving the bedside table "last week." Review of Resident #3's incident reports between 11/30/16 and 03/14/17 revealed: -The resident had 7 emergency room visits since 11/30/16 related to falls. -The resident was described as "laying on the [bedroom] floor" in 7 of the 7 incident report descriptions. -On 11/30/16 at 9:55pm, the resident had a "raised red knot" injury on the back of her head	D 270		

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after a fall and was sent to the emergency department; family and provider were notified by 10:14pm.
-On 12/17/16 at 10:00pm, the resident was discovered on the floor with an abrasion and sent to the emergency department; family and provider were notified by 11:39pm.
-On 01/26/17 at 9:45pm, the resident was observed sitting on the floor and sent to the emergency department with no injuries; family and provider were notified by 9:57pm.
-On 02/07/17 at 5:45pm, the resident was discovered on the floor "in the nightstand" with a head wound on her left side and sent to the emergency department; family and provider were notified by 7:10pm.
-On 03/12/17 at 12:04am, the resident was discovered on the floor with a "swelling" on the back of the head and sent to the emergency department; family and provider were notified by 12:48am.
-On 03/13/17 at 12:09am, the resident was discovered on the floor with a "bump" on the head and sent to the emergency department; family and provider were notified by 12:21am.
-On 03/14/17 at 8:03pm, the resident was discovered on the floor with a "knot on the forehead" and sent to the emergency department; attempted contact with family member at 8:18pm and provider notified at 8:21pm.
-The fall locations were "by the bed", "by the nightstand" and "in the room."
-All incident reports indicated Resident #3 was alert and oriented after each incident.

Interview with 2 family members of Resident #3 on 03/16/17 at 11:45am revealed:
-The facility had notified both family members of all emergency department admissions.
-Resident #3 fell on occasion when checking on

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the roommate (who is also Resident #3's family member).
-Resident #3 always fell in the room by the bed in the resident's bedroom.

Interview with Resident #3's Physician Assistant on 03/16/17 at 3:20pm revealed:
-She was very familiar with Resident #3's medical status and diagnoses.
-Resident #3's falls were always in her room.
-The injuries sustained in the room were caused by Resident #3 falling into the nightstand upon getting out of bed to check on her roommate.
-She was always notified by the facility of injuries, falls and emergency department visits.
-She had recommended 1-hour visual checks on Resident #3 as of 03/16/17 after the last 3 successive falls on 03/12/17, 03/13/17, and 3/14/17.
-She would recommend that the facility move the nightstand to the other side of her bed to prevent further injuries.
-She had not realized earlier that "something as simple as moving the nightstand would probably prevent future injuries."
-Resident #3 had received CT scan, staples, and stitches after injuries which resulted from the falls but was overall in good health.
-She would start Resident #3 on antibiotics for a possible urinary tract infection which historically may have contributed to Resident #3's falls.
-Resident #3 was at her baseline neurologically and did not suffer any changes as a result of the falls.
-There were no immediate interventions she would recommend for Resident #3 other than 1-on-1 observation to prevent any injuries, an option the facility did not offer.
-She would write orders for a physical therapy consult but felt Resident #3's diagnoses would

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prevent it from being beneficial.
-Resident #3 should always use the walker that had been provided to her.

Observation of Resident #3's room on 03/17/17 at 2:50pm revealed that the nightstand room that was formerly between the two beds on 03/16/17 was now on the right side of the resident's bed near the corner.

Interview with the Executive Director on 03/17/17 at 4:30pm revealed:
-The Physician Assistant had issued new orders on 03/17/17 to prevent falls including an order for antibiotics for a possible urinary tract infection and increased hourly checks.
-The furniture in Resident #3's room had been moved on 03/17/17 per provider order.
-Resident #3 was currently on 30 minute checks.
-Staff were instructed to log fall monitoring.
-Staff were instructed to continue to assist Resident #3 with ambulation and transfers.
-Resident #3 had a history of falling when trying to get out of bed to check on the roommate.
-All of Resident #3's falls had been in the bedroom.
-All residents are monitored according to the facility's fall's policy.

Review of the facility's fall log book on 03/17/17 at 4:45pm revealed Resident #3 had a 30 minute check log sheet signed by various staff initials at 30 minute increments.

Observation of Resident #3 on 03/21/17 at 11:30am revealed:
-The resident was walking down the 100 Hallway with staff assistance.
-The resident had a slow shuffling gait.
-The resident was using a walker.

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D 270	Continued From page 39 Review of Resident #3's record on 03/17/17 at 10:10am revealed there were no fall risk assessments in the record. Request for the 72-hour post-fall documentation binder kept at the nurse's station on 03/17/17 at 9:00am and 12:10pm was unsuccessful. Refer to the confidential staff interviews. Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 10:33am. Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 11:47am. Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/17/17 at 2:07pm Refer to the interview with the ED on 03/21/17 at 7:29pm. C. Review of Resident #2's current FL-2 dated 11/30/16 revealed: -Diagnoses included dementia, Alzheimer's, Down syndrome, Hashimoto's disease and hearing loss. -The resident was constantly oriented. -The resident was ambulatory. Review of Resident #2's Resident Register revealed that the resident was admitted on 10/21/15. Review of Resident #2's personal service plan dated 11/3/16 revealed:	D 270		

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D 270	Continued From page 40 -The resident required feeding assistance. -The resident needed reminders at times to take showers or change clothes. -The resident liked to walk daily but would occasionally use a wheelchair when needed. -The resident required occasional prompting for toileting, bathing, dressing, grooming and transferring. -The resident wore glasses. Observation of Resident #2 on 03/15/17 at 9:39 a.m. revealed: -The resident was laying on the floor in the middle of the 200 Hallway, approximately 50-feet from the nurse's station with no staff members around the resident. -At 9:39 a.m. a surveyor alerted the Business Office Manager (BOM) that a resident was laying on the floor on the 200 Hallway. -Two staff members responded to Resident #2 before the surveyors reached the area where Resident #2 was laying in the hallway. -The resident was laying on her left side, fully dressed with sneakers on, there was no assistive ambulatory device and the resident was not wearing glasses. -The resident stated "I fell" to a Personal Care Aide (PCA) who came to the resident's aide. -At 9:40 a.m. a Medication Aide (MA) walked out of resident room 202 (3 rooms down from the area where Resident #2 was laying). -At 9:43 a.m. a resident walking down the 200 hallway commented "Done fell again, fell last night". -At 9:45 a.m. the MA took the resident's blood pressure using the resident's left arm and remained with the resident talking to her. -At 9:47 a.m. a PCA touched Resident #2's left arm and asked did that hurt and the resident responded yes.	D 270		

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D 270	Continued From page 41 -At 9:52 a.m. the resident was complaining of her left knee hurting. -Staff had notified Emergency Medical Service (EMS) which arrived at 9:55 a.m. and transported the resident to the local hospital. Interview with one of the PCA's that assisted Resident #2 when she was laying on floor on 03/15/17 at 9:55 a.m. revealed: -Resident #2 did not use any assistive device to walk. -The PCA usually worked "nights". -The PCA was not aware of any falls Resident #2 had yesterday after 3:00 p.m. Review of Resident #2's incident reports between 08/1/16 and 03/15/17 revealed: -The resident had 6 emergency room visits since 09/05/16 related to falls and being "found on floor". -All falls occurred in different locations and times of day. -The resident had an emergency room visit after a fall on 09/05/16. -The resident had fallen on 11/30/16 but EMS refused to transport due to resident refusal and lack of visible injury. -The resident had an emergency room visit on 01/10/17 with a lower ear injury after hitting a medication cart during a fall. -The resident had two emergency room visits on 02/09/17 and 02/15/17 related to falls. -The resident had two emergency room visits on 03/14/17 and 03/15/17 related to falls. -No fall assessment information was fuond on the incident reports. Attempted interviews with a family member of Resident #2 on 03/16/17 at 11:30am and 5:30pm were unsuccessful.	D 270		

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D 270	Continued From page 42 Interview with the Physician Assistant for Resident #2 on 03/16/17 at 4:05pm revealed: -He was very familiar with Resident #2's medical status and diagnoses. -Resident #2's emergency room visits were not all related to falls. -Resident #2 could ambulate freely throughout the facility and would sometimes decide to "sit down on the floor in the hallway." -Resident #2 had a wheelchair available when needed for occasional back pain. -The facility kept him updated on all emergency room visits. -Resident #2 had minor injuries on 3 occasions that were actual witnessed falls. -Resident #2 could benefit from a higher level of care related to the facility's 1 on 1 supervision not being offered which would prevent future falls. -Resident #2's falls were not linked to her seizure activity. -Resident #2 could get up on her own and did not ask for assistance. -He was satisfied with the level of observation by the facility for Resident #2. -Resident #2 was not a candidate for physical therapy (PT) or occupational therapy (OT) due to the resident's mental status and memory issues. -He had made contact with the facility on 003/15/17 to "seek out alternative placement to hospice, palliative care or nursing facility but did not feel [the resident] would qualify for any services other than palliative care as [the resident] did not require physical therapy or occupational therapy." -He wanted to continue encouraging the resident's current ability to walk in the present facility. -Resident #2 is pleasant and there were no immediate interventions he would recommend	D 270		

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other than 1-on-1 observation to prevent any injuries, an option the facility did not offer.

Interview with the Executive Director (ED) on 3/16/17 at 4:30pm revealed:
-The Physician Assistant called her regarding Resident #2's plan of care.
-The facility was seeking alternative placement options per the provider's request on 03/15/17.
-Resident #2's emergency room visits were not always related to falls.
-The facility was "doing all they could" to prevent further emergency room visits but Resident #2 was free to walk without assistance.
-Resident #2 did not require assistance with walking.
-Staff were encouraged to place her in a wheelchair when Resident #2 showed any signs of pain or difficulty walking.
-Facility supervision after the return from the emergency department visit on 3/15/17 included keeping Resident #2 by the nurse's station in the wheelchair, but there were no instructions to prevent her from getting up from the wheelchair and walking on her own again.
-Resident #2 was always kept by the nurse's station after returning from each emergency department visit prior to 03/15/17.
-Staff were instructed to monitor Resident #2 every 30 minutes after each fall episode upon Resident #2's return from each emergency department visit.
-Staff were instructed to log fall monitoring.

Interview with the ED on 03/21/17 at 7:29 p.m. revealed:
-Interventions implemented for Resident #2 on 3/15/17 related to falls included assuring she was wearing the correct shoes, assuring the walkways and hallways were clear, assuring she wore her

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glasses, and having the physician review her medications.
-Resident #2 had been placed on 30 minute checks since the start of the survey.

Observation of Resident #2 on 03/21/17 at 1:42pm revealed:
-The resident was walking down the Central Hallway by herself without her glasses.
-The resident had a slow but steady gait.
-There were no staff members in her vicinity.

Confidential staff interview revealed:
-Resident #2 "has been bumped into by smoking residents when they are heading outside for their cigarette breaks when [Resident #2] is walking in the opposite direction in the hallway."
-Resident #2 needed reminders to wear her glasses and shoes to prevent falls.
-Resident #2 needed assistance when getting up in the morning when the fall risk was greater related to back pain.
-Resident #2 could walk freely without staff assistance.

Confidential interview with a second staff revealed:
-Resident #2 used a wheelchair on occasion but would get up on her own to walk.
-Resident #2 walked frequently and was not always monitored by staff.
-Staff would check on Resident #2 every 2 hours but checks were not documented.
-Resident #2 was walking immediately after returning from each emergency room visit and had no restrictions or modifications in her supervision.
-It was not possible to prevent Resident #2's falls since there was no walking restriction nor 1-on-1 supervision provided.

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D 270	Continued From page 45 Confidential interview with a third staff member revealed : -Resident #2 would usually fall in the hallways of the facility. -Resident #2's most recent falls had occurred during first shift, but other past falls occurred on other shifts. -Resident #2 can be standing and "Just fall." -Resident #2 had never been pushed by another resident to cause a fall that the staff member knew of. -It was difficult to get Resident #2 to sit down. Review of Resident #2's record revealed there were no fall risk assessments in the record. Request for the 72-hour post-fall documentation binder on 03/17/17 at 9:00am and 12:10pm was unsuccessful. Refer to the confidential staff interviews. Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 10:33am. Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 11:47am. Refer to the interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/17/17 at 2:07pm Refer to the interview with the ED on 03/21/17 at 7:29pm. Confidential staff interviews revealed: -Residents were visually checked on by staff	D 270		

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every "few minutes" to at least every 2 hours; staff were constantly on the halls and in and out of residents' rooms.
-The facility had a fall policy which consisted of the use of preprinted 72 hour charting forms; the forms were supposed to be used for documentation for each resident after any fall.
- The Medication Aides (MA) documented falls on a 72 hour charting form each shift which included documentation of the residents vital signs and checking the residents for bruising.
-The 72 hour charting forms were given to the Care Manager (or Executive Director since the facility had not had a Care Manager) after the documentation was completed.
-Residents were placed on a every 30 minute check after falling.
-The Nursing Aides (NA) were responsible for documenting on the 30 minute checks where the resident was and if the resident was "ok;" the MAs could help with the 30 minute observations and documentation if needed.
-When a resident fell, the resident would stay on the 30 minute checks for 72 hours, then the Care Manager or Executive Director (Executive Director since the facility had not had a Care Manager) would determine when the resident would no longer require a every 30 minute check with documentation.
-There had not been any staff meetings for discussion of resident falls since 2016; none of the staff interviewed could recall the date of the last fall management meeting.
-The last staff meeting was held a "couple of months ago."
-During the last staff meeting, resident issues related to falls were not discussed and no resident interventions were reviewed.
-The MAs were responsible for completing an Incident/Accident report when a resident fall

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occurred that required more than first aide. The incident and accident report was then given to the Executive Director.

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 10:33am revealed:
-The facility had a fall policy that had not been implemented since the previous Executive Director and previous Regional Director of Operations (RDO)/Interim Executive Director (IED) were responsible for the facility in November 2016.
-The monthly fall meetings and 72 hour charting had not been completed during the time when the previous Executive Director and RDO/IED were responsible for the facility.
-She (the Vice President of Quality Assurance and Regulatory Compliance) had taken over responsibility of the building; she would "assess the situation" and make corrections as needed.

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 11:47am revealed:
-All residents should have a fall risk assessment.
-The RN/CSS would start the process of completing a fall risk assessment on all residents that day (03/16/17).

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/17/17 at 2:07pm revealed:
-A fall risk assessment had been completed for all residents "as of today" (03/17/17).
-A leaf had been placed at the doors of residents identified as a fall risk on the fall risk assessments.

Interview with the Executive Director (ED) on

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D 270	Continued From page 48 03/21/17 at 7:29pm revealed: -Interventions implemented for residents with multiple falls included assuring residents were wearing proper shoes, maintaining an uncluttered environment, having the physician review medications, completing toileting rounds every two hours or more, and having staff "constantly up and down the halls" to check on the residents. -She first began working in the facility as the ED on 01/03/17. -Upon arrival to the facility, her focus was on correcting the violations identified from the previous survey (completed in November 2016) because "not one thing had been done" to address the statement of deficiencies. -She did not realize the fall policy was not being followed when she first got to the facility. -She did not know fall risk assessments had not been completed for each resident. -"Around the end of January" (2017), the facility started to utilize the fall policy again (after she realized it had not been followed by the previous ED and Regional Director of Operations/Interim ED). _____ The facility's failure to provide supervision to 4 of 7 residents sampled (#1, #2, #3, and #8) in accordance with their assessed needs and symptoms and the facility's fall and behavioral policies to include fall risk assessments not being completed for all residents resulted in serious injury as evidenced by Resident #1 sustaining hip and humerus fractures and Resident #3 and Resident #2 sustaining multiple injuries due to falls, and Resident #8, who had a history of physical altercations with other residents, to sustain an atypical femoral fracture due to a physical altercation with another resident. This non-compliance constitutes a TYPE A1 VIOLATION for serious physical harm and	D 270		

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D 270	Continued From page 49 neglect. Review of the Plan of Protection (POP) dated 03/15/17 and addendum to the POP dated 03/17/17 submitted by the facility revealed: -Supervision will increase to every 30 minutes for any resident with increased falls until evaluated by primary care provider. -The Fall Management Program would be implemented to include, but not limited to: fall risk assessment completed 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 on name plate; "Who am I form" will be completed on all memory care residents and made available to assure employees are informed of needs; employees will be trained on preventive measures, interventions, possible contributing environmental and medical factors. -Fall Management meetings will be held monthly to review all incident reports including falls, interventions. -Meeting will be conducted by the Executive Director and include department heads and other providers as necessary. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 22, 2017.	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	D 273		

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D 273	Continued From page 50 of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations, interviews and record reviews, the facility failed to meet the health care needs for 2 of 7 residents sampled related to failure to assure a resident received follow up visits with a psychiatric provider and notifying the resident's licensed health care providers regarding behaviors (#8), and notifying the licensed health care providers of a resident's inability to tolerate an ordered gastrointestinal (GI) preparation for ordered GI tests and failing to assure the resident went to scheduled GI appointments/tests (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 11/30/16 revealed: -Diagnoses included vascular dementia, Type II diabetes, hypertension, and gastroesophageal reflux disease (GERD). -Resident #4 was constantly disoriented. Review of the Resident Register for Resident #4 revealed Resident #4 was "forgetful-needs reminders" and required assistance with scheduling appointments. Interview with a Medication Aide (MA) on 03/16/17 at 3:41pm revealed Resident #4 had a history of vomiting "a lot" at no specific time and had been sent to the hospital in February 2017 for	D 273		

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"coffee ground" emesis.

Interview with a second MA on 03/16/17 at 6:25pm revealed:
-Resident #4 vomited two to three times weekly which resembled the food she had eaten or was clear in color.
-Resident #4 vomited "maybe during or after meals."
-Resident #4 sat up after meals, but still vomited.

Telephone interview Resident #4's family member/Health Care Power of Attorney (HCPOA) on 03/15/17 at 4:30pm revealed:
-Resident #4 had a history of "bleeding ulcers" and had been on medication "for years" for GERD.
-Towards the end of the summer of 2016, Resident #4 began to have increased incidents of vomiting; she would vomit almost daily and many times after meals.
-The HCPOA was concerned Resident #4 was not getting "adequate nutrition."
-The HCPOA discussed her concerns with the Executive Director (ED); the ED told the HCPOA she would ask Resident #4's physician for a gastroenterology (GI) consult.

Review of a "Physician's Order Request" for Resident #4 dated 08/19/16 revealed:
-"May we have an order for resident to have consult for GI due to resident vomiting on a daily bases (sic) after meals."
-The Physician's Order Request was signed by Resident #4's Nurse Practitioner (NP) and dated 08/24/16 with an order for a GI consult for diagnosis of "colitis."

Review of a "Physician's Order Request" for Resident #4 dated 10/20/16 revealed:

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D 273	Continued From page 52 -There was an order for a colonoscopy and esophagogastroduodenoscopy (EGD) for "vomiting" and "iron deficiency anemia." (A colonoscopy is a test used to evaluate/visualize the large intestines to locate ulcers, colon polyps, tumors, inflammation, and/or bleeding. An EGD is a test ordered to evaluate symptoms to include vomiting, unexplained anemia, and abdominal pain which allows visualization of the esophagus, stomach, and parts of the small intestine). -The order was signed by the GI physician. Telephone interview with a staff member who answered the appointment line at Resident #4's GI physician's office on 03/16/17 at 2:20pm revealed Resident #4 was evaluated in the GI office on 10/20/16. Review of an additional undated physician order for Resident #4 revealed: -An order for Golytely 4 liters and Biscodyl 5mg. laxative, take as directed. (Golytely is a solution used for bowel cleansing prior to colonoscopy. Biscodyl is a laxative). -The order was signed by the GI physician. -Attached to the GI physician's order were two pages of instructions for colon "prep" to include diet instructions and medication instructions. -The medication instructions included: "The day before your procedure ...take 4 Dulcolax (generic Biscodyl); at 6:00pm begin drinking the Golytely. Drink 8 ounces (1 cup) every 15 minutes until you have had half of the Golytely (8 cups)." -"The morning of your procedure: Start drinking the 2nd half of the Golytely 6 hours before your scheduled procedure time, Drink 8 ounces every 15 minutes until you have finished the Golytely." -The "procedure date and time" was documented on the top of the instructions sheet as 11/21/16 at 3:00pm, with an arrival time of 2:00pm.	D 273		

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D 273	Continued From page 53 Review of Resident #4's November 2016 computer generated Medication Administration Records (MARs) revealed: -There was an entry for Golytely with directions which read "11/20/16 6:00pm, begin drinking the Golytely, drinks 8 ounces every 15 minutes until you have drank half of the container" with an administration time of 6:00pm. -There was a second entry for Golytely with directions which read "11/21/16 8:00am, start drinking the second half of Golytely at rate of 8 oz. (ounces) every 15 minutes until finished." -Golytely was documented as administered at 6:00pm on 11/20/16. -There was documentation dated 11/21/16 at 8:12am which read "unable to give" Golytely. -There was documentation dated 11/21/16 at 4:44pm which read "med (medication) not in facility" for Golytely. Interview with a Medication Aide (MA) who initialed Resident #4's November 2016 MARs on 03/16/17 at 3:41pm revealed the MA did not recall Resident #4 having any special prep orders or not being able to tolerate or be prepped for any GI tests. Review of the "Care Notes" for Resident #4 dated 11/21/16 (no time documented) revealed: -Resident #4 "was not prepped enough for colonoscopy today, doctor's office called and procedure rescheduled." -The entry was signed by the Transporter/Activity Director. Interview with the Transporter/Activity Director on 03/16/17 at 6:05pm revealed: -He was responsible for scheduling outside/referral appointments and completing any	D 273		

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necessary paperwork for the appointments.
-Resident #4 went to a GI physician on 10/20/16 and a colonoscopy was ordered/scheduled for 11/21/16.
-On 11/21/16, he was told that Resident #4 was "throwing up" the colonoscopy prep and was not able to tolerate the prep for 2nd or 3rd shift staff the previous day (11/20/16).
-He notified the GI physician's office on 11/21/16 and was told the procedure would have to be rescheduled.
-The procedure was rescheduled for 01/09/17.
-He was out of work from 12/01/16-01/23/17.
-After he returned to work (on 01/23/17), he was notified by a MA (unsure of the date) that Resident #4 did not tolerate the prep for the GI appointment that had been rescheduled for 01/09/17; the appointment had been canceled and had not been rescheduled.
-He did not know who canceled Resident #4's 01/09/17 appointment or when it was canceled.
-He had spoken to Resident #4's Nurse Practitioner (NP) during the "first week or two" after returning to work (unsure of the date); the NP wanted him to contact the GI physician to see if a different GI prep was available and to schedule another appointment.
-Before he could do that, Resident #4 went to the hospital and never returned.
-When he was out of work (from 12/01/16-01/23/17), the MAs (primarily 1st shift MAs) were responsible for scheduling outside appointments. He was not sure who transported the residents to their appointments when he was on leave.

Review of a "Physician's Order Request" for Resident #4 dated 01/06/17 revealed:
- A MA requested "Need a new rx (prescription) for colonoscopy prep."

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-The NP's response was "Please order colonoscopy ...;" the response was signed by the NP and dated 01/06/17.

Review of Resident #4's January 2017 computer generated MARs revealed there were no entries for Golytely or Biscodyl (used for colonoscopy prep) on the MAR.

Interview with a MA on 03/16/16 at 6:25pm revealed the MA did not recall why she requested a new prescription for colonoscopy prep for Resident #4 on 01/06/17.

Telephone interview with a staff member who answered the appointment line at Resident #4's GI physician's office on 03/16/17 at 2:20pm revealed Resident #4 was a "no show" for an appointment on 01/09/17; "no show" meant she did not come to the appointment or call to cancel the appointment.

Confidential staff interview revealed:
-A third shift staff member reported that Resident #4 was vomiting the prep needed for her GI appointment scheduled for 01/09/17.
-The staff did not know if the physician was notified that Resident #4 could not tolerate the prep.
-When the Transporter/Activity Director was out of work, the MAs completed his duties (mostly 1st shift MAs).

Confidential interview with a second staff revealed:
-A MA who no longer worked at the facility "took it upon herself to cancel" Resident #4's GI appointment scheduled for 01/09/17 because "they could not get her to keep the prep down."
-The Transporter/Activity Director was out of work

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during that time and the MA had not told the staff covering for the Transporter/Activity Director that Resident #4's appointment needed to be rescheduled.

Attempted telephone interview with the MA identified by staff who canceled Resident #4's GI appointment (scheduled on 01/09/17) on 03/21/17 at 2:16pm was unsuccessful.

Review of the Care Notes for Resident #4 revealed there was no documentation dated in January 2017 that she did not tolerate the prep for the 01/09/17 appointment, no documentation of the physician being notified, and no documentation that Resident #4 missed the GI appointment or if it had been rescheduled.

Interview with the Executive Director (ED) on 03/15/17 at 4:20pm revealed:
-The ED had started working in the facility on 01/03/17.
-She was not aware of Resident #4 missing any GI appointments.
-She thought the former Care Manager (CM) had told her that Resident #4 "would not drink" the GI prep and vomited the prep (unsure of the date).
-The ED expected the CM to document that Resident #4 did not tolerate the GI prep and notify the physician.
-The ED expected the appointment to be rescheduled.

Review of the "Care Notes" for Resident #4 dated 02/28/17 revealed:
-"Spoke with [GI physician's name] nurse regarding [Resident #4's name] 1/6/17 appointment. Nurse states only info she has is that it was canceled." (The appointment had actually been scheduled for 01/09/17).

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D 273	Continued From page 57 -The entry was signed by the Transporter/Activity Director. Interview with the Transporter/Activity Director on 03/16/17 at 8:45am: -He acknowledged writing the Care Note dated 02/28/17, which was after Resident #4 had already been discharged from the facility. -He was going back through the charts to make sure all had notes documented and wanted to see for himself who canceled Resident #4's GI appointment and why it was canceled; he called the GI office and documented the call in the Care Notes. Telephone interview with a Registered Nurse (RN) at Resident #4's GI physician's office on 03/20/17 at 2:10pm revealed: -Resident #4 was scheduled for an EGD and colonsocpy on 11/21/16; the appointment had been rescheduled to 01/09/17. -The RN was not able to ascertain when the 11/21/16 had been rescheduled to 01/09/17. -Resident #4 did not show for the 01/09/17 appointment. -The GI office could not locate any communication from the facility in regards to Resident #4 not tolerating the prep for the 01/09/17 appointment/procedure or canceling the appointment. -The GI physician would expect to be notified if Resident #4 did not tolerate the prep. -The GI physician would expect the appointment procedures to be performed as ordered and rescheduled if needed. Review of a "Physician's Order Request" for Resident #4 dated 02/24/17 revealed: -"Chart audit revealed the following (please sign below acknowledging notification)."	D 273		

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D 273	Continued From page 58 -Resident #4's GI "procedure" scheduled for 11/21/16 was "rescheduled to inadequate prep ... Procedure was rescheduled for 01/09/17 but was canceled due to non-tolerance of prep." -"No record of the verbal order to contact GI to see (sic) alternative prep (for colonoscopy) was located, therefore, order was not executed." -"Order for GI consult, ordered 02/09/17 and stool for c. diff and ova and parasite was not executed." -The order request was signed by the facility's Registered Nurse/Clinical Support Specialist (RN/CSS). -The order request was signed by Resident #4's NP and dated 02/26/17. Interview with the RN/CSS on 03/15/17 at 4:45pm revealed: -She (the RN/CSS) was assigned to cover/assist at the facility effective 02/13/17 due to the ED having a family emergency. -The ED asked the RN/CSS to complete a "chart audit." -During the chart audit for Resident #4, the RN/CSS noted the orders that she documented on the "Physician Order Request" dated 02/24/17 for Resident #4 had not been implemented; she notified Resident #4's NP. -The RN/CSS felt like Resident #4's orders noted on the 02/24/17 "Physician Order Request" were not implemented because the "ball got dropped." Review of a physician's order for Resident #4 dated 02/09/17 revealed: -There was an order for a follow up with GI for "chronic nausea/vomiting, and diarrhea." -There were orders for multiple labs to include CBC (complete blood count), CMP (comprehensive metabolic count), and TSH (thyroid stimulating hormone).	D 273		

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D 273	Continued From page 59 -There was an order for "stool for c. diff (clostridium difficile), ova, and parasite." Review of the "Care Notes" for Resident #4 dated 02/11/17 revealed: -The facility's contracted home health (HH) provider had drawn Resident #4's labs (ordered 02/09/17). -"Staff to obtain stool specimen" for ova and parasite. Review of a physician's order for Resident #4 dated 02/17/17 revealed: -There was an order for speech therapy consult. -There were orders for multiple labs to include CBC (complete blood count), CMP (comprehensive metabolic count), and TSH (thyroid stimulating hormone). Interview with the RN/CSS on 03/15/17 at 4:45pm revealed: -On 02/17/17, the NP wrote lab orders for Resident #4. -The orders were sent to the contracted home health (HH) provider on 02/17/17, but the HH provider contacted the facility back to report it was "too close to re-draw" the labs. -That same day (02/17/17), the RN/CSS requested that the HH provider fax the facility Resident #4's previous lab results (which were dated 02/11/17). -The RN/CSS received/reviewed Resident #4's lab results dated 02/11/17 upon receipt from the HH provider on 02/17/17 and noted a hemoglobin result of 7.7 g/dL. (The reference/normal range for hemoglobin is 11.2-15.7 g/dL). -The RN/CSS notified Resident #4's NP immediately on 02/17/17 and received an order to send the resident to the hospital. -Resident #4 never returned to the facility after	D 273		

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being sent to the hospital on 02/17/17.

Interview with an RN from the contracted home HH provider on 03/16/17 at 3:50pm revealed:
-The HH agency drew blood for Resident #4's labs on 02/11/17 (from the 02/09/17 order) and transported the labs to the hospital laboratory (lab) for processing/results.
-The facility was supposed to collect the stool sample for the c. diff and ova and parasite labs.
-The RN was not able to locate any lab results for the stool labs ordered for Resident #4 on 02/09/17.

Telephone interview with the RN/Performance Improvement Coordinator from the contracted HH provider on 03/17/17 at 10:35am revealed:
-The process for lab draws was as follows: the order was received by the HH provider from the facility; the HH provider drew the labs; the HH provider transported the labs to the laboratory; the HH provider received the lab results from the lab; and then the HH provider notified the provider of the results.
-Resident #4's labs ordered on 02/09/17 were drawn on 02/11/17 (with the exception of the stool labs) by the HH provider.
-The HH provider received Resident #4's lab results on 02/13/17, but was "unable to verify" if Resident #4's lab results were faxed to the ordering provider.
-The HH provider was responsible for notifying the ordering provider of all lab results to include any critical lab results.
-Resident #4's hemoglobin result of 7.7 g/dL was not considered a critical value; the 7.7 value was noted as "low" per the lab range reference.

Attempted interview with the laboratory Director on 03/16/17 at 2:25pm and 03/17/17 at 9:13am

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revealed the messages left were not returned.

Review of the "Care Notes" for Resident #4 dated 02/17/17 at 3:00pm revealed:
"The physician and I discussed [Resident #4's name] and her having a GI consult. I told him that I had witnessed her vomiting x1 (one time) on Saturday night after her meal ...I told him that the staff had only reported it that one time that day (Saturday) and that it had not been reported to me anymore in the last few days."
-The entry was signed by the Executive Director.

Interview with the current Executive Director (ED) on 03/15/17 at 4:20pm revealed:
-The NP had written orders for Resident #4 to have a GI consult, but the ED did not think the order was implemented.
-The ED had a "general discussion" with Resident #4's NP on 02/17/17 so she documented the discussion in the Care Notes.

Review of the "Care Notes" for Resident #4 dated 02/17/17 at 4:40pm revealed "[Nurse Practitioner's name] wanted resident sent to [hospital name] for GI consult, transfusion for low hemoglobin check and stool for guaiac. Vitals was (sic) collected and responsible party was called."

Review of the "Emergency Department Encounter" for Resident #4 dated 02/17/17 revealed:
-The "chief complaint" was documented as "low blood count."
-Resident #4 arrived to the hospital "after coffee grounds emesis x1 (one time) today. Had labs on 02/11/17 Hgb (hemoglobin) was 7.7. MD ordered patient transfer here for blood transfusion."
-Review of Resident #4's hospital lab results

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dated 02/17/17 revealed a hemoglobin of 7.0 "critical values confirmed." (The reference/normal range for hemoglobin was documented as 11.2-15.7g/dL).

Review of the hospital "Gastroenterology Consult" dated 02/18/17 revealed:
-The "History of present illness" included documentation that Resident #4 was admitted for "nausea/vomiting with coffee ground emesis X1 (one time), and recent blood work showing anemia (02/11/17-hemoglobin of 7.7)."
-Resident #4 received one unit of blood and was transferred to another hospital at the family's request.
-Resident #4 "saw [GI physician's name] in 10/2016 for the same symptoms... EGD and colonoscopy scheduled to assess cause of nausea, vomiting, and anemia. Procedures canceled without further notes. [Family member] is unaware that these were scheduled or that she was seen in our office."

Review of the "Hospitalist Discharge Summary" for Resident #4 dated 02/20/17 revealed:
-Resident #4 was admitted 02/17/17 and discharged 02/20/17.
-Discharge diagnoses included "upper GI bleed" and "severe erosive esophagitis."

Telephone interview with Resident #4's family member/ HCPOA on 03/15/17 at 4:30pm revealed:
-On 02/17/17, the HCPOA was notified by the facility that Resident #4 had been sent to the hospital for weakness and vomiting that resembled "coffee grounds."
-Resident #4 was diagnosed with a GI bleed which required a blood transfusion and was transferred to another hospital for further

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D 273	Continued From page 63 evaluation and treatment. -While hospitalized, Resident #4 had a consult with a GI physician. -The hospital GI physician told the HCPOA that Resident #4 was in the GI office's "system," and was last seen at the GI office in October 2016. -The HCPOA had "no idea" Resident #4 had been to the GI physician in October 2016; therefore the GI physician verified Resident #4's identity with the HCPOA. -The GI physician told the HCPOA that Resident #4 was diagnosed with anemia at the October 2016 appointment and had been ordered/scheduled additional GI tests, which had subsequently been canceled. -The HCPOA assumed the facility had canceled Resident #4's GI tests because the family had no knowledge of the tests until Resident #4 was hospitalized (on 02/17/17). -The HCPOA was concerned because the facility had never notified the HCPOA of the GI appointments or cancellation of the additional tests ordered by the GI physician. -If the HCPOA had known about Resident #4's GI appointments, she would have gone to the appointments with Resident #4. -Resident #4 had an "unwitnessed fall" in February 2017 and went to the hospital (this occurred prior to 02/17/17). -A few days prior to that fall, Resident #4 complained to the HCPOA of her "heart dancing in her chest," dizziness, and not feeling well; Resident #4 was pale on that day (this could be related to the anemia and GI bleed). -The HCPOA asked the Nurse Aide (NA) to check Resident #4's vital signs and call her for any concerns; the NA said she would. -The HCPOA wondered if the physician was notified of these symptoms; she would expect the physician to be notified.	D 273		

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D 273	Continued From page 64 -The HCPOA wanted to know why Resident #4 had to wait until she had an "active GI bleed" before receiving the ordered GI tests and treatment. -The GI bleed "could have killed her." -The four month "delay in care" was "neglect." Interview with the Transporter/Activity Director on 03/21/17 at 2:03pm revealed: -He had not notified Resident #4's family or HCPOA about her GI appointments. -Resident #4's family never took her to her appointments; the facility always transported Resident #4 to her outside appointments. Review of the "Care Notes" for Resident #4 revealed: -On 2/06/17 at 6:55pm: Resident #4 was "observed on floor laying on her back...sent to [hospital name] to be evaluated." -On 02/06/17 at 9:25pm: Resident #4 returned to the facility with "no new orders." -There was no documentation of Resident #4's February 2017 complaints of not feeling well, dizziness, or notification of the physician. Confidential staff interview revealed: -"Maybe a couple weeks" before Resident #4 left and did not return (02/17/17), Resident 4's family mentioned she was pale and did not feel good. -The family member asked if Resident #4 had eaten. -The staff kept an eye on Resident #4 and she did not have any complaints. -The staff did not know if Resident #4's physician was aware of her complaints. Additional confidential staff interviews revealed: -Resident #4 was always pale. -Staff had not noticed any acute changes in	D 273		

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D 273	Continued From page 65 Resident #4's condition prior to 02/17/17. Telephone interview with Resident #4's NP on 03/17/16 at 10:10am revealed: -Resident #4 had a history of regurgitation and anemia. -The facility was usually "pretty good" about notifying him of any changes in residents' condition or status. -He did not recall the facility notifying him about Resident #4 complaints of dizziness or not feeling well. -He would expect to be notified of any changes; he was available by phone or fax 24 hours a days, seven days a week. -He was in the facility on the morning of 02/17/17 before lunch to see other residents when he noticed Resident #4 looked pale. -He talked with Resident #4 and asked staff if she was at her baseline and was told she was. -He ordered labs that day (02/17/17). -He did not recall ever receiving Resident #4's 02/11/17 lab result from the facility or the lab prior to 02/17/17. -He did not recall the facility notifying him about Resident #4's canceled GI appointments, but recalled speaking to the Transporter/Activity Director about Resident #4's not tolerating the GI prep (he could not recall the date). -He expected Resident #4's orders to be implemented as written for the GI consult, GI tests, and labs. -He expected to be notified if Resident #4 did not tolerate the GI prep and expected the facility to reschedule the GI appointment as soon as possible. Review of the "Speech Dictation" note from Resident #4's NP dated 02/17/17 revealed: -Resident #4 was evaluated that day for "anemia,	D 273		

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vomiting, and weakness."
-Resident #4 was "pale complected with pale conjunctiva."
-"I have discussed with facility transporter the need for colonoscopy as well as following up with GI as ordered previously."
-"I was informed today that there were two attempts made to prep for the GI series and she would not tolerate prep."

Interview with the ED on 03/21/17 at 7:29pm revealed:
-She "would hope" the residents' POAs and/or guardians were notified at the time an outside appointment was made.
-The ED was not notified that Resident #4 did not tolerate the GI prep.
-The Care Manager was responsible for notifying the physician that the prep was not tolerated; the ED expected the Care Manager to notify the physician.
-The ED did not know anything about Resident #4's missed GI appointment until "after the fact" when the RN/CSS conducted the chart audit.
-When the Transporter/Activity Director was out of work, the Care Manager was supposed to be scheduling outside appointments.
-The Care Manager was responsible for assuring orders were implemented as written.
-The Care Manager was still working at the facility at the time Resident #4 missed her GI appointment on 01/09/17.
-If any order or appointment could not be implemented, staff was supposed to notify the physician and/or reschedule the appointment.

2. Review of Resident #8's current FL-2 dated 03/07/17 revealed:
-Diagnoses included dementia, hypertension, femoral fracture, gastro-esophageal disease and

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anemia.
-The resident was constantly disoriented.
-The resident's medication orders included Wellbutrin 75 mg daily (a medication used for mood disorder), Depakote sprinkles 125 mg daily at bedtime (a medication used for dementia with behaviors), Cymbalta 30 mg daily (a medication used for depression and anxiety), Buspirone HCL 10 mg three times daily (a medication used to treat anxiety), Haldol 5 mg every 8 hours as needed (a medication used to treat mental disorders), Zyprexa 5 mg one every 6 hours as needed (a medication used to treat mental disorders).

Review of a previous FL-2 dated 11/29/16 revealed:
-Diagnoses included Alzheimer's disease, urinary tract infection, delirium, gastro-esophageal reflux disease and hypertension.
-The resident was intermittently disoriented.
-The resident was a wanderer.
-The resident's medications included Wellbutrin 75 mg daily, Depakote sprinkles 125 mg daily at bedtime, and Cymbalta 30 mg daily.

Review of Resident #8's Resident Register revealed an admission date of 05/07/15.

Review of Resident #8's "Care Notes" from 02/07/16 - 03/13/17 revealed Resident #8 had five documented altercations with other residents resulting in Resident #8 sustaining an atypical femoral fracture on 02/04/17.

Review of an admission record from a local rehabilitation center for Resident #8 revealed:
-The resident was admitted to the rehabilitation center from a local hospital on 02/09/17.
-The admitting diagnosis was an atypical femoral

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fracture.

Review of Resident #8's assessment and plan of care dated 03/14/17 revealed:
-The resident was always disoriented with a significant memory loss requiring direction.
-The resident was verbally abusive and resisted care.
-The resident was not receiving any mental health or medications for mental health behaviors.

Review of Resident #8's previous assessment and plan of care dated 12/07/15 revealed:
-The resident was sometimes disoriented and forgetful, needing reminders.
-The resident was a wanderer, verbally and physically abusive.
-The resident was not receiving any mental health or medications for mental illness.
-The resident needed to be redirected when she became verbally and physically aggressive.

Review of Resident #8's special care unit Resident Profile and Care Plan Update Form for 11/02/16 and 12/20/16 revealed:
-The resident's behavioral pattern was documented as "N/A" (not applicable).
-There was no intervention documentation for the resident.

Review of a psychiatric initial visit on 10/05/15 for Resident #8 revealed:
-The resident voiced no mental health complaints.
-The resident had a flat affect, mood irritable and poor eye contact.
-The resident was a poor historian. The resident's history was obtained from staff who reported that the resident was tearful and agitated.
-The resident's findings included depression

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unstable, anxiety unstable, dementia with behavior unstable.
-Recommendations included to start Wellbutrin 75 mg every day and Depakote 125 mg every hour of sleep for dementia with behaviors.

Review of a psychiatric follow up note dated 11/12/15 for Resident #8 revealed:
-The resident was seen on 11/10/15 for a follow up visit.
-The resident had a flat affect, mood irritable and poor eye contact.
-Staff reported no issues.
-The resident's findings included depression stable, anxiety stable, dementia with behavior stable and adjustment disorder unstable.
-Recommendations included to continue to monitor, no medication changes warranted at this time and follow up in 4 to 8 weeks.

Review of Resident #8's Medication Administration Record (MAR) for December 2016 and January 2017 revealed the resident's medications included Wellbutrin 75 mg and Depakote 125 mg Sprinkles at bedtime.

Review of Resident #8's record revealed there was no documentation of further follow up with the psychiatric provider after the 11/12/15 follow up or the primary care provider related to behavioral interventions.

Based on observations, interviews and record review Resident #8 was not interviewable due to not engaging in conversation and a diagnosis of dementia.

Confidential interviews with staff members revealed:
-Resident #8 and another resident [named]

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argued a lot.
-Resident #8 was very critical and picked on a resident [named].
-A resident [named] would argue or talk back with Resident #8, which made Resident #8 even more hostile.
-They were aware that the two residents had a physical fight, in which Resident #8 fell and broke her hip when the resident [named] shoved Resident #8.
-Two of the staff members did not know of any behavioral issues or interventions for Resident #8.
-One to two months ago, the staff received report from another staff that the resident got tired of being picked on so she pushed Resident #8 back; Resident #8 fell and broke her hip.
-Another staff member received report from another staff member that Resident #8 had an altercation with another resident in which Resident #8 "messed up her hip" and needed surgery; the resident had pushed Resident #8 after being pushed first by Resident #8.
-Resident #8 would "slap" other residents "out of the blue" before she fell and broke her hip.
-The Medication Aides (MAs), Care Manager (CM), and/or Executive Director were supposed to be notified of any residents exhibiting behaviors that could be harmful to themselves or others.
-The MAs or CM notified the physician of any resident behaviors.
-Staff were expected to notify the primary care provider if a resident had behavioral issues and the primary care provider would refer the resident to mental health if needed.

Confidential telephone interview with 3 former staff members revealed:
-Resident #8 got "very agitated" and would "swing

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at you" if "she doesn't get her way."
-Resident #8's behaviors were directed mainly at other residents.
-The former staff thought Resident #8's physician was aware of her behavior, but was not sure.
-Resident #8 sometimes would hit other residents when she thought no one was looking.
-Sometimes Resident #8 used an open or a closed fist to hit other residents.
-It was common knowledge Resident #8 would slap other residents.
-Resident #8 and another resident [named] used to go at it like sisters fussing but it was just verbal between the two.--Depending on the altercation, the primary care provider or family was called but the staff was never told to call the primary care provider and the family on every altercation.
-One former staff member was never told to report behaviors to the primary care provider.
-Resident #8's behavior was never addressed.

Interview with the Executive Director (ED) on 03/21/17 at 7:29 p.m. revealed:
- Behavior interventions included preadmission assessment, care plan with quarterly reviews, medications, mental health referrals, and physician notification.
-Since arriving in the facility on 01/03/17, she had gotten mental health providers "very much involved" and they were in the facility weekly; primary care providers were also in the facility weekly.
-Physicians were notified of behaviors at weekly facility visits or could be called at any time, depending on the severity of the behavior.
-She expected the physician to be notified of behaviors as needed and expected documentation to be maintained.
-Resident #8 had left the facility on 02/04/17 due to a fall and "broken hip" and returned on

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D 273	Continued From page 72 03/09/17. -The ED got report from the Business Office Manager (BOM) that Resident #8 pushed another resident; that resident pushed her back, which resulted in Resident #8 falling and sustaining the hip fracture on 02/04/17. -She reviewed the video surveillance footage of the 02/04/17 incident and observed the following: Resident #8 and the other resident were near the nurses' station; Resident #8 pushed the other resident; the resident pushed Resident #8 back; Resident #8 fell. -Prior to 02/04/17, she had not been notified by any staff that Resident #8 had any behaviors or any incidents between Resident #8 and the resident that pushed her. No interventions had been implemented. Telephone Interview with Resident #8's family member on 03/22/17 at 12:25 p.m. revealed: -Resident #8 had an unobserved fall on the first Saturday in February 2017; no one observed the fall when the resident broke her hip that she was aware of. The facility did not elude to what caused the fall. -Resident #8 did have some anxiety issues but had as needed medications for that. -The family member was not aware of any recent mental health services for Resident #8. -The family member goes at least one time a week and other family members visit as well. Telephone Interview with the ED and the Clinical Support Specialist on 03/23/17 at 11:27 a.m. revealed: -The ED had not had time to review Resident #8's chart. -Prior to the conversation with the surveyor, the ED had no knowledge of Resident #8's history of altercations.	D 273		

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D 273	Continued From page 73 -There was no documentation of any interventions for Resident #8's behavior. -The ED expected for the resident's physician to be notified and to notify mental health services or ask the primary care provider for a mental health referral. -If Resident #8's primary care provider was notified and interventions were put into place, it should be documented in the care notes. -The ED would have expected for interventions to have been put into place to keep other residents safe from any other residents' behavior. -All staff received training related to behaviors during orientation. Staff knew what they were supposed to be doing. -The ED expected family members to be notified of behaviors of both the aggressor and the receiver. Telephone interview with a Medical Assistant for Resident #8's primary care provider on 03/23/17 at 8:55 a.m. revealed: -The Registered Medical Assistant did remember one time the facility called regarding an incident of an altercation with Resident #8 around the end of 2016. -There was documentation that the resident was found on the floor on 02/04/17, but there was no information that there was an altercation with Resident #8 and another resident that caused the fall. -There was no notification of any behavioral issues or interventions regarding Resident #8; she was "calm with no issues". -The primary care provider would have expected increased supervision to be put into place for any resident exhibiting changes in behavior and would have expected to be notified of any behavioral issues including behavioral interventions put into place for Resident #8.	D 273		

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D 273	Continued From page 74 -The primary care provider would have expected to be notified of any behaviors in order to treat the resident and to see what was going on with that resident. The behavior could be related to something as simple as a urinary tract infection. -She was not aware of any mental health services involved in Resident #8's care. The facility neglected to coordinate the health care needs of 2 of 7 residents sampled (#4, #8) as related to notification of Resident #4's GI and primary care physicians of non-tolerance of prep for ordered GI tests and failure to assure Resident #4 went to GI appointments as ordered, resulting in a four month delay in evaluation and treatment; notification of Resident #8's mental health provider and primary physician of aggressive behaviors to include multiple physical altercations with other residents; and failure to assure Resident #8 received mental health services as ordered, resulting in an altercation between Resident #8 and another resident in which Resident #8 suistained an atypical femoral fracture (hip fracture). This non-complinace constitutes an unabated Type A1 Violation for serious neglect. Review of the Plan of Protection (POP) dated 03/17/17 and POP addendum dated 03/23/17 submitted by the facility revealed: -Clinical support personnel would be assigned to the facility to assist with facilitation of health care needs of the residents to include, but not limited to: auditing charts for health care referral and follow up; any discrepancies identified would be referred to primary care physician for review and follow up orders; physician orders forwarded to the primary care physicians for review and any other recommendations; training on "new order processing system" will be provided by an RN.	D 273		

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D 273	Continued From page 75 -Memory Care Manager (MCM), Executive Director (ED) in conjunction with clinical support personnel and Quality Assurance Nurse will monitor the "new order processing system" to ensure health care needs have been addressed by the primary care provider. -All orders or recommendations received from health care providers will be processed through the "new order tracking system" and facilitated by the MCM and monitored by the ED, clinical support personnel, and quality assurance nurses. -Training would be provided on procedure for accident and incident reporting to responsible staff to include but not limited to: completion of accident and incident reports; contributing factors related to incidents; implementation of behavior tracking and interventions program through electronic tracking system; notification of responsible party and/or family member to include contributing factors to incident; notification of primary care provider by phone and fax to inform of incident/accident and contributing factors related to incident; notification of reportable accident/incident reports to DSS by fax or email; notification of emergency medical personnel and/or law enforcement should a resident be at risk or need medical evaluation or treatment. -Facility management will follow up with responsible party/family member to ensure notification of accident/incident to include discussion on contributing factors. Follow up would be documented on the primary care notification fax. -ED will review all accident/incident reports for required documentation and notification. THE CORRECTION DATE FOR THIS UNABATED TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 22, 2017.	D 273		

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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, record reveiws, and interviews the facility failed to assure each resident was free of abuse and neglect as related to health care, supervsion, and the overall management of the facility. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to meet the health care needs for 2 of 7 residents sampled related to failure to assure a resident received follow up visits with a psychiatric provider and notifying the resident's licensed health care providers regarding behaviors (#8), and notifying the licensed health care providers of a resident's inability to tolerate an ordered gastrointestinal (GI) preparation for ordered GI tests and failing to assure the resident went to scheduled GI appointments/tests (#4). [Refer to Tag D273, 10A NCAC 13F.0902 (b) Health Care (Type Unabated A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility Administrators failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right to be free of serious harm and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to supervision, health care, and residents'	D914		

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D914	Continued From page 77 rights, all of which are the responsibility of the Administrator. [Refer to Tag D980, G.S. 131D-25 Implementation (Type Unabated A1 Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs and current symptoms for 4 of 7 residents sampled (#1, #2, #3 and #8) related to three residents with multiple falls resulting in serious physical injuries to include hip and humerus fractures (#1), multiple head injuries to include a head injury requiring staples (#3), and a knot on the back of the head and ear injury (#2) and for a resident with a docmented history of reoccurring physical altercations with other residents at the facility (#8), resulting in a physical altercation with another resident causing Resident #8 to fall and sustain an atypical femoral fracture. [Refer to Tag D270, 10A NCAC 13F.0901 (b) Personal Care and Supervision (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations, interviews, and record	D980		

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	HAL071015	A. BUILDING: _____ B. WING _____	C 03/23/2017

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D980	Continued From page 78 reviews, the facility Administrators failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right to be free of serious harm and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to supervision, health care, and residents' rights, all of which are the responsibility of the Administrator. The findings are: Confidential staff interviews revealed: -The facility had been without a Care Manager since January 2017. -The Care Manager supervised the Medication Aides (MAs). - The Care Manager assisted the MAs with provider orders. -It was easier to assure provider orders were implemented when there was a Care Manager to provide assistance. -The Care Manager was supposed to review the orders/"bucket system" daily. -When the Transporter/Activity Director was on leave in January 2017, the MAs were responsible for completing the Transporter/Activity Director's duties. -"A lot" of orders were missed when the last Care Manager was working there. -The example provided by staff was as follows: the physician would ask where a prescription was and it had never been sent to the pharmacy by the Care Manager. -Staff did not know if the Executive Director (ED) was aware of the missed orders. Interview with the Business Office Manager on 03/16/17 at 2:30pm revealed:	D980		

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D980	Continued From page 79 -The facility had one Care Manager that was employed from 07/12/16-11/07/16. -The facility had a second Care Manager that was employed from 11/28/16-01/26/17. Interview with the ED/Administrator on 03/21/17 at 7:29pm revealed: -She took over responsibility as the ED of the facility on 01/03/17 from the former Regional Director of Operations who had been the facility's Administrator and was acting as the Interim ED after the previous ED left (the previous ED left in November 2016). -The former Regional Director of Operations no longer worked for the company and had left without notice. -After the former Regional Director of Operations left the company, she also became Administrator of the facility. -She lived in the facility. -The Care Manager quit on 01/26/17. -After the Care Manager quit, she (the ED) was "trying to do both rolls." -The Registered Nurse/Clinical Support Specialist (RN/CSS) came to the facility to provide assistance in February 2017 (unsure of the date). - After the Care Manager quit, applications were immediately accepted to fill the position. -Several interviews were completed; there were various reasons a Care Manager was not hired immediately. -A new Care Manager had been hired within the "last two weeks" and was in training. -When the ED first became the acting ED and became responsible for the facility, she did not realize the facility fall policy was not being followed and did not know fall risk assessments had not been completed for each resident. -"Around the end of January" (2017), the facility	D980		

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D980	Continued From page 80 started to utilize the fall policy again (after she realized it had not been followed by previous ED and Regional Director/Interim ED). -Upon arrival to the facility, her focus was on correcting the violations identified from the previous survey (completed in November 2016) because "not one thing had been done" to address the statement of deficiencies. Interview with the RN/CSS on 03/15/17 at 4:45pm revealed: -She (the RN/CSS) was assigned to cover/assist at the facility effective 02/13/17 due to the ED having a family emergency. -The ED asked the RN/CSS to complete a "chart audit;" the RN/CSS completed the audit on all resident records. -While completing the chart audit, the RN/CSS noted some provider orders had not been implemented; the former Care Manager had just filed some of the orders back into the residents' records without implementing the orders. -The facility had had two different Care Managers who had quit (the RN/CSS did not know the dates of the Care Managers employment). -The RN/CSS had notified the medical providers of the orders found during chart audit that were not implemented. -"I cannot say who was doing orders" from the time of the previous survey (November 2016) through the time that the former Regional Director of Operations was acting as the interim ED for the facility. -After the Care Managers quit and the current ED took over responsibility of the facility (on 01/03/17), the current ED and MAs were responsible for provider orders. -The Care Manager and/or ED were supposed to check provider orders in the "bucket system" daily.	D980		

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D980	Continued From page 81 -Interview with the Vice President of Quality Assurance and Regulatory Compliance on 03/16/17 at 10:33am revealed: -The former ED of the facility was no longer employed due to the last facility survey; the Regional Director of Operations took over (for the former ED) as the Administrator and Interim ED after the last survey (completed in November 2016). -The current ED started in the facility in early January 2017. -The Regional Director of Operations was no longer employed as of 01/16/17; he left without notice. -The Care Manager left without notice shortly after the current ED took over at the facility. -The RN/CSS was sent to the facility to assist as needed because the current ED recognized "there were problems." -A new ED and Care Manager had been hired for the facility; both were Licensed Practical Nurses (LPNs). -The facility fall policy had not been implemented since the previous Executive Director and previous Regional Director of Operations were responsible for the facility (after the previous survey completed in November 2016). -The monthly fall meetings and 72 hour charting had not completed during the time when the previous Executive Director and Regional Director of Operations were responsible for the facility. -There were "systemic failures" in the facility; she was unsure what the failures were, but she would "assess the situation" and make corrections where needed. Non-compliance was identified in the following areas:	D980		

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D980	Continued From page 82 1. Based on observations, interviews and record reviews, the facility failed to meet the health care needs for 2 of 7 residents sampled related to failure to assure a resident received follow up visits with a psychiatric provider and notifying the resident's licensed health care providers regarding behaviors (#8), and notifying the licensed health care providers of a resident's inability to tolerate an ordered gastrointestinal (GI) preparation for ordered GI tests and failing to assure the resident went to scheduled GI appointments/tests (#4). [Refer to Tag D273, 10A NCAC 13F.0902 (b) Health Care (Type Unabated A1 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs and current symptoms for 4 of 7 residents sampled (#1, #2, #3 and #8) related to three residents with multiple falls resulting in serious physical injuries to include hip and humerus fractures (#1), multiple head injuries to include a head injury requiring staples (#3), and a knot on the back of the head and ear injury (#2) and for a resident with a docmented history of reoccurring physical altercations with other residents at the facility (#8), resulting in a physical altercation with another resident causing Resident #8 to fall and sustain an atypical femoral fracture. [Refer to Tag D270, 10A NCAC 13F.0901 (b) Personal Care and Supervision (Type A1 Violation)]. _____ The Administrators' failure to assure the policies and procedures of the facility were implemented and in substantial compliance with the rules and statutes resulted in Resident #1 sustaining hip and humerus fractures after falling, Resident #8	D980		

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D980	Continued From page 83 sustaining an atypical femoral fracture after a physical altercation with another resident, and a four month delay in Resident #4 receiving medical tests ordered by licensed health care providers and requiring hospitalization for a GI bleed and blood transfusion;. This non-compliance constitutes an unabated TYPE A1 VIOLATION for serious physical harm and neglect. Review of the Plan of Protection submitted by the facility dated 03/23/17 revealed: -Two Administrators who are LPNs had been assigned until all procedures, policies, and rule areas are re-established and fully practiced. These two Administrators will be under the direct supervision of the Vice President of Quality Assurance and Regulatory Compliance in coordination with the Vice President of Operations until such time it is determined by internal quality assurance audits that the community is in substantial compliance in sited (sic) areas to include but not limited to: personal care and supervision, health care, residents' rights, reporting of accidents and incidents. -Once that period is reached, one of the two Administrators will remain as permanent Administrator. -A "Licensed Nurse" had been hired as the permanent Memory Care Manager. -All processes and procedures will be reviewed, revised, and updated as needed to address the needs of the residents and community in relation to the deficiencies identified by the survey team. The on-going procedures will be audited with a re-defined schedule of daily, weekly, monthly, and/or quarterly by a corporate representative, clinical support specialist, and quality assurance nurses.	D980		

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D980	Continued From page 84 THE CORRECTION DATE FOR THIS TYPE UNABATED A1 VIOLATION SHALL NOT EXCEED APRIL 22, 2017.	D980		