STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043024	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTER'S REST HOME	40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and complaint investigation on November 13-16, 2017. The Harnett County Department of Social Services initiated the complaint investigation on October 2, 2017.	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, ceilings, and floors were kept clean and in good repair for 3 common bathroom/shower rooms and 4 resident rooms (8S, 9S, 11S, 14S) on the South Hall of the facility and for 3 common bathroom/shower rooms, the spa room, and 4 resident rooms (1N, 2N, 7N, 11N) on the North Hall of the facility. The findings are: 1. Observation of the common bathroom on the right side of the South Hall (women's hall) on 11/13/17 at 4:15 p.m. revealed: -There was a 1.5 inches by 24 inches area of rust on top of the base heater. -The wall above the soap dispenser had a 4 inches by 3 inches area that had no paint and	D 074		

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D 074	Continued From page 1 chipped plaster. -There was a 2 inches by 2 inches area of rust on the floor in the corner behind the door. -There were multiple gray colored stains of various sizes on the back of the door. -The floor between the two toilets had 2 areas each 1 inch by 1 inch with missing tile. -There was dust covering the ceiling vent. Observation of the common bathroom on the left back side of the South Hall on 11/13/17 at 4:25 p.m. revealed: -There were multiple areas of various sizes of rust on top of the base heater. -There was a 1 inch by 2 inches area of rust on the floor in the corner behind the door. -There was a 36 inches by 2 inches gray colored stain on the back of the door. -There were two areas (3 inches by 2 inches and 2 inches by 2 inches) of rust on the wall under the sink. -The floor between the two toilets had 2 areas 1 inch by 1 inch each with missing tile. -There was dust covering the ceiling vent. Observation of the resident room 14S on 11/13/17 at 4:30 p.m. revealed: -There were 3 black scuff marks (2 inches by 3 inches each) on the wall beside the bed at the window. -The ceiling vent near the door was covered with dust. Observation of the resident room 11S on 11/13/17 at 4:35 p.m. revealed the ceiling vent near the door was covered with dust. Observation of the resident room 9S on 11/13/17 at 4:40 p.m. revealed the ceiling vent near the door was covered with dust.	D 074		

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D 074	Continued From page 2 Observation of resident room 8S on 11/13/17 at 4:45 p.m. revealed: -The wall above the soap dispenser had a 4 inches by 12 inches area that had no paint and chipped plaster. -The ceiling vent near the door was covered with dust. Observations of the common bathroom on the left side of the South Hall (closest to staff office) on 11/13/17 at 4:50 p.m. revealed: -There was a .5 inch round hole in the wall to the left of the toilet paper dispenser. -There was a 2 inches by 12 inches area on the right side wall of the shower that had no paint and chipped plaster. -There was a 2 inches by 12 inches area on the left side wall of the shower that had no paint and chipped plaster. -There were multiple areas of various sizes of rust on top if the base heater. -The wall below the soap dispenser had a 2 inches by 3 inches area that had no paint and chipped plaster.. -There was a 2 inches by 2 inches area of rust on the floor in the corner behind the door. -There were 3 gray colored stains of various sizes on the back of the door. -The floor between the two toilets had 2 areas 1 inch by 1 inch each with missing tile. -There was dust covering the ceiling vent. Interview with Administrator in Charge (AIC), Registered Nurse/Clinical Support Specialist, and Clinical Support Specialist on 11/13/17 at 4:55 p.m. revealed: -The observations noted were shown to each via a facility tour. -The contracted maintenance group had already	D 074		

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D 074	Continued From page 3	D 074		

been called and scheduled to come out over the next few weeks.
-The AIC will notify the contracted maintenance group of the findings revealed by the survey team to insure they are aware.

Refer to interview with the Administrator-in-Charge (AIC) on 11/13/17 at 3:40 p.m. and 3:52 p.m.

Refer to interview with Clinical Support Specialist on 11/14/17 at 8:28 a.m.

Refer to interview with a housekeeper on 11/14/17 at 9:40 a.m.

Refer to interview with a second housekeeper on 11/14/17 at 9:50 a.m.

Refer to interview with a third housekeeper on 11/15/17 at 9:22 a.m.

2. Observation of resident room 1N on 11/13/17 at 10:30 a.m. revealed:
-The first closet door had multiple scratches along the bottom portion of the door from the third hinge downward.
-The closet door was metal and the scratches were rust-colored.

Attempted interview on 11/13/17 at 10:32 a.m. with a resident who resided in room 1N revealed the resident was not interviewable and the interview was unsuccessful.

Observation of resident room 11N on the North Hall on 11/13/17 at 10:45 a.m. revealed:
-There were two ceiling air vents that were covered with dust.
-Both of the ceiling air vents had rusted areas on

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D 074	Continued From page 4 the vents. Interview with a resident in room 11N on 11/13/17 at 10:45 a.m. revealed: -He was moved to this room a few months ago. -The ceiling air vents were dusty and rusted when he moved into the room. Observation of resident room 7N on the North Hall on 11/13/17 at 11:02 a.m. revealed: -There were two ceiling air vents that were covered with dust. -Both of the ceiling air vents had rusted areas on the vents. Interview with a resident in room 7N on 11/13/17 at 11:02 a.m. revealed: -He did not know how long the dust and rust had been on the ceiling air vents. -He did not know when the ceiling air vents were last cleaned. Observation of the residents' common bathroom between resident rooms 4N and 6N on 11/13/17 at 11:13 a.m. revealed: -The wall-mounted heating unit located next to the floor, just above the baseboard, had numerous, large, rust-colored areas along the top of the unit; there was a metal rod that extended approximately 3 inches from the heating unit, that was bolted to the wall on each side of the heating unit, and had scattered rust-colored areas along the length of the rod, as well as various gray areas that were missing paint. -There were rust-colored areas along the caulking on the floor that extended the length of the bathtub. -There were scattered areas of rust-colored stains along the ceiling tiles. -The inside of the door was scuffed and had	D 074		

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D 074	Continued From page 5 areas of missing paint and rust-colored scrapes. Observation of resident room 2N on 11/13/17 at 11:15 a.m. revealed the inside door jamb was separated from the cement wall from the top of the door jamb, extending approximately one foot down the length of the door, and creating tiny crevices along the wall. Attempted interview on 11/13/17 at 11:15 a.m. with the resident who resided in room 2N revealed the resident was not interviewable and the interview was unsuccessful. Observation of the bathing spa on the North Hall on 11/13/17 at 11:20 a.m. revealed there were two broken tiles along the baseboard of the wall on the right side of the room. Observation of the common hall bathroom beside resident room 7N on the North Hall on 11/13/17 at 11:18 a.m. revealed: -There was a wall-mounted heating unit near the floor, just above the baseboard, with numerous rust-colored areas along the top of the unit. -There was a metal rod that extended approximately 3 inches from the heating unit and was bolted to the wall on each side of the heating unit with scattered rust-colored areas along the length of the rod. -The floor around the bottom of the door frame on the hinged side of the door was uneven with broken pieces of tile. -There were rust stains and brown debris at the bottom of both sides of the door frame. -The metal protective strip at the bottom of the door had missing paint and rust stains. -There were two round holes about ½ inches in diameter in the tile floor near the toilet. -There were 3 small holes in the wall above the	D 074		

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D 074	Continued From page 6	D 074		

toilet paper holder.
-There were scattered areas of rust-colored stains along the ceiling tiles, including a rusted area about 12 inches long near the ceiling exhaust fan.
-There was missing paint and sheetrock on the right side of the wall beside the paper towel holder.
-The wall above the soap dispenser had an area of missing paint and sheetrock.
-There were scattered rust stains on the wall below the sink.

Interview with the Administrator-in-Charge (AIC) on 11/13/17 at 3:52 p.m. revealed:
-They had puttied around the broken tile at the bottom of the door frame in the common bathroom on North Hall beside room 7N (no time frame specified).
-She would have the maintenance company check it again.

Observation of the common hall bathroom beside Room 10N on the North Hall on 11/13/17 at 11:28 a.m. revealed:
-There was a wall-mounted heating unit near the floor, just above the baseboard, with numerous rust-colored areas along the top of the unit.
-There was a metal rod that extended approximately 3 inches from the heating unit and was bolted to the wall on each side of the heating unit with scattered rust-colored areas along the length of the rod.
-There were rust-colored and brown stains along the caulking near the floor that extended the length of the bathtub.
-There were scattered areas of rust-colored stains along the ceiling tiles.
-There were rust stains and brown debris at the bottom of both sides of the door frame.

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D 074	Continued From page 7 -The metal protective strip at the bottom of the door had missing paint and rust stains. -There were two round holes about ½ inches in diameter in the tile floor near the toilet. -There were 6 small round nail/screw holes in the wall above the toilet paper holder. -There were several brown smears on the wall above toilet paper holder and above the wall-mounted heating unit. -There were scattered areas of rust-colored stains along the ceiling tiles, including a rusted area about 12 inches long near the ceiling exhaust fan. -There was missing paint and areas of putty above and on the right side of the wall beside the paper towel holder. -There were scattered rust stains and areas of putty on the wall below the sink. Observation on 11/14/17 at 8:00 a.m. revealed three maintenance staff from a contracted construction company working on the North Hall in the bathing spa. A second observation of resident room 11N on the North Hall on 11/14/17 at 5:18 p.m. revealed: -The dust had been cleaned from both ceiling air vents. -Both of the ceiling air vents had rusted areas on the vents. A second observation of resident room 7N on the North Hall on 11/14/17 at 5:19 p.m. revealed: -The dust had been cleaned from both ceiling air vents. -Both of the ceiling air vents had rusted areas on the vents. A second observation of the common hall bathroom beside Room 7N on the North Hall on	D 074		

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D 074	Continued From page 8 11/14/17 at 5:21 p.m. revealed: -The wall-mounted heating unit near the floor, just above the baseboard, had a new coat of white paint. -The metal rod around the heating unit had a new coat of white paint. -The floor around the bottom of the door frame on the hinged side of the door was uneven with broken pieces of tile. -There were rust stains and brown debris at the bottom of both sides of the door frame. -The metal protective strip at the bottom of the door had been replaced. -There were two round holes about ½ inches in diameter in the tile floor near the toilet. -There were 3 small holes in the wall above the toilet paper holder. -There were scattered areas of rust-colored stains along the ceiling tiles, including a rusted area about 12 inches long near the ceiling exhaust fan. -There was missing paint and sheetrock on the right side of the wall beside the paper towel holder. -The wall above the soap dispenser had an area of missing paint and sheetrock. -There were scattered rust stains on the wall below the sink. A second observation of the common hall bathroom beside Room 10N on the North Hall on 11/14/17 at 5:25 p.m. revealed: -The wall-mounted heating unit near the floor, just above the baseboard, had a new coat of white paint. -The metal rod around the heating unit had a new coat of white paint. -There was new white caulking around the base of the bathtub with a few rust-colored stains that had not been covered by the new caulking.	D 074		

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-There were scattered areas of rust-colored stains along the ceiling tiles.
-There were rust stains and brown debris at the bottom of both sides of the door frame.
-The metal protective strip at the bottom of the door had been replaced with a new silver protective strip.
-There were two round holes about ½ inches in diameter in the tile floor near the toilet.
-There were 6 small round nail/screw holes in the wall above the toilet paper holder.
-There were two brown smears on the wall above toilet paper holder. .
-There were scattered areas of rust-colored stains along the ceiling tiles, including a rusted area about 12 inches long near the ceiling exhaust fan.
-There was missing paint and areas of putty above and on the right side of the wall beside the paper towel holder.
-There were scattered rust stains and areas of putty on the wall below the sink.

A second observation of resident room 1N on 11/16/17 at 8:55 a.m. revealed housekeeping staff was in the room cleaning the room.

A second observation of the common hall bathroom between resident rooms 4N and 6N on 11/16/17 at 9:05 a.m. revealed:
-The wall-mounted heating until located next to the floor, just above the baseboard, had a new coat of white paint.
-There were scattered areas of rust-colored stains along the ceiling tiles.
-There were rust-colored stains along the caulking around the toilet.

A second observation of resident room 2N on 11/16/17 at 9:08 a.m. revealed the inside door

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D 074	Continued From page 10 jamb was separated from the cement wall from the top of the door jamb, extending approximately one foot down the length of the door. Refer to interview with the Administrator-in-Charge (AIC) on 11/13/17 at 3:40 p.m. and 3:52 p.m. Refer to interview with Clinical Support Specialist on 11/14/17 at 8:28 a.m. Refer to interview with a housekeeper on 11/14/17 at 9:40 a.m. Refer to interview with a second housekeeper on 11/14/17 at 9:50 a.m. Refer to interview with a third housekeeper on 11/15/17 at 9:22 a.m. Interviews with the Administrator-in-Charge (AIC) on 11/13/17 at 3:40 p.m. and 3:52 p.m. revealed: -The ceiling air vents were usually cleaned during deep cleaning. -One or two resident rooms were usually deep cleaned each week. -The facility's maintenance company had painted all the hallways, doors and door frames and they were currently working on more painting at the facility. -The holes in the walls would be puttied and painted by the maintenance company. Interview with the Clinical Support Specialist on 11/14/17 at 8:28 a.m. revealed: -The facility's maintenance company was at the facility today, 11/14/17, to work on sinks and to do more painting. -There had been a long list of needed repairs to complete including removing some half walls in	D 074		

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the living room.
-The maintenance company was still working on completing needed repairs.

Interview with a housekeeper on 11/14/17 at 9:40 a.m. revealed:
-It was her 3rd day of work and she was still in training.
-The process for cleaning bathrooms was "from top down".
-The walls, doors and handles, sink, toilet, showers and floors were cleaned with a disinfectant.
-She was not aware of a set cleaning schedule yet since she was still in orientation.

Interview with a second housekeeper on 11/14/17 at 9:50 a.m. revealed:
-She had been employed by facility for 3 months.
-The bathrooms were cleaned daily.
-The process for cleaning the bathrooms was to disinfect the door handles, sink, towel handle, shower, shower curtain and privacy curtain around toilet.
-The floors were cleaned with a disinfectant.
-She cleaned ceiling vents if they were dirty.
-She had not realized that serveral ceiling vents were dusty, but would clean them immediately.
-She informed the AIC if she saw repairs that were needed.

Interview with a third housekeeper on 11/15/17 at 9:22 a.m. revealed:
-The housekeepers usually deep cleaned one resident room per day.
-Deep cleaning included moving the furniture and cleaning under it and dusting it, and cleaning everything in the room.
-They swept and mopped every day.
-They cleaned the bathrooms every day including

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D 074	Continued From page 12 sweeping, mopping, showers/bathtubs, and toilets.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the facility was clean and free of hazards in 3 common resident bathrooms/shower rooms and 3 resident rooms (5S, 9S, 14S) on the South Hall of the facility and in 3 common resident bathrooms/shower rooms and the bath spa on the North Hall of the facility. The findings are: 1. Observation of the residents' common bathroom between resident rooms 4N and 6N on 11/13/17 at 11:13 a.m. revealed: -The bathtub was covered in specks of dirt and multiple black smudges. -The bolts that anchored the toilet to the floor were uncapped on both sides of the toilet; the bolts measured approximately 2 inches long. -There was a raised toilet seat over the toilet.	D 079		

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D 079	Continued From page 13 Observation of the common hall bathroom beside Room 7N on the North Hall on 11/13/17 at 11:18 a.m. revealed: -The knob on the wall-mounted heating unit was missing and a round metal stem was sticking out about ½ inch where the knob was supposed to be. -The metal drain in the tub had multiple rusted areas. -There were brown stains and debris in the bathtub and a missing non-skid strip with brown stains where the strip was missing. -The cover for the toilet paper holder was missing. -The shower curtain had rust-colored stains along the top of the curtain and around the metal holes that hooked the curtain to the rod. -There were 5 holes of the shower curtain that were not attached to the rod causing the shower curtain to droop down in those areas. -The privacy curtain beside the toilet had brownish red stains near the top of the curtain. -There were 4 rings of the privacy curtain that were not attached to the sliding track, causing the curtain to droop down in those areas. Observation of the bathing spa on the North Hall on 11/13/17 at 11:20 a.m. revealed the window blind had two broken slats. Observation of the common hall bathroom beside Room 10N on the North Hall on 11/13/17 at 11:28 a.m. revealed: -The knob on the wall-mounted heating unit was missing and a round metal stem was sticking out about ½ inch where the knob was supposed to be. -The shower curtain had rust-colored stains along the top of the curtain and around the metal holes	D 079		

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that hooked the curtain to the rod.
-The sink was loose from the wall.
-Water splashed out of the sink and onto the floor and the wall-mounted heating unit when the faucet was turned on.
-The water stream could not be adjusted to prevent the splashing without turning the faucet off.
-The metal drain in the tub had corrosion and multiple rusted areas.
-There were brown stains and debris in the bathtub with yellowish brown streaks running down on the inside wall of the tub.
-The privacy curtain beside the toilet had brown stains near the middle of the curtain.
-The bolts that anchored the toilet to the floor were uncapped on both sides of the toilet and were approximately 1 inch long.

Interview with the Administrator-in-Charge (AIC) on 11/13/17 at 11:38 a.m. revealed:
-She was not aware there was a problem with the water splashing from the sink in the common resident bathroom on the North Hall.
-She would get someone to mop the water from the floor.
-They would get the sink repaired.

Interview with a housekeeper on 11/13/17 at 11:43 a.m. revealed:
-She had worked at the facility a couple of months.
-She had not noticed a problem with the sink in the common resident bathroom on the North Hall.
-The bathrooms in the facility were cleaned every day.

Interview with the AIC on 11/13/17 at 3:42 p.m. revealed:
-The maintenance company was currently

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working on repairing the sink in the common resident bathroom on the North Hall.
-They were replacing parts on the faucet.

Interview with a medication aide on 11/13/17 at 3:50 p.m. revealed:
-The baseboard heating units in the bathrooms worked to her knowledge.
-The staff used the knobs to turn the units on and off.
-She had not noticed the knobs were missing from the heating units.
-She could not remember the last time the baseboard heating units in the bathrooms had been used.

Observation on 11/14/17 at 8:00 a.m. revealed three maintenance staff from a contracted construction company working on the North Hall in the bathing spa.

Interview with Maintenance staff from the facility's maintenance company on 11/14/17 at 8:18 a.m. revealed:
-They had replaced the faucet at the sink in the common hall bathroom beside Room 10N today, 11/14/17.
-They had brackets for any loose sinks in the facility but it was working better to put bolts into the walls to prevent the sinks from lifting up and they were working on that currently.
-There would still be "slight" movement of the sinks but that was normal.

A second observation of the common hall bathroom beside Room 7N on the North Hall on 11/14/17 at 5:21 p.m. revealed:
-The knob on the heating unit had not been replaced.
-The metal drain in the tub had multiple rusted

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areas.
-There were brown stains in the bathtub and a missing non-skid strip with brown stains where the strip was missing.
-The cover for the toilet paper holder was missing.
-The shower curtain and rings had been replaced with a new clean curtain and rings.
-The privacy curtain beside the toilet had light brownish red stains near the top of the curtain.
-There were 4 rings of the privacy curtain that were not attached to the sliding track, causing the curtain to droop down in those areas.

A second observation of the common hall bathroom beside Room 10N on the North Hall on 11/14/17 at 5:25 p.m. revealed:
-The knob on the heating unit had been replaced with a new black knob.
-The shower curtain and rings had been replaced with a new clean curtain and rings.
-The sink had been repaired with a new faucet and the water did not splash out of the sink when the faucet was turned on.
-The metal drain in the tub had corrosion and multiple rusted areas.
-The debris in the bathtub had been cleaned but there were light yellowish brown streaks running down on the inside wall of the tub.
-The privacy curtain had been cleaned.
-The bolts that anchored the toilet to the floor had been covered with a white cap.

A second observation of resident room 5S on the South Hall on 11/14/17 at 5:32 p.m. revealed:
-There was new white caulking around the back of the sink.
-The sink was not loose.

Observation of the common resident hall

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bathroom on the North Hall beside room 4N on 11/14/17 at 4:49 p.m. revealed:
-There was a large tool bag sitting on the floor in the bathroom.
-The tool bag was unzipped and opened so the contents of the bag could be seen.
-There were multiple tools in the bag including visible tools on top that included a hammer, a 12 volt power drill, a pair of pliers, and a roll of duct tape.
-The bag was unattended and no staff were observed on the North Hall.

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 11/14/17 at 4:51 p.m. revealed:
-She was not aware the tool bag had been left unattended.
-The tool bag belonged to the facility's maintenance company staff.
-They were not supposed to leave the tool bag unattended in the facility (special care unit).
-She would put the tool bag in a secure location and speak with the maintenance company staff.

Observation of the residents' common bathroom between resident rooms 4N and 6N on 11/16/17 at 9:05 a.m. revealed:
-The shower curtain had been replaced.
-The bathtub was covered in specks of dirt and multiple black smudges.
-The bolts anchoring the toilet to the floor had been covered.

Refer to interviews with the Administrator-in-Charge (AIC) on 11/13/17 at 3:40 p.m. and 3:52 p.m.

Refer to interview with the Clinical Support Specialist on 11/14/17 at 8:28 a.m.

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D 079	Continued From page 18 Refer to interview with a contracted maintenance person on 11/14/17 at 11:05 a.m. Refer to interview with a housekeeper on 11/14/17 at 9:40 a.m. Refer to interview with a second housekeeper on 11/14/17 at 9:50 a.m. Refer to interview with a third housekeeper on 11/15/17 at 9:22 a.m. 2. Observation of resident room 5S on the South Hall on 11/13/17 at 11:50 a.m. revealed: -The hand sink in the room was loose from the wall and moved up and down when touched. -The caulking around the back of the sink was cracked and pulling away from the wall. Interview with a resident in room 5S on 11/13/17 at 11:50 a.m. revealed the resident was in bed and did not want to answer any questions. Observations of the common bathroom on the right side of the South Hall on 11/13/17 at 4:15 p.m. revealed: -There were 4 rusted screws protruding 1.5 inches, one on the base of each side of the two toilets. Observations of the common bathroom on the left side of the South Hall on 11/13/17 at 4:25 p.m. revealed: -There were 4 rusted screws protruding 1.5 inches, one on the base of each side of the two toilets. -The privacy curtain around the toilet had a 1 inch by 2 inches dark brown spot. -There was no shower curtain.	D 079		

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D 079	Continued From page 19 Observation of the resident room 14S on 11/13/17 at 4:30 p.m. revealed the window had 3 missing blinds and 10 blinds that were bent. Observation of resident room 9S on 11/13/17 at 4:40 p.m. revealed the ceiling vent near the window was partially hanging from the ceiling on two corners. Observations of the common bathroom on the left side of the South Hall (closest to staff office) on 11/13/17 at 4:50 p.m. revealed there were 4 rusted screws protruding 1.5 inches, one on the base of each side of the two toilets. Interview with Administrator in Charge (AIC), Registered Nurse/Clinical Support Specialist, and Clinical Support Specialist on 11/13/17 at 4:55 p.m. revealed: -The observations noted were shown to each via a facility tour. -The contracted maintenance group would be working the next couple of weeks to complete repairs. -The AIC would notify the contracted maintenance group of the new findings for repair. Refer to interviews with the Administrator-in-Charge (AIC) on 11/13/17 at 3:40 p.m. and 3:52 p.m. Refer to interview with the Clinical Support Specialist on 11/14/17 at 8:28 a.m. Refer to interview with a contracted maintenance person on 11/14/17 at 11:05 a.m. Refer to interview with a housekeeper on 11/14/17 at 9:40 a.m.	D 079		

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D 079	Continued From page 20 Refer to interview with a second housekeeper on 11/14/17 at 9:50 a.m. Refer to interview with a third housekeeper on 11/15/17 at 9:22 a.m. _____ Interviews with the Administrator-in-Charge (AIC) on 11/13/17 at 3:40 p.m. and 3:52 p.m. revealed: -They had ordered sinks last week. -She thought the sinks were supposed to come in "maybe this week". -The facility's maintenance company had painted all the hallways, doors and door frames and they were currently working on more painting at the facility. -The facility was planning to replace the bathtubs but she did not have a timeframe on when that would be done. -The shower curtains would be cleaned during deep cleaning. -Deep cleaning was done in one to two rooms per week. Interview with the Clinical Support Specialist on 11/14/17 at 8:28 a.m. revealed: -The facility's maintenance company was at the facility today, 11/14/17, to work on sinks and to do more painting. -There had been a long list of needed repairs to complete including removing some half walls in the living room. -The maintenance company was still working on completing needed repairs. Interview with a contracted maintenance person on 11/14/17 at 11:05 a.m. revealed: -They have been working on painting halls but are working on bathrooms next.	D 079		

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D 079	Continued From page 21 They are working on fixing the protruding screws on each side of the toilets. -He would order more covers for the screws. Interview with a housekeeper on 11/14/17 at 9:40 a.m. revealed: -It was her 3rd day of work and she was still in training. -The process for cleaning bathrooms was "from top down". -The walls, doors and handles, sink, toilet, showers and floors were cleaned with a disinfectant. Interview with a second housekeeper on 11/14/17 at 9:50 a.m. revealed: -She had been employed by facility for 3 months. -The bathrooms were cleaned daily. -The process for cleaning the bathrooms was to disinfect the door handles, sink, towel handle, shower, shower curtain and privacy curtain around toilet. -The floors were cleaned with a disinfectant. -She informed the AIC if she saw repairs that were needed. Interview with a third housekeeper on 11/15/17 at 9:22 a.m. revealed: -The housekeepers usually deep cleaned one resident room per day. -Deep cleaning included moving the furniture and cleaning under it and dusting it, and cleaning everything in the room. -They swept and mopped every day. -They cleaned the bathrooms every day including sweeping, mopping, showers/bathtubs, and toilets.	D 079		

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio	D 234		

10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations
(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to assure 2 of 5 residents sampled (#3, #4) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.

The findings are:

1. Review of Resident #4's current FL-2 dated 06/08/17 revealed diagnoses included Alzheimer's, dementia, paranoia, vertigo and depression.

Review of Resident #4's Resident Register revealed an admission (from another adult care facility) on 03/04/14.

Review of Resident #4's tuberculosis (TB) tests revealed:
-There was one TB skin test placed on 05/23/08 and read as negative on 05/26/08.
-There was one TB skin test placed on 05/30/09 and read as "erythema, chest x-ray" with no date

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included.
-There was one TB skin test placed on 08/04/17 and read as 5.0 mm negative on 08/07/17.
-There was no documentation of any other TB skin tests in the record.
-There was no documentation of any chest x-ray results in the record.

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

Interview with the Registered Nurse/Clinical Support Specialist on 11/14/17 at 1:05 p.m. revealed:
-She was performing chart audits and discovered there was no chest x-ray on file from the other facility for Resident #4.
-She gave one TB test to Resident #4 on 08/04/17 that was read as 5.0 mm negative on 08/07/17.
-She would give Resident #4 a second TB test "as soon as possible".

2. Review of Resident #3's FL-2 dated 09/01/16 revealed diagnoses included Alzheimer's dementia, diabetes, hypertension, anemia, and rectal pain.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 09/02/14.

Review of Resident #3's tuberculosis (TB) information in the closed record revealed:
-There was a copy of a printed computer screen with documentation indicating one TB skin test was placed on September 2nd at 12:11 p.m. but there was no year specified on the form.
-There was computer printed initials on the form but no credentials.

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D 234	Continued From page 24 -There was a handwritten note on the copy "to be read on 09/04 or 09/05". -There was no documentation the TB skin test was read. -There was no documentation of any other TB skin test in the closed record. Review of hospital records in Resident #3's closed record revealed the resident was admitted to the hospital on 06/06/17 and expired on 06/08/17. Interview with the Clinical Support Specialist on 11/15/17 at 6:35 p.m. revealed: -They had been unable to locate any other TB testing information for Resident #3. -The Executive Director (ED) and /or the Resident Care Coordinator (RCC) would have been responsible for making sure TB testing was completed as required at the time Resident #3 was admitted to the facility. -The current ED and RCC were not employed in those positions at the time the resident was admitted.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by:	D 269		

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D 269	Continued From page 25 FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. Based on observation, record reviews and interviews, the facility failed to provide personal care tasks in accordance with care plans for 3 of 5 sampled residents (Residents #1, #2 and #5) as evidenced by failing to apply a barrier cream as ordered during incontinent care for Resident #2; failing to trim Resident #1's fingernails resulting in excessively long nails which contributed to a self-inflicted scrotal laceration requiring sutures; and failing to trim Resident #5's fingernails resulting in excessively long nails which allowed the resident to scratch his lower extrimeties. The findings are: 1. Review of Resident #2's current FL-2 dated 11/07/17 revealed: -Diagnoses included dementia/Alzheimer's and decubitus ulcers to sacral area. -The resident was non-ambulatory, non-verbal and incontinent of bowel and bladder. Review of Resident #2's Resident Register revealed an admission date of 02/17/16. Review of a Licensed Health Professional Support (LHPS) note dated 08/21/17 revealed: -The LHPS nurse observed area of redness with blanching on the resident's right buttock. -The LHPS nurse recommended that a barrier cream be used to areas of redness. Review of a Physician's Order Form for Resident #2 dated 09/12/17 revealed an order to apply a barrier cream to buttocks as needed for irritation.	D 269		

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Review of Resident #2's electronic medication administration (eMAR) record for September 2017 revealed:
-There was an entry dated 09/13/17 for Dermacloud ointment, apply to buttocks twice daily as needed (PRN) for incontinent care.
-There was no documentation of application of Dermacloud from 09/13/17 - 09/30/17.

Review of Resident #2's eMAR for October 2017 revealed:
-There was an entry dated 09/13/17 for Dermacloud ointment, apply to buttocks twice daily PRN for incontinent care.
-There was no documentation of application of Dermacloud from 10/01/17 - 10/31/17.

Review of Resident #2's eMAR for November 2017 revealed:
-An entry dated 09/13/17 for Dermacloud ointment, apply to buttocks twice daily PRN for incontinent care.
-There was no documentation of application of Dermacloud from 11/01/17 - 11/13/17.

Observation of Resident #2's medication on hand on 11/14/17 at 9:40am revealed:
-There was a jar of Dermacloud labeled for the resident dated 09/13/17.
-The 1 pound jar of Dermacloud appeared half empty.

Interview with a Personal Care Aide (PCA) on 11/13/17 at 11:20am revealed:
-The PCAs did not apply barrier creams on residents.
-The PCA reported observations of irritation noted during incontinent care to the Medication Aide (MA).
-The MA applied barrier cream to residents after

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SENTER'S REST HOME	40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526

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D 269	Continued From page 27 reports of redness. Interview with a MA on 11/14/17 at 9:45am revealed: -The PCAs reported redness observed during incontinent care. -The MAs applied barrier creams, if ordered, when the PCAs reported redness or irritation. -The MA would document application of the barrier cream once applied. -The MA could not explain why there was no documentation of application of Dermacloud to Resident #2. Review of a Physician's Oder Form for Resident #2 dated 09/29/17 revealed an order for Home Health to evaluate and treat area on resident's right buttocks. Review of a Care Note dated 09/30/17 and signed by a Home Health Nurse revealed Resident #2 had a new Stage II decubitus on his right buttock. Review of a local hospital's emergency room (ER) discharge orders dated 10/04/17 revealed Resident #2 was treated for an abscess with cellulitis of the right buttock. Review of a Physician's Order Form for Resident #2 dated 10/06/17 revealed that daily wound care by Home Health was ordered until wound on right buttock was healed. 2. Review of Resident #1's current FL-2 dated 10/23/17 revealed: -Diagnosis included Alzheimer's dementia. -Resident #1 was constantly disoriented, non-ambulatory and incontinent of bowel and bladder.	D 269		

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D 269	Continued From page 28 Review of Resident #1's Resident Register revealed an admission date of 04/19/12. Observation of Resident #1 during incontinent care on 11/13/17 at 11:55am revealed: -There were sutures on his scrotum. -The resident's fingernails extended approximately 1/2 inch beyond his fingertips. -There was a black substance underneath his nails. Interview with a Personal Care Aide (PCA) on 11/13/17 at 11:55am revealed: -The resident grabbed his scrotum during incontinent care on 10/30/17 and his fingernails cut him. -The Activity Director provided nail care to non-diabetic residents. Interview with a Medication Aide (MA) on 11/15/17 at 4:50pm revealed: -The Activity Director did nail care "a lot;" she would polish the female residents' nails one day and cut the male residents' nails another day. -Sometimes, the Resident Care Coordinator would cut the residents' nails. -The PCAs were supposed to do nail care; "some do and some don't." -The MA had noticed Resident #1's nails being long; he had a history of "digging and scratching." Review of Resident #1's care plan dated 10/26/17 revealed that nail care was to be done each visit by the Home Health PCA. Review of a local hospital emergency room (ER) discharge summary dated 10/30/17 revealed: -The resident was seen in the ER for an open wound of the scrotum and testes.	D 269		

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D 269	Continued From page 29 -The resident required 15 sutures to close the wound. Telephone interview with Resident #1's primary care physician (PCP) on 11/15/17 at 3:58pm revealed: -The resident had grabbed his scrotum and "dug his fingernails in" causing the wound. -The wound was self-inflicted from the resident's scratching. -The PCP saw the wound on 11/13/17 when he was at the facility; he planned to remove the sutures next Monday (11/20/17), when he came back to the facility. Interview with the Vice President of Clinical Operations on 11/15/17 at 6:20pm revealed: -The PCAs were supposed to be performing nail care as needed. -The Activity Director incorporated manicures as one of the resident activities which did not replace daily nail care ordered on care plans. 3. Review of Resident #5's current FL-2 dated 1/12/17 revealed: -Diagnoses included Alzheimer's/dementia, bipolar, edema, venous stasis, lipidosis, hypertension, recurrent dermatitis, history of fungal infections -Resident #5 was constantly disoriented, semi-ambulatory, and incontinent to bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 3/10/99. Review of Resident #5's care plan and service plan dated 9/7/17 revealed staff would provide nail care to resident every Thursday on 3p.m.-11p.m. shift.	D 269		

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D 269	Continued From page 30 Review of physician's visit notes dated 10/09/17 revealed resident had several areas of open wounds and scratches across both lower extremities. Observation of Resident #5 on 11/13/17 at 12:00 p.m. revealed: -The resident was sitting in a wheelchair in the front lobby with a chair alarm draped over the back of the wheelchair. -Ace bandages were noted on both of his lower extremities. -The resident's fingernails were long with a dark, brown substance underneath each nail. Observation of Resident #5 on 11/13/17 at 5:05 p.m. revealed: -Resident #5 was seated in the dining room and had been served his supper meal. -The resident was picking at the inside of both ears. -His fingernails were long, and a brown substance was underneath each fingernail. Interview with a Medication Aide (MA) on 11/15/17 at 4:50pm revealed: -The Activity Director did nail care "a lot;" she would polish the female residents' nails one day and cut the male residents' nails another day. -Sometimes, the Resident Care Coordinator would cut the residents' nails. -The PCAs were supposed to do nail care; "some do and some don't." Interview with Medication Aide/Supervisor (MA/S) on 11/15/17 at 5:05 p.m. revealed: -The activity director performed nail care on residents sometimes during the activities, but there was no set schedule for when she did it.	D 269		

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D 269	Continued From page 31 -The PCAs should all be doing nail care but not all of them do. Interview with Resident #5's primary care provider (PCP) on 11/15/17 at 4:00 p.m. revealed resident has had good response with the unna boots to help with blood flow and swelling and to protect the wounds from the resident scratching. Interview with the Vice President of Clinical Operations on 11/15/17 at 6:20pm revealed: -The PCAs were supposed to be performing nail care as needed. -The Activity Director incorporated manicures as one of the resident activities which did not replace daily nail care ordered on care plans. Attempted interview with Resident #5's family member on 11/16/17 at 11:30 a.m. was unsuccessful.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to assure the acute	D 273		

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and routine health care needs were met for 1 of 5 residents sampled (#3) as related to failure to obtain a gastrointestinal consult, physical therapy, speech therapy, and labwork for the resident; and failure to send the resident to the emergency room after initial symptoms of nausea and vomiting.

The findings are:

Review of Resident #3's FL-2 dated 09/01/16 revealed:
-Diagnoses included Alzheimer's dementia, diabetes, hypertension, anemia, and rectal pain.
-The resident was intermittently disoriented.
-The resident was semi-ambulatory with a walker or wheelchair.
-The resident required assistance with bathing and dressing.

Review of Resident #3's assessment and care plan dated 01/19/17 revealed:
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident was verbally and physically abusive.
-The resident required extensive assistance for toileting, ambulation, bathing, dressing, and transferring.
-The resident required limited assistance with grooming (including hair and mouth care) and eating.

A. Review of an Emergency Medical Services (EMS) report dated 03/17/17 for Resident #3 revealed:
-The chief complaint was hypotension.
-EMS noted the resident's blood pressure was 92/42 and heart rate was 74.
-The facility staff stated the resident was not

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acting her usual self.
-The resident had been running a low grade fever and had been given Tylenol.
-The resident was transported to a local hospital.

Review of a hospital discharge summary dated 03/23/17 for Resident #3 revealed:
-The resident was admitted to the emergency room (ER) on 03/17/17.
-The resident was released from the ER but per EMS, the facility did not feel comfortable accepting the resident back.
-Per EMS, the resident's oxygen level was 90% on room air when she returned to the facility, so the resident was sent back to the ER on 03/17/17.
-The facility staff reported the resident was not acting herself.
-The resident was noted to have some wheezing upon arrival to the ER but chest x-ray was unremarkable.
-The resident was admitted to the hospital.
-The resident was diagnosed with sinusitis.
-The resident was found to have normocytic anemia but there were no signs of an active bleed and her H/H (hematocrit/hemoglobin) were stable.
-The resident's hematocrit was 28.3 (reference range 33.6 - 44.6) and her hemoglobin was 9.0 (reference range 11.3 - 15.0) on 03/22/17.
-The etiology of her altered mental status upon admission was likely acute illness superimposed on her underlying dementia.
-The resident was weaned off oxygen therapy and discharged back to the facility on 03/23/17.
-Discharge instructions included: CBC (complete blood count) to monitor H/H (hematocrit and hemoglobin); recommend follow-up with GI (gastrointestinal) for further evaluation as outpatient if family wishes.

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D 273	Continued From page 34 -Discharge summary problems included sepsis (resolved), sinusitis (acute), altered mental status (acute), hypokalemia (resolved), pneumonia (ruled out), atrial fibrillation (chronic), dementia (chronic), hypertension (chronic), diabetes (chronic), and anemia (chronic). -There were recommendations to follow-up with speech therapy (ST) at the facility to assess tolerance of oral intake and pureed with nectar thick liquids. 1. Review of Resident #3's health care provider notes and progress notes revealed no documentation of a gastrointestinal (GI) referral being done for Resident #3. Interview with a medication aide on 11/15/17 at 1:59 p.m. revealed: -She was the Resident Care Coordinator (RCC) when Resident #3 resided at the facility. -If there was a referral on hospital discharge forms, the RCC would give the paperwork to the facility's Transporter. -The Transporter was responsible for making the appointments. -She did not recall seeing the instructions for a GI consult for Resident #3. Interview with a second medication aide on 11/15/17 at 6:55 p.m. revealed: -Resident #3 had never complained to her about GI symptoms like vomiting, heartburn, or indigestion. -The resident always asked for coffee and chocolate. Interview with the Clinical Support Specialist on 11/15/17 at 10:38 a.m. revealed: -They could not find any documentation in regards to a GI consult for Resident #3.	D 273		

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D 273	Continued From page 35 -An appointment for a GI consult was never made. -The Transporter checked the appointment book and found no documentation. Telephone interview with the Transporter on 11/15/17 at 3:44 p.m. revealed: -The RCC would let her know if an appointment needed to be made for a resident. -She would make the appointments and document in the appointment book. -She did not receive any paperwork for a GI consult for Resident #3 and she was not asked to make an appointment for a GI consult. -She was not aware of Resident #3 having any stomach issues. Telephone interview with Resident #3's primary care provider (PCP) on 11/15/17 at 5:41 p.m. revealed: -She no longer worked with the primary practice who serviced the facility. -She was the PCP for Resident #3 when Resident #3 lived at the facility. -She did not have access to Resident #3's record. -She was not aware of recommendations for a GI referral. -She did not recall being notified by the facility about the GI referral. -The resident had not complained about any stomach issues during any of her visits. -Staff had not reported any stomach issues for Resident #3. Telephone interview with Resident #3's family member on 11/13/17 at 4:30 p.m. revealed: -The resident went to the hospital in March 2017 and was supposed to have a GI consult for further evaluation. -It was never done.	D 273		

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D 273	Continued From page 36 -She was never made aware by the facility that the resident needed a GI consult. -The resident would have heartburn but her medication usually helped with those symptoms. -Some staff reported to the family member later that the resident had really bad heartburn the night before she was sent to the hospital in June 2017. 2. Review of Resident #3's health care provider notes and progress notes revealed no documentation of a speech therapy consult being done for Resident #3. Interview with a medication aide (MA) on 11/15/17 at 4:50 p.m. revealed Resident #3 received a regular diet with regular liquids and had no problems swallowing. Telephone interview with a personal care aide (PCA) on 11/15/17 at 5:52 p.m. revealed: -Resident #3 required assistance with everything except eating. -Resident #3 usually received regular diet with regular liquids and did not have problems swallowing. Interview with a second MA on 11/15/17 at 6:55 p.m. revealed Resident #3 did not have any problems swallowing her foods or liquids. Interview with a third MA on 11/15/17 at 1:59 p.m. revealed: -She was the Resident Care Coordinator (RCC) when Resident #3 resided at the facility. -If there was a referral on the hospital discharge forms, the RCC would give the paperwork to the facility's Transporter. -The Transporter was responsible for making the appointments.	D 273		

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D 273	Continued From page 37 -She did not recall seeing the instructions for speech therapy consult for Resident #3. -The resident did not have swallowing problems to her knowledge. -The resident's meats were usually chopped and she received regular liquids, not thickened. -The RCC or the MA on duty were responsible for clarifying an orders or instructions if different from current plan of care. Interview with the Assistant Rehabilitation Director (ARD) for the facility's contracted rehabilitation provider on 11/15/17 at 11:50 a.m. revealed: -She recalled having an open claim for Resident #3 but she could not recall the date. -The open claim could have been from years before. -She did not know if anyone from their rehabilitation services or from the facility called to find out about the open claim. -They would not have been able to provide any services to the resident, including ST, until the claim was closed. -Their process would be to let the facility know and the facility would be responsible for notifying the PCP. -She would search for further information regarding the ST. A second interview with the ARD on 11/15/17 at 1:13 p.m. revealed: -She did not find a billing form for Resident #3 for ST. -If the ST referral was on a hospital discharge form, they would have to get an order for ST from the PCP. -She could not find an order from the PCP for ST. -Either their rehabilitation group or the facility could have contacted the PCP to get an order for ST.	D 273		

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D 273	Continued From page 38 Telephone interview with Resident #3's primary care provider (PCP) on 11/15/17 at 5:41 p.m. revealed: -She no longer worked with the primary practice who serviced the facility. -She was the PCP for Resident #3 when Resident #3 lived at the facility. -She did not have access to Resident #3's record. -She was not aware of recommendations for a ST referral. -She did not recall being notified by the facility about the ST referral. 3. Review of Resident #3's labwork revealed no documentation of a CBC (complete blood count) being done for Resident #3 as ordered on the hospital discharge summary on 03/23/17. Interview with a medication aide on 11/15/17 at 1:59 p.m. revealed: -She was the Resident Care Coordinator (RCC) when Resident #3 resided at the facility. -The RCC would have been responsible for setting up the labwork for the CBC to get done. -She did not recall if a CBC was done for Resident #3 because she did not recall seeing the instructions for a CBC to be done on the hospital paperwork. Telephone interview with Resident #3's primary care provider (PCP) on 11/15/17 at 5:41 p.m. revealed: -She no longer worked with the primary practice who serviced the facility. -She was the PCP for Resident #3 when Resident #3 lived at the facility. -She did not have access to Resident #3's record. -She did not recall if a CBC was done as ordered.	D 273		

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D 273	Continued From page 39 Telephone interview with Resident #3's family member on 11/13/17 at 4:30 p.m. revealed: -The resident went to the hospital in March 2017 and was supposed to have a CBC. -It was never done. -She did not understand why it was not done. B. Review of a visit note by the primary care provider (PCP) dated 03/30/17 for Resident #3 revealed: -The resident told the PCP her neck hurt on the left side. -The resident's head was tilted to the right and she had stiffness to the muscles on the left side of the neck. -The PCP ordered physical therapy (PT) to evaluate and treat for neck pain and stiffness. -The PCP ordered a follow-up in one month. Review of Resident #3's health care provider notes and progress notes revealed no documentation the resident was evaluated and treated by PT as ordered on 03/30/17. Interview with a medication aide (MA) on 11/16/17 at 11:35 a.m. revealed: -She used to be the Resident Care Coordinator (RCC) and she was responsible for coordinating physical therapy when she was the RCC. -Resident #3 would complain of neck pain after sleeping in her recliner. -She recalled the resident having an order for physical therapy but she did not remember if the resident received any physical therapy services. -The resident only complained of pain in her neck for "a short time" and then the resident stopped complaining about it. -She could not recall any timeframes related to the resident's neck pain or when physical therapy was ordered.	D 273		

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D 273	Continued From page 40 Interview with the Assistant Rehabilitation Director (ARD) for the facility's contracted in-house provider on 11/15/17 at 11:50 a.m. revealed: -She recalled having an open claim for Resident #3 but she could not recall the date. -The open claim could have been from years before. -She did not know if anyone from their rehabilitation services or from the facility called to find out about the open claim. -They would not have been able to provide any services to the resident, including PT, until the claim was closed. -Their process would be to let the facility know and the facility would be responsible for notifying the PCP. -She would search for further information regarding the PT. A second interview with the ARD on 11/15/17 at 1:13 p.m. revealed: -She found an initail billing form for insurance purposes for Resident #3 in their paperwork for PT. -This form was required to be filled out prior to a resident receiving services. -The resident would not have received PT since there was an open claim. -She did not know if the facility contacted them to follow-up on the PT not being done for Resident #3. Review of an outpatient billing form for Resident #3 for the rehab provider revealed: -The therapy requested was PT. -It was requested on 04/10/17. -The PCP practice was noted as the referring physician. -The information regarding verification of	D 273		

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D 273	Continued From page 41 insurance or prior authorization was blank. Review of Resident #3's progress notes revealed: -There was no documentation the rehabiliation company was contacted to follow-up on the PT order. -There was no documentation the PCP was notified the resident did not receive PT services as ordered. C. Review of resident care notes for Resident #3 revealed: -On 06/05/17 (no time noted): The resident had "been throwing up tonight". The resident's family member was called and the family member "didn't want me to send her out". -On 06/06/17 (no time noted): The resident was throwing up - checked her. Emergency Medical Services (EMS) was called 6:30 a.m. She went to the hospital. Staff talked to the resident's family member. Review of an EMS report dated 06/06/17 for Resident #3 revealed: -The call to 911 was received at 7:56 a.m., EMS was dispatched at 7:59 a.m., and EMS arrived to the resident at the facility at 8:11 a.m. -The chief complaint was nausea / vomiting with a duration of 10 hours. -Facility staff stated the resident was up all night with complaints of nausea / vomiting. -Facility staff stated they thought the resident would feel better this morning but they saw she had vomited again while sitting in her chair. -Facility staff wished for the resident to be seen at the emergency room (ER) for further evaluation. -The resident stated she had been vomiting for "some time" and her stomach was upset. -The resident had no other complaints. -The resident was noted to have a normal	D 273		

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generalized abdominal assessment by EMS and the resident had no complaints of pain upon palpation of the abdominal area.
-The resident was transported as non-emergent (no lights and siren) to a local hospital.

Review of a hospital admission record for Resident #3 dated 06/06/17 revealed:
-The resident was evaluated in the ER for nausea and vomiting on 06/06/17.
-The assessment noted vomiting, diarrhea, lactic acidosis, atrial fibrillation, elevated troponin, hypertension, type 2 diabetes mellitus, and advanced dementia.
-The lactic acidosis was a combination of dehydration from nausea/vomiting, atrial fibrillation, and elevated blood sugar.

Review of a hospital death record for Resident #3 rdated 06/08/17 revealed:
-The resident's overall prognosis was poor and it was discussed with the family and the resident was made comfort measures only.
-The resident expired on 06/08/17.

Interview with a personal care aide (PCA) on 11/15/17 at 4:38 p.m. revealed:
-About 2 days prior to Resident #3 going to the hospital in June 2017, the resident complained of heartburn.
-She reported it to the medication aides on duty (could not recall which MAs).
-It was unusual for the resident to complain of heartburn.
-She was not working when the resident went to the hospital in June 2017.

Telephone interview with a medication aide (MA) on 11/15/17 at 10:40 p.m. revealed:
-She worked as a MA on third shift the night of

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D 273	Continued From page 43 06/05/17 (10:00 p.m.) - 06/06/17 (6:00 a.m.). -Resident #3 vomited a small amount when the MA first got to the facility around 10:00 p.m. on 06/05/17. -The resident said she did not feel good. -Around 12:00 midnight, Resident #3 vomited a second time and it was a large amount, "all of her dinner". -It appeared to have chunks of food in the vomit. -There was no blood in the vomit. -A little vomit got on the resident's bed sheets so she changed the resident's sheets. -She thought the resident would feel better after she vomited because it sometimes helped with the sick feeling if you could vomit. -The MA called Resident #3's family member (health care power of attorney) "sometime after 12:30 a.m.", but she could not recall the exact time. -The MA told the family member about the resident vomiting and the resident did not feel good. -The family member told the MA a stomach bug had been going around and the family member thought the resident had it. -The MA told the family member that the resident said she felt like she "was going to die". -The family member told the MA that the resident said that all the time. -The MA could tell the resident did not feel good and she wanted to send the resident out to the hospital. -The family member did not want the resident to go to the hospital because no one could go with the resident to the hospital. -The family member told the MA to keep her posted but the family member did not ask the MA to call back at a certain time. -The resident did not sleep well that night and she vomited "a little" one more time around 4:00 a.m.	D 273		

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and it was more like "clear phlegm".
-The resident did not vomit anymore on third shift that night.
-She did not receive any other calls during third shift from the family member.
-The facility's procedure at that time was to notify the family of concerns or issues with residents and get approval from the family member to send a resident to the hospital.
-She reported to the MA coming on first shift duty on 06/06/17 that Resident #3 had been sick and vomiting.
-The first shift MA reported she was going to send the resident out to the hospital.
-The facility's procedure now was to send a resident to the hospital if they had a fever, a fall, or if vomiting.
-They now call the RCC first when sending a resident to the hospital.

Interview with a medication aide (MA) on 11/15/17 at 4:50 p.m. revealed:
-She was working as a first shift MA on 06/06/17.
-When she arrived to the facility about 5:50 a.m., one of the PCAs told her Resident #3 was vomiting.
-She could smell the vomit before she got to the resident's room.
-The vomit smelled like "bowel" and there were chunks of food in it.
-She could not recall the color of the vomit.
-The third shift MA and PCA reported the resident had vomited throughout the night and said "I'm dying".
-Third shift staff reported they called the resident's family member but the family member did not want the resident sent to the hospital.
-She told the first shift PCA to stay with the resident and the MA called 911.
-She called 911 before calling the family member

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because other staff reported the family did not want the resident sent out.
-Then the resident's family member called to check on the resident.

Telephone interview with a personal care aide (PCA) on 11/15/17 at 5:52 p.m. revealed:
-She worked as a PCA on first shift on 06/06/17.
-When she got to work at 6:00 a.m. on 06/06/17, she went to Resident #3's room and the resident said she was not feeling well and she needed to vomit.
-She got the trash can for the resident and the resident vomited.
-Then, the resident started vomiting "a lot".
-The vomit was black and had a strange smell, like a "blood smell".
-The resident said she was sick and she was going to die.
-She reported it to the MA on duty and she thought the MA called 911.
-The resident's family member also called and spoke with the MA.
-The resident was taken to the hospital by EMS.
-She worked on first shift on the day before, 06/5/17, and the resident was not sick.

Interview with a medication aide on 11/15/17 at 1:59 p.m. revealed:
-She was the Resident Care Coordinator (RCC) when Resident #3 resided at the facility.
-She was not working when Resident #3 was sent to the hospital in June 2017.
-The first shift MA called her because she was the RCC at the time.
-The first shift MA reported that Resident #3 had been throwing up all night and they called the family member but the family did not want the resident sent to the hospital.
-The first shift MA had already called 911 and was

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D 273	Continued From page 46 waiting for EMS to arrive. -The resident was sent to the hospital on first shift because she was diabetic and she kept vomiting. -The first shift MA reported the vomit looked "nasty". -Third shift should have sent the resident to the hospital since she was diabetic. -At that time, the procedure was to call the family before sending the resident to the hospital. -But if a family had a tendency to not want the resident sent to the hospital, she would sometimes call 911 before calling the family. -Resident #3 was sent to the hospital on 06/06/17 and she passed away while in the hospital. Interview with a medication aide on 11/15/17 at 6:55 p.m. revealed: -She was not working in June 2017 when Resident #3 was sent to the hospital. -Resident #3 had never complained to her about vomiting, heartburn, or indigestion. -The resident always asked for coffee and chocolate. -The resident's family member did not usually want the resident sent out to the hospital. -She called the family member on one occasion to let her know the resident had fallen and the MA had called 911 (could not recall date). -The family member asked the MA if EMS was already on the way because the family member did not want the resident sent to the hospital. Telephone interview with Resident #3's primary care provider (PCP) on 11/15/17 at 5:41 p.m. revealed: -She no longer worked with the primary practice who serviced the facility. -She could not speak to the incident when Resident #3 went to the hospital in June 2017.	D 273		

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D 273	Continued From page 47 Telephone interview with Resident #3's family member on 11/13/17 at 4:30 p.m. revealed: -In June 2017, the resident was vomiting bowel for 10 hours and she was concerned about the delay in sending the resident to the hospital. -The resident died of sepsis while in the hospital in June 2017. -A MA called her one time on third shift on 06/06/17 between 1:00 a.m. and 3:00 a.m. and reported the resident had vomited twice. -The MA reported there were peaches in the vomit and they cleaned the resident and she was resting. -She told the MA to check the resident every 15 minutes and call her back in an hour. -The MA never called her back. -She tried to call the facility back but no one answered until about 6:00 a.m. - 6:30 a.m. -She talked with the first shift MA who reported the resident was still vomiting and she was going to send her out. -She agreed to send the resident to a local hospital. -It was unusual for the resident to vomit unless she had a stomach virus. -Some staff reported to the family member later that the resident had really bad heartburn the night before she was sent to the hospital. -Within 12 hours of being at the hospital, sepsis set in and the resident went into renal failure.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from	D 282		

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D 282	Continued From page 48 contamination. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure the kitchen area, as well as the dining area, was kept clean as evidenced by dirt around the hand-washing sink, black stains underneath the window air conditioning unit, dirt and dust on the PVC water pipes running around the kitchen, greasy build up on the oven and crumbs from previous snack service on dining tables preset with silverware and napkins for the next meal. The findings are: Observations during the kitchen tour on 11/14/17 at 10:58am revealed: -There was greasy build-up on the sides of the stove and edges of oven door. -There was dirt on the edge of the wall above the hand-washing sink. -The caulking around the edge of the sink was pitted and dirt was in the pitted areas. -The window ledge below the window mounted air conditioner was splattered with a black substance. -The white PVC water pipes running around the interior of the kitchen were dusty with clumps of black material. -There were orange cracker crumbs on dining tables that were set with silverware and napkins for the lunch meal. Interview with a kitchen aide on 11/14/17 at 11:15am revealed: -The floors of the kitchen were swept and mopped after each meal. -The dining tables were cleaned after each meal. -She was not aware of a cleaning schedule. Interview with the Kitchen Manager on 11/14/17	D 282		

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D 282	Continued From page 49 at 11:19am revealed: -The kitchen staff did not have a deep cleaning schedule. -He voiced understanding of the areas that needed cleaning. -He would put in a work order to have the hand washing sink re-caulked which would make cleaning easier. -The orange crumbs on the table were from the snack crackers served at 10:00am on 11/14/17. -He would see that the dining tables with crumbs were cleaned and re-set with clean napkins and silverware. Observation of the kitchen on 11/15/17 at 8:25am revealed the stove had been cleaned. Interview with the Kitchen Manager on 11/15/17 at 8:40am revealed: -He had found a cleaning schedule that had been used in the past. -The Kitchen Manager and the Business Office Manager had scheduled a time to review and update the cleaning schedule. -The updated cleaning schedule would be utilized in the future.	D 282		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	D 338		

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D 338	Continued From page 50 TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to implement effective interventions, that were ordered by the residents' primary care provider or in accordance with the facility's falls management program, for 3 of 3 sampled residents, who had been identified by the facility as high risk for falls and had experienced multiple falls with injuries (#4, #5, #6). The findings are: Interview with the Registered Nurse/Clinical Support Specialist (RN/CSS) on 11/14/17 at 12:50 p.m. revealed: -The facility had a Falls Management Program that any resident was admitted to if the resident had greater than one fall. -Staff were to complete incident reports for all falls. -A falls risk worksheet/assessment was completed on all residents in the program. -The falls management team reviews incident reports monthly. Interview with the RN/CSS on 11/15/17 at 10:00 a.m. revealed: -She came to the facility on 07/14/17, and began assessing residents who had a history of falls. -The facility's falls management program was implemented for any resident who had more than one fall. -Based upon the RN/CSS assessments, the falls management program would be implemented at that time for any resident who had fallen more than once. Interview with the RN/CSS on 11/16/17 at 8:15	D 338		

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D 338	Continued From page 51 a.m. revealed: -As a result of the previous survey (in July 2017), any resident with falls was placed on 30 minute checks. -If the resident had another fall, after the 30 minute checks were implemented, the resident was placed on 15 minute checks. Review of the Fall Risk Worksheet revealed: -The form was to be completed by a Care Manager, Nurse or Executive Director to determine if there was a medical or physical factor that could possibly contribute to falls. -The resident was scored in six areas, including gait, level of consciousness, mobility, diagnosis, medications and history of falls. -Any score of 5 or above indicated a high risk for falls. Review of the Fall Management Team Meeting form revealed: -The team met once a month to analyze the previous month's falls. -The team consisted of the Executive Director, Care Manager, Nurse (if applicable) and one Supervisor. -All Incident reports for the previous month and resident records were to be brought to the meetings. -The form included the resident's name, date of fall, shift and injured area. -There were questions that asked if staff completed the 72 hour report, could the fall have been prevented and were there any recent medication changes previous to fall. -The last item on the form included steps the team would implement to assist in preventing this type of fall again. 1. Review of Resident #4's current FL-2 dated	D 338		

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D 338	Continued From page 52 06/08/17 revealed: -Diagnoses included Alzheimer's, dementia, paranoia, vertigo and depression. -Resident #4 was constantly disoriented, ambulatory and incontinent of bowel and bladder. Review of Resident #4's Resident Register revealed an admission from another adult care facility on 3/4/14 Based on observations, record reviews, and interviews, Resident #4 was not interviewable. Review of Resident #4's Resident Service Plan (care plan) dated 9/7/17 revealed: -Resident #4 had a history of wandering. -She had limited ability for ambulation. -There was no reference to the use of any assistive device for ambulation. -She had daily incontinence of bowel and bladder. -She was fully dependent on staff for bathing, dressing, and toileting and required limited assistance for transferring. -Risk management provisions for Resident #4 included fall precautions due to vertigo. Observation of Resident #4's room on 11/13/17 at 11:05 a.m. revealed: -The resident was not in the room. -There were two Personal Care Aides (PCAs) in the room. -There was a sensor to a bed alarm laying on the side dresser. -The sensor's battery was dead. -There was not a bed alarm on the bed. -One PCA pulled out two bed alarms from the resident's side dresser drawer; one with the sensor and one without the sensor. Interview with a PCA on 11/13/17 at 11:10 a.m.	D 338		

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revealed:
-The PCA noted that the alarm laying on the bedside table had a dead battery.
-The PCA was going to plug it into the bed pad but could not locate the pad.
-The PCA found an extra pad in the drawer but noted the battery was dead.

Review of an Incident/Accident Report dated 06/27/17 revealed:
-The incident occurred at 7:15 a.m. in the hallway.
-The resident was walking down the hall and tripped over her feet and fell on her left arm.
-The resident was taken to the Emergency Room (ER) and the Primary Care Provider (PCP) was notified at 7:15 a.m.
-The status of Resident #4 after the ER visit was documented as "fracture of distal end of humerus; follow-up care orthopedics; returned to facility."

Review of Care Notes for Resident #4 revealed there was no staff documentation related to the fall on 6/27/17.

Review of a Physician Face to Face Encounter form dated 7/6/17 for Resident #4 revealed:
-The PCP saw Resident #4 for routine follow up.
-The PCP noted to keep arm elevated and follow-up in one month.

Review of an Incident/Accident Report dated 07/13/17 revealed:
-The incident occurred at 5:40 p.m.
-The location of the incident was not documented.
-The resident got up from the couch, started walking, lost her balance and fell.
-The resident had a bloody nose.
-The resident was taken to the ER and the

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Primary Care Provider (PCP) was notified at 6:05 p.m.
-The status of Resident #4 after the ER visit was documented as "injury of head; contusion; follow-up with primary physician."

Review of an ER report for Resident #4 dated 7/13/17 revealed:
-Resident #4 was seen for fall.
-A CT scan of the head was completed and results revealed a soft tissue hematoma over the right frontal bone. (A computed tomography scan is a three-dimensional image often used to assist in diagnosing hemorrhage or stroke when scanning the head).
-A CT scan of the cervical spine was completed and results revealed no acute process.

Review of Care Notes for Resident #4 for 7/13/17 revealed that Resident #4 was sent to the hospital for a fall and hitting her head.

Review of a Physician Face to Face Encounter form dated 7/20/17 for Resident #4 revealed:
-The PCP saw Resident #4 for follow-up of fall.
-The PCP noted bruising over the right side of her face and a soft cast on her left arm.
-The PCP noted to keep arm elevated and follow-up in one month.
-The PCP noted staff reported no issues.

Review of an Incident/Accident Report dated 07/29/17 revealed:
-The incident occurred at 8:40 p.m. in the hallway.
-The PCA was assisting the resident to her room and the resident lost her balance in the hallway.
-The resident was taken to the ER and the Primary Care Provider (PCP) was notified at 8:55 p.m.

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D 338	Continued From page 55 -The status of Resident #4 after the ER visit was documented as "Intraoral laceration without sutures; follow-up with PCP on next visit." Review of Care Notes for Resident #4 for 7/29/17 revealed that Resident #4 was sent to hospital for a fall. Review of a Physician Face to Face Encounter form dated 8/10/17 for Resident #4 revealed: -The PCP saw Resident #4 for breathing difficulty at night. -The PCP noted that resident requires 1+ assist to leave facility due to her altered mental status and risk for falls. -The PCP noted plan for physical therapy to evaluate and treat for mobility. Review of Fall Risk Worksheet for Resident #4 dated 8/25/17 revealed: -Resident #5 had shuffling gait. -She was confused. -The resident's mobility was limited to wheelchair. -Resident #4 scored a total of 14 points, which indicated high risk for falls. Review of an Incident/Accident Report dated 10/6/17 revealed: -The incident occurred at 6:25 p.m. in the hallway. -The resident stood up from the wheelchair and started to walk and lost her balance. -The resident was taken to the ER and the Primary Care Provider (PCP) was notified at 6:30 p.m. -The status of Resident #4 after the ER visit was documented as "fall; follow-up with PCP." Review of an ER report for Resident #4 dated 10/6/17 revealed:	D 338		

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-Resident #4 was seen for fall.
-An x-ray of the pelvis was completed and results revealed a normal examination of the pelvis and hips.

Review of Care Notes for Resident #4 revealed there was no staff documentation related to the fall on 10/6/17.

Review of a Physician Face to Face Encounter form dated 10/9/17 for Resident #4 revealed:
-The PCP saw Resident #4 for a fall follow-up.
-The PCP noted that resident requires 24/7 1+ assist to leave facility due to her dementia.
-The PCP noted that staff reported resident has a semi electric hospital bed and a floor mattress.
-The PCP noted that resident is lacking a chair alarm and would order one to further reduce the risk for falls.

Review of physician's orders for 10/9/17 revealed an order for a chair alarm.

Review of a Physician Face to Face Encounter form dated 10/16/17 for Resident #4 revealed:
-The PCP saw Resident #4 for a fall follow-up.
-The PCP noted that staff reported increased difficulty to care for resident without 2+ assistance due to weakness and cognitive limitations displayed by the resident.
-The PCP noted that resident would benefit from hospice services due to advancing symptoms related to dementia.
-The PCP noted that resident requires 24/7 1+ assist due to dementia.

Observation of Resident #4 on 11/14/17 at 9:45 a.m. revealed:
-Resident was lying in her bed singing.
-There was a floor mat beside the bed.

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D 338	Continued From page 57 -There was no chair alarm in the wheelchair. Observation of Resident #4 on 11/14/17 at 11:50 a.m. revealed: -The resident was sitting in her wheelchair being fed lunch by a PCA in the dining room. -The resident did not have a chair alarm in her wheelchair. Interview with PCA on 11/14/17 at 11:55 a.m. revealed: -Resident #4 "does not have a chair alarm". -She had never known Resident #4 to have a chair alarm. Interview with the Administrator in Charge (AIC) and the Clinical Support Specialist (CSS) on 11/14/17 at 12:25 p.m. revealed: -Neither staff member was aware that Resident #4 had an order for a chair alarm. -They were not sure why the order for the chair alarm was overlooked. -Neither staff member recalled Resident #4 ever having a chair alarm. -The AIC explained the process for once an order was written it would be faxed immediately to the Pharmacy, and if it's for durable medical equipment they would check to see if it's in-house first before ordering it. Interview with the CSS on 11/14/17 at 12:35 revealed: -The CSS found an alarm that could be used for the bed or the chair in Resident #4's dresser. -The CSS would put it on the resident's wheelchair immediately. Interview with another PCA on 11/14/17 at 5;45 p.m. revealed: -She had never seen a chair alarm on Resident	D 338		

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D 338	Continued From page 58 #4's wheelchair. -"I just saw it on her chair for the first time tonight." Interview with a PCA on 11/15/17 at 1:55 p.m. revealed: -She had never used a chair alarm for Resident #4 and never knew her to have one ordered. -Resident #4 "use to walk but now she has to stay in the wheelchair and we have to watch her closely". Interview with Medication Aide/ Supervisor (MA/S) on 11:15/17 at 2;00 p.m. revealed; -She had not known Resident #4 to ever have a bed alarm or chair alarm. -Resident #4 has had multiple falls. -She first noticed that Resident #4 had a chair alarm today. Interview with Resident #4's primary care provider (PCP) on 11/15/17 at 4:00 p.m. revealed: -Resident #4 was at risk for falls. -Resident #4 was lacking a chair alarm so he ordered one to further ensure reduction of falls risk. -He was not aware that Resident #4 did not have a chair alarm. -He expected her to have a chair alarm at all times when in the wheelchair. Interview with Resident #4's family member on 11/16/17 at 10:15 a.m. revealed: -He travels frequently and doesn't get to see Resident #4 except for a few times per year. -He had concerns with all of her falls and having to be sent to the ED. -He did not voice his concerns to the facility staff. -He was not aware that the physician had ordered a chair alarm for her.	D 338		

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D 338	Continued From page 59 -He thought she had a bed alarm. 2. Review of Resident #6's current FL-2 dated 01/06/17 revealed: -Diagnoses included dementia, cerebrovascular accident, coronary artery disease and intracranial hemorrhage. -The resident was semi-ambulatory. -He was intermittently confused. -The resident was incontinent of bowel and bladder. -The medication orders included Aspirin 325mg daily (Aspirin is a blood thinner and nonsteroidal anti-inflammatory medication used to reduce the risk of heart attack and reduce fever, pain and inflammation.) Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 01/11/17. -He required assistance with all activities of daily living and the use of a wheelchair. -Resident #6's memory was documented as forgetful. Review of Resident #6's Resident Service Plan/Care Plan dated 03/02/17 revealed: -Resident #6 had a history of wandering. -He was ambulatory with an assistive device. -The resident had daily incontinence of bowel and bladder. -He was sometimes disoriented, forgetful and needed reminders. -Resident #6 required extensive staff assistance with bathing, dressing, toileting and transferring. Review of an Incident/Accident Report dated 07/03/17 revealed:	D 338		

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-The incident occurred at 5:30 a.m. in the bathroom.
-The resident bumped his left elbow on the left side of the wall going into the bathroom.
-He had a skin tear to his left elbow.
-The resident was not taken to the emergency room (ER) or seen by the Primary Care Provider (PCP).

Review of a note to the PCP from the facility's Registered Nurse (RN) on 07/05/17 revealed:
-Resident #6 continued to be at risk for falls.
-The resident stood up after unhooking his seatbelt, stepped forward, fell against the wall and down to the floor; he had a skin tear on his left elbow that had re-opened.
-The RN requested orders for dressing changes and a seatbelt restraint that the resident could not release.
-The PCP responded, "see notes dated 07/06/17."

Review of a Physician Face to Face Encounter form dated 07/06/17 for Resident #6 revealed:
-The PCP saw Resident #6 for post fall and wound care.
-Staff reported to the PCP that the resident was getting up from his chair, trying to walk and falling; the resident had a seatbelt on his chair, but the resident was able to disconnect it.
-The resident had open skin tears on both elbows.
-The PCP ordered daily wound care to the resident's elbows, chair alarm and two elbow protectors, on in the morning and remove at night.

Review of a Physician Face to Face Encounter form dated 07/13/17 for Resident #6 revealed:
-The PCP saw Resident #6 for a bruise on his

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hip.
-Staff reported to the PCP that the resident had fallen recently.
-The PCP noted that wound care had been ordered, but neither arm had a dressing applied.
-The PCP also noted that a chair alarm had been ordered, but was not on Resident #6 at the time of the PCP's visit.
-The PCP noted that elbow protectors were ordered to be placed on in the morning and removed at night, but were not on the resident at the time of the PCP's visit.

Review of an emergency room (ER) report for Resident #6 dated 07/19/17 revealed:
-The resident was seen for facial laceration to the right lateral eyebrow, closed head injury and unwitnessed, mechanical ground-level fall.
-Resident #6 received sutures to the facial laceration that were ordered to be removed in ten days.

Review of Incident/Accident reports provided by the facility revealed there was no incident report completed for the fall that occurred on 07/19/17.

Review of Care Notes for Resident #6 revealed there was no staff documentation related to the fall on 07/19/17.

Review of a Physician Face to Face Encounter form dated 07/20/17 for Resident #6 revealed:
-The PCP saw Resident #6 for follow-up to a fall.
-The resident fell the night before and sustained a laceration to the right side of his forehead.
-The PCP noted the chair alarm was on, but the string was too long; the resident was able to bend all the way forward and would need to fall out of the chair for the alarm to sound.
-The PCP shortened the string on the alarm and

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educated staff on the proper length.
-The PCP ordered daily wound care to the laceration and to ensure that the string on the chair alarm was shortened to make sure the chair alarmed before the resident fell out of the chair.

Review of Care Notes for Resident #6 dated 07/22/17 revealed:
-The first entry had no time documented; however, staff documented that the resident "currently" had bruising on his right back side and right buttocks.
-A second entry was written at 10:00 p.m.; staff documented the resident was found on the floor on the mat in his room. Staff looked the resident over and did not see bruising at that time.

Review of Incident/Accident reports provided by the facility revealed there was no incident report completed for the fall that occurred on 07/22/17.

Interview on 11/14/17 at 12:35 p.m. with a medication aide (MA), who documented the Care Note dated 07/22/17 revealed:
-The MA did not know about Resident #6's falls; she was never working when the resident's falls occurred.
-She always just heard about his falls from other staff.

A second interview with the same MA on 11/14/17 at 12:55 p.m. revealed:
-The MA confirmed her written Care Note dated 07/22/17.
-She "was passing along information to the next shift" in that Care Note.
-Her note would have said she called the doctor had she witnessed an incident with Resident #6.
-Resident #6 would often roll from the bed or be on all fours trying to get up from a fall; "he'd fall

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D 338	Continued From page 63 softly." Review of Care Notes for Resident #6 dated 07/23/17 revealed: -There was no time documented for the first entry; staff documented Resident #6 was sent to the hospital for a fall. The resident returned to the facility at 1:15 a. m. -There was a second entry with no time documented; staff documented the resident was trying to get up and walk around, and was trying to fight staff. Review of an ER report for Resident #6 dated 07/23/17 revealed Resident #6 was seen for acute contusion to the right flank area. Review of Incident/Accident reports provided by the facility revealed there was no incident report completed for the fall that occurred on 07/23/17. Interview on 11/15/17 at 4:50 p.m. with the MA, who documented the Care Note dated 07/23/17 revealed: -Resident #6 was "just busy." -The Clinical Support Specialist put fifteen minute checks in place at one time due to his falls. -He had a bed alarm that would alarm if he moved at all; the MA had not worked 3rd shift in a long time, so she was not sure if it worked all the time, but it worked when she was on duty. -The MA was not sure why there was no Incident/Accident Report for Resident #6's fall on 07/23/17; it had been a long time ago, so the report may have been misplaced. Review of a Fall Management Team Meeting form for Resident #6 dated 07/23/17 revealed: -The resident fell on 2nd shift and sustained bruising (there was no site not specified).	D 338		

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-Documentation revealed "the fall could not have been prevented."
-Resident #6 had recent medication changes, included ear drops for wax build-up.
-The only step implemented to prevent falls was to "monitor for ear wax build-up, which could affect balance."

Review of Care Notes for Resident #6 revealed there was no documentation regarding staff monitoring for ear wax build-up.

Review of Resident #6's Increased Supervision and Accountability Check Lists revealed:
-Fifteen minutes checks were implemented on 07/23/17 at 6:00 a.m. for Resident #6.
-The fifteen minutes checks were discontinued on 07/24/17 at 5:45 a.m. when the resident was last documented as being observed in the hallway.
-Fifteen minute checks were documented on 07/24/17 from 2:00 p.m. - 10:00 p.m. when Resident #6 was last observed in his bedroom; there were further fifteen minute checks documented after 10:00 p.m.
-Fifteen minutes checks were documented on 07/25/17 at 6:00 a.m. and continued through 08/01/17 at 5:45 a.m.

Review of an Incident/Accident Report dated 08/14/17 revealed:
-The incident occurred at 4:30 p.m. in the resident's bedroom.
-The resident was found on the floor at his bedroom door on his left side.
-There was a "red spot" documented on the resident's head, indicating the location of the injury.
-The resident was taken to the ER and a message was left with the PCP at 4:40 p.m.
-The status of Resident #6 after ER visit was

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D 338	Continued From page 65 documented as "put on 15 minute checks, fall prevention and follow-up with PCP on 08/17/17." Review of an ER report for Resident #6 dated 08/14/17 revealed: -Resident #6 was seen for a fall. -A CT scan of the head was completed and results revealed no acute process. (A computed tomography scan is a three-dimensional image often used to assist in diagnosing hemorrhage or stroke when scanning the head). Review of a Fall Management Team Meeting form for Resident #6 dated 08/14/17 revealed: -Resident #6 fell on 2nd shift and had no injuries. -"The fall could not have been prevented" was documented. -The only step implemented revealed "PT (physical therapy) referral pending." Review of Resident #6's Care Notes revealed physical therapy evaluated Resident #6 two weeks later, on 08/29/17. Review of a Physician Face to Face Encounter form dated 08/17/17 for Resident #6 revealed: -The PCP saw Resident #6 for follow-up to hospital visit for a fall. -Staff reported that the resident was in bed and then was on the floor behind the door. -The PCP noted the resident had a chair and bed alarm available, as well as a floor mat. -The PCP ordered for staff to ensure the bed and chair alarms were utilized. Review of Resident #6's Increased Supervision and Accountability Check Lists revealed: -Fifteen minutes checks were implemented on 08/16/17 at 6:00 a.m. and continued until 08/24/17 at 5:45 p.m.	D 338		

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D 338	Continued From page 66 -On 08/18/17, from 12:30 p.m.-4:30 p.m., staff documented Resident #6 was at the hospital. -The fifteen minute checks were implemented again on 08/26/17 at 6:00 a.m. and continued until 08/27/17 at 4:45 p.m. Review of an Incident/Accident Report dated 08/18/17 revealed: -The incident occurred in the hallway (no time was documented). -Resident #6 got out of wheelchair and fell on the floor, hitting his head. -A laceration was documented as the resulting injury. -The resident was taken to the ER by emergency medical services (EMS) at 12:15 p.m. Review of an ER report for Resident #6 dated 08/18/17 revealed: -The resident was seen for laceration of occipital scalp and minor head injury. -Resident #6 received staples to the scalp laceration. Review of a Fall Management Team Meeting form for Resident #6 dated 08/18/17 revealed: -Resident #6 fell on 1st shift and sustained a laceration. -There was documentation indicating the fall could have been prevented if there was a "shorter string on the chair alarm." -The only step implemented to prevent falls was to "check chair alarm for proper functioning." Review of Resident #6's electronic medication administration records (e-MAR) for July and August 2017 revealed: -There was no entry on the July e-MAR for a chair alarm. -There was a computer-generated entry on the	D 338		

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D 338	Continued From page 67 August e-MAR for chair/bed alarm, check for placement every shift; the original order date was 08/30/17. -There was documentation the chair/bed alarm was checked on 2 of 3 shifts on 08/30/17 and all shifts on 08/31/17. Review of Resident #6's Care Notes revealed no documentation that staff were checking the chair alarm for proper functioning. Review of the Fall Risk Worksheet-Initial Assessment for Resident #6 dated 08/25/17 revealed: -Resident #6 had a shuffling gait. -He was confused. -The resident's mobility was limited. -Resident #6 scored a total of 17 points, which indicated a high risk for falls. -Pre-printed documentation at the bottom of the worksheet revealed the resident was to be monitored for 72 hours after a fall, including immediate evaluation for the reason for fall. Review of a Plan of Care and Care Notes for Physical Therapy for Resident #6 revealed: -Physical Therapy evaluated Resident #6 on 08/29/17. -The physical therapist saw the resident for a total of 6 visits; the last visit was on 09/16/17. -Physical therapy visits included therapeutic exercises and activities. -The resident participated better with hands-on assistance from the therapist, and also followed one-step commands. -The therapist documented wheelchair to bed transfers and wheelchair to chair transfers. -On 09/16/17, the therapist documented spending extra time looking for the resident's shoes.The resident only had compression hose on his feet,	D 338		

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D 338	Continued From page 68 "making him greater fall risk due to slipping." Review of a Physician Face to Face Encounter form dated 08/31/17 for Resident #6 revealed: -The PCP saw Resident #6 for hospital follow-up. -The PCP noted the resident had a fall and sustained a laceration to the head; stitches had been removed and the site was almost healed. -The PCP ordered a referral for Physical Therapy to evaluate and treat for frequent falls, and for staff to ensure chair and bed alarms were utilized. Review of Resident #6's Increased Supervision and Accountability Check Lists revealed: -Fifteen minute checks were initiated on 08/29/17 at 6:00 a.m. and stopped at 1:45 p.m. -The fifteen minute checks resumed on 08/30/17 at 2:00 p.m. and stopped at 5:45 a.m. on 08/31/17. -At 10:00 p.m. on 08/31/17, Resident #6 was on fifteen minute checks until 09/01/17 at 5:45 a.m. Review of Resident #6's Care Notes dated 09/09/17 revealed: -There was no time documented for the entry. -The staff documented the resident was sent to the ER on 1st shift for a fall. Review on an Incident/Accident Report dated 09/09/17 revealed: -The incident occurred at 2:00 p.m. in the resident's bedroom. -Resident #6 was found on the floor face up when staff was checking halls. -No injury was documented. -The resident was taken to the ER via EMS at 2:15 p.m. Review of an ER report for Resident #6 dated 09/09/17 revealed the resident was seen for a	D 338		

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D 338	Continued From page 69 fall. Interview on 11/15/17 at 4:25 p.m. with a third MA, who documented the Care Notes dated 09/09/17 revealed: -Resident #6 fell mostly on 3rd shift; the MA did not recall the resident falling when she was working. -The MA confirmed the documentation on the Care Note dated 09/09/17; the MA could not recall the details, but she thought the personal care aide (PCA) found Resident #6 on the floor when she was doing rounds. The PCA nor the MA were sure if the resident fell or not, so the MA sent the resident to the hospital for evaluation. -He had bed and chair alarms, and they worked. -The PCA or the MA would check the alarms to make sure they were working. -At one time, he was on fifteen minute checks for falls (unable to recall dates). Review of a Fall Management Team Meeting form for Resident #6 dated 09/09/17 revealed: -Resident #6 fell on 2nd shift; no injury was documented. -Documentation indicated the fall could not have been prevented. -The only step to prevent falls included" increasing one on one activities." Review of the Care Notes for Resident #6 revealed there was no documentation that staff had implemented one on one activities for Resident #6. Review of Resident #6's Increased Supervision and Accountability Check Lists revealed: -Fifteen minutes were initiated on 09/09/17 at 2:00 p.m. and continued until 5:45 a.m. on 09/10/17.	D 338		

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D 338	Continued From page 70 -The checks were resumed on 09/10/17 at 2:00 p.m. and continued until 09/11/17 at 10:00 p.m. -Fifteen minute checks were initiated again on 09/12/17 at 6:45 a.m. and continued until 5:45 a.m. on 09/13/17; they resumed at 10:00 p.m. on 09/13/17 for third shift. Review of Care Notes for Resident #6 dated 09/12/17 at 10:00 a.m. revealed the staff documented the resident's "thumb was red, happened when fall occurred." Review of Incident/Accident reports provided by the facility revealed there was no incident report completed for the fall that occurred on 09/12/17. Interview on 11/15/17 at 2:10 p.m. with the former Resident Care Coordinator (RCC)/MA, who documented the Care Note dated 09/12/17 revealed: -She worked as the RCC, but was currently a MA. -Resident #6 was a "faller;" he was always trying to get up. -She was not sure about the note on 09/12/17 for Resident #6; she wondered if the injury she was referring to came from a prior fall and not from a second fall on 09/12/17. -He had an alarm and a seat belt in his wheelchair; he also had a floor mat by his bed. -Someone had to sit with him, and his family requested the seat belt be placed in his wheelchair. -He got the chair and bed alarms at the same time. Review of an Incident/Accident Report dated 09/14/17 revealed: -There was no time or location documented regarding the incident. -The personal care aide (PCA) documented that	D 338		

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D 338	Continued From page 71 she was walking on North Hall and noticed Resident #6 on the floor on his knees; the PCA got the Executive Director (ED), who checked the resident for bruises. -There was no injury documented. -The resident was not taken to the ER nor was the PCP notified. Review of an Incident/Accident Report dated 09/18/17 revealed: -The incident occurred at 5:15 a.m. in the resident's bedroom. -Resident #6 was laying on his back on the floor. -The resident was not alone at the time of the incident. -A skin tear to the back of the resident's head was the documented injury. -Resident #6 was taken to the ER via EMS. Review of Resident #6's Care Notes dated 09/18/17 revealed: -There were no entries documented by third shift staff. -The RN/CSS documented an entry at 8:00 a.m. that Resident #6 was sent to the ER at 5:30 a.m. for fall and head injury. The RN/CSS had spoken with the 3rd shift Supervisor, who reported that the PCA had been in the resident's room for a 30 minute check; the PCA left to get linen and upon return, found Resident #6 lying on his fall mat with bleeding noted at the back of his head. The Supervisor stated the fall mat and bed/chair alarm were in place. -The RN/CSS documented a second entry at 9:45 a.m. on 09/18/17 that she had directed staff to rearrange the resident's room so that the night stand was not near the bed as it was possible the resident's head struck it prior to him landing on the floor mat.	D 338		

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D 338	Continued From page 72 Review of a Fall Management Team Meeting form for Resident #6 dated 09/18/17 revealed: -Resident #6 fell on 3rd shift and sustained an injury to the back of his head. -Documentation indicated the fall could have been prevented. -The only step implemented to prevent falls included "checking chair alarm for proper functioning." Review of Resident #6's MAR for September 2017 revealed: -There was a computer-generated entry on the September e-MAR for chair/bed alarm, check for placement every shift. -There was documentation the chair/bed alarm was checked on all shifts from 09/01/17-09/17/17 and 09/23/17-09/28/17. -There was documentation Resident #6 was in the hospital from 09/18/17-09/22/17, and passed away on 09/29/17. Review of Resident #6's Care Notes revealed there was no documentation that staff were checking the chair or bed alarm for proper functioning. Review of a hospital discharge summary for Resident #6 dated 09/22/17 revealed: -Resident #6 had a mechanical fall while staff at the facility were changing the resident's linen. -The resident had a small open wound to the back of the head with some bleeding. -A CT scan of the head revealed an acute hemorrhage with chronic ischemic changes. -The resident's discharge diagnosis was acute intracranial hemorrhage. -The resident was to receive comfort care and hospice services at the facility.	D 338		

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D 338	Continued From page 73 Telephone interview on 11/15/17 at 10:10 p.m. with the PCA, who was working on 09/18/17 when Resident #6 fell, revealed: -He recalled the fall "very well." -It was close to shift change, and the PCA went in to Resident #6's room to check on him; he bathed Resident #6. -The PCA went out of the room to get a change of linen from the linen cart that was located near the resident's room in the hallway. -Resident #6 was still in bed when the PCA went out of theroom. -The light in Resident #6's room was on, so he probably thought it was time to get up for the day. -When the PCA went back into the resident's room, he was on the floor; his body was on the floor mat, but his head was not. -Resident #6's head must have hit the night stand, because it was right next to the bed. -His head was bleeding, so the PCA did not move or touch Resident #6; the resident was awake and talking. -The PCA got the MA. -Resident #6 had a bed alarm; he did not recall the alarm not working. -The PCA thought he remembered hearing the alarm sound that morning while he was out of the room. -The resident had to put "a certain amount of weight on the bed to make the alarm sound." Telephone interview on 11/15/17 at 10:20 p.m. with a fourth MA, the MA who was working when Resident #6 fell on 09/18/17 revealed: -The MA primarily worked 3rd shift. -The morning Resident #6 fell (unable to recall date), the MA had gone to his room; the MA could not recall why she went to Resident #6's room, but she went in and turned the light on. -The MA left the room for something (the MA did	D 338		

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not recall why she left Resident #6's room) and when she went back in, he was on the floor.
-No other staff was with her at the time she went to Resident #6's room.
-The resident's head was injured and she told the PCA who was working that they needed to send Resident #6 to the ER.
-The MA did not recall if Resident #6 had a bed alarm or if she heard the alarm sounding from his room during that shift.
-The MA thought Resident #6 just rolled out of bed.
-By the time her shift ended, Resident #6 had not left the facility.
-She completed an Incident/Accident report.
-Before she got home from working her shift, she received a call from management that she needed to change the Incident/Accident report she had completed; the MA could not remember what she was asked to change, but she thought it had something to do with a "name or something."

Interview with the RN/CSS on 11/15/17 at 6:40 p.m. revealed:
-Resident #6 did not have an order for a fall mat; it was a part of the facility's fall management program.
-Resident #6 was on 15 minute checks; the CSS had the resident on 30 minute checks, but the frequency was increased to 15 minutes due to the number of falls Resident #6 was having.
-The RN/CSS completed the Fall Risk Worksheet for Resident #6 dated 08/25/17 and the team meeting worksheets for several falls that Resident #6 had.
-The RN/CSS documented the fall on 09/18/17 could have been prevented had a new bed/chair alarm been obtained.
-When the RN/CSS arrived at the facility on the morning of 09/18/17, it was 6:15 a.m.; "something

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made me come in early that morning."
- "All I can say is the bed alarm was working when I got here that day."

Review of Hospice Service Narratives for Resident #6 revealed:
-Resident #6 was admitted to hospice care on 09/22/17 at 2:50 p.m.
-Resident #6 was minimally responsive on 09/25/17.
-Resident #6 passed away on 09/29/17 at 12:53 p.m.

Telephone interview with Resident #6's Power of Attorney (POA) on 11/14/17 at 7:42 p.m. revealed:
-Resident #6 was a "busybody and was constantly trying to get up."
-He fell at home prior to coming to the facility, and had a brain bleed; his Dementia had gotten worse.
-He figured out how to take his shirt off when the chair alarm was in place.
-The POA was aware of the number of falls the resident had while at the facility.
-The staff always contacted the POA when there was a fall, because EMS was notified.
-With the last fall, on 9/18/17, Resident #6 got up and he fell.
-The POA understood the staff went in his room to change him and it was early in the morning.
-The resident was very routine, and probably thought it was time for him to make his bed.
-Resident #6 had a puncture wound on the back of his head; the CT scan revealed several bleeds. (Computed Tomography scan is a three-dimensional image often used to assist in diagnosing hemorrhage or stroke when scanning the head).
-The POA did not think there was any staff in the

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D 338	Continued From page 76 room when the fall occurred. Interview with a resident on 11/15/17 at 6:09 p.m. revealed: -The resident's room was near Resident #6's. -Resident #6 fell from his wheelchair one time and hit his head; staff were not watching him. -Most of the time, Resident #6 fell at night. -The resident never heard Resident #6's bed alarm go off. Interview with a fifth MA on 11/16/17 at 9:30 a.m. revealed: -Resident #6 had a chair alarm. -Resident #6 was up all the time. -A lot of times, residents had bed alarms as well, and if they had chair alarms too, it was usually the same alarm. -The MA thought Resident #6 used the same alarm for the chair and bed. -The MA had never come to work and found his bed alarm unplugged or not on, but she had come to work and found his chair alarm not hooked to him. -She knew that the male PCA was working when Resident #6 fell the last time, and the PCA had left Resident #6's room to get something when Resident #6 fell. -The MA did not know if the bed alarm was on or not, but if it was on, the PCA should have heard it. - "It does not take much to set off those bed alarms; the residents do not have to move very much to cause the alarm to sound." -Resident #6's room was close to the nurse's station and close to where the linen cart was usually kept in the hallway; the alarm would have been easily heard. Interview with a second PCA on 11/15/17 at 4:45 p.m. revealed:	D 338		

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D 338	Continued From page 77 -Resident #6 had falls; he was a "busybody." -He could walk, but needed assistance and he would get out of bed or out of the chair without help. -The PCA did not know about the last fall that occurred. Telephone interview with a third PCA on 11/15/17 at 5:55 p.m. revealed: -Resident #6 had a chair and bed alarm; she never found the bed alarm not working when she came into work. -The PCA did not work Resident #6's hall a lot, but if she did, she would get Resident #6 up for breakfast and the alarm was working because it would go off. Telephone interview with the former Primary Care Provider/Nurse Practitioner (PCP/NP) for Resident #6 on 11/15/17 at 5:40 p.m. revealed: -The PCP/NP recalled that Resident #6 could get up on his own and fell frequently. -He did not like to be told to stay in bed. -He had bed and chair alarms, and a seatbelt in his wheelchair that he could unlatch. -The PCP/NP remembered Resident #6 received Physical Therapy at one time, but was unable to recall the specific timeframe. -As far as the PCP/NP knew, the staff were telling her when Resident #6 fell; "if they did not tell me, I wouldn't know it, I guess." -The PCP/NP could not recall a specific time when she visited Resident #6 and his chair alarm was not attached; she no longer had access to her notes regarding the resident since she was not working at the provider's office, so she could not be 100% sure. "It may have been several months ago." Based on interviews and record reviews,	D 338		

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D 338	Continued From page 78 Resident #6 experienced nine falls from 07/05/17-09/18/17. Five of the nine falls resulted in injuries that required transportation to the emergency room for medical evaluation. The resident had a fall mat on the floor next to his bed and the Primary Care Provider ordered a chair alarm on 07/07/17. Fifteen minute checks were implemented at various times, with the first time being on 07/23/17. The resident fell five additional times, after which a bed alarm was ordered on 08/17/17. Physical therapy evaluated Resident #6 on 08/29/17 and saw the resident for a total of six visits; however, the resident continued to have falls. The facility failed to implement effective interventions to prevent Resident #6's falls, who was known by staff to frequently get out of bed on his own. On 09/18/17, Resident #6 fell in his bedroom, after being left alone by staff, and sustained a head injury, resulting in an intracranial hemorrhage for which hospice services was initiated, and the resident passed away eleven days later. Based on interviews, it could not be determined if the resident's bed alarm was on and functioning properly. Staff working on 09/18/17 could not recall if they heard the bed alarm sound when the resident got out of bed. It could also not be determined if an assessment of Resident #6's room and other enviornment had been completed and if interventions had been implemented as a result. 3. Review of Resident #5's current FL-2 dated 1/12/17 revealed: -Diagnoses included Alzheimer's/dementia, bipolar, edema, venous stasis, lipidosis, hypertension, recurrent dermatitis, history of fungal infections -Resident #5 was constantly disoriented, semi-ambulatory, and incontinent to bowel and bladder.	D 338		

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D 338	Continued From page 79 Review of Resident #5's Resident Register revealed an admission date of 3/10/99. Review of Resident #5's Resident Service Plan (care plan) dated 9/7/17 revealed: -Resident #5 had a history of wandering, was verbally and physically abusive. -He was non-ambulatory and used a wheelchair for locomotion. -He had daily incontinence of bowel and bladder. -He was always disoriented and resisted care. -He had very limited vision and heard only loud sounds/voices. -He required extensive staff assistance with bathing, dressing, toileting and transferring. Review of Resident #5's Resident Care Coordinator's notes to the Primary Care Provider (PCP) and the facility's Incident/Accident Reports revealed the resident experienced four falls and one documented bruise to the right hip from 07/31/17-10/20/17. Review of a Fall Management Team Meeting form for Resident #5 dated 8/25/17 revealed: -Resident #5 fell on 2nd shift. -It was not noted if the resident sustained any injuries from the fall. -It was documented that the fall could have been prevented by "moving the chair closer to the wall". -Steps implemented were "Put recliner closer to wall, PT (Physical Therapy) referral, Audio tape: War is Over". Review of Fall Risk Worksheet for Resident #5 dated 8/25/17 revealed: -Resident #5 had a shuffling gait. -He was confused. -The resident's mobility was limited to wheelchair.	D 338		

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D 338	Continued From page 80 -Resident #5 scored a total of 12 points, which indicated high risk for falls. Review of note dated 10/20/17 from the Resident Care Coordinator (RCC) faxed to the PCP revealed "status post (previous) fall out of bed, no injury; we would like orders for a hospital bed, fall mat and bed alarm for safety". Review of physician note dated 10/23/17 revealed "will evaluate and write face-to-face today". Review of a Physician Face to Face Encounter form dated 10/23/17 for Resident #5 revealed: -The PCP saw Resident #5 for a fall follow-up. -The PCP noted the resident "has no precautions in place". -The PCP noted medical decision "ordering a fall mat and semi-electric (SE) hospital bed with bed rails for improved safety and reduced falls risk." -The PCP noted "the SE hospital bed is warranted due to patient's significant muscle weakness and advanced dementia. -The PCP noted the resident requires 2+ assist for transfers and positioning in bed. Review of physician orders dated 10/23/17 revealed: -Semi electric hospital bed with guard rails. -Guard rails for safety and falls prevention, not for restraining. -Fall mat. Observation of Resident #5 on 11/13/17 at 12:00 p.m. revealed: -The resident was sitting in a wheelchair in the front lobby with a chair alarm draped over the back of the wheelchair. -Ace bandages were noted on both of his lower extremities.	D 338		

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D 338	Continued From page 81 -The resident's fingernails were long and had a dark, brown substance underneath each nail. -He was quiet and calm. Observation of Resident #5 on 11/13/17 at 5:05 p.m. revealed: -Resident #5 was seated in the dining room and had been served his supper meal. -The resident was picking at the inside of both ears. -He was quiet and not interacting with the other residents seated at the table. Observation of Resident #5 on 11/14/17 at 12:00 p.m. revealed: -The resident was sitting in a wheelchair in the dining room being fed by a PCA (Personal Care Aide). -A chair alarm was draped over the back of the wheelchair. Observation of Resident #5 on 11/14/17 at 5:30 p.m. revealed: -Resident #5 was in the staff office sitting in wheelchair and was agitated and shouting out noises and words that were not understandable. -A PCA reported "the resident was agitated because of noises in the dining room, so we took him to the staff office". -Staff members gave him some cookies that he ate. -Approximately 15 minutes later, Resident #5 was calm sitting in wheelchair (with chair alarm attached) still in office with several staff members. Observation of Resident #5 on 11/15/17 at 10:15 a.m. revealed: -Resident #5 was yelling and cursing. -His chair alarm was beeping.	D 338		

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D 338	Continued From page 82 -Staff were pushing the resident, who was in his wheelchair, to his room. Observation on 11/15/17 at 3:00 p.m. of Resident #5's room revealed: -The resident was not in the room. -The bed had no guard rails and there were no guard rails noted anywhere in the room. -There was a floor mat beside the bed. Interview with Resident #5's PCP on 11/15/17 at 4:00 p.m. revealed: -Resident #5 was at risk for falls and was total care assist. -He did not consider the guard rails a restraint for the resident. -"The resident's ability to pull himself up is very limited and he cannot sit up on the bed from a laying position". -He last visited Resident #5 on 11/16/17 and was not sure if he saw guard rails on the resident's bed. -He was not aware that the guard rails were not on the bed. -He ordered the guard rails on 10/23/17 and expected Resident #5 to have them installed immediately. Interview with a MA on 11/15/17 at 4:45 p.m. revealed: -She performed personal care frequently on Resident #5. -Resident #5 had a wheelchair alarm but she has not seen him ever with a bed alarm. -She had never seen any guard rails on Resident #5's bed. Observation of Resident #5 on 11/15/17 from 7:00 p.m.- 7:10 p.m. revealed: -The resident was lying in his bed; there were no	D 338		

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guard rails on the bed.
-The night stand was located next to the head of the resident's bed.
-The resident was nearly rolling out of the bed; his legs were hanging half way off the bed, and his head was partially off the bed.
-A MA was notified that Resident #5 needed assistance, and the MA came to the resident's room and repositioned the resident.

Interview with the RCC and the Clinical Support Specialist (CSS) on 11/15/17 at 7:35 p.m. revealed:
-The CSS was not aware of the order for Resident #5's guard rails.
-The RCC was not aware that guard rails were allowed in the facility.
-The RCC would contact the PCP for clarification.
-The process for physician orders was the RCC would receive the order and have the Supervisor enter it in the eMAR and then the RCC would sign off before it's implemented.

Attempted interview with Resident #5's family member on 11/16/17 at 11:30 a.m. was unsuccessful; message was left to return call.

Interview with the Vice President of Clinical Services on 11/15/17 at 8:00 p.m. revealed:
-She was not aware that Resident #5 had an order for guard rails.
-They would contact the PCP for clarification.

Observation of Resident #5's room on 11/15/17 at 9:40 p.m. revealed:
-The nightstand had been moved and turned so that it was not sitting next to the resident's bed; it was several feet away.
-The bed rails were in place.

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D 338	Continued From page 84 Observation on 11/16/17 at 9:05 a.m. of Resident #5's room revealed: -The resident was not in the room. -The bed had guard rails on each side that were half side rails. -There was a floor mat beside the bed. Interview with the Administrator in Charge on 11/16/17 at 9:45 a.m. revealed: -The PCP was called and the guard rail order was clarified and rewritten on 11/15/17. -The restraint assessment and care plan was completed on 11/15/17. -The guard rails were put on Resident #5's bed on evening of 11/15/17. Interview with the CSS on 11/16/17 at 10:25 a.m. revealed that Resident #5's POA gave consent for guard rails. Interview with the RN/CSS on 11/16/17 at 8:15 a.m. revealed: -She was aware of how Resident #5 responded when the chair alarm sounded. -There was no other setting that the alarm could have been changed to so that the alarm did not make such a loud noise. -There had been no other interventions implemented or evaluated to consider as an alternative to the chair alarm. -The RN/CSS knew that the PCP had discussed the level of care for Resident #5, and placement was being sought at a skilled nursing facility. Based on observations, interviews and record reviews, Resident #5 had experienced four falls and was on the facility's Fall Management Program. The facility had implemented interventions for the resident, including a floor mat and a chair alarm, which was not ordered by	D 338		

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D 338	Continued From page 85 the PCP. The PCP had ordered guard rails, which were not implemented by the facility until 11/15/17, when staff had to be contacted as the resident was observed to be nearly halfway off the bed. The resident was also observed to become agitated when the chair alarm sounded each time during the survey. No other interventions had been implemented by the facility. _____ The facility's failure to provide the services necessary to maintain the residents' physical and mental health by not implementing interventions identified by the facility's fall management program and/or as ordered by the primary care provider for three sampled residents, who had a history of falls, resulting in Resident #6 sustaining a fatal head injury with intracranial hemorrhage; and resulting in Resident #5 being observed nearly halfway off the bed and staff had to be notified of the resident's urgent need to be repositioned on the bed. This noncompliance constitutes a Type A1 Violation for serious physical harm and serious neglect. _____ Review of the facility's Plan of Protection dated 11/15/17 revealed: -The night stand has been moved away from the head of the bed until side rails arrive in approximately 9 minutes from now per estimated time of arrival. (9:27 p.m.-Side rails here and being applied to bed.) -All bed/chair alarms will be checked every shift and documented to ensure in place and operating properly. -Will continue to follow company falls management program. -Executive Director (ED) or designee will monitor/observe all interventions to ensure ongoing compliance.	D 338		

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D 338	Continued From page 86 THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 16, 2017.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#3, #4) sampled including failure to implement an order for a potassium supplement (#3), failure to decrease the dose of an anti-anxiety medication (#3), and failure to discontinue the use of a topical antibiotic ointment for a skin rash after the stop date and the rash had healed (#4). The findings are: 1. Review of Resident #3's FL-2 dated 09/01/16 revealed diagnoses included Alzheimer's dementia, diabetes, hypertension, anemia, and rectal pain. A. Review of hospital emergency room discharge	D 358		

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forms dated 03/29/17 for Resident #3 revealed:
-The resident was seen for low blood sugar and low potassium.
-One of the resident's oral diabetic medications was discontinued.
-There was a prescription for Potassium Chloride ER 20mEq daily and 10 tablets were to be dispensed with no refills. (Potassium Chloride is a potassium supplement used to treat low levels of potassium.)

Review of a visit note by the primary care provider (PCP) dated 03/30/17 for Resident #3 revealed:
-The PCP noted the resident went to the hospital for low blood sugar and low potassium.
-The PCP discontinued one of the resident's oral diabetic medications.
-The PCP ordered Potassium Chloride ER 10mEq take 1 tablet daily.

Review of Resident #3's March 2017 medication administration record (MAR) revealed:
-There was an entry for Potassium Chloride ER 20mEq take 1 tablet every day and it was scheduled to be administered at 8:00 a.m.
-The original date of the order was noted to be 03/30/17.
-Potassium Chloride ER 20mEq was documented as administered once on 03/31/17.

Review of Resident #3's April 2017 MAR revealed:
-There was an entry for Potassium Chloride ER 20mEq take 1 tablet every day and it was scheduled to be administered at 8:00 a.m.
-Potassium Chloride ER 20mEq was documented as administered daily at 8:00 a.m. from 04/01/17 - 04/30/17.
-There was no entry for Potassium Chloride ER

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D 358	Continued From page 88 10mEq as ordered on 03/30/17. Review of Resident #3's May 2017 MAR revealed: -There was an entry for Potassium Chloride ER 20mEq take 1 tablet every day and it was scheduled to be administered at 8:00 a.m. -Potassium Chloride ER 20mEq was documented as administered daily at 8:00 a.m. from 05/01/17 - 05/31/17. -There was no entry for Potassium Chloride ER 10mEq as ordered on 03/30/17. Review of Resident #3's June 2017 MAR revealed: -There was an entry for Potassium Chloride ER 20mEq take 1 tablet every day and it was scheduled to be administered at 8:00 a.m. -Potassium Chloride ER 20mEq was documented as administered daily at 8:00 a.m. from 06/01/17 - 06/05/17. -There was no entry for Potassium Chloride ER 10mEq as ordered on 03/30/17. -No Potassium Chloride ER was documented as administered on 06/07/17 - 06/08/17 due to resident being in the hospital. Review of pharmacy dispensing records dated 01/01/17 - 06/06/17 for Resident #3 revealed: -Ten Potassium Chloride ER 20mEq tablets were dispensed on 03/30/17. -There was no other Potassium Chloride ER tablets dispensed for the resident. Telephone interview with a pharmacist at the primary pharmacy on 11/16/17 at 9:35 a.m. revealed: -The only order the pharmacy received for Potassium Chloride for Resident #3 was the prescription from the hospital dated 03/30/17.	D 358		

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-The prescription dated 03/30/17 was for Potassium Chloride ER 20mEq 1 tablet daily and only 10 tablets were ordered with no refills.
-They only dispensed 10 tablets as indicated on the prescription.
-They never received an order for Potassium Chloride 10mEq and never dispensed any.
-No Potassium was dispensed by the back-up pharmacy because it would show in their records for billing purposes.

Review of a lab report dated 04/27/17 for Resident #3 revealed the resident's potassium level was 3.6 (reference range 3.6 - 5.1).

Interview with two medication aides (MAs) on 11/16/17 at 11:10 a.m. revealed:
-If a medication was not in the medication cart, they were supposed to check the back-up supply in the facility.
-If not in the back-up supply, they were supposed to notify the RCC or the pharmacy.
-If a medication was not administered, they were supposed to document why it was not administered on the MARs.
-They could not explain why Resident #3's Potassium Chloride was documented as administered for over 2 months when there would have been none available to administer.

Interview with the Administrator-in-Charge (AIC) on 11/16/17 at 10:45 a.m. revealed:
-She was not sure what happened with Resident #3's Potassium Chloride because she did not work at the facility when Resident #3 lived at the facility.
-The medication aides should not document a medication was administered if a medication was not on hand at the facility.

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Telephone interview with Resident #3's primary care provider (PCP) on 11/15/17 at 5:41 p.m. revealed:
-She no longer worked with the primary practice that serviced the facility.
-She did not have access to Resident #3's records.
-She was Resident #3's PCP when the resident resided at the facility.
-She could not recall any details about the resident's medications, including the Potassium Chloride.

Review of hospital records for Resident #3 dated 06/06/17 revealed:
-The resident was evaluated in the emergency room (ER) for nausea and vomiting on 06/06/17.
-The resident had possible viral gastroenteritis and lactic acidosis.
-The resident's potassium level at the hospital on 06/06/17 was 3.9 (reference range 3.5 - 5.0).
-The resident expired on 06/08/17.

B. Review of Resident #3's FL-2 dated 09/01/16 revealed an order for Clorazepate 3.75mg 1 tablet twice daily. (Clorazepate is a controlled substance used for anxiety and/or agitation.)

Review of a physician's order from the primary care provider (PCP) dated 02/09/17 for Resident #3 revealed an order for Clorazepate 3.75mg twice daily.

Review of order from Resident #3's mental health provider (MHP) dated 03/22/17 revealed:
-There was an order to discontinue Clorazepate 3.75mg twice a day.
-There was a new order for Clorazepate 3.75mg take 1 tablet daily.

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D 358	Continued From page 91 Review of a hospital discharge summary dated 03/23/17 for Resident #3 revealed an order to continue taking Clorazepate 3.75mg twice daily. Review of Resident #3's signed physician's order sheet dated and signed by the PCP on 03/30/17 revealed an order for Clorazepate 3.75mg 1 tablet twice a day. Review of clarification orders signed by Resident #3's PCP on 03/30/17 for the hospital orders from 03/29/17 revealed an order for Clorazepate 3.75mg 1 tablet daily at 8:00 a.m. Review of Resident #3's March 2017 medication administration record (MAR) revealed: -There was an entry for Clorazepate 3.75mg twice daily and it was documented as administered at 8:00 a.m. and 8:00 p.m. from 03/01/17 - 03/17/17 (8:00 a.m.). -Staff documented the resident was in the hospital from 03/17/17 - 03/23/17. -There was an entry for Clorazepate 3.75mg once a day entered on 03/23/17 with a stop date of 03/23/17 with none documented as administered. -There was a third entry for Clorazepate 3.75mg twice a day at 8:00 a.m. and 8:00 p.m. and it was documented as administered from 03/24/17 - 03/31/17. Telephone interview with a pharmacist at the primary pharmacy on 11/16/17 at 9:35 a.m. revealed: -The pharmacy received the order dated 03/22/17 to decrease Clorazepate to once daily on 03/23/17. -They received the hospital discharge summary on 03/23/17 with an order for Clorazepate 3.75mg twice a day.	D 358		

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D 358	Continued From page 92 Review of an order by the PCP dated 04/27/17 for Resident #3 revealed an order for Clorazepate 7.5mg take ½ tablet (3.75mg) twice a day. Review of Resident #3's April 2017 MAR revealed: -There was an entry for Clorazepate 3.75mg twice daily and it was documented as administered at 8:00 a.m. and 8:00 p.m. from 04/01/17 - 04/27/17 (8:00 a.m.). -There was an entry for Clorazepate 7.5mg take ½ tablet (3.75mg) twice daily and it was documented as administered at 8:00 a.m. and 8:00 p.m. from 04/28/17 - 04/30/17. Review of a visit note dated 04/26/17 by the MHP for Resident #3 revealed: -The resident was very sleepy and slept a lot during the day. -She had ordered the Clorazepate to be decreased to once a day due to duplicate medications but it did not appear to happen per the MAR. -She would verify with the RCC and may need to make a new order. Review of order from Resident #3's MHP dated 05/24/17 revealed an order for Clorazepate 7.5mg take 1 tablet daily for 5 days, then stop. Review of Resident #3's May 2017 MAR revealed: -There was an entry for Clorazepate 7.5mg take ½ tablet (3.75mg) twice daily and it was documented as administered at 8:00 a.m. and 8:00 p.m. from 05/01/17 - 05/24/17. -There was an entry for Clorazepate 7.5mg 1 tablet daily for 5 days and it was documented as administered from 05/26/17 - 05/30/17.	D 358		

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D 358	Continued From page 93 Review of Resident #3's June 2017 MAR revealed there was no entry for Clorazepate on the June 2017 MAR. Review of the controlled substance (CS) log for Resident #3's Clorazepate dated 03/01/17 - 05/30/17 revealed: -Clorazepate 3.75mg was documented as administered twice daily from 03/01/17 - 03/16/17. -Clorazepate 3.75mg was documented as administered once on 03/17/17 (resident in hospital when second dose was due). -The resident was in the hospital from 03/17/17 - 03/23/17. -Clorazepate 3.75mg was documented as administered twice daily from 03/24/17 - 04/10/17. -Clorazepate 3.75mg was documented as administered once on 04/11/17 (resident was in hospital when second dose was due). -Clorazepate 3.75mg was documented as administered twice daily from 04/12/17 - 04/27/17. -Clorazepate 7.5mg ½ tablet (3.75mg) was documented as administered once on 04/28/17. -Clorazepate 7.5mg ½ tablet (3.75mg) was documented as administered twice daily from 04/29/17 - 05/19/17. -Clorazepate 7.5mg ½ tablet (3.75mg) was documented as administered once on 05/20/17 (resident in hospital when second dose due). -Clorazepate 7.5mg ½ tablet (3.75mg) was documented as administered twice daily from 05/21/17 - 05/24/17. -No Clorazepate was documented as administered on 05/25/17. -Clorazepate 7.5mg 1 tablet was documented as administered once daily from 05/26/17 - 05/30/17.	D 358		

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Review of pharmacy dispensing records for Resident #3 revealed:
-Sixty Clorazepate 3.75mg tablets were dispensed on 02/09/17.
-Sixty Clorazepate 3.75mg tablets were dispensed on 03/13/17.
-Thirty Clorazepate 7.5mg tablets were dispensed on 04/27/17.
-Five Clorazepate 7.5mg tablets were dispensed on 05/25/17.

Interview with a medication aide on 11/15/17 at 6:55 p.m. revealed:
-She recalled there was a medication error with Resident #3's Clorazepate but she could not recall the details of the time or the error.
-Resident #3 was very agitated and combative.
-Resident #3 was not having problems with being too sleepy to her knowledge.

Telephone interview with Resident #3's primary care provider (PCP) on 11/15/17 at 5:41 p.m. revealed:
-She no longer worked with the primary practice that serviced the facility.
-She did not have access to Resident #3's records.
-She was Resident #3's PCP when the resident resided at the facility.
-She could not recall any details about the resident's medications, including the Clorazepate.

[The mental health practice that provided services to Resident #3 was no longer in business.]

Review of hospital records for Resident #3 dated 06/06/17 revealed:
-The resident was evaluated in the emergency room (ER) for nausea and vomiting on 06/06/17.
-The resident had possible viral gastroenteritis

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and lactic acidosis.
-The resident expired on 06/08/17.

2. Review of Resident #4's current FL-2 dated 06/08/17 revealed diagnoses included Alzheimer's, dementia, paranoia, vertigo and depression.

Review of Resident #4's Resident Register revealed an admission from another adult care facility on 3/4/14

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

Review of a physician's order for Resident #4 dated 10/9/17 revealed Mupirocin 2% ointment; apply thin layer to rash on left side nostril area three times per day for 5 days.

Review of Resident #4's electronic Medication Administration Records (eMAR) for October 2017 revealed:
-There was an entry for Mupirocin 2% ointment apply a thin layer to rash on left side of nostril area three times a day for 5 days.
-Mupirocin 2% ointment was documented as administered on 10/10/17 two doses and on 10/11-10/31/17 three doses each day.

Review of Resident #4's electronic Medication Administration Records (eMAR) for November 2017 revealed:
-There was an entry for Mupirocin 2% ointment apply a thin layer to rash on left side of nostril area three times a day for 5 days.
-To the right of the entry, there was "D/C'd" (discontinued) entered.
-Mupirocin 2% ointment was documented as administered on 11/1-11/5/17 and 11/7-11/8 three

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D 358	Continued From page 96 doses each day. -On 11/6/17 it was documented that the 8:00 a.m. dose was not administered due to "medication not in facility". The other 2 doses were documented as administered that day at 2:00 p.m. and 8:00 p.m. --On 11/6/17 it was documented that the 8:00 a.m. and 2:00 p.m. doses were not administered due to "medication not in facility". The other dose was documented as administered that day at 8:00 p.m. -On 11/10/17 it was documented that the 8:00 a.m. dose was not administered due to "medication discontinued". The other 2 doses had no initials on the eMAR for that day at 2:00 p.m. and 8:00 p.m. -The remainder of the month showed no initials on the eMAR for any days. Review of Resident #5's medications on hand revealed there was no Mupirocin 2% ointment in the medication cart. Review of Consultant Pharmacist Progress Notes revealed that the last quarterly review was performed on 9/7/17. Observation of Resident #5 on 11/16/17 at 9:15 a.m. revealed: -Resident was in wheelchair in main living area with other residents. -The resident did not have any redness, rash or irritation around her nose. Interview with a Medication Aide (MA) on 11/16/17 at 11:00 a.m. revealed: -She gave the Mupirocin 2% ointment as documented for October and November. -She "gave it because it was in the medication cart and on the eMAR".	D 358		

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D 358	Continued From page 97 -She gave the Mupirocin 2% ointment on 11/8/2017 because it was in the cart and on the eMAR. -She did not give it on 11/9/17 because it was not in the cart. -The facility process was if the medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, then it would be reported to the Resident Care Coordinator (RCC) to verify the order and return the medication to the pharmacy if needed. Interview with the Medication Aide/Supervisor (MA/S) on 11/16/17 at 11:05 a.m. revealed: -The process to follow if a medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, would be to validate the order with the Pharmacy and provider's order and return the medication to pharmacy if applicable and inform the RCC to update the eMAR. Interview with another MA/S on 11/16/17 at 11:10 a.m. revealed: -She gave the Mupirocin 2% ointment on 11/7/2017 because it was in the cart and on the eMAR. -She documented medication discontinued and did not give it on 11/10/17 because it was not in the cart and she validated the medication was to be discontinued after 5 days. -The process to follow if medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, was to validate the order and send the medication back to the pharmacy if applicable. Interview with the Administrator in Charge on 11/16/17 at 11:15 a.m. revealed: -She was not aware that the Mupirocin 2%	D 358		

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D 358	Continued From page 98 ointment was not given as ordered to Resident #5. -The process to follow if medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, was to validate the order, fax it to the pharmacy and they would enter the update in Quick MAR. The RCC would validate the order, approve and sign off before the change was implemented.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the county department of social services of incidents requiring referral for emergency medical evaluation for 1 of 7 residents sampled (#6). The findings are: Review of Resident #6's current FL-2 dated 01/06/17 revealed: -Diagnoses included dementia, cerebrovascular accident, coronary artery disease and intracranial hemorrhage. -The resident was semi-ambulatory and intermittently confused.	D 451		

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Review of an emergency room (ER) report for Resident #6 dated 07/19/17 revealed:
-The resident was seen for facial laceration to the right lateral eyebrow, closed head injury and unwitnessed, mechanical ground-level fall.
-Resident #6 received sutures to the facial laceration that were ordered to be removed in ten days.

Review of Incident/Accident reports provided by the facility revealed there was no incident report completed for the fall that occurred on 07/19/17.

Review of Care Notes for Resident #6 revealed there were entries from staff dated 07/19/17.

Review of an ER report for Resident #6 dated 07/23/17 revealed Resident #6 was seen for acute contusion to the right flank area.

Review of Incident/Accident reports provided by the facility revealed there was no incident report completed for the fall that occurred on 07/23/17.

Review of Care Notes for Resident #6 dated 07/23/17 revealed:
-There was no time documented by the first entry; staff documented Resident #6 was sent to the hospital for a fall. The resident returned to the facility at 1:15 a. m.
-There was a second entry with no time documented or staff signature; staff documented the resident was trying to get up and walk around, and was trying to fight staff.

Interview on 11/15/17 at 4:50 p.m. with the medication aide (MA), who documented the first entry on 07/23/17 in the Care Notes for Resident #6 revealed:
-The MAs completed Incident/Accident reports

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and gave them to the Executive Director (ED) or Resident Care Coordinator (RCC).
-Incident/Accident reports were always done with any incident, especially if the resident was injured.
-The MA was not sure why there was no Incident/Accident Report for Resident #6's fall on 07/23/17; it had been a long time ago, so the report may have been misplaced.

Interview with the former Resident Care Coordinator (RCC) on 11/15/17 at 2:10 p.m. revealed:
-Incident/Accident reports were done by the MAs/Supervisors; then, they turned them in to the RCC or ED.
-The former RCC used to fax the reports to the local county Department of Social Services (DSS), but she was not sure who was doing that now.
-Staff were to always complete a report with a fall or injury to a resident.
-She was not sure about the note on 09/12/17 for Resident #6; she wondered if the injury she was referring to came from a prior fall and not from another fall on 09/12/17.

Interview with a second shift MA on 11/15/17 at 4:25 p.m. revealed:
-The Incident/Accident report was completed for falls.
-The Incident/Accident report was given to the RCC or ED if they were there at the time of the fall or the next day.

Interview with the Registered Nurse/Clinical Support Specialist on 11/15/17 at 6:40 p.m. revealed:
-The MAs completed the Incident/Accident reports after they assessed and checked the

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D 451	Continued From page 101 resident. -The MA determined if the resident needed to be sent to the hospital for evaluation unless the RCC or another management staff was at the facility was in the facility at the time of the incident. -Once the Incident/Accident reports were completed, a nurse reviewed them prior to sending to DSS. Telephone interview with the local DSS Social Worker (SW) on 11/16/17 at 12:30 p.m. revealed: -The SW had only received Incident/Accident Reports for Resident #6 for 08/14/17, 09/09/17 and 09/18/17. -She had not received any reports prior to August 2017.	D 451		
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 reviews, and interviews, the facility failed to assure the services necessary to maintain the residents' physical and mental health. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to implement effective interventions, that were ordered by the residents' primary care provider or in accordance with the facility's falls management program, for 3 of 3 sampled residents, who had been identified by the facility as high risk for falls and had	D914		

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D914	Continued From page 102 experienced multiple falls with injuries (#4, #5, #6). [Refer to Tag D338, 10A NCAC 13F. 0909 Resident Rights (Type A1 Violation)].	D914		