STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073003	A. BUILDING: _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HILLS ASSISTED LIVING	5660 DURHAM ROAD ROXBORO, NC 27573

(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 and Person County Department of Social Services conducted an annual survey on March 19, 2019 through March 21, 2019.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents with a history of falls (Resident #1, #2 and #6). The findings are: Review of the Facility's Incident and Accident Reports for January 2019 revealed 34 falls for multiple residents. Review of the Facility's Incident and Accident Report tracking log for February 2019 revealed	D 270		

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D 270	Continued From page 1 47 falls for multiple residents. Review of the Facility's Incident and Accident Report tracking log for March 2019 revealed 17 falls between 03/01/19-03/13/19 for multiple residents. Review of the facility's Falls Policy dated January 2017 revealed: -Incident reports should be completed for any resident fall. -Family and Physicians would be notified about the fall. -Incident reports would be reviewed by the Resident Care Coordinator (RCC) and the Administrator. -Copies of the incident report would be kept by the Administrator for review and discussion at the quarterly safety meetings. -Residents that fell and hit their head and were on blood thinners would need to be evaluated by a Physician. -If a resident fell more than three times in a month, the physician would be asked about physical therapy to see the resident -Measures would be implemented if a resident was a fall risk including a move to a room as close to the front as possible, put the bed up next to the wall if falling out of bed, keep residents door open as much as possible and frequent checks on the resident. Review of the facility's Falls Policy addendum dated September 2018 revealed: -The resident would be assessed by the staff on the shift. -If obvious injury, suspected fracture, severe laceration or head injury, the resident would be sent out. -If the resident hit their head and was on a blood	D 270		

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thinner, they would be sent out for evaluation.
-Physicians and Power Of Attorney's (POA) would be notified about the fall.
-Incident reports would be completed on all falls, slips, etc.

Interview with a Supervisor on 03/19/19 at 6:15pm revealed:
-The facility had a bowel and bladder program for residents.
-If a resident was checked on every two hours and they were always dry they moved that resident to every four-hour checks.

1. Review of Resident #1's FL-2 dated 03/06/19 revealed:
-Diagnoses included a history of falls, hypertension, peripheral vascular disease, hyperlipidemia, and dementia without behavior disturbance.
-Resident #1 was intermittently disoriented.
-Resident #1 was non-ambulatory and used a wheelchair.

Review of Resident #1's Resident Register revealed an admission date of 03/22/18.

Review of the Care Plan for Resident #1 dated 04/10/18 revealed:
-Resident #1 required extensive assistance with toileting, dressing, grooming, personal hygiene, transferring and ambulation.
-Resident #1 needed a walker to ambulate per physical therapy.
-Resident #1 was monitored for falls with transfers.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 01/04/19 revealed:

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-Resident #1 required assistance with ambulation with the use of a wheelchair.
-Resident #1 had multiple falls during the last quarter.
-One facility staff was to assist with transfers to wheelchair and with propelling wheelchair in facility.

Review of a charting note for Resident #1 dated 01/11/19 (no time) revealed:
-Resident #1 was found on the floor in her room.
-She was getting out of the wheelchair and it was not locked and when the chair rolled she fell
-There were no visible bruising or skin tears.

Review of Resident #1's Incident and Accident Reports dated 01/11/19 at 5:35 pm revealed:
-Resident #1 was found on the floor in her room.
-There were no visible bruises or skin tears; she was not sent to the hospital.
-She was reminded to ring the call bell for staff assistance and to lock the wheelchair.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 01/11/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated 01/17/19 at 6:40 am revealed:
-Resident #1 was found on her bedroom floor near the bathroom; she stated she was coming out of the bathroom and lost her balance.
-Resident #1 complained of hip pain and was given acetaminophen for her pain.

Review of Resident #1's Incident and Accident Report dated 01/17/19 at 6:00 am revealed:
-Resident #1 was found on her bedroom floor near her bathroom; she stated she was coming

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out of the bathroom and lost her balance while pushing her wheelchair.
-She complained of left hip pain, but she could stand on her legs; she was given acetaminophen for her pain and she was not sent to the hospital.
-Staff told Resident #1 to ring the call bell for assistance and to not push her wheelchair.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 01/17/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated 01/21/19 (no time) revealed:
-Resident #1 was found on the floor in her room by the bathroom door; she stated she was coming out of the bathroom and she fell.
-There were no visible bruises or skin tears; she stated her left arm hurt, but she was able to move it around.

Review of Resident #1's Incident and Accident Report dated 01/21/19 at 8:50 am revealed:
-Resident #1 was found on the floor in her room by the bathroom door; she was coming from the bathroom when she fell.
-There were no new bruises or skin tears; she stated her arm hurt but she could move it around and the resident was not sent to the hospital.
-The staff reminded Resident #1 to use the wheelchair at all times, and to ring the call bell for assistance.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 01/21/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated

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D 270	Continued From page 5 02/01/19 (no time) revealed: -Resident #1 was pushing her wheelchair in the hallway and fell. -She hit her head on the railing in the hall and she cut her leg on her wheelchair; her wound was cleaned, dried and dressed. Review of Resident #1's Incident and Accident Report dated 02/01/19 at 4:00 pm revealed: -Resident #1 was pushing the wheelchair down the hall and fell; she hit her head on the rails and she cut her leg on the wheelchair. -Her leg wound was cleaned, dried and a bandage was applied; she was not sent to the hospital. -Staff reminded her to not push the wheelchair and to ask for assistance when needed. Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 02/01/19 to prevent or reduce the frequency of Resident #1's falls. Review of a charting note for Resident #1 dated 02/04/19 at 11:20 pm revealed: -Resident #1 was found on her bedroom floor near her bed; she stated she rolled off the bed. -She complained of pain in her left hip; there was no bruising at the time. -Staff told the resident if her pain got worse she would be sent out for an x-ray; facility staff checked on the resident later in the night and she stated her hip pain was better. Review of Resident #1's Incident and Accident Report dated 02/04/19 at 11:20 pm revealed: -Resident #1 was found on her bedroom floor near her bed; she rolled of her bed. -There were no bruises present, and she complained of hip pain; the resident was not sent	D 270		

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to the hospital.
-She was reminded by staff to ring the call bell for assistance when she needed to get out of the bed to go to the bathroom.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 02/04/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated 02/05/19 (no time) revealed a message was left for Resident #1's family member to request permission for an x-ray due to her continued complaints of pain in hip; there was no response from the family member.

Review of a charting note for Resident #1 dated 02/13/19 (no time) revealed:
-Resident #1 was found on the floor in her room; she stated she was getting into bed and fell.
-She complained of shoulder pain and had a large skin tear to her left arm; the resident was sent to the hospital on 02/13/19.

Review of Resident #1's Incident and Accident Report dated 02/13/19 at 1:00 pm revealed:
-Resident #1 was found on the floor by her bed; she stated she was getting into the bed and fell.
-She complained of left shoulder pain with a large skin tear on her left arm; her arm was cleaned and the physician thought stiches were needed and she was sent to the hospital for evaluation.
-She was reminded to stay in the wheelchair and ring the call bell for staff assistance.

Review of a charting note for Resident #1 dated 02/13/19 revealed physical therapy was ordered for increased strength, balance and gait as appropriate.

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D 270	Continued From page 7 Review of a charting note for Resident #1 dated 02/15/19 revealed a physical therapy visit with Resident #1 for strength, balance and gait; the physical therapist was able to work on gait with the rollator-walker with decreased weight bearing on lower extremities. Review of a charting note for Resident #1 dated 02/17/19 at 10:40 pm revealed: -Resident #1 was found on the floor by her wheelchair; she lost her balance when she got up to go to the bathroom. -The resident had skin tears to her right and left legs; both skin tears wear cleaned and dressed and she did not complain of pain. Review of Resident #1's Incident and Accident Report dated 02/17/19 at 8:30 pm revealed the resident was found on the floor and had skin tears to her left and right leg that was dressed and bandaged; the resident was not sent to the hospital. Review of a charting note for Resident #1 dated 02/18/19 revealed she had a physical therapy visit where she was able to perform gait with a two wheeled walker; the physical therapist recommended a two wheeled walker verses a wheelchair for fall prevention. Review of a charting note for Resident #1 dated 02/22/19 (no time) revealed the resident's roommate reported to the staff that the resident had fallen; the resident had no new bruises or skin tears. Review of Resident #1's Incident and Accident Report dated 02/22/19 for a fall at 1:37 pm revealed the resident's roommate reported to	D 270		

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staff that the resident had fallen; the resident was not sent to the hospital.

Based on observations and interviews it was determined Resident #1's roommate was not interviewable.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 02/22/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated 02/22/19 (no time) revealed the resident had a second fall; she was found on the floor by her bed; the resident stated she fell when she tried to sit on the bed after going to the bathroom.

Review of Resident #1's Incident and Accident Report dated 02/22/19 at 4:30 pm revealed:
-The resident was found on the floor by her bed; she stated she went to sit on the bed when she returned from the bathroom and missed the bed.
-The resident had no new bruises and no skin tears; she was not sent to the hospital and she was reminded to ring call bell for staff assistance.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 02/22/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated 02/25/19 and 02/27/19 revealed physical therapy visited with the resident to improve standing, balance and gait to the bathroom.

Review of a charting note for Resident #1 dated 03/04/19 (no time) revealed:
-Resident #1 was found on the floor in her room;

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she stated she was putting on her pajamas and she fell.
-The resident had a large skin tear to her left hand; she was sent to the local hospital for evaluation.

Review of Resident #1's Incident and Accident Report dated 03/04/19 at 6:10 pm revealed:
-Resident #1 was found on the floor in her room and had a very large skin tear to the back of her left hand that had a lot of bleeding; the resident was sent to the hospital for evaluation.
-The resident was reminded to ring the call bell for staff assistance.

Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 03/04/19 to prevent or reduce the frequency of Resident #1's falls.

Review of a charting note for Resident #1 dated 03/06/19 revealed a visit with physical therapy was limited due to recent injury to the resident's left hand.

Review of a charting note for Resident #1 dated 03/09/19 (no time) revealed:
-The resident was found on the floor in her bedroom; she stated she tried to get out of the bed, fell and she hit her left arm.
-Her left arm had a puncture wound below her elbow.
-Resident #1's family member was called and the family member refused for the resident to be sent to the hospital; the family member wanted staff to clean and "steri-strip" the wound.
-Her arm was cleaned and dressed and wrapped in a bandage from the knuckle to her elbow to cover wounds from previous falls; the physician was notified and she was monitored.

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D 270	Continued From page 10 Review of Resident #1's Incident and Accident Report dated 03/09/19 at 4:30 pm revealed: -The resident was trying to get out of bed and fell; she hit her left arm below the elbow and she had a deep puncture. -The family member was called and refused for the resident to be sent to the hospital; the wound was cleaned and dressed and she was not sent to the hospital. -The resident was reminded to always ring call bell for help. Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 03/09/19 to prevent or reduce the frequency of Resident #1's falls. Review of a charting note for Resident #1 dated 03/11/19 revealed a physical therapy visited with the resident to improve balance and gait with assistance to improve safety. Review of a charting note for Resident #1 dated 03/16/19 (no time) revealed: -Resident #1 was found on the floor in her bedroom near her bathroom. -Resident #1 was using the bathroom and fell; she did not use her wheelchair or push the call bell. Review of Residents #1's Incident and Accident Reports revealed no incident report was documented for Resident #1's fall on 03/16/19. Review of Resident #1's record revealed there was no documentation the facility implemented interventions after a fall on 03/16/19 to prevent or reduce the frequency of Resident #1's falls.	D 270		

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D 270	Continued From page 11 Observation of Resident #1 on 03/19/19 at 9:39 am revealed: -The top of her left hand was red and swollen; there were three large skin tears that had begun to heal. -Her right calf had a large bruise and a skin tear that was bleeding; her left calf had a large bruise and a skin tear that had healed over. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Interview with a medication aide (MA) on 03/20/19 at 9:15 am revealed: -She knew Resident #1 had frequent falls. -Most of Resident #1's falls were from transfers without assistance, because Resident #1 forgot to push the call bell button. -Resident #1 was supposed to sit in her wheelchair for assisted ambulation, but she used her wheelchair like a walker and would fall while walking. -Resident #1's falls were due to her cognitive issues. -A Physical Therapist visited Resident #1 about once a week, but the MA had not seen improvement in Resident #1. -The MA had the personal care aides (PCA) do routine checks on Resident #1 every two hours. -The MA would increase the checks on Resident #1 to every half an hour for 72 hours after a fall. -The two hour checks were documented per policy, but the half hour checks were not policy and not documented. Interview with a PCA on 03/20/19 at 11:45 am revealed: -She worked on Resident #1's hall from 6:00 am to 6:00 pm.	D 270		

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-Resident #1 fell a lot, because she tried to get out of bed without pushing the call button and tried to walk instead of using her wheelchair.
-Resident #1 got up to go to the bathroom, put on lipstick or get something out of the refrigerator on her own.
-There was a bladder and bowel chart on the inside of Resident #1's bathroom door; the PCA checked on Resident #1 and initialed the chart every two hours.
-The PCA checked on Resident #1 every thirty minutes, because she knew Resident #1 had a lot of falls.
-At the thirty minute checks, the PCA asked Resident #1 if she needed to get up or go to the bathroom.
-Resident #1 would forget to push the call button when she needed help and used her wheelchair like a walker.

Telephone interview with the LHPS Nurse on 03/20/19 at 11:10 am revealed:
-Resident #1 was a fall risk.
-She recommended physical therapy for Resident #1 to increase strength and gait.
-Resident #1 needed assistance from one staff for transfers.
-Resident #1 would not remember to use the call bell when she needed assistance and would fall.

Telephone interview with Resident #1's Physical Therapist (PT) on 03/20/19 at 2:55 pm revealed:
-She had been providing physical therapy for Resident #1 since 02/13/19 due to recurrent falls.
-She had provided physical therapy for Resident #1 six times in February 2019 and five times in March 2019.
-She had worked on improving Resident #1's balance, strength and gait to help prevent falls.
-She provided education to the facility staff on

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transfers and assisted walking with Resident #1.
-She had initially seen some improvement with Resident #1, but Resident #1 had regressed with the most recent falls.
-Resident #1's falls were because she forgot to push the call button for assistance and she tried to get herself up.
-She did not see improvement in Resident #1; Resident #1 would continue to fall and her goal for Resident #1 was to "keep her safe".

Interview with the Resident Care Coordinator (RCC) on 03/20/19 at 3:15 pm revealed:
-Resident #1's falls happened more frequently in the afternoon.
-Resident #1 had dementia and would forget to ring the call bell for assistance and would then fall; facility staff would remind her to use the call bell.
-Resident #1 was scheduled for physical therapy; she had shown improvement with physical therapy and was not falling as frequently.
-Resident #1 required assistance from one staff with transfers and was cooperative with staff.
-Resident #1 preferred to stay in her room and did not like to sit at the nurse's station or sit in the living room area; she did like to participate in activities.

Interview with the Administrator on 03/20/19 at 4:00 pm revealed:
-Resident #1 used a walker when she was admitted to the facility, but physical therapy had her use a wheelchair.
-Resident #1 had a wheelchair with hand breaks on the back; physical therapy recommended a different wheelchair, but the family refused to purchase another chair.
-Resident #1 had frequent falls due to her mental status; she would forget and tried to walk on her

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D 270	Continued From page 14 own. -Resident #1 had been going to physical therapy with some improvement, but she would never get back to a walking status. -Resident #1 was on a two hour bladder and bowel check; bladder and bowel checks were documented. -She did not realize how many falls Resident #1 had from January 2019 to March 2019, but she knew there were a lot. -She suggested to Resident #1's family member that Resident #1 needed to be moved to a facility with more skilled care, but the family member wanted to keep Resident #1 in the current facility. -Resident #1 was having more injuries with her falls. Interview with the evening Supervisor on 03/20/19 at 6:30 pm revealed: -Resident #1 had dementia; she forgot to push the call bell for help and she tried to walk. -Resident #1 used her wheelchair like a walker and would fall when she stood or pushed the wheelchair. -Resident #1 could not lock her own wheelchair while sitting because the breaks were on the back of the wheelchair. -Resident #1's falls were from sliding out of the bed or the wheelchair or falling while trying to push her wheelchair. -After a fall, Resident #1 was often found on the floor by the bed or the floor by the bathroom door. -The MAs and PCAs did four hour bladder and bowel checks on Resident #1 and increased the checks to every forty-five minutes or one and a half hours for 72 hours after a fall. Telephone interview with Resident #1's family member on 03/21/19 at 10:45 am revealed: -Resident #1 had frequent falls; the facility staff	D 270		

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would call him when Resident #1 fell.
-Resident #1 had dementia, and she forgot to use the call bell button when she needed assistance.
-Resident #1 had declined in her mental status since being admitted to the facility.
-Resident #1 had been doing physical therapy to increase balance; Resident #1 had "maintained status quo" physical strength with physical therapy.
-The family member did not want Resident #1 to be sent to the hospital for every fall; the facility staff were fully capable of taking care of any of Resident #1's needs.

Telephone interview with Resident #1's Primary Care Physician (PCP) on 03/21/19 at 11:05 am revealed:
-Resident #1 had a history of falls.
-The PCP had Resident #1's blood pressure monitored for two weeks to make sure changes in medication had not contributed to frequent falls; medication changes were ruled out as a cause of frequent falls.
-Resident #1 had been referred for physical therapy on 02/13/19 due to muscle weakness.
-Resident #1 should continue with physical therapy to reduce falls.
-Resident #1 had cognition issues that contributed to her falls.

Refer to the interview with a MA on 03/20/19 at 3:07pm.

Refer to the interview with a Supervisor on 03/20/19 at 6:15pm.

Refer to the interview with the RCC on 03/20/19 at 3:18pm.

Refer to the interview with the Administrator on

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D 270	Continued From page 16 03/20/19 at 3:55pm. 2. Review of Resident #6's current FL2 dated 01/17/19 revealed: -Diagnoses included iron deficiency anemia secondary to blood loss, muscle weakness, abnormalities of gait and mobility and dementia. -The resident was intermittently disoriented. -The resident was semi-ambulatory. Review of Resident #6's Resident Register revealed an admission date of 01/16/19. Review of Resident #6's Care Plan dated 01/30/19 revealed: -The resident was ambulatory with a walker and wheelchair. -The resident required extensive assistance with toileting, ambulation, and dressing. -The resident required total assistance with bathing. -The resident required limited assistance with transfer and to monitor for falls. Review of Resident #6's staff charting notes revealed Physical therapy started care on 01/19/19. Review of a charting note for Resident #6 dated 01/29/19 at 8:30pm revealed Resident #6 was in the bathroom, lost her balance and fell; no injuries. Review of Resident #6's Incident and Accident Reports revealed a report dated 01/29/19 at 7:30pm revealed an unwitnessed fall and Resident #6 had no injuries or pain. Review of Resident #6's record revealed there was no documentation the facility implemented	D 270		

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interventions after a fall on 01/29/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a charting note for Resident #6 dated 02/03/19 at 12:30am revealed Resident #6 slid out of her recliner onto the floor; no injuries.

Review of Incident and Accident Reports for Resident #6 revealed there was no report available for review related to the fall that occurred on 02/03/19.

Review of Resident #6's Incident and Accident Reports tracking log for February 2019 revealed on 02/03/19 Resident #6 slid out of her recliner chair.

Review of Resident #6's record revealed there was no documentation the facility implemented interventions after a fall on 02/03/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a charting note for Resident #6 dated 02/06/19 (no time) revealed Resident #6 was found lying in her bedroom floor, near the bathroom door; no injuries.

Review of Resident #6's Incident and Accident Reports tracking log for February revealed on 02/06/19 at 3:30am Resident #6 was found on the floor near the bathroom door.

Review of Incident and Accident Reports for Resident #6 revealed there was no report available for review related to the fall that occurred on 02/06/19 at 3:30am.

Review of Resident #6's record revealed there was no documentation the facility implemented interventions after a fall on 02/06/19 to prevent or

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reduce the frequency of Resident #6's falls.

Review of a second charting note for Resident #6 dated 02/06/19 (no time) revealed Resident #6 was found in her floor; small red area on her left cheek.

Review of Resident #6's Incident and Accident Reports tracking log for February revealed on 02/06/19 at 4:50pm Resident #6 lost her balance while getting out of the bed and fell.

Review of Incident and Accident Reports for Resident #6 revealed there was no report available for review related to the fall that occurred on 02/06/19 at 4:50pm.

Review of Resident #6's record revealed there was no documentation the facility implemented interventions after a second fall on 02/06/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a charting note for Resident #6 dated 02/24/19 (no time) revealed Resident #6 was found on her bedroom floor near the bathroom; no injuries.

Review of Resident #6's Incident and Accident Reports tracking log for February revealed on 02/24/19 Resident #6 was found on the floor near her bathroom.

Review of Incident and Accident Reports for Resident #6 revealed there was no report available for review related to the fall that occurred on 02/24/19.

Review of Resident #6's record revealed there was no documentation the facility implemented

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interventions after a fall on 02/24/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a second charting note for Resident #6 dated 02/24/19 (no time) revealed Resident #6 was found on her bedroom floor, once near the heater and next she was near her recliner; no injuries.

Review of Resident #6's Incident and Accident Reports tracking log for February revealed on 02/24/19 Resident #6 was found on the floor near her bathroom.

Review of Incident and Accident Reports for Resident #6 revealed there was no report available for review related to the fall that occurred on 02/24/19.

Review of Resident #6's record revealed there was no documentation the facility implemented interventions after a fall on 02/24/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a charting note for Resident #6 dated 02/28/19 at 9:30pm revealed:
-Resident #6 was found on her bedroom floor, she had a hematoma on the back of her head and a skin tear to her left arm.
-Resident #6 was sent to the emergency department (ED) at a local hospital to be evaluated.

Review of Resident #6's Incident and Accident Report dated 02/28/19 at 9:25pm revealed Resident #6 had an unwitnessed fall, a skin tear to her left arm and was sent to the ED.

Review of Resident #6's record revealed there was no documentation the facility implemented

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interventions after a second fall on 02/28/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a charting note for Resident #6 dated 03/01/19 revealed Resident #6 returned from the ED with no new orders.

Review of Resident #6's hospital discharge report dated 02/28/19 revealed:
-Resident #6 was seen in the ED secondary to a fall.
-Resident #6 reported she had a fall, hit the back of her head and did not remember the fall.
-Resident #6 had a history of falls.
-Resident #6 had no lacerations and x-ray and computed tomography (CT) scan did not show bleeding or fractures.

Review of a charting note for Resident #6 dated 03/06/19 (no time) revealed Resident #6 was found on the floor, no injuries.

Review of the Facility's Incident and Accident Reports tracking log for March 2019 revealed on 03/06/19 at 10:30pm Resident #6 lost her balance on the way to the bathroom.

Review of Resident #6's Incident and Accident Reports for a fall on 03/06/19 at 10:30pm revealed an unwitnessed fall and Resident #6 had no injuries or pain.

Review of Resident #6's record revealed there was no documentation the facility implemented interventions after a second fall on 03/06/19 to prevent or reduce the frequency of Resident #6's falls.

Review of a charting note for Resident #6 dated

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D 270	Continued From page 21 03/07/19 (no time) revealed Resident #6 was found on the floor in her room, no injuries. Review of Resident #6's Incident and Accident Reports tracking log for March 2019 revealed on 03/07/19 at 1:30pm Resident #6 was found on the floor at her door after reportedly sliding out of her wheelchair. Review of Resident #6's Incident and Accident Reports dated 03/07/19 at 1:39pm revealed an unwitnessed fall and Resident #6 had no injuries or pain. Review of Resident #6's record revealed there was no documentation the facility implemented interventions after a second fall on 03/07/19 to prevent or reduce the frequency of Resident #6's falls. Interview with a medication aide (MA) on 03/20/19 at 6:49pm revealed: -Resident #6 had falls while she was on duty; she had completed Incident and Accident Reports for falls that occurred on her shift for Resident #6. -Resident #6's falls were because she thought she could still walk with a walker and did not need assistance. -Resident #6 was on a bowel and bladder program and was checked by the personal care aide (PCA) and/or the MA every four hours for toileting. -Because Resident #6 was at risk for falls she was checked on every two hours by the PCA and/or MA. -Resident #6 was pushed to and from meals in her wheelchair by staff. -Resident #6 was strong-willed and wanted to do things on her own. -Resident #6 had signs posted in her room to	D 270		

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remind her to ask for assistance.
-Resident #6's responsible party put the signs in the room to remind Resident #6 to ask for assistance.

Interview with a personal care aide (PCA) on 03/21/19 at 11:15am revealed:
-Resident #6 was on bowel and bladder checks every four hours.
-Resident #6 was checked at least every two hours because she was at risk for falls.
-She had not observed any falls for Resident #6 but she had heard at the change of shift report Resident #6 had fallen.
-If Resident #6 had a fall she checked on her more often, "usually every 30 minutes."
-No one told her to check on Resident #6 every 30 minutes, she just did it.
-Resident #6 had memory loss and forgot to ring her bell for assistance.

Interview with another MA on 03/21/19 at 11:40am revealed:
-Resident #6 required assistance with dressing and toileting.
-Resident #6 was able to roll her wheelchair independently to and from the dining room and activities.
-Resident #6 was on every four-hour bowel and bladder checks for toileting.
-Staff checked on Resident #6 at least every two hours because she was at risk for falls.
-Most of Resident #6's falls were at night.
-Resident #6 forgot to use her call bell for assistance.
-Staff usually checked on Resident #6 more often than every two hours.
-Staff made sure Resident #6's call bell was within reach, they would also prop her door open and encourage her to go to activities.

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D 270	Continued From page 23 Interview with Resident #6 on 03/21/19 at 11:44am revealed: -She had several falls since she had been at the facility. -She knew she was supposed to use her call bell for assistance but she forgot. -She did not know why she fell but "sometimes her head did swim a little bit and it made her dizzy". Telephone interview with Resident #6's family member on 03/21/19 at 11:55am revealed: -He was aware Resident #6 had multiple falls since she was admitted to the facility. -He thought most of Resident #6's falls were because she did not remember to use her call bell for assistance and that she wanted to be independent. -He went to the emergency department on 02/28/19 when Resident #6 was being evaluated. -While Resident #6 was at the emergency department they ran a lot of tests and found no injuries other than a small area that was bleeding on the back of her head; it did not require any stitches. -He had put notes in Resident #6's room to remind her to use her call bell for assistance. -He had acquired a new wheelchair for Resident #6; the chair was wider and more comfortable for Resident #6 and he thought that would help her from trying to get up as often. -Several friends had suggested a bed/chair alarm for Resident #6 but he had not talked to the facility about it. Interview with the Resident Care Coordinator (RCC) on 03/21/19 at 1:18pm revealed -Resident #6 had several falls. -Staff was checking on her more frequently than	D 270		

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every two hours; they looked in on Resident #6 every time they walked by her room.
-Staff only documented checking on Resident #6 when they checked her for the bowel and bladder program.
-She had observed Resident #6 trying to transfer without assistance.
-She had reminded her to use her call bell for assistance; Resident #6 forgot to use her call bell.
-Resident #6 had signs in her room to remind her to use her call bell.
-They would take Resident #6 to activities to get her out of her room where she could be monitored.
-She had been receiving physical therapy twice a week since January 2019, but it was increased last week to three times per week due to falls.

Interview with the Administrator on 03/21/19 at 1:18pm revealed:
-She was aware Resident #6 had several falls; she thought more of her falls were when she first moved into the facility.
-Resident #6 was on a bowel and bladder program.
-Resident #6 was in a room close to the nurse's station which helped staff keep a closer eye on her.
-Resident #6 was receiving physical therapy to increase her strength; she had been receiving physical therapy since January 2019.

Telephone interview with a nurse at Resident #6's Primary Care Provider's (PCP) office on 03/21/19 at 2:37pm revealed:
-The PCP was aware of Resident #6's falls through receiving incident reports from the facility.
-The PCP's goal would be for Resident #6 not to have any falls.
-The PCP ordered physical therapy for Resident

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D 270	Continued From page 25 #6 secondary to falls; the goal for physical therapy was for Resident #6 to increase her strength and decrease her falls. -Resident #6's mental condition kept her from retaining safety concerns and she did not ask for assistance or always use her assistive devices. -Physical therapy was the only plan currently in place for Resident #6 to decrease falls. Attempted interview with the Physical Therapist on 03/21/19 at 11:00am was unsuccessful. Attempted interview with the Licensed Health Professional Support nurse on 03/21/19 at 1:06pm was unsuccessful. Refer to the interview with a MA on 03/20/19 at 3:07pm. Refer to the interview with a Supervisor on 03/20/19 at 6:15pm. Refer to the interview with the RCC on 03/20/19 at 3:18pm. Refer to the interview with the Administrator on 03/20/19 at 3:55pm. 3. Review of Resident #2's current FL2 dated 09/09/18 revealed: -Diagnoses included muscle weakness with difficulty walking, fall risk, essential hypotension, and metabolic encephalopathy. -The resident was constantly disoriented. -The resident was non-ambulatory. Review of Resident #2's Resident Register revealed an admission date of 10/02/17. Review of Resident #2's Care Plan dated	D 270		

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11/01/18 revealed:
-The resident was ambulatory with a wheelchair.
-The resident was on a two-hour bowel and bladder checks.
-The resident required total assistance with bathing and dressing.
-The resident required extensive assistance with transfers and had frequent falls to watch closely.

Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 01/04/19 revealed:
-The task of ambulation, transferring and wander guard were documented and evaluated by the nurse.
-Resident ambulated with a wheelchair and required the assistance of one with transfers.
-Resident #2 had several falls during the previous quarter.

Review of Resident #2's charting notes on 01/05/19 (no time) revealed resident was found on the floor in front of her bed; the wheelchair was unlocked. No visible injuries.

Review of Resident #2's Incident and Accident Reports dated 01/05/19 at 11:00am revealed:
-Resident #2 had an unwitnessed fall with no injuries or pain.
-Resident #2 was reminded to not transfer from her wheelchair without locking it.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 01/05/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's charting notes on 01/11/19 (no time) revealed resident was found on the floor, she was trying to get from her bed to

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CAMBRIDGE HILLS ASSISTED LIVING	5660 DURHAM ROAD ROXBORO, NC 27573

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her wheelchair; the wheelchair was not locked. No visible injuries.

Review of Resident #2's Incident and Accident Reports dated 01/11/19 at 3:15pm revealed:
-Resident #2 had an unwitnessed fall with no injuries or pain.
-Resident #2 was reminded to lock her wheelchair when transferring from bed to wheelchair.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 01/11/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's charting notes on 01/15/19 revealed resident was found on the floor of her room; she was changing her brief. No injuries.

Review of Resident #2's Incident and Accident Reports dated 01/15/19 at 9:00am revealed:
-Resident #2 had an unwitnessed fall and no injuries or pain.
-Resident #2 was reminded to use her call bell for assistance with toileting and dressing.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 01/15/19 to prevent or reduce the frequency of Resident #2's falls.

Review of a second charting note for Resident #2 on 01/15/19 revealed resident was found on the floor again by her closet. No injuries.

Review of Resident #2's Incident and Accident Reports revealed a report dated 01/15/19 at 1:00pm of an unwitnessed fall and no injuries or

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pain; the resident was reminded to use her call bell for assistance.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a second fall on 01/15/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's Incident and Accident Reports dated 01/22/19 at 4:00pm revealed:
-Resident #2 had an unwitnessed fall and no injuries or pain.
-Resident #2 was reminded to use her call bell for assistance before getting up to go to the bathroom.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 01/22/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's charting notes on 01/27/19 (no time) revealed resident was found on the floor; she slid to the floor. No injuries.

Review of Resident #2's Incident and Accident Reports dated 01/27/19 at 6:45pm revealed:
-Resident #2 had an unwitnessed fall and no injuries or pain.
-Resident #2 was reminded to use her call bell for assistance before getting up alone.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 01/27/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's charting notes on 02/08/19 revealed resident was found on the floor

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D 270	Continued From page 29 of her room; she slid out of her wheelchair. No injuries. Review of Resident #2's Incident and Accident Reports dated 02/08/19 at 8:00pm revealed: -Resident #2 had an unwitnessed fall and no injuries or pain. -Resident #2 was reminded to use her call bell for assistance. Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 02/08/19 to prevent or reduce the frequency of Resident #2's falls. Review of Resident #2's charting notes on 02/11/19 revealed resident was found lying on her floor near the end of her bed; she reported she was going to the bathroom. No injuries. Review of Resident #2's Incident and Accident Reports dated 02/11/19 at 12:30am revealed: -Resident #2 had an unwitnessed fall and no injuries or pain. -Resident #2 was reminded to use her call bell for assistance. Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 02/11/19 to prevent or reduce the frequency of Resident #2's falls. Review of a second charting note for Resident #2 on 02/11/19 (no time) revealed resident was found on the floor of her room; she reported she was looking for a tissue and fell out of her chair. No injuries. Review of Resident #2's Incident and Accident Reports dated 02/11/19 at 12:30pm revealed:	D 270		

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-Resident #2 had an unwitnessed fall with a skin tear to her right elbow.
-Resident #2 was reminded to use her call bell for assistance.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a second fall on 02/11/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's Incident and Accident Reports dated 02/11/19 at 3:30pm revealed:
-Resident #2 had an unwitnessed fall and no injuries or pain.
-Resident #2 was reminded to use her call bell for assistance.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a third fall on 02/11/19 to prevent or reduce the frequency of Resident #2's falls.

Review of Resident #2's charting notes on 02/12/19 (no time) revealed resident slid out of her wheelchair.

Review of Resident #2's Incident and Accident Reports dated 02/12/19 at 4:30pm revealed:
-Resident #2 had an unwitnessed fall and no injuries or pain.
-Resident #2 was reminded to use her call bell for assistance.

Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 02/12/19 to prevent or reduce the frequency of Resident #2's falls.

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D 270	Continued From page 31 Review of Resident #2's staff charting notes on 02/13/19 revealed resident was found sitting on the floor; no injuries. Review of Resident #2's Incident and Accident Report dated 02/13/19 at 7:00pm revealed: -Resident #2 had an unwitnessed fall and no injuries or pain. -Resident #2 was reminded to use her call bell before getting up. Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 02/13/19 to prevent or reduce the frequency of Resident #2's falls. Review of Resident #2's charting notes on 02/19/19 (no time) revealed resident was found sitting on the floor by her bed; no injuries. Review of Resident #2's Incident and Accident Report dated 02/19/19 at 8:00pm revealed: -Resident #2 had an unwitnessed fall and no injuries or pain. -Resident #2 was reminded to use her call bell before getting up. Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 02/19/19 to prevent or reduce the frequency of Resident #2's falls. Review of Resident #2's charting notes on 02/25/19 (no time) revealed resident slid out of her bed; she had a skin tear to the left elbow. Review of Resident #2's Incident and Accident Report dated 02/25/19 at 3:45pm revealed: -Resident #2 had an unwitnessed fall; the resident had a skin tear to her left forearm.	D 270		

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D 270	Continued From page 32 -Resident #2 was reminded to use her call bell. Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 02/25/19 to prevent or reduce the frequency of Resident #2's falls. Review of Resident #2's charting notes on 03/13/19 (no time) revealed resident was found lying on the floor; no injuries. Review of Resident #2's Incident and Accident Report dated 03/13/19 at 8:30pm revealed: -Resident #2 had an unwitnessed fall and no injuries or pain. -Resident #2 was reminded to use her call bell before getting up. Review of Resident #2's record revealed there was no documentation the facility implemented interventions after a fall on 03/13/19 to prevent or reduce the frequency of Resident #2's falls. Interview with Resident #2 on 03/20/19 at 11:40am revealed: -She knew she was supposed to use her call bell but sometimes she forgot. -She had "a lot of falls." -Sometimes she slid out of her wheelchair or off the bed. -The staff came to help her when she asked, but she did not "always ask." Interview with a personal care aide (PCA) on 03/20/19 at 2:31pm revealed: -She worked the morning/day shift. -She checked on Resident #2 every 15-20 minutes to see if she needed anything. -All residents were checked on every two hours, but if a resident had a fall she checked on them	D 270		

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more often.
-No one had told her to check on the residents with falls more often, she just did it.
-She knew who was a fall risk because the medication aide's (MA) tell the staff.
-Resident #2 had not had any falls on her shift that she could recall; she usually fell at night.
-Resident #2 fell because she tried to do things on her on.
-Resident #2 seemed more confused in the early evening, around 5:30pm.
-Some days Resident #2 did better with remembering to use her call bell than other days.
-Resident #2 needed assistance for transfers.
-Someone was at the desk at all times to let staff know when call bells were pushed.
-The staff had a communication meeting at every shift to discuss residents.

Interview with a MA on 03/20/19 at 3:16pm revealed:
-All residents were checked on every two hours.
-She tried to keep fall risks close by to keep an eye on them.
-Residents who had fallen were checked on every hour; she did not document when a resident was checked on.
-Resident #2 tried to transfer independently because she did not remember to use her call bell.
-They tried to keep Resident #2 in "eye shot" and checked on her frequently.
-Resident #2 had physical therapy about 8-10 months ago.

Interview with another PCA on 03/20/19 at 4:12pm revealed:
-If a resident had a history of falls, she watched them closely.
-She was up and down the hall all the time, so

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she checked on residents with a history of falls every thirty minutes to an hour.
-The Administrator, the Resident Care Coordinator (RCC) and the MA told her to check on residents with falls more often.
-Resident #2 thought she could do things on her on, like transferring from her bed to her wheelchair.
-She did not think Resident #2 knew to use her call bell.
-The staff talked about residents who had falls at shift change.

Interview with a third PCA on 03/21/19 at 11:15am revealed:
-Resident #2 was on the bowel and bladder program and was taken to the bathroom every four hours for toileting.
-Resident #2 was checked on every two hours because she was a fall risk.
-Resident #2 was confused and forgot to use her call bell for assistance.
-When she worked with Resident #2, she always made sure she locked the wheelchair and would take Resident #2 to an area where they could keep a closer eye on her, such as the nurse's station or to a structured activity.
-She checked on Resident #2 at least every 30 minutes after a fall for the shift she worked; she did not document checking on Resident #2 every 30 minutes.

Interview with another MA on 03/20/19 at 6:15pm revealed:
-Resident #2 had a lot of falls related to her dementia and not remembering to use her call bell before transferring and would stand up without locking her wheelchair.
-When she worked with Resident #2, she would put her to bed early as possible since a lot her

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falls were in the evening.
-She had not thought about making sure Resident #2's wheelchair wheels were always locked.

Telephone interview with Resident #2's family member on 03/21/19 at 9:57am revealed:
-The facility staff always called her when Resident #2 had a fall.
-She felt the facility was doing a good job of meeting Resident #2's needs.
-Resident #2 had fallen before moving to the facility.
-Resident #2 had received physical therapy when she was first admitted to the facility but was refusing it and therefore it was discontinued.
-The facility staff had not had a meeting with her to discuss interventions to decrease the number of falls Resident #2 had.
-She knew the facility could not restrain Resident #2 but the small rail she had purchased to help her in/out of the bed had been helpful.
-Resident #2 could not remember to ask for help and thought she could do things for herself.

Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 03/20/19 at 11:12am revealed:
-She saw Resident #2 on 01/02/19.
-She did not know Resident #2 had been falling frequently; she had a couple of falls the previous quarter.
-Resident #2 probably did not remember to use her call bell.
-If a resident had a lot of falls she would look at what was going on medically.
-She would recommend a physical therapy consult if a resident had repeated falls.

Telephone interview with a representative of the Primary Care Provider's Office (PCP) on 03/21/19

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D 270	Continued From page 36 at 11:30am revealed: -The PCP was aware of Resident #2's numerous falls. -Resident #2 had been reminded repeatedly to use her call bell, but she had dementia and did not remember to use it. -The PCP had talked to Resident #2's family about needing a higher level of care. -The PCP had not talked to anyone at the facility about Resident #2 needing a higher level of care. -The number of falls Resident #2 had, spoke to the need Resident #2 needed to be somewhere she could get more assistance. Interview with the Resident Care Coordinator (RCC) on 03/20/19 at 3:18pm revealed: -The staff had been bringing Resident #2 out of her room and had her sit at the nurse's desk area every day; the staff had been doing this for a couple of months so they could watch her closer. -In the summer of 2018, Resident #2 was ambulatory and started having more falls. -Resident #2 tried to get up on her on. -Resident #2 did not remember she could not get up on her on. -Resident #2's family did not think physical therapy was needed when it was discussed in the fall of 2018 because she would not be safe with a walker and was safer with a wheelchair. -Resident #2 did not like a lot of activities. -Staff tried to redirect Resident #2 when she was attempting to do things on her own and she was good about doing whatever they asked at the moment. -Resident #2 was an ideal assisted living resident but her falls were an issue. -She had not discussed using a bed/chair alarm with Resident #2 because if a resident needed that type of device, they needed a higher level of care.	D 270		

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D 270	Continued From page 37 Interview with the Administrator on 03/20/19 at 3:55pm revealed: -Resident #2 had a lot of falls. -They had implemented things to reduce her falls such as sitting her at the nurse's station. -She was on her radar that she may need a higher level of care. -Resident #2 was on a bowel and bladder program every two hours. -Resident #2 tried to get up on her own. -Resident #2's falls were related to her cognitive status. Attempted interview with the Physical Therapist on 03/21/19 at 11:00am was unsuccessful. Refer to the interview with a MA on 03/20/19 at 3:07pm. Refer to the interview with a Supervisor on 03/20/19 at 6:15pm. Refer to the interview with the RCC on 03/20/19 at 3:18pm. Refer to the interview with the Administrator on 03/20/19 at 3:55pm. _____ Interview with the medication aide (MA) on 03/20/19 at 3:07pm revealed: -The condition of the resident was charted on the shift report for the first 24 hours after a fall. -The information was documented in the charting notes. -If a resident was a high falls risk, he or she would be checked every hour by the personal care aide (PCA). -The PCA did not document the hourly checks, and there was no time limit on the hourly checks.	D 270		

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D 270	Continued From page 38 -The supervisor-in-charge (SIC) determined how often the resident should be checked after a fall, and it was based on resident's cognition and the ability to ring the call bell. Interview with a Supervisor on 03/20/19 at 6:15pm revealed: -She worked 6:30pm-6:30am, 2nd/3rd shift. -When the staff changed shifts, they had a meeting to communicate what happened on the previous shift. -She assigned the residents to the PCAs; the PCAs usually had about five residents to assist with showers between 6:30pm-8:00pm. -There were two MAs who worked from 5:00pm-9:00pm. -The two MA's helped in the dining room, and they each had two residents they assisted with showers. -After 6:30pm the MAs were responsible for their medication pass but were available to assist with resident care, respond to call bells and check on residents. -The PCAs finished with the resident's' baths between 8:00pm-8:30pm. -A lot of residents were on a two hour or four hour bowel and bladder program. -If a resident was not wet at their two hour check, their checks would be moved to every four hours. -All residents who did not remember to use their call bells were checked on at least every two hours. -If a resident had a history of falls they were checked on more frequently, "like every hour." -When the first shift reported to her any changes with a resident, she planned the night based on those changes. -She reported to the next shift what they did on their shift. -She thought by checking on the residents more	D 270		

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D 270	Continued From page 39 often, they had decreased the number of falls they had on 2nd /3rd shift over the past six months. Interview with the Resident Care Coordinator (RCC) on 03/20/19 at 3:18pm revealed: -Anytime a resident slid out of a wheelchair or bed, fell backwards or fell forward and went down to the floor, it was considered a fall. -The staff completed incident reports any time a resident "went down" and was on the floor. -Residents were sent to the hospital if an injury or if the resident was taking a blood thinner; injuries were fractures, complaints of pain and bleeding that could not be stopped with applied pressure. -After a resident fall the resident would be educated about use of the call bell for assistance, and the resident would be watched for new injuries or complaints. -Residents were watched by staff after a fall by bringing them to the front desk, checking in on the resident more often, having the resident involved in activities and sitting in the living room near the nurse's station. -If a resident had a fall, the staff completed an assessment, called the family and faxed the PCP. -Residents were checked on every two hours. -They did not increase the frequency of checks after a fall. -If a resident fell a lot they would bring them to the desk to watch them; a lot of falls meant a resident who fell daily. -If a resident had a fall that did not normally fall, they would check them for a urinary tract infection to rule it out as the reason they fell. -If a resident had 3 or more falls in a quarter, she would contact the PCP to ask for physical therapy evaluation. -They had a safety committee meeting quarterly where falls were discussed.	D 270		

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	HAL073003	A. BUILDING: _____ B. WING _____	03/21/2019

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D 270	Continued From page 40 -Each shift had a meeting to discuss falls. -Physical therapy would be recommended if there were frequent falls by a resident, and the resident would need to be moved into a skilled facility if they continued to fall after physical therapy. Interview with the Administrator on 03/20/19 at 3:55pm revealed: -Anything that happened to a resident such as if they slid off a bed, slip off a chair, or if they were on the floor it was documented. -If a resident fell and hit their head and were on blood thinners, they were automatically sent out. -If a resident had a fall, they would check them to make sure no injury and their vitals were okay, they would notify the family and PCP. -If a resident had more than three falls a month, the resident were referred to physical therapy. -If a resident had a history of falls, they watched them closely, but they did not document it and it was not part of the policy. -If a resident was falling out of the bed they would put the bed against the wall. -If a resident had a history of falls they kept the residents' door open, so staff could keep a closer eye on them. -Staff reminded residents to use their call bells. -There was a safety committee meeting quarterly where the managers discussed residents with falls; they discussed things they can implement such as moving the bed, keeping doors open, and visually checking on the resident such as taking the resident to activities or have them sit at the nurse's station. _____ The facility failed to provide adequate supervision for 3 of 3 sampled residents with a history of falls related to Resident #2 who had 15 falls in 66 days; Resident #1 who had 12 falls in 57 days and five falls resulting in injuries, complaints of	D 270		

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D 270	Continued From page 41 pain in her hips and shoulder and one fall requiring transfer to the emergency department; and Resident #6 who had 9 falls in 37 days with two falls resulting in skin tears and one additional fall requiring transfer to the emergency department. The facility's failure resulted in physical injuries to the residents, and placed the residents at substantial risk for further physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/20/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 21, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #4) related to the resident's blood sugar being greater than 180.	D 273		

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D 273	Continued From page 42 The findings are: Review of Resident #4's current FL-2 dated 01/08/19 revealed diagnoses included memory changes, diabetes mellitus (DM), hypertension, hypothyroidism, macular degeneration, Degenerative Disc Disease (DDD) lumbar spine, osteoporosis and chronic atrial fibrillation. Review of a subsequent physician's order for Resident #4 dated 01/16/19 revealed: -There was an order for finger stick blood sugar (FSBS) testing to be done every morning and to be sent weekly to the physician. -There was also an order to call and report to the physician if the blood sugar was less than 60 and greater than 180. Review of Resident #4's 01/16/19 to 01/31/19 electronic Medication Administration Record (eMAR) for January 2019 revealed: -There was an entry to check FSBS every morning and to send results weekly to the resident's physician and to call the resident's physician and report if FSBS was less than 60 and greater than 180. -Resident #4's FSBS was documented greater than 180 one time before breakfast; her FSBS was documented as 199 on 01/21/19 at 6:30am. -There was no documentation the physician had been notified of Resident #4's FSBS being greater than 180. Review of Resident #4's February 2019 eMAR revealed: -There was an entry to check FSBS every morning and to send results weekly to the resident's physician and to call the resident's physician and report if FSBS was less than 60	D 273		

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D 273	Continued From page 43	D 273		

and greater than 180.
-Resident #4's FSBS was documented greater than 180 one time before breakfast; her FSBS was documented as 190 on 02/26/19 at 6:30am.
-There was no documentation the physician had been notified of Resident #4's FSBS being greater than 180.

Review of Resident #4's March 2019 eMAR revealed:
-There was an entry to check FSBS every morning and to send results weekly to the resident's physician and to call the resident's physician and report if FSBS was less than 60 and greater than 180.
-Resident #4's FSBS was documented greater than 180 four times before breakfast; her FSBS was documented as 185 on 03/02/19 at 6:30am, 189 on 03/03/19 at 6:30am, 184 on 03/20/19 at 5:56am and 188 on 03/21/19 at 5:25am.
-There was no documentation the physician had been notified of Resident #4's FSBS being greater than 180.

Review of Resident #4's progress notes revealed there was no documentation related to the physician being notified of resident having a FSBS greater than 180 six times on 01/21/19 at 5:44am, 02/26/19 at 5:48am, 03/02/19 at 5:32am, 03/03/19 at 5:30am, 03/20/19 at 5:56am and 03/21/19 at 5:25am.

Attempted telephone interview with Resident #4's physician on 03/21/19 at 8:59am was unsuccessful.

Attempted telephone interview with the medication aide (MA) on 03/21/19 at 9:35am was unsuccessful.

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D 273	Continued From page 44 Telephone interview with a second MA on 03/21/19 at 9:48am revealed: -She worked on 03/20/19 and Resident #4's FSBS was 184. -She did know Resident #4's physician should be notified if the resident's blood sugar reading was greater than 180. -The MA was responsible for notifying the physician of Resident #4's blood sugar reading being greater than 180. -She had not notified Resident #4's physician about the resident's FSBS being greater than 180 because the resident had a bag of cookies on the table at the bedside. Interview with the Resident Care Coordinator on 03/21/19at 10:00am revealed: -Resident #4's physician had not been notified of the resident having FSBS greater than 180 on 01/21/19 at 5:44am, 02/26/19 at 5:48am, 03/02/19 at 5:32am, 03/03/19 at 5:30am, 03/20/19 at 5:56am and 03/21/19 at 5:25am. -The information would have been documented on the eMARs notes. -The MA should have notified Resident #4's physician about the resident's blood sugar being greater than 180. Interview with the Administrator on 03/21/19 at 11:15am revealed: -She did not know the MA had not notified Resident #4's physician of the resident's blood sugar being greater than 180. -The MA should have notified Resident #4's physician and documented the information on the eMAR.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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D 276	Continued From page 45 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#3) regarding the application and of the removal of thromboembolic deterrent hose. The findings are: Review of Resident #3's current FL2 dated 4-11-18 revealed: -Diagnosis included Alzheimer's disease, HTN, below knee osteoarthritis, Lymphedema, mixed urge/stress continence. Review of Resident #3's record on 4-11-18 revealed: -There was an order for thromboembolic deterrent (TED) hose- apply every morning and remove at bedtime. Review of Resident #3's current Care Plan dated 5-1-18 revealed "on her skin lots of swollen,	D 276		

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bruised areas" and "needs assistance with bathing and dressing."

Observation of Resident #3 on 3-19-19 at 2:45 pm revealed:
-Resident #3 raised her pant legs to just below the knee and had on black ankle high socks.
-Resident #3 did not have compression stockings on.
-Resident #3's lower legs were swollen and blue/black in color.
-There was no compression stockings observed in Resident #3's room.

Observation of Resident #3 on 3-20-19 at 9:05am revealed she did not have TED hose on her legs.

Review of Review of Resident #3's March 2019 Medication Administration Record (MAR) (Treatment Section) revealed:
-There was an order to apply TED hose every morning and remove at bedtime.
-There was documentation Resident #3's TED hose had been offered but refused on 3-1-19, 3-5-19, 3-6-19, 3-9-19, 3-10-19, 3-11-19, 3-14-19, 3-15-19, and 3-19-19.
-There was documentation TED hose had been applied on 3-2-19, 3-3-19, 3-4-19, 3-7-19, 3-8-19, 3-12-19, 3-13-19, 3-16-19, 3-17-19, 3-18-19.
-There was documentation that Resident #3's TED hose have been removed every day from 3-1-19 to 3-19-19.

Interview with a morning shift medication aide (MA) on 3-19-19 at 9:31 am and 3/19/19 at 2:30pm revealed:
-The night shift MA was responsible for applying Resident #3's TED hose and responsible for removing them.
-She did not routinely check to see if resident was

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wearing TED hose because morning shift MA is not responsible for TED hose.
-She had not realized that Resident #3 was not wearing her TED hose until now, 3-19-19 at 9:31 am.
-She did not know if Resident #3 had ever been measured for TED hose.
-Resident #3's TED hose would usually be kept in a drawer in Resident #3's room.
-She checked Resident #3's room and could not locate Resident #3's TED hose, today 3/19/19.
-She located several pairs of black compression socks which she referred to as TED hose.
-Resident #3's Ted hose should have been discontinued because Resident #3 had refused to wear them since her admission on 4-13-18.

Interview with Resident #3 on 3/19/19 at 4:05pm and 3/20/19 at 8:45am revealed:
-She has not put on TED hose since admission 11 months ago.
-She does not think that she has ever been measured for TED hose.
-She will wear compression socks sometimes but they hurt her legs.
-She does not like to wear TED hose because they make her legs sweat.
-She believes that her TED hose are at home; not meaning the facility.
-No one had offered her TED hose while at the facility but they had tried to get her to wear her compression socks.

Telephone interview with Resident #3's family member on 3-19-19 at 2:51 pm revealed:
-He came to visit Resident #3 at the facility often.
-He did not know Resident #3 had an order for TED hose and had never seen her wearing them.
-He did not know if Resident #3 had ever been measured for TED hose.

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-He had seen black compression socks at her home and in her room at the facility.
-He has seen Resident #3 wearing black compression socks on several occasions but not TED hose.

Telephone interview with Resident #3's Primary Care Provider's (PCP's) nurse on 3-20-19 at 3:20 pm revealed:
-Resident #3 had an order for TED hose due to Lymphedema.
-He had ordered TED hose to protect Resident #3's legs from further swelling and damage to her legs.
-He had last visited her on 3-11-19 and she was not wearing the TED hose at the time.
-He had not questioned the facility staff about Resident #3 not wearing the TED hose.
-He expected facility staff to follow his order for TED hose.
-He did not know why Resident #3 was not wearing TED hose on 3-11-19.

Attempted telephone interview with the night shift MA who documented application of Resident #3's TED hose on 3-19-19 at 4:00pm was unsuccessful.

Interview with the Resident Care Coordinator (RCC) on 3-20-19 at 3:41 pm revealed:
-She did not know Resident #3 had an order for TED hose.
-She found out Resident #3 had been refusing to wear her TED hose on today's date, 3-20-19.
-She sent Resident #3's PCP a notice that Resident #3 has been refusing her TED hose and asked for this order to be discontinued on today's date, 3-20-19 due to non-compliance.
-The order for TED hose was not on Resident #3's electronic medication administration record

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D 276	Continued From page 49 (eMAR). -The order for TED hose was on Resident #3's treatment sheet and did not show up on the eMAR. -MAS were supposed to report to the RCC if anyone is not using TED hose. -The RCC would contact PCP after 3 consecutive days of non-compliance if notified by the MA. Interview with the Administrator on 3-20-19 at 5:40pm revealed: -She knew that Resident #3 had been refusing TED hose. -She had known this for several months as the MAS would talk about it in report. -She thought that this had been handled because no one had mentioned this as a concern to her in many months. -She expected MAS to follow PCP's orders. -It was the responsibility of the RCC to complete renewal FL2's and review this for accuracy. -It was the responsibility of the RCC to order TED hose. -It was the responsibility of The RCC to contact the PCP if she had any questions regarding the TED hose. -She did not know there were no TED hose in Resident #3's room.	D 276		
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 contamination.	D 282		

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D 282	Continued From page 50 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination including the shelves, door gaskets and floors of the walk-in refrigerator and freezer, undated and uncovered food in the dry storage, walk-in freezer and walk-in refrigerator. The findings are: Review of the most current NC Division of Environment Health sanitation report dated 01/23/19 revealed a score of 100. Observation of the walk-in refrigerator on 03/19/19 at 1:55 pm revealed: -There were six opened , one gallon containers of relish, BBQ sauce, tartar sauce, ranch dressing, banana pepper rings and coleslaw dressing not dated with an opened date. -There was a small metal pan with left over three bean salad that was not dated or labeled. -There were various containers with items prepared for the salad bar for the next day's lunch meal that were not dated or labeled. -There were twenty yellow squeeze bottles that contained mustard and were not dated and labeled and had an opened and exposed tip. -There were sixteen red squeeze bottles that contained ketchup and were not dated and labeled and had an opened and exposed tip. -There were sixteen squeeze bottles that contained mayonnaise and were not dated and labeled and had an opened and exposed tip. -There were nineteen squeeze bottles that contained ranch dressing and were not dated and labeled and had an opened and exposed tip. -There were twenty squeeze bottles that contained tartar sauce that were not dated and	D 282		

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labeled and had an opened and exposed tip.
-There were two packs of sliced American cheese that were taken out of the original packaging and wrapped in plastic wrap; both packs did not have a date or label.
-There was a large container of brownish liquid that was not dated and labeled.
-There was a thick layer of dust and a white fuzzy substance on the the covers to the fans on the compressor motor.
-There was a buildup of dust, food and a layer of white and gray fuzzy substance on three of the four shelves, and chipped paint and rust on a fourth shelf.
-There was a buildup of a dried brownish liquid around the legs of the shelves and in the corners of the floors.
-There were seven milk crates with food items stored on them, including eggs, ice tea and juice; there was debris on the floor under the milk crates.
-There was a thick black substance and black spots on door gasket to the walk-in refrigerator had ; the door gasket was split down the length of the door.

Observations of the walk-in freezer on 03/19/19 at 2:07 pm revealed:
-There was thick ice buildup on the floor under the fan motor and ice buildup on the pipes leading to the fan motor.
-There was food debris, peeled packing tape, paper, and cardboard boxes, and dust on the floor.
-There was an opened box of biscuits and pancakes that were not covered.
-There was a tray of assorted slices of pie that were not dated and labeled; the plastic wrap was not covering the entire tray and some of the pie slices were exposed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 282	Continued From page 52 -There were four milk crates used to support food items and bags of ice; there was dust and debris under the milk crates. Observation of the kitchen dry storage pantry on 03/20/19 at 8:45 am revealed: -A dented can of tuna and a dented can of fruit were on the same shelf with the undented cans. -Multiple food items were opened and not labeled, dated or properly wrapped; including a carton of instant mashed potatoes, sunflower seeds, dried cranberries and raisins, dried pinto beans, egg noodles, rotini noodles, coco powder, powdered sugar, cereal, grits, coconut, sugar, flour and cornmeal. Interview with the kitchen manager on 03/19/19 at 1:55 pm revealed: -Kitchen staff swept and mopped the walk-in refrigerator every day and the freezer floors were swept and cleaned once a month. -He did not think he needed to date opened food items; he thought the manufacturers expiration and use by date was enough. -Left over food items in the walk-in refrigerator were dated on the day they were opened and discarded three days after opened. -The shelves in the walk-in refrigerator were cleaned once a month with soapy water; the shelves were cleaned last month. -He thought it was okay to use milk crates as shelving as long as the food items were off the floor. -He would clean the door gasket and notify maintenance to have the door gasket replaced. -The squeeze bottles were cleaned once a week; the product inside the bottles were discarded and the bottles were washed, dried and refilled. -He never covered the opened tips and he never dated or labeled the squeeze bottles because he	D 282		

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D 282	Continued From page 53 knew what was inside the bottles. Interview with the kitchen manager on 03/20/19 at 8:45 am revealed: -All kitchen staff should date and label left over food items when items were stored. -He knew he opened the slices of American cheese a few days ago, so he did not date or label them. -He did not date the various salad bar items because he used them every day; the kitchen staff rotated the items by placing the new on the bottom and the old on the top. -He did not have a designated area for the storage of dented cans and no way of insuring the kitchen staff did not use the dented cans; he just left the dented cans on the shelf until the supply company picked them up. -All kitchen staff were responsible for the daily cleaning in the kitchen; all dietary staff cleaned after themselves at the end of their shift and initialed the cleaning schedule. -There was not a weekly or monthly cleaning schedule for deep cleaning of equipment; he did any needed cleaning himself once a month; he deep cleaned all kitchen equipment last month. -He had taken a nationally recognized food safety course and had been trained in the proper handling and storage of food items. Observation of the kitchen on 03/19/19 at 2:15 am revealed: -There was three ring book with a current daily cleaning schedule with documentation of equipment cleaning once completed. -The floor in the walk-in refrigerator was not included on the daily cleaning schedule. -There was a schedule for wiping and refilling of the squeeze bottles; there was no place to document completion of the task.	D 282		

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D 282	Continued From page 54 Interview with the Administrator on 03/21/19 at 9:25 am revealed: -The kitchen staff was responsible for the daily cleaning of the kitchen. -The cleaning schedule was posted in the kitchen and kitchen staff should be documenting completed deep cleaning tasks daily, weekly and monthly. -The kitchen manager was responsible for reviewing the cleaning schedules, and assuring the kitchen was kept clean. -She had seen the milk crates in the refrigerator and freezer and thought they were acceptable as long as they kept food products off the floors. -She did not know about the rusted shelves, the split in the door gasket for the walk-in refridgerator or the ice build up in the freezer; she would have a repair company come in to do needed repairs. -The shelves in the walk-in refrigerator and freezer should be wiped off weekly and deep cleaned when the weather permitted by taking the shelves outside and pressure washing them. -The floors in the walk-in refrigerator and freezer were swept and mopped at the end of the day. -All food opened by staff and not used right away was to be dated and labeled. -Dry goods were utilized every thirty days before they went out of date. -The squeeze bottles were on a weekly cleaning schedule and product inside the bottles were thrown out when the bottles were cleaned. -She expected everything in the refrigerator, freezer and dry storage to be covered.	D 282		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service	D 298		

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D 298	Continued From page 55 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure snacks were offered or made available to all residents three times daily. The findings are: Review of the facility's week four spring/summer menu dated 03/15/19 through 03/21/19 revealed: -Evening snacks were listed as served Monday through Sunday. -The evening snacks were listed as "fruit drink and evening snack of choice" for each day. -There was no service time listed for evening snacks. -There were no other snacks or times listed on the menu. Interview with nine residents on 03/19/19 between 8:55 am and 9:30 am revealed: -The residents only received a snack in the evening; snacks were not offered at any other time. A snack was not offered between breakfast and lunch. -Juice was offered between lunch and dinner. -Staff brought snacks around to resident rooms. -The evening snack was half a sandwich and something to drink and was served around 8:00 pm; at around 2:00 pm staff offered juice.	D 298		

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D 298	Continued From page 56 -Only juice and ginger ale were offered in the afternoon; no food was offered in the afternoon. -A cookie would be nice to have once in a while. Interview with the kitchen manager on 03/20/19 at 9:45 am revealed: -Milk, punch and ginger ale were offered to all residents at 2:00 pm every day. -Facility staff took a beverage cart around to offer beverages to residents at 2:00 pm. -The evening snack was half a sandwich and a choice of milk, punch or ginger ale, evening snack was offered to every resident at 8:00 pm. Interview with the kitchen manager on 03/21/19 at 9:20 am revealed: -Residents could come to the kitchen and ask for a snack anytime of the day; the kitchen staff would make sandwiches or give crackers and moon pies if a resident did not want a sandwich. -Not too many residents came to the kitchen to ask for snacks between meals. -Residents could not access the kitchen from 9:30 am to 10:30 am, because the doors were locked for mopping the dining room floor during that time. -He did not know food and beverages should be offered as snacks to all residents three times a day. -He would add food to the afternoon beverage service and offer another snack time at 10:00 am. Observation of the dry storage pantry on 03/21/19 at 9:25 am revealed there were single serving sized bags of chips and four ounce cans of diet and regular ginger ale; there were no other snack items in the dry storage pantry. Interview with a personal care aide (PCA) on 03/20/19 at 11:45 am revealed:	D 298		

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D 298	Continued From page 57 -She worked 6:00 am to 6:00 pm. -Afternoon snacks were passed to every resident between 2:00 pm and 2:30 pm; snacks were passed by the PCAs. -Afternoon snacks were only ginger ale, diet ginger ale, milk or juice. -No food was offered to residents; most residents had their own snacks. Interview with the Administrator on 3/21/19 at 9:25 am revealed: -Snacks were offered to all residents in the afternoon and in the evening. -In the afternoon, all residents were offered juice; the facility staff took a cart around with juice and offered it to the residents. -In the evening, snack was offered to all residents; evening snack was a half a sandwich and milk. -Coffee and tea were always available in the dining room and residents could help themselves. -Residents could ask the kitchen staff for other foods, like fruit if they wanted something to eat between meals. -She did not know food and beverages were supposed to be offered three times a day as snack. -Residents usually had their own snacks in their rooms. -When the facility staff offered snacks three times a day, the residents would "stock pile" food in their rooms and it would become a problem with stale and old sandwiches as well as graham crackers. Observation of the 100 hall on 03/20/19 at 2:15 pm revealed a PCA took a cart with cups, ginger ale, diet ginger ale, fruit punch and half pint cartons of milk to resident rooms and offered beverages to the residents; there was no food on	D 298		

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D 298	Continued From page 58 the cart.	D 298		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice daily with meals. The findings are: Review of the menu dated 03/19/19 to 03/21/19 revealed 8 ounces of milk was to be served for the breakfast and dinner meal. Observation of the breakfast meal service on 03/20/19 at 8:30 am revealed: -Water and juice were preset before the meal; staff went around the dining room offering coffee. -Residents that got cold cereal were given milk to pour over their cereal. -After pouring milk on their cereal some residents drank the remaining milk in the cartons. -Residents were not offered milk if they did not	D 299		

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D 299	Continued From page 59 get cold cereal. Observation of the walk in refrigerator in the kitchen on 03/20/19 at 8:45 am revealed; there were six cases of eight-ounce milk; 50 half pints per case were on a shelf in the cooler for a total of 300 eight-ounce cartons of milk. Based on the census and the menu the facility required 144 eight-ounce cartons of milk a day. Observation of the dinner meal service on 03/20/19 at 5:00 pm revealed: -Water and ice tea were preset before meal service, and coffee was offered during the meal. -None of the residents were offered or given milk with their meal. Observation of the lunch meal service on 03/21/19 at 11:50 am revealed: -Residents were not offered milk or served milk. -Water and ice tea were preset before the lunch meal; two residents had milk preset on their tables. Interview with eleven residents on 03/19/19 between 8:55 am and 1:00 pm revealed: -They did not get milk to drink. -They liked milk and missed having it to drink. -They had not asked for milk to drink. -They were not offered milk at lunch or dinner. -A resident was served milk at breakfast. -Two residents had milk today with their cereal; milk was not offered milk unless they had cereal. -One resident did not recall when she had milk offered to her. -A resident said she would drink milk every day if it was offered. -One resident had moved in a few months ago; she had not been offered milk since she had	D 299		

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D 299	Continued From page 60	D 299		

been in the facility.
-A resident had milk with his breakfast; he had not been offered milk to drink other than breakfast.
-A resident said he could ask for milk to drink, but had not.
-One resident was not served or offered milk at lunch, dinner or snack times.
-If you wanted milk for lunch or dinner, you had to ask for it.
-One resident would like to drink milk with his meals if it were offered; he never asked for milk with his meal.
-The staff preset the tables with water and ice tea and went around the dining room with a coffee cart asking residents if they would like coffee.

Interview with a resident on 03/21/19 at 1:00pm revealed:
-Milk was only served or offer during breakfast.
-If you wanted milk for lunch or dinner, you had to ask for it.

Interview with two personal care aides (PCA) on 03/21/19 at 12:00 pm revealed:
-The PCAs pretty much knew what each resident liked so the tables were preset with water and ice tea before the lunch and dinner meals; breakfast was preset with juice.
-Coffee was offered at every meal.
-Milk was given at breakfast only, not at lunch or dinner.
-Two residents liked milk at lunch time; the two residents' milk was preset before the lunch meal.
-Residents would let the staff know if they wanted anything else to drink at meal times.

Interview with a kitchen staff on 03/21/19 at 12:15 pm revealed:
-She used a beverage list to preset the resident's

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tables.
-The beverage list was a seating chart with the resident's preferences.
-There was a seating chart for each meal; the seating chart was updated when new residents came into the facility.
-Residents got milk at breakfast, and she knew who liked to get milk.
-Residents were good about letting her know if they wanted something different to drink with their meals.
-She knew of two residents that got milk at lunch; none of the residents got milk at dinner.

Interview with the kitchen manager on 03/21/19 at 12:55 pm revealed:
-The staff did not offer residents milk at any meals; milk was given with cereal at breakfast.
-In the past, the staff had preset milk on the resident tables before the breakfast and dinner meal service, but he was throwing a lot of milk away and the residents complained of the waste.
-The staff used the seating chart as a preference list for beverages and preset the tables before each meal.
-The seating chart was updated as residents moved or left; the seating chart had last been updated on August 2018.
-The staff knew which residents liked milk and which residents did not like milk.
-Residents could always ask the staff for milk if they wanted milk with their meal.

Interview with the Administrator on 03/21/19 at 1:30 pm revealed:
-Milk was offered in the morning with breakfast for cereal.
-Milk was offered in the evening with the evening snack.
-She thought milk only needed to be offered two

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D 299	Continued From page 62 times a day and she thought the evening snack counted as the second offering even though it was on the menu for breakfast and dinner. -The facility staff tried to keep up with residents' preferences; residents could always let staff know what they wanted. -At one time the facility had placed milk out at two meals a day and was "throwing it all away" after the meals.	D 299		
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 assure sliding scale insulin (Humalog) was administered as ordered by the licensed prescribing practitioner for 1 of 4 sampled residents (#7) during a medication pass resulting in fast-acting insulin being administered	D 358		

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D 358	Continued From page 63 1 hour and 30 minutes before Resident #7 was served a meal or offered a snack. The findings are: The medication error rate was 4% as evidenced by the observation of 1 error out of 25 opportunities during the 8:00 am medication pass on 03/20/19 and the 4:00pm medication pass on 03/20/19. Review of Resident #7's current FL-2 dated 09/19/18 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, hyperlipidemia, chronic renal disease, anxiety and severe depression. -There was an order for finger stick blood sugar (FSBS) testing before meals and at bedtime. -There was an order for Humalog insulin with the following sliding scale (Humalog insulin is a fast-acting insulin that starts to work in 15 minutes): -If FSBS was 71-150 do not administer insulin. -If FSBS was 151-200 administer 2 units. -If FSBS was 201-250 administer 4 units. -If FSBS was 251-300 administer 6 units. -If FSBS was 301-350 administer 8 units. -If FSBS was 351-400 administer 10 units. -If FSBS was less than 70 and greater than 400 call the physician. Review of subsequent physician's order for Resident #7 dated 02/14/19 revealed: -There was an order for Humalog insulin with the following sliding scale: -If FSBS was 71-150 do not administer insulin -If FSBS was 151-200 administer 2 units. -If FSBS was 201-250 administer 4 units. -If FSBS was 251-300 administer 6 units. -If FSBS was 301-350 administer 8 units.	D 358		

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D 358	Continued From page 64 -If FSBS was 351-400 administer 10 units. -If FSBS was less than 70 and greater than 400 call the physician. Observation during the medication pass on 03/20/19 at 4:13pm revealed: -Resident #7 had a FSBS of 155 at 4:13pm. -Resident #7 was administered 2 units of Humalog insulin at 4:14pm, based on the sliding scale. Review of Resident #7's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog insulin with the following sliding scale: -If FSBS was 71-150 do not administer insulin -If FSBS was 151-200 administer 2 units. -If FSBS was 201-250 administer 4 units. -If FSBS was 251-300 administer 6 units. -If FSBS was 301-350 administer 8 units. -If FSBS was 351-400 administer 10 units. -If FSBS was less than 70 and greater than 400 call the physician. -There was documentation of FSBS of 155 on 03/20/19 at 5:00pm. Observation in the dining room on 03/20/19 at 5:08pm revealed Resident #7 was not in the dining room. Interview with the Supervisor/ medication aide (MA) on 03/20/19 at 5:05pm revealed: -Resident #7 did not want to eat dinner. -She was aware the resident needed to eat something after being administered insulin. -She would offer him a snack around 6:00pm. Observation on 03/20/19 at 5:08pm in room #125B revealed:	D 358		

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D 358	Continued From page 65 -Resident #7 was lying on his bed. -Resident #7 had no signs or symptoms of hypoglycemia. Interview with Resident #7 on 03/20/19 at 5:08pm revealed: -He was not hungry. -He was feeling okay. -He would usually eat a meal or sandwich after he was given his insulin. Interview with the Supervisor/MA on 03/20/19 at 5:40pm revealed she had not offered Resident #7 anything to eat. Interview with the Supervisor/MA on 03/20/19 at 5:45pm revealed: -She gave Resident #7 a sandwich to eat, and he ate the sandwich. Observation on 03/20/19 at 6:00 pm in room #125B revealed Resident #7 was not in his room. Telephone interview with Resident#7's primary care physician (PCP) on 03/21/19 at 8:59am revealed: -He expected the MA to give the resident a snack 15-30 minutes after the resident was administered insulin. -Resident #7's blood sugar could drop, and he could have signs and symptoms of hypoglycemia. Telephone interview with the pharmacist on 03/21/19 at 9:35am revealed: -Humalog insulin should be given 15 minutes prior to a meal. -If the resident was not served a meal or offered a snack for an hour and 30 minutes, it could cause the resident to have signs and symptoms of hypoglycemia.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073003	A. BUILDING: _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 66 -Humalog insulin should be given with the first bite of food or after the resident consumed at least 50% of the meal. Interview with the Resident Care Coordinator (RCC) on 02/21/19 at 10:00am revealed: -The MA should have been aware of the timeframe between administering Humalog insulin to the resident and eating a meal. -Resident #7 should have had a snack to eat 15-30 minutes after receiving Humalog insulin on 03/20/19 at 4:14pm. -The issue was administering and checking the blood sugar 45 minutes before the meal was served. -Resident #7's blood sugar should have been checked closer to 5:00pm. -All MAs had diabetic training before administering insulin. Interview with the Administrator on 03/21/19 at 11:15am revealed: -She did know Resident #7 refused to eat dinner on 03/20/19 at 5:00pm. -She did know the MA did not offer a snack within the15-30 minutes timeframe of administering the insulin. -The resident should have been offered a snack between 15-30 minutes of being administered Humalog insulin. -The blood sugar should have been checked closer to 5:00pm.	D 358		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 67 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents with a history of falls (Resident #1, #2 and #6). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		