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SPRING ARBOR OF GREENSBORO	5125 MICHAUX ROAD GREENSBORO, NC 27410

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 01/23/20 through 01/24/20 and on 01/27/20. The complaint was initiated by the Adult Care Licensure Section on 01/23/20.	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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' needs and current symptoms for 3 of 5 sampled residents (#1, #3, and #5) including a resident who exhibited exit seeking behaviors (#5), a resident who eloped from the facility (#3), and two residents who had multiple falls which resulted in a knee injury (#1 and #3), a head contusion (#3) and a resident who inappropriately touched female residents (#5). The findings are:	D 270		

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1. Review of Resident #3's current FL2 dated 01/22/20 revealed:
-Diagnoses included dementia, gastrointestinal reflux disease, osteoarthritis, hypertension, anxiety, hyperlipidemia, and depression.
-Resident #3 was constantly disoriented.
-Resident #3 was semi-ambulatory with a wheelchair.

a. Review of Resident #3's Care Plan dated 10/28/19 revealed:
-Resident #3 required limited assistance with toileting, ambulation, bathing, dressing, grooming and transfers.
-Resident #3 had limited ambulation ability and ambulated with a wheelchair.
-Resident #3 kept to herself and did not come out of his room.
-Resident #3 was sometimes disoriented, forgetful, and needed reminders.

Review of Resident #3's Licensed Health Professional Support (LHPS) dated 11/07/19 revealed:
-Resident #3 used a wheelchair.
-Resident #3 could self-propel in her room without assistance, but she required staff assistance to push her for longer distances.

Observation of Resident #3 on 01/23/20 at 3:11pm revealed:
-Resident #3 was in her room sitting in her recliner with her feet propped up on a footstool ottoman.
-She had dark colored bruising under her right eye.

Review of the facility's "Falls Management and Interventions" program revealed:
-A resident is automatically placed on the

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program upon move in or any readmission from a hospital or rehab stay.
-The resident may come off the program if he/she has not had a fall in 60 days.
-Interventions should be developed to help manage the individual's risk of falling.
-The Fall Risk Awareness and Interventions form will be completed and placed in the program binder, and also in the front of the personal care services (PCS)/activities of daily living (ADL) log book.
-Staff on all three shifts are expected to check on residents proactively and regularly for any unmet need, and see that the resident is safe, has a call-pendent readily available, and that indicated interventions are in place.
-Resident interventions will be reviewed during the Weekly Falls Management Meeting.

Review of the Hot Box: Concept/Guidelines revealed:
-The Hot Box was a system used to assure additional attention was given to residents who may have experienced a temporary change in condition.
-The practice of using the Hot Box system involved placing the identified resident's chart in a designated are to alert all supervisors and medication aides on each shift a resident required additional attention and documentation.
-A resident was placed in the Hot Box upon move in for 4 days.
-A resident was placed in the Hot Box for 3 days or longer if the resident had a fall or an event.

Review of Resident #3's Fall Risk Assessment revealed:
-Resident #3 was assessed by the facility in-house physical therapy (PT) department on four occasions between 10/10/19 and 12/18/9

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was assessed to be a lower fall risk.
-Resident #3 was assessed by the facility in-house PT department on 12/18/19 and was assessed to be a higher fall risk.

Review of Resident #3's home health notes revealed:
-On 10/14/19, home health skilled nursing (SN) completed a start of care assessment due to an irregular heartbeat, pain in hips and knees, and SN was to continue education on hypertension and fall prevention.
-On 10/14/19, physical therapy (PT) completed an initial evaluation and Resident #3 was to be seen 2 times a week for 7 weeks and then 1 time a week for 2 weeks.
-On 10/17/19, occupational therapy (OT) completed an initial evaluation and Resident #3 was to be seen 1 time a week and then 2 times a week to address activities of daily living, endurance, bathroom and kitchen mobility, and overall safety.
-On 10/18/19, Resident #3 refused a PT visit.
-On 10/25/19, Resident #3 refused a PT visit.
-On 10/29/19, Resident #3 refused 2 attempted PT visits.
-On 10/29/19, SN discontinued services due to all goals met.
-On 11/01/19, OT attempted to schedule visit with Resident #3 on 10/30/19, but Resident #3 was not agreeable to OT services.
-On 11/14/19, Resident #3 refused a PT visit; Due to inconsistent participation, Resident #3 was discharged from PT services on 11/14/19.
-On 12/16/19, SN made a referral to PT due to recent history of falls.
-On 12/19/19, PT attempted to complete an initial evaluation, but Resident #3 refused the visit.
-On 12/23/19, PT reattempted to complete an initial evaluation, but Resident #3 refused the

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visit; There would be no further attempts to complete a PT evaluation.
-On, 01/10/20, Resident #3 was discharged from the home health agency.

Review of Resident #3's Resident Notes and Incident and Accident reports revealed Resident #3 had 2 falls in October 2019.

Review of Resident #3's Resident Notes dated 10/26/19 (no time indicated) revealed:
-Resident #3 told staff she was getting out of bed to get into her wheelchair, but the wheelchair was not locked and it rolled out from under her.
-Resident #3 landed on the floor.
-There were no injuries.
-There was no documentation of any increased supervision provided to Resident #3 to reduce falls.

Review of an Incident and Accident Report for Resident #3 dated 10/26/19 at 7:42pm revealed:
-Resident #3 had an unwitnessed fall in her apartment.
-Resident #3 said she was getting out of the bed to get into her wheelchair, but her wheelchair was not locked.
-The wheelchair rolled out from under Resident #3 and she landed on the floor.
-Resident #3 was assessed for bruising (no results indicated).
-Staff reminded Resident #3 to push her pendant for help.
-No injuries were documented.
-Emergency medical services (EMS) was not called and resident was not sent to the hospital.
-Resident #3's primary care physician (PCP) and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall

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D 270	Continued From page 5 on 10/26/19. Interview on 01/27/20 at 1:46pm with the medication aide (MA) who documented the Resident Note and Incident and Accident Report dated 10/26/19 revealed: -She found Resident #3 on the floor in her room. -Resident #3 told her she had slipped out of her chair. -Resident #3 did not have any injuries. -She was not told to increase supervision for Resident #3 after her fall on 10/26/19. -The personal care aides (PCA) were supposed to check on all resident every 2 hours or every 1 hour. -The facility had a "Falls Management and Intervention" program and residents on the program were supposed to be checked on each time staff passed that resident's room. -Resident #3 was on the "Falls Management and Intervention" program, but she did not know if staff checked on her each time they passed her room. Review of a timeline for Resident #3 provided by the Executive Director (ED) on 01/27/20 revealed: -Resident #3 fell on 10/26/19 due to getting out of bed and transferring to wheelchair without locking the wheelchair brakes. -After Resident #3's fall on 10/26/19, Resident #3 had PT and education. -Resident #3 was seen by a psychotherapist on 10/28/19. -There was a fall risk assessment completed by the in-house Rehabilitation Director. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 10/26/19. Review of Resident #3's Resident Notes and	D 270		

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Incident and Accident reports revealed Resident #3 had 1 fall in November 2019.

Review of Resident #3's Resident Notes dated 11/30/19 at 2:00am revealed:
-Resident #3 was observed on the floor laying on her right side.
-Resident #3 complained of right knee pain.
-There was no bruising noted.
-An as needed pain medication was given and was effective.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 11/30/19.

Review of the Incident and Accident Report for Resident #3 dated 11/30/19 at 1:55am revealed:
-She heard Resident #3 calling for help and observed her laying on the floor on her right side.
-She notified other staff members of Resident #3 laying on the floor.
-Resident #3 was checked for injuries and she complained of right knee pain.
-Resident #3 was assisted up from the floor and as needed medication was offered for right knee pain.
-EMS was not called and Resident #3 was not sent to the hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 11/30/19.

Interview on 01/27/20 at 2:07pm with the MA Supervisor who wrote the Resident Note and Incident and Accident Report dated 11/30/19 revealed:
-She just happened to be in the medication room next door to Resident #3's apartment and heard

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Resident #3 yelling for help.
-She found Resident #3 on the floor in her apartment complaining of right knee pain.
-Staff "pretty much" just did 2 hour rounds to check on residents.
-There was a "Fall Management and Interventions" program and there was a weekly meeting to talk about interventions for residents on the program.
-She did not remember ever being told to check on Resident #3 more frequently than every 2 hours.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed laying on the floor on 11/30/19.
-Staff met with Resident #3's responsible party on 12/02/19 regarding mental health issues and goals of getting Resident #3 committed to a behavioral health hospital.
-On 12/03/19, staff received verbal orders from the mental health provider to increase dosages of psychotropic medications.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 11/30/19.

Review of Resident #3's Resident Notes and Incident and Accident reports revealed Resident #3 had 13 falls in December 2019.

Review of Resident #3's Resident Notes dated 12/06/19 at 7:00am revealed:
-Resident #3 was heard yelling for help and staff went in to assist.
-Resident #3 was observed on the floor.
-EMS was called and Resident #3 was transported to a local hospital.
-There was no documentation of any increased

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supervision provided to Resident #3 after her fall on 12/06/19.

Review of the Incident and Accident Report for Resident #3 dated 12/06/19 at 6:30am revealed:
-Resident #3 was yelling for help and staff went in her apartment to assist her.
-Resident #3 was observed on the floor.
-EMS was called and Resident #3 was taken to a local hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/06/19.

Interview on 01/27/20 at 12:11pm with the MA Supervisor who completed the Resident Note and Incident and Accident Report dated 12/06/19 revealed:
-She did not remember the details of Resident #3's fall without reviewing the Resident Note or Incident Accident Report.
-Resident #3 had multiple falls and was a high fall risk
-Staff completed wellness rounds checking on residents every 2 hours.
-"When we heard her (Resident #3), we would go in and put an eye on her."
-If there was any increase in supervision, there would be directives from the Resident Care Director (RCD) or ED to complete 30 minute or 1 hour checks.
-She was not told to increase supervision of Resident #3 after her fall on 12/06/19.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor on 12/06/19.

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-Resident #3 was sent to the emergency room (ER) for a psychiatric evaluation due to behaviors.
-There was a Fall Risk Assessment completed by the in-house Rehabilitation Director.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/06/19.

Review of Resident #3's Resident Notes dated 12/07/19 (no time indicated) revealed:
-Staff heard Resident #3 calling out for help and resident #3 was observed on the floor.
-Resident #3 had a "hematoma" on the left side of her forehead and it was bleeding.
-EMS was called and Resident #3 was taken to the hospital.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/07/19.

Review of the Incident and Accident Report for Resident #3 dated 12/07/19 at 3:40am revealed:
-Staff heard Resident #3 calling out for help.
-Staff observed Resident #3 on the floor beside her bed bleeding from her head.
-EMS was called and Resident #3 was transported to a local hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/07/19.

Interview on 01/27/20 at 2:07pm with the MA Supervisor who completed the Resident Note and Incident and Accident Report dated 12/07/19 revealed:
-She observed Resident #3 in her apartment on the floor beside her bed bleeding from her head.
-She did not see anything beside Resident #3's

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bed that she could have hit her head on, so she did not know how Resident #3 hit her head.
-There was a "Fall Management and Interventions" program and there was a weekly meeting to talk about interventions for residents on the program.
-She did not remember if she had been told to increase supervision for Resident #3 after her fall on 12/07/19.
-She had not completed any scheduled safety checks for Resident #3.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor beside her bed on 12/07/19.
-A Fall Risk Assessment was completed by the in-house Rehabilitation Director.
-Resident #3 was seen by her psychotherapist and her mental health provider who wrote an order for a psychotropic medication.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/07/19.

Review of Resident #3's Resident Notes dated 12/12/19 revealed:
-Resident #3 was found laying on her left side outside of her bathroom door and she was nowhere near her wheelchair.
-Resident #3 could not explain what happened.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/12/19.

Review of Resident #3's Incident and Accident Report dated 12/12/19 at 9:20pm revealed:
-Staff went to Resident #3's apartment to give her medications.
-Resident #3 was observed laying outside her

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bathroom door on her left side.
-Resident #3's wheelchair was beside her bed and was nowhere near Resident #3.
-EMS was not called and Resident #3 was not sent to the hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/12/19.

Interview 01/27/20 at 1:46pm with the MA Supervisor who completed the Resident Note and Incident and Accident Report dated 12/12/19 on revealed:
-She observed Resident #3 laying on the floor by her bathroom when she went into her apartment to give her scheduled medications.
-Resident #3 did not have any injuries.
-She did not know how Resident #3 got on the floor by the bathroom door, because she could not walk.
-Resident #3 was on the "Falls Management and Interventions" program and staff was supposed to check on residents on this program every time they passed the resident's room.
-Residents were to be placed in the "Hot Box" where MAs should document any pain, bruises, or further falls on every shift for 3 days.
-She was not told to increase supervision for Resident #3 after her fall on 12/12/19.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor on 12/12/19.
-Resident #3 was seen by her PCP and there were medication changes.
-There was no documentation of any increased supervision provided to Resident #3 after her fall

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D 270	Continued From page 12 on 12/12/19. Review of Resident #3's Resident Notes dated 12/13/19 at 3:20pm revealed: -Resident #3 was observed lying on her left side beside her bed and stated a man pushed her out of the bed, but he was gone. -No injuries were noted. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/13/19. Review of Resident #3's Incident and Accident Report dated 12/13/19 at 2:45pm revealed: -Resident #3 was observed laying on her left side beside her bed and stated a man pushed her out of the bed, but he was gone. -No injuries were noted. -EMS was not called and Resident #3 was not sent to the hospital. -Resident #3's PCP and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/13/19. Attempted Interview on 01/27/20 at 12:10pm with the MA/Supervisor who documented the Resident Note and Incident and Accident Report dated 12/13/19 was unsuccessful. Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed: -Resident #3 was found on 12/13/19 laying on her left side beside the bed and stated a man pushed her out of bed. -Resident preferred staff to leave her door open to check on her but this request was subject to change per Resident #3's mood. -There was no documentation of any increased	D 270		

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supervision provided to Resident #3 after her fall on 12/13/19.

Review of Resident #3's Resident Notes dated 12/14/19 at 7:00am revealed:
-Resident #3 was observed on the floor in her apartment twice on third shift at 2:45am and 4:15am.
-EMS was called both times and Resident #3 was taken to a local hospital by EMS after the second fall because she stated she hit her head.
-No injuries were observed.
-Resident #3 was observed to be agitated and combative with EMS.
-Resident #3's PCP was contacted.
-There was no documentation of any increased supervision provided to Resident #3 after her falls on 12/14/19.

Review of Resident #3's Incident and Accident Report dated 12/14/19 at 2:30am revealed:
-Resident #3 was observed on the floor of her apartment during wellness rounds.
-Resident was assessed for injuries and none were found.
-EMS was called but Resident #3 was not taken to the hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/14/19.

Review of Resident #3's Incident and Accident Report dated 12/14/19 at 4:15am revealed:
-Resident #3 was observed on the floor of her apartment during wellness rounds.
-Resident #3 stated she hit her head and was sent by EMS to a local hospital.
-Resident #3's PCP and responsible party were

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notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/14/19.

Interview on 01/27/20 at 12:11pm with the MA Supervisor who completed the Resident Note and Incident and Accident Reports dated 12/14/19 at 2:30am and 12/14/19 at 4:15am revealed:
-She remembered there was a day when Resident #3 had multiple falls, but she did not remember the details of the falls without looking at the Resident Note or Incident Accident Reports.
-Resident #3 had multiple falls and was a high fall risk.
-Staff completed wellness rounds checking on residents every 2 hours.
-She was not told to increase supervision of Resident #3 after any of Resident #3's falls.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor 2 times on 12/14/19.
-Resident #3 was sent to a local hospital for evaluation and there were no new orders.
-There was no documentation of increased supervision provided.
-There was no documentation of any increased supervision provided to Resident #3 after either of her two falls on 12/14/19.

Review of Resident #3's Resident Notes dated 12/16/19 at 6:00am revealed:
-Resident #3 was observed on the floor and she stated she hit her head.
-Resident #3 also stated her left knee was hurt.
-EMS was called and Resident #3 was transported to a local hospital.

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D 270	Continued From page 15 -Resident #3 returned to the facility with no new orders and no injuries. -Resident #3's responsible party was contacted. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/15/19. Resident #3's Incident and Accident Report dated 12/15/19 at 11:30pm revealed: -Resident #3 was heard yelling for help and staff went to assist. -Resident #3 was observed on the floor of her apartment. -Resident #3 was assessed for injuries and none were observed. -Resident complained of left knee pain and a head injury. -Resident #3's PCP was contacted on 12/16/19 at 6:00am and her responsible party was contacted on 12/16/19 at 7:00am. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/15/19. Interview on 01/27/20 at 12:11pm with the MA Supervisor who completed the Resident Note dated 12/16/19 at 6:00am and Incident and Accident Report dated 12/15/19 revealed: -She did not remember the details of Resident #3's fall without reviewing the Resident Note or Incident Accident Report. -Resident #3 had multiple falls and was a high fall risk -Staff completed wellness rounds checking on residents every 2 hours. -"When we heard her (Resident #3), we would go in and put an eye on her." -If there was any increase in supervision, there would be directives from the Resident Care Director (RCD) or ED to complete 30 minute or 1	D 270		

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hour checks.
-She was not told to increase supervision of Resident #3 after her fall on 12/15/19.

Review of a local hospital After Visit Summary for Resident #3 dated 12/16/19 revealed:
-Resident #3 was seen in the Emergency Room (ER) on 12/16/19 due to a fall.
-Resident #3 was diagnosed with a fall and a contusion of the left knee.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was found on the floor on 12/15/19.
-Resident #3 was administered a psychotropic medication injection by the home health provider.
-PT was restarted due to history of falls, but it was discontinued due to Resident #3 non-compliance and refusals.
-The ED and the psychotherapist called a behavioral health unit at a local hospital to gather information regarding admission of residents into the unit.
-There was no documentation of any increase in supervision provided after her fall on 12/15/19.

Review of Resident #3's Resident Notes dated 12/18/19 revealed:
-Resident #3 was observed on the floor in her apartment living room area.
-Resident #3 told staff she was "just trying to crawl."
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/18/19.

Review of the Incident and Accident Report for Resident #3 dated 12/18/19 at 3:50pm revealed:
-A PCA observed Resident #3 on the floor in her apartment in the living room area.

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D 270	Continued From page 17 -Resident #3 stated she was "trying to crawl." -Resident #3 was assessed for injuries and no injuries were observed. -Resident #3 was repositioned into her wheelchair. -EMS was not called and Resident #3 was not sent to the hospital. -Resident #3's PCP and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/18/19. Interview on 01/27/20 at 1:16pm with the MA who completed the Resident Note and Incident and Accident Report dated 12/18/19 revealed: -She was notified by a PCA through a walkie talkie she needed to go to Resident #3's room. -When she got to Resident #3's room, Resident #3 was on her bottom with her back against her wheelchair. -Resident #3 was on the "Fall Management and Interventions" program. -If a resident was not on the program, staff checked on the resident every 2 hours. -If a resident was on the program, staff checked on the resident the resident more often, but there was not specified time. -Staff was supposed to check on residents on the program each time they passed the resident's room by going into the room to see where the resident was. -Staff did not document resident checks anywhere. -She was told by the Special Care Coordinator (SCC)/Memory Care Coordinator (MCC), the ED, and the Activity Director to start 30 minute checks on Resident #3 on 01/26/20. Review of a timeline for Resident #3 provided by	D 270		

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the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor on 12/18/19.
-A Fall Risk Assessment was completed by the in-house Rehabilitation Director.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/18/19.

Review of Resident #3's Resident Notes dated 12/19/19 at 7:15am revealed:
-Resident #3 was observed on the floor around 11:20pm on 12/18/19.
-Resident #3 complained of right knee pain.
-Resident #3 was taken to the hospital for evaluation.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/18/19.

Review of the Incident and Accident Report for Resident #3 dated 12/18/19 at 11:20pm revealed:
-A PCA observed Resident #3 on the floor in her apartment and notified the MA Supervisor.
-The MA Supervisor checked Resident #3 for injuries and Resident #3 complained of right knee pain.
-EMS was called and Resident #3 was transported to a local hospital.
-Resident #3's PCP was notified, but the MA Supervisor was informed not to notify the responsible party until later.
-The ED notified the responsible party on 12/19/19 at 11:00am.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/18/19.

Interview on 01/27/20 at 1:16pm with the MA Supervisor who completed the Resident Note and

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D 270	Continued From page 19 Incident and Accident Report dated 12/18/19 revealed: -She did not remember the details Resident #3's fall on 12/18/19. -Staff was supposed to check on Resident #3 frequently because she was on the "Fall Management and Interventions" program, but there was no precise time frame for checking on her. -Staff did not document the frequent checks on residents on the "Fall Management and Interventions" program. -She did not remember if she had been told to increase supervision for Resident #3 after her fall on 12/18/19. -She had not completed any scheduled safety checks for Resident #3. Review of a local hospital After Visit Summary dated 12/19/19 revealed: -Resident #3 was seen in the ER due to a fall. -Resident #3 was diagnosed with a fall, contusion of the face, and dementia with behavioral disturbance. Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed: -Resident was observed on the floor by a PCA on 12/18/19. -Medication changes were made. -Labs and imaging were completed. -There was no documentation of any increased supervision for Resident #3 after her second fall on 12/18/19. Review of Resident #3's Resident Notes dated 12/20/19 at 1:40pm revealed: -Resident #3 was found on the floor in her apartment on her hands and knees and was unable to say how she got there.	D 270		

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-Resident #3 was assessed for injuries and no injuries were noted.
-Resident #3 was assisted up and in to her wheelchair.
-The RCD was notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/20/19.

Review of an Incident and Accident Report for Resident #3 dated 12/20/19 (no time indicated) revealed:
-Resident #3 was observed on the floor on her hands and knees in her apartment.
-Resident #3 assessed for injuries and none were noted.
-Resident was assisted up and into her wheelchair.
-EMS was not called and Resident #3 was not sent to the hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/20/19.

Interview on 01/27/20 at 12:54pm with the MA Supervisor who completed the Incident and Resident Note and Incident Accident Report dated 12/20/19 revealed:
-She was called down to Resident #3's room and found Resident #3 on her hands and knees.
-Resident #3 said she slid out of her chair.
-She did not remember if the chair was a wheelchair or straight back chair.
-Resident #3 did not have any injuries.
-Staff checked on Resident #3 every 2 hours and possibly every hour.
-After a fall, staff usually increased checks to every hour, but did not document the increased

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checks anywhere.
-There had been residents in the past who had scheduled 30 minute checks due to frequent observations on the floor.
-The last scheduled 30 minute check she was aware of was about 2 to 3 months ago.
-There had not been scheduled 30 minute checks put in place for Resident #3 after any of her falls.
-The RCD was responsible for deciding who received 30 minute checks.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was found on the floor on 12/20/19.
-There was a care plan meeting with Resident #3's responsible party and spouse to discuss changing setting and/or need for sitters due to recent falls.
-Resident #3 was encouraged to use her wheelchair for ambulation.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/20/19.

Review of Resident #3's Resident Notes dated 12/21/19 at 5:00am revealed:
-Resident #3 was observed on the floor during wellness rounds with both her eyes closed.
-EMS was called to assist with helping Resident #3 off the floor onto her bed.
-There were no visible injuries observed.
-Resident was last observed resting in her bed with her eyes closed.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/21/19.

Review of the Incident and Accident Report dated 12/21/19 at 4:15am revealed:
-Resident #3 was observed on the floor during a

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wellness check.
-The MA called EMS after assessing Resident #3 for injuries and there were none noted.
-Resident #3 was not transported to the hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/21/19.

Interview on 01/27/20 at 12:11pm with the MA Supervisor who completed the Resident Note and Incident and Accident Report dated 12/21/19 revealed she was not told to increase supervision of Resident #3 after her fall on 12/21/19.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor on 12/21/19.
-Resident #3 was lying on the floor with her eyes closed.
-Resident #3 was observed a few hours earlier walking around the room when staff did their safety checks.
-Resident #3 was asked to sit in her wheelchair to prevent a fall.
-Resident #3 laughed and said, "I do not fall, I just sit down."
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/21/19 at 5:00am.

Review of Resident #3's Resident Notes dated 12/21/19 at 9:00pm revealed:
-Resident #3 moved to the Memory Care Unit (MCU).
-Resident was adjusting to the MCU.
-Resident was in her apartment in her wheelchair when she slid herself out of the chair onto the

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floor and laid herself on the floor. (The note does not indicate whether or not this was observed.)
-Resident ## was observed on the floor asleep by a PCA who called for a MA.
-The MA observed Resident #3 on the floor, sleeping, and laying on her left side.
-There was no documentation of any increased supervision provided to Resident #3 after her second fall on 12/14/19.

Review of Incident and Accident Reports for Resident #3 revealed there was no Incident and Accident Report dated 12/21/19 at 9:00pm.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 slid to the bottom of her recliner.
-Resident #3 was relocated to the MCU for increased supervision. (According to Resident #3's notes, Resident #3 fell after being relocated to the MCU.)
-There was no documentation of any increased supervision after her second fall on 01/21/19 at 9:00pm.

Review of Resident #3's Resident Notes dated 12/24/19 at 1:00am revealed:
-Resident #3 was observed on the floor by a PCA.
-A MA Supervisor was called EMS for assistance.
-Resident #3 was transported to the hospital.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/24/19.

Review of the Incident and Accident Report for Resident #3 dated 12/24/19 at 12:35am revealed:
-A PCA observed Resident #3 on the floor in her apartment.
-EMS was called and transported Resident #3 to

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the hospital.
-Resident #3's PCP and responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/24/19.

Interview on 01/27/20 at 9:56am with the MA who completed the Incident and Accident Report on 12/24/19 revealed:
-She did not remember the details of the fall on 12/24/19.
-She did frequently checked on Resident #3, but she did not know how often and did not document the checks anywhere.
-She was not told to increase supervision for Resident #3 after her fall on 12/24/19.
-She knew to check on residents in the MCU every 30 minutes or more often.

Review of a local hospital After Visit Summary dated 12/24/19 revealed:
-Resident #3 was seen in the ER on 12/24/19 due to a fall.
-Resident #3 was diagnosed with a fall.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3's mental health provider and her PCP collaborated to discontinue medication which could cause adverse effects in the elderly population.
-There was no documentation of any increased supervision after her fall on 12/24/19.

Review of Resident #3's Resident Notes dated 12/26/19 revealed:
-Resident #3 was observed on the floor in front of her recliner.
-EMS was called and the MA supervisor and

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management were notified.
-Resident #3's responsible party was notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/26/19.

Review of the Incident and Accident Report dated 12/26/19 at 8:25am revealed:
-Resident #3 was observed on the floor in front of recliner.
-EMS was called at 8:35am, but Resident #3 was not transported to the hospital.
-Resident #3's PCP and responsible party were contacted.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 12/26/19.

Interview on 01/27/19 at 10:45am with the MA who completed the Resident Note and Incident and Accident Report dated 12/26/19.
-Resident #3 slid on the floor from her recliner with the foot rest of her electric recliner at her back.
-The foot rest was touching the floor and the recliner was tilted forward.
-There were no injuries noted.
-Prior to the fall on 12/26/19, staff had last checked on Resident between 7:00am and 7:30am.
-After Resident #3 fell on 12/26/19, she and another staff checked on Resident every hour to 30 minutes, but the checks were not documented anywhere.
-Resident #3 was on the "Falls Management and Interventions" program and the protocol was to provide frequent checks, but there was no documentation.
-Staff used to implement 30 minute checks for residents who had frequent falls, but they stopped

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using the 30 minute checks.
-She did not know why the 30 minute checks were stopped, but they were restarted on 01/26/20.
-Resident #3 was now on 30 minute checks.

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor in front of her recliner on 12/26/19.
-A pad sensor alarm was implemented for Resident #3's bed and recliner.
-There was no documentation of any increased supervision for Resident #3 after her fall on 12/26/19.

Review of Resident #3's Resident Notes and Incident and Accident reports revealed Resident #3 had 3 falls in January 2020.

Review of Resident #3's Resident Note dated 01/03/20 at 9:47am revealed:
-Resident #3 was observed on the floor in front of her recliner sitting on her buttocks with her back against the recliner.
-Resident #3 said it took a long time to get out of the chair.
-The Supervisor and the SCC/MCC were alerted.
-Resident #3's responsible party was notified and voiced concern about sending Resident #3 out to the hospital.
-EMS was called and Resident #3 was taken to the hospital due to complaints of knee pain and lower back pain.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 01/03/20.

Review of the Incident and Accident Report for Resident #3 dated 01/03/20 at 8:10am revealed:

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D 270	Continued From page 27 -Resident #3 was found on the floor of her apartment in front of her recliner on her buttocks with her back against her recliner. -EMS was called and Resident #3 was transported to a local hospital. -Resident #3's PCP and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 01/03/20. Interview on 01/27/20 at 10:45am with the MA who completed the Resident Note and Incident and Accident Report dated 01/03/20 revealed: -A PCA found Resident #3 on the floor sitting in front of her recliner. -Resident #3 had used the electronic remote to lower the footrest. -Resident #3 had complained about pain. -EMS was contacted and Resident #3 was transported to a local hospital. -When Resident #3 returned from the hospital, staff was not told to increase supervision of Resident #3 after her fall on 01/03/20. -Staff tried to get Resident #3 to come out of her room into the living room area more often. -Staff had last checked on Resident #3 around 7:15am on 01/03/20 prior to her fall. -Resident #3 was on the "Falls Management and Interventions" program and the protocol was to provide frequent checks, but there was no documentation. Review of a local hospital After Visit Summary dated 01/03/20 revealed: -Resident #3 was seen in the ER due to a fall and left knee pain. -Resident #3 was diagnosed with a fall and left knee pain.	D 270		

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Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on the floor on 01/03/20.
-A new wheelchair was ordered for Resident #3.
-A halo bed rail was added to Resident #3's bed. (Review of Resident #3's physician's orders dated 01/08/20 revealed an order for a halo system to bed to assist with transfers.)
-There was no documentation of increased supervision provided to Resident #3 after her fall on 01/03/20.

Observations of Resident #3's room on 01/27/20 at 10:55am revealed there was no halo in place on Resident #3's bed.

Review of Resident #3's Resident Note dated 01/08/20 at 6:20pm revealed:
-Resident #3 was observed sitting in an upright position on the floor with the footrest of the recliner under her buttocks.
-Resident #3 was attempting to get out of the recliner unassisted without lowering the footrest.
-Resident #3 was assisted into the wheelchair by staff and she denied any discomfort.
-There were no visible injuries or bruising noted.
-Resident #3's responsible party and PCP were notified of the incident.
-There was no documentation of any increased supervision provided to Resident #3 after her fall on 01/08/20.

Review of the Incident and Accident Report for Resident #3 dated 01/08/20 at 6:20pm revealed:
-Resident #3 was observed sitting in an upright position on the floor with her footrest to recliner under her buttocks.
-Resident #3 was attempting to get of the recliner unassisted without lowering the footrest.

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D 270	Continued From page 29 -Resident #3 was assisted into the wheelchair by staff. -Resident #3 denied any discomfort and there were no visible injuries or bruising noted. -EMS was not called and Resident #3 was not sent to the hospital. -Resident #3's PCP and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 01/08/20. Interview with the SCC/MCC on 01/27/20 at 8:33am revealed: -He completed the Resident Note and Incident Accident Report dated 01/08/20. -Resident #3 attempted to get out of her recliner by herself on 01/08/20. -Resident #3 scooted on to the floor and the footrest of the recliner was on the floor with the chair tilted up. -He just happened to be walking by Resident #3's room when he saw Resident #3 on the floor. -Resident #3 was on the "Falls Management and Interventions" program. -He did not think Resident #3 had ever graduated from the "Falls Management and Interventions" program due to her ongoing falls. -Usually when a resident fell, staff alerted the responsible and the physician, residents would be checked on more frequently (no time frame). -As a result of Resident #3's frequent falls, a pad sensor alarm was placed on Resident #3's chair and bed. -Resident #3 started using an ottoman to prop her feet up instead of the footrest of the electric recliner. -Staff also made more frequent checks on Resident #3 and tried to get her to come out of her room.	D 270		

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-There were no scheduled checks or documentation of the checks.
-"There should have been 30 minute checks for Resident #3."
-Thirty minute checks had been implemented for Resident #3 as of 01/24/20 and the 30 minute checks for Resident #3 would continue as long as needed.
-If Resident #3 had another fall, the frequency of the safety checks would increase to every 15 minutes.
-Thirty minute checks had been used in the past for other resident and he did not know why 30 minute checks had not been used for Resident #3.
-The 30 minute safety checks were never stopped, but "they were not being implemented as they should have been."

Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed:
-Resident #3 was observed on 01/08/20 on the floor in front of her recliner with the footrest underneath her.
-Resident #3 began using an ottoman to elevate her feet instead of the footrest of the recliner.
-There was no documentation of increased supervision provided to Resident #3 after her fall on 01/08/20.

Review of Resident #3's Resident Note dated 01/09/20 revealed:
-Resident #3 was observed on the floor beside her bed.
-Resident #3 was checked for injuries and none were noted.
-The SCC/MCC and the responsible party were notified.
-There was no documentation of any increased supervision provided to Resident #3 after her fall

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D 270	Continued From page 31 on 01/09/20. Review of the Incident and Accident Report for Resident #3 dated 01/09/20 revealed: -Resident #3 was observed on the floor beside her bed and was assisted to her recliner. -Resident #3 was assessed or injuries and there were no injuries noted. -The SCC/MCC and Resident #3's responsible party were notified. -EMS was not called and Resident #3 did not go to the hospital. -Resident #3's PCP and responsible party were notified. -There was no documentation of any increased supervision provided to Resident #3 after her fall on 01/09/20. Interview on 01/27/20 at 9:56am with the MA who completed the Resident Note and Incident and Accident Report dated 01/09/20 revealed: -She found Resident #3 on the floor in her apartment on 01/09/20. -Resident #3 did not have any injuries. -The protocol for checking on residents was safety checks every 2 hours. -She was not told to increase supervision for Resident #3 after her fall on 01/09/20, but frequent checks were a part of her job. -She provided frequent checks for residents in the MCU, but she did not know how often. -Safety checks were not documented anywhere. Review of a timeline for Resident #3 provided by the ED on 01/27/20 revealed: -Resident #3 was observed on the floor beside her bed on 01/09/20. -Resident #3 was assessed by a geriatrician. -There were medications recommendations and a fall mat was added for Resident #3.	D 270		

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D 270	Continued From page 32 -There was no documentation of increased supervision provided to Resident #3 after her fall on 01/09/20. Interview with the ED on 01/24/20 at 10:47am revealed: -The facility had a "Falls Management and Interventions" program which was initiated for all new residents upon admission for 30 days and came off the program after the 30 if the resident did not have any falls. -Resident #3 was on the "Falls Management and Interventions" program. -Resident #3 liked to be left alone in her room and had thrown staff and home health services out of her room. -The facility has provided interventions for Resident #3 after falls by having the in-house rehabilitation department complete fall assessments, medication recommendations from her mental health provider, and 1-on-1 activities which depended on Resident #3's attention span. -Resident #3 being on the "Falls Management and Interventions" was her increased supervision. -Staff had not completed scheduled checks on Resident #3, but staff was should have checked on Resident #3 every time they passed her room. Interview with the Activity Director (AD) on 01/24/20 at 4:27pm revealed: -Resident #3 liked to stay in her room and did not participate in many activities. -One-on-one activities were provided for Resident #3 to engage her as much as she would staff to and to increase supervision. -Resident #3 had a daily Personalized Programing chart which was used to provide engagement and increase supervision of Resident #3. -The Personalized Programming chart was	D 270		

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D 270	Continued From page 33 implemented on 01/24/20. Review of the Recreation Therapy/Activity Progress Notes for October 2019 through January 2020 revealed a 1-on-1 activity was completed with Resident #3 on 4 days from 12/09/19 to 01/23/20 with no amount of time indicated. Interview with a MA Supervisor on 01/27/20 at 12:23pm revealed: -She had recommended to the Resident Care Director (RCD) and the ED in December 2019 Resident #3 have a sitter. -Staff did the best they could with the staff they had to check on Resident #3. -She thought if Resident #3 had a sitter where there was someone there all the time to help and watch her, she probably would not have had as many falls. -She did not feel like staff provided enough supervision to meet Resident #3's needs because they did not have the "man power". Interview with a MA on 01/24/20 at 3:14pm revealed: -She checked on Residents every 2 hours. -If a Resident was on the "Falls Management and Interventions" program, staff tried to put eyes on the resident as they passed the resident's room. -Frequent checks were mandatory on the "Falls Management and Interventions" program, but the frequent checks were not time specific and were not documented anywhere. -There had been no further instructions given to increase supervision for Resident #3 other than the "Falls Management and Interventions" program protocol. Interview with a MA on 01/27/20 at 1:50pm	D 270		

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revealed:
-Staff checked on residents every 2 hours or more often if the resident was on the "Falls Management and Interventions" program, but there were no time specifications.
-Whoever passed Resident #3's room was supposed to check on her.
-She did not think staff provided enough supervision for Resident #3.

Interview with Resident #3's mental health provider on 01/27/20 at 4:04pm revealed:
-She saw Resident #3 every 1 to 2 weeks.
-She knew about Resident #3's multiple falls as well as behaviors.
-She had been trying to tweak Resident #3's medications to find what was effective for her.
-Due to Resident #3's medications and diagnoses, she was a high fall risk.
-She was doing her best to try to get Resident #3 moved to a behavioral health facility, but had not been successful yet.

Interview with the Resident Care Director on 01/27/19 at 4:27pm revealed:
-Resident #3 had multiple falls on the assisted living side of the facility prior to going to the MCU.
-Resident #3 was on the "Falls Management and Interventions" program.
-Staff told her they checked on Resident #3 often, but she did not know how often.
-There had been conversations with staff to keep an eye on Resident #3.
-There were no formal checks on Resident #3 and the checks were not documented.
-Staff should have had a heightened awareness to check on Resident #3.
-Staff were made aware of residents who had fallen through shift to shift reports and the resident was also listed in the "hot box."

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D 270	Continued From page 35 -A resident went into the "hot box" if they had a fall or change of condition. -She thought Resident #3 had been in the "hot box" since being admitted in October 2019. -A Resident had to go 60 days with no falls to get out of the "hot box." -Staff had discussed Resident #3 getting a sitter, moving to the MCU, and a psychiatric placement. -Residents in the past had documented 30 minute checks related to falls. -Thirty minute checks were never implemented for Resident #3 due to falls, but she felt like staff checked on Resident #3 close to that time frame. -She or the ED made the decision of who would received scheduled 30 minute checks. Interview with Resident #3's PCP on 01/27/20 at 5:08pm revealed: -Resident #3 had a lot of psychiatric issues and difficulty with mobility. -Resident #3 was on the "Falls Management and Interventions" program and staff checked on her every hour or so. -She did not know if staff could "pay a lot of attention" to residents in the assisted living setting. -She felt like Resident #3 needed more frequent checks, but staff could not keep an eye on Resident #3 every minute unless she had a sitter. Attempted interview with Resident #3's responsible party on 01/27/20 at 5:38pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. b. Review of Resident #3's current FL2 dated 01/22/20 revealed:	D 270		

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D 270	Continued From page 36 -Resident #3 had a diagnosis of dementia. -Resident #3 was constantly disoriented. Review of Resident #3's Care Plan dated 10/28/19 revealed: -Resident #3 had limited ability with ambulation and used a wheelchair. -Resident #3 was sometimes disoriented, forgetful and needed reminders. -Resident #3 required limited assistance with ambulation and transferring. Review of Resident #3's Resident Notes dated 11/22/19 at 7:00am revealed: -Resident #3 assaulted staff twice and attempted to leave the community (There were no details documented). -Resident #3's responsible party was contacted. -Emergency Medical Services (EMS) was contacted and Resident #3 was transported to a local hospital for evaluation. -There was no documentation of any increased supervision provided to Resident #3 after she attempted to elope from the facility on 11/22/19. Interview on 01/27/20 at 12:23pm with the MA Supervisor who completed the Resident Note dated 11/22/19 revealed: -She witnessed Resident #3 attempting to leave the facility but did not remember when. -She redirected Resident #3 from the front entrance and contacted law enforcement because Resident #3 was combative. -She did not complete an Incident and Accident Report. -She was not told to increase supervision for Resident #3 after she observed Resident #3 attempting to elope. Review of Resident #3's Resident Note dated	D 270		

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12/01/19 at 7:00am revealed:
-Resident #3 wandered in the community the entire shift asking staff to clear her room of 3 men.
-There was no documentation of any increased supervision provided to Resident #3 after her wandering behaviors on 12/01/19.

Review of Resident #3's Resident Notes dated 12/01/19 at 9:15pm revealed:
-Resident #3 was found outside the facility yelling for her family member.
-Resident stated she wanted to leave and go to her family member's home.
-Staff returned Resident #3 to the facility.
-Resident #3's responsible party was contacted.
-There was no documentation of any increased supervision provided to Resident #3 after she eloped on 12/01/19.

Review of an Incident and Accident Report for Resident #3 dated 12/01/19 at 9:15pm revealed:
-The type of incident was an elopement.
-Resident #3 was found outside the front doors of the facility going into the parking lot.
-Staff brought Resident #3 back into the facility.
-Resident punched and bit staff.
-Resident #3's responsible party was contacted and her Primary Care Physician (PCP) were notified.

Interview with the Assistant Resident Care Director (ARCD) on 01/24/20 at 5:05pm revealed:
-She completed the Resident Note and the Incident and Accident Report dated 12/01/19.
-Resident resided on the assisted living (AL) side of the facility when she was first admitted to the facility, but she moved to the Memory Care Unit (MCU) on 12/21/19.
-On 12/01/19, Resident #1 went out the front door

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of the facility in her wheelchair.
-When Resident #3 exited the facility, the alarm went off to staff's pager.
-Resident #3 did not wear a wander guard.
-When staff received the alarm page, it identified which door alarm was set off.
-Staff went to get Resident #3 and brought her back into the facility.
-Resident #3 went out the facility looking for her deceased spouse.
-After Resident #3 eloped, staff watched her "closely" and had staff sitting in the hallway outside of her door for the remainder of the shift.
-She did not know if the increased supervision was documented.
-She had mentioned to Resident #3's family, after her elopement on 12/01/19, they may want to think about getting a sitter for Resident #3, but they were not very receptive.
-Resident #3's room was located right beside her office when Resident #3 resided on the AL side of the facility and she went into Resident #3's room several times a day to check on her.
-There was no documentation she checked on Resident #3 several times a day.

Review of Resident #3's Resident Note dated 12/04/19 at 6:00am revealed:
-Resident #3 was wandering into the apartment of other residents yelling for help.
-There was no documentation of increased supervision provided to Resident #3 after her wandering behaviors on 12/04/19.

Review of Resident #3's Resident Note dated 12/05/19 at 6:00am revealed:
-Resident #3 wandered the community twice during third shift stating she wanted to go home.
-There was no documentation of increased supervision provided to Resident #3 after her

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D 270	Continued From page 39 wandering behaviors on 12/05/19. Review of Resident #3's Resident Note dated 12/10/19 at 6:00am revealed: -Resident #3 wandered the community asking for help with numbers on her wall. -There was no documentation of increased supervision provided to Resident #3 on 12/10/19 after her wandering behaviors. Review of Resident #3's Resident Note dated 12/19/19 at 10:35pm revealed: -Resident #3 was up in the front lobby with staff getting Christmas gifts. -Staff went to go do something and Resident #3 went out the front door stating she was going to the front desk. -About 30 minutes after Resident #3 went out the front door, she tired to go out the 100 hall exit door. -Resident #3 was taken to the memory care unit for a while. Interview with the Activity Director on 01/27/20 at 11:09 revealed: -She observed Resident #3 attempt to elope from the facility on 12/19/19. -There were family and friends in the facility on 12/19/19 and residents were receiving gifts. -She was taking pictures of residents and had just finished with Resident #3 and a PCA pushed her away from the picture booth which was in the center of the entrance lobby. -She took another resident's picture and then turned around and saw Resident #3 going out the front door into the vestibule. -Resident #3 had not made it to the entrance door. -Resident #3 was taken to the MCU on 12/19/19.	D 270		

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D 270	Continued From page 40 Interview with the Resident Care Director (RCD) on 01/27/20 at 5:55 revealed: -She spoke with a former employee on 01/27/20 who witnessed Resident #3 attempt to elope from the facility for the second time on 12/19/19. -The former employee found Resident #3 at the door located at the front of the 100 hall after her pager alarmed that the front door at the 100 hall was opened. -Resident #3 had the door cracked open, but she did not get out of the door. Attempted telephone interview with the former employee on 01/27/20 at 6:29pm was unsuccessful. Review of Resident #3's Resident Note dated 12/21/19 at 6:45am revealed: -Resident #3 came out of her room wandering the halls asking people to take her to the door so she could get out of the facility. -There was no documentation of any increased supervision provided to Resident #3 on 12/21/19 after her wandering behaviors. Review of Resident #3's Resident Noted dated 12/23/19 at 6:45am revealed: -Resident #3 had been exit seeking saying she wanted to go home and wanted to go out the back door to see her family member. -There was no documentation of any increased supervision provided to Resident #3 on 12/23/19 after her exit seeking behaviors. Observation of the facility on 01/23/20 at 9:45am revealed: -There were two doors at the front of the building. -The main entrance door led from the outside to a vestibule and there was another door which led from the vestibule to front lobby area.	D 270		

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D 270	Continued From page 41 -These doors were not alarmed, but there was a receptionist seated at the front desk beyond the lobby area. Observation of the facility on 01/24/20 at 5:10pm revealed: -There was a door at each end of the 100 hall. -One of the doors at the end of the 100 hall led to the front of the facility and the other door led to the back of the facility. -The doors had an alarm which sounded when opened and were deactivated with a keypad. Interview with the RCD on 01/27/20 at 4:27pm revealed: -She was sure she knew of Resident #3's elopement because she signed the Incident and Accident Report, but she did not remember the details without looking at the notes. -Resident #3 was still on the AL side on 12/19/19 and after she attempted to elope the second time on 12/19/19, Resident #3 was taken to the MCU for about an hour or so to get her away from the stimulation of the Christmas party. -There was nothing else new or different put in place for Resident #3 after her elopement and attempts to elope. -Staff received reminders to "watch" Resident #3, but there were no formal scheduled safety checks for Resident #3 at that time. Interview with the Executive Director (ED) on 01/24/20 at 4:16pm revealed: -She considered an elopement to be out of view of staff, outside of the facility, outside the limits of a safe environment. -She did not know of anyone who resided on the AL side of the facility within the last 3 months who had wandering behaviors, exit seeking behaviors, or eloped from the facility.	D 270		

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D 270	Continued From page 42 -Resident #3 attempted to elope from the front door because she thought there was a fire in the building, but she never got out. -She did not remember Resident #3 eloped from the facility on 12/01/19 and had made other attempts to elope from the facility. -All doors in the facility sounded and alarmed to staff pagers. -The front door of the facility was unalarmed during the day, when a receptionist was present from 7:00am through 8:00pm on Monday through Friday and from 10:00am through 8:00pm on Saturdays and Sundays. -The front door was locked from the outside and the door alarm was activated every evening at 8:00pm. -Once the front door was locked and alarmed, the pagers were set off when the door was opened from the inside. Interview with Resident #3's PCP on 01/27/20 at 5:08pm revealed: -She remembered staff reported to her Resident #3 eloped, but she did not remember the date. -Resident #3 had a lot of psychiatric issues and difficulty with mobility. -She did not know if staff could "pay a lot of attention" to residents in the AL setting. -She felt like Resident #3 needed more frequent checks, but staff could not keep an eye on Resident #3 every minute except for a sitter. Attempted interview with Resident #3's responsible party on 01/27/20 at 5:38pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 270		

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D 270	Continued From page 43 2. Review of Resident #5's current FL2 dated 12/24/19 revealed: -Diagnoses included Alzheimer's disease, hyperlipidemia, and history of colon cancer. -Resident #5 was constantly disoriented. -Resident #5 was ambulatory. -Resident #5 was a wanderer. a. Review of Resident #5's Resident Register revealed Resident #5 was admitted on 12/26/19. Review of Resident #5's Pre-Admission Screening revealed: -Resident #5 had a history of exit seeking or elopement. -Resident #5 wandered often during sleep time. Review of Resident #5's care plan revealed Resident #5's care plan had not been completed by the facility. Review of the facility's "Falls Management and Interventions" program revealed: -A resident is automatically placed on the program upon move in or any readmission from a hospital or rehab stay. -The resident may come off the program if he/she has not had a fall in 60 days. -Interventions should be developed to help manage the individual's risk of falling. -The Fall Risk Awareness and Interventions form will be completed and placed in the program binder, and also in the front of the personal care services (PCS)/activities of daily living (ADL) log book. -Staff on all three shifts are expected to check on residents proactively and regularly for any unmet need, and see that the resident is safe, has a call-pendent readily available, and that indicated interventions are in place.	D 270		

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-Resident interventions will be reviewed during the Weekly Falls Management Meeting.

Review of Resident #5's Fall Risk Awareness and Interventions revealed:
-The date listed as opened was 01/02/20.
-The date added or updated was 01/08/20.
-Interventions were listed as: admit to program as a new resident, supervision due to risk of elopement, and ensure proper footwear during ambulation.

Review of Resident #5's Incident and Accident Report dated 12/29/19 revealed:
-At 2:30pm Resident #5 exited the Special Care Unit (SCU) behind a staff member.
-Resident #5 was found on the 300 hall in the Assisted Living Unit.
-Staff assisted Resident #5 back to the SCU after redirecting him.
-Resident #5's family member was notified on 12/29/19 at 2:45pm.
-The type of incident was documented as elopement.

Observation of 300 hallway on the Assisted Living Unit, where Resident #5 was found, was measured by Occupational Therapists to be 109 feet from the locked door at the SCU on 01/27/20 at 2:13pm.

Interview with the medication aide (MA) on 01/27/20 at 1:20pm that completed the incident report dated 12/29/19 revealed:
-Resident #5 followed kitchen staff out the SCU into the Assisted Living Unit.
-Assisted living staff came and asked if they had any missing residents, while the missing resident remained by himself in the hallway.
-Staff went back to the hallway and assisted

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Resident #5 back into the SCU.
-The manager on duty was notified and was responsible for notifying the management team.
-She notified the family of his exiting the SCU.
-She was not instructed to increase supervision or to document supervision, but she knew she should since Resident #5 eloped.

Review of Resident #5's Incident and Accident Report dated 12/31/19 revealed:
-Resident #5 exited the SCU following a visitor out the main door.
-Housekeeping staff assisted Resident #5 back to the SCU.
-Resident #5's family member was notified on 12/31/19.
-The type of incident was documented as exit seeking.

Interview with the medication aide (MA) on 01/27/20 at 1:45pm that completed the incident report dated 12/31/19 revealed:
-Housekeeping staff had informed her that Resident #5 had followed a visitor out the back door of the facility.
-Resident #5 had made it just outside the locked unit, but did not make it to the second set of doors which were unlocked and led outside to the parking lot.
-Staff spoke with Resident #5 to prevent him from leaving the locked unit again.
-The SCU had ample staff, but they could not watch Resident #5 around the clock.
-They had not tried having one on one for the entire shift and they had not tried using a sitter to supervise Resident #5.
-They tried to keep Resident #5 in the common area so they could watch him.
-She was not instructed to increase supervision or to document supervision.

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D 270	Continued From page 46 Review of Resident #5's progress notes revealed: -On 12/29/19 at 3:15pm, Resident #5 exited the SCU behind a staff member to the 300 hall in the Assisted Living; the SCU staff was notified and was able to walk the resident back to the SCU. -On 12/29/19 at 9:00pm, Resident #5 was exit seeking and had packed his clothes as well as put on many layers of clothing. Resident was redirected by staff. -On 12/31/19 at 2:45pm, Resident #5 followed a visitor out of the SCU; housekeeping staff saw him and got him back in the SCU. -On 01/02/20 at 3:00pm, Resident #5 attempted to follow staff out of the SCU into 300 hall; the resident wasunsuccessful. Staff had to redirect Resident #5 as he kept pushing on the exit door. -On 01/02/20 at 3:15 pm, Resident #5 became agitated, upset, and exit seeking at the courtyard fence. Staff was able to redirect Resident #5 by telling him his family member would be visiting later in the day. -On 01/03/20 at 2:20pm, Resident #5 was exit seeking. -On 01/03/20 concerns of recent exit seeking behavior and agitation was shared with Resident #5's family member, who shared the information with Resident #5's primary care provider (PCP); new orders were received. -On 01/08/20 at 11:00am, Resident #5's family met with staff for his 2-week post move in meeting; resident behaviors were discussed at length. -On 01/13/20 at 11:20am, staff spoke with Resident #5's spouse regarding the resident's behaviors and exit seeking. She agreed to a mental health evaluation. -On 01/14/20 Resident #5 was evaluated by mental health providers. New medication orders were received.	D 270		

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D 270	Continued From page 47 -There were no notations of any increased supervision. Review of Resident #5's Recreation Therapy and Activity Progress Notes revealed: -On 12/26/19, Resident #5 moved into the SCU. -On 12/30/19, an activities assessment was completed one on one with a staff member. -On 01/02/20, staff had a one on one talk with Resident #5. -On 01/04/20, Resident #5 refused an activity and became agitated. -On 01/07/20, Resident #5 participated in an activity with staff. -On 01/08/20, post move in meeting was held with Resident #5's family. -On 01/10/20, Resident #5 had one on one activities completing puzzles with staff. -On 01/10/20, Resident #5 had one on one activities completing puzzles with staff. -On 01/13/20, Resident #5 participated in a small group activity completing puzzles. -On 01/21/20, Resident #5 had one on one activities completing puzzles with staff. -On 01/22/20, Resident #5 had one on one activities talking and walking with staff. Attempted telephone interview with Resident #5's family member on 01/27/20 at 11:15am was unsuccessful. Telephone interview with the Mental Health Provider (MHP) on 01/27/20 at 4:24pm revealed: -Resident #5 was severely demented, confused and needed frequent redirection and supervision. -Facility staff had informed her of his exit seeking behaviors with his initial consultation. -She had adjusted Resident #5's medication for anxiety.	D 270		

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Telephone interview with the Primary Care Physician (PCP) on 01/27/20 at 4:43pm revealed:
-He did not know Resident #5 had exit seeking behaviors.
-Resident #5 had a history of 2 previous elopements from his home.
-He had ordered Ativan for Resident #5's anxiety due to an adjustment disorder.

Interview with the Special Care Coordinator (SCC)/Memory Care Coordinator (MCC) on 01/23/20 at 5:30 pm revealed:
-New residents were automatically placed on the Falls Management and Interventions Program which included elopements.
-Staff was instructed to watch Resident #5 closely due to his exit seeking behaviors.
-Staff was instructed to do one on one activities with Resident #5.

Interview with the Resident Care Director (RCD) on 01/27/20 at 5:20pm revealed:
-She knew Resident #5 had exhibited exit seeking behavoirs and had left the SCU 2 times.
-They increased supervision, but nothing formally was done.
-She had collaborated with the SSC/MCC and the Administrator in regards to Resident #5's exit seeking behaviors and they felt it was an adjustment period for the resident as well as an adjustment period for his medications.

Interview with the Administrator on 01/27/20 at 9:37am revealed:
-She was aware Resident #5 left the SCU into the Assisted Living Unit two times.
-There was a Fall Awareness Program book, pink in color, in the medication room.
-Interventions for the resident was listed on their individual sheet.

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D 270	Continued From page 49 -The residents on the program were discussed weekly to ensure interventions were in place. -When interventions were developed, the SCC/MCC took them back to the SCU and placed them on the fall awareness sheets and then placed in a communication book for staff to read and sign that they had read the update. -One on one time was completed daily by a staff member or by activity staff. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. b. Review of Resident #5's current FL2 dated 12/24/19 revealed: -Diagnoses included Alzheimer's disease, hyperlipidemia, and history of colon cancer. -Resident #5 was constantly disoriented. -Resident #5 was ambulatory. -Resident #5 was a wanderer. Review of Resident #5's progress notes revealed: -There were 3 notes documenting in December 2019 of the resident inappropriately touching or kissing a female resident. -There were 10 notes documenting in January 2020 of the resident inappropriately touching or kissing a female resident. -On 01/01/20, Resident #5 was observed putting his hand down a female resident's shirt and after being redirected he was observed kissing the same female resident on the mouth two times. -On 01/10/20, Resident #5 was observed kissing a female resident on the mouth. -On 01/17/20, Resident #5 was found in a female resident's bed laying beside the female resident and rubbing her hand. -On 01/17/20, Resident #5 was rubbing on a female resident's hands and legs.	D 270		

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D 270	Continued From page 50 -On 01/20/20, Resident #5 was observed holding a female resident's hand and he attempted to kiss her on the mouth and hands. -On 01/21/20, Resident #5 tried to kiss a female resident on the mouth. Interview with a medication aide (MA) on 01/24/20 at 2:30pm revealed: -On 01/10/20, Resident #5 was observed kissing a female resident on the mouth; he became agitated when staff redirected him. The female resident's power of attorney (POA) was notified via telephone message and they never returned the call to the facility. She did not document the incident in the female resident's record. -On 01/20/20, Resident #5 was observed holding a female resident's hand and attempting to kiss her on her lips and hands while she sat at the dining table. She redirected him. -On 01/21/20, Resident #5 was observed trying to kiss a female resident on her lips; she redirected him. -She did not document the incidents of inappropriate touching or kissing the female resident in her record. -The Resident #5 thought the female resident was his spouse as they looked similar. -They sat the Resident #5 at a table with the other male residents for meals. -The Special Care Coordinator (SCC)/Memory Care Coordinator (MCC) had been informed of each incident with a female resident, including touching a female resident's breast. -When she had to leave the SCU, she made sure staff was in the common areas to watch the residents. -She made rounds every 15-20 minutes. -If the SCC/MCC wanted rounds completed every 15-30 minutes, it would had been written in the Special Care Unit (SCU) update book.	D 270		

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D 270	Continued From page 51 Interview with the SCC/MCC on 01/24/20 at 5:10pm. -Normally, when a resident kissed another resident, staff would redirect the resident, then inform the family of the female resident to make sure that it was okay with the resident being kissed. -Staff had let residents hold hands before, as if they were boyfriend and girlfriend, but staff made sure it did not go too far like going to the room and becoming intimate. -Staff tried to keep affection between residents to a minimal. -Resident #5 thought several of the female residents were his wife and he would call them momma (an affectionate nickname he used for his wife). -Rounds were made every 2 hours or as needed. -When a resident had behaviors, they tried to keep them in the common areas so they could be watched constantly. -They provided one on one activities for the named male resident but did not provide a sitter for around the clock or even on the shifts in which he was observed being inappropriate. -Staff had provided a lot of one on one time and redirection with the named male resident. -He knew a resident inappropriately touching another resident could violate residents' rights. -Initially the named male resident was signed up to see the facility physicians and mental health providers. -Upon admission, the family requested for the named male resident to keep his regular primary care physician (PCP). -On 01/01/20, Resident #5 put his hand down a female resident's shirt and then kissed her on the mouth twice. -The female resident had a similar hair color as	D 270		

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his spouse.
-On 01/13/20, staff spoke with Resident #5's family members and obtained permission for him to be evaluated by mental health.
-On 01/14/20, Resident #5 was evaluated by mental health.
-He had previously spoken to Resident #5's family member regarding his behavior and she was not upset and said, "he's always been a lady's man".
-When asked what had been put in place to protect the female residents, no answer was given.

Interview with a second shift MA on 01/27/20 at 10:40am revealed:
-Resident #5 was adjusting to his recent move into the facility and he missed his spouse.
-She checked on residents constantly every 1 to 1 and ½ hours.
-Staff did not document when they checked on residents unless they were on the Falls Prevention Program; then they had to document every shift.
-A pink sheet in the personal care log listed interventions for the resident.
-Resident #5 was very friendly, loving, and very affectionate as he liked the women.
-One lady would wave at Resident #5 then he would go over and sit with her and held her hand.
-He held their hands and gave them hugs.
-Staff had reported to her Resident #5 put his hand down a female resident's shirt, but she could not recall which female resident it was.
-She was not sure if the physician was notified or if the female residents' family were notified.
-Resident #5 had to constantly be redirected.
-Staff tried to get Resident #5 involved in activities.
-She thought the Administrator knew of Resident

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#5's behavior as she had written notes on the back of the 24 hour report.
-The 24 hour report was slid under the SCC/MCC's office door and he filed them in a notebook.
-On 12/28/19, she redirected Resident #5 as he was kissing a female resident's hands, but she could not recall which female resident.
-She did not recall Resident #5 being overly affectionate with a female resident even though she had documented the incident in the named male resident progress notes.
-Interventions for Resident #5 was in a notebook in the medication room.
-Staff had sat with Resident #5, but there had not been a sitter for him.

Interview with a third shift MA on 01/27/20 at 12:30pm revealed:
-The Resident #5 been observed multiple times touching female residents inappropriately on their hands and shoulders and kissing them on their lips and face.
-Resident #5 had been found in a female resident's room laying in the bed beside her.
-She did not think the families of the female resident had been notified.
-Resident #5 touched the female residents nightly.
-It was impossible to watch Resident #5 enough to prevent him from touching the female residents.

Interview with a weekend MA on 01/27/20 at 1:07pm revealed:
-Resident #5 tended to favor women as he thought they were his wife.
-He had been observed hold holding a female resident's hands and rubbing them and hugging them.

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D 270	Continued From page 54 -She did not tell Resident #5's family members because she was told not to by another MA who was instructed by the SCC/MCC to only document Resident #5's record because they already knew about the inappropriate behaviors. Interview with a first shift MA on 01/27/20 at 1:20pm revealed: -On 01/02/20, Resident #5 tried to kiss a female resident on the mouth, but he was redirected by staff. -Staff tried to make sure Resident #5 did not get to close to the female residents. -She only documented the incident in Resident #5's record, but she did not recall why. -She did not notify the female resident's family member or the named male resident's physician. -Staff did not do anything different after the incident to protect the female residents. Interview with another MA on first shift on 01/27/20 at 1:45pm revealed: -The Resident #5 thought the ladies were his spouse. -She had observed Resident #5 hold the ladies' hands and sit beside them at meal times. It was not just one female. It was several. -She tried to make sure Resident #5 did not get too close to the female residents, but when he did, she took him to the dining room and worked a puzzle with him. Interview with Resident #5's mental health provider on 01/27/20 at 4:24pm revealed: -The Resident #5 was very demented and severely confused. -She knew he held some of the female residents' hands. -She did not know that he had inappropriately touched or kissed any of the female residents on	D 270		

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the SCU.
-There were no medications that would help his inappropriate touching or kissing the female residents.
-Resident #5 needed more redirection and supervision.

Interview with Resident #5's primary care provider (PCP) on 01/27/20 at 4:43pm revealed:
-He did not know about Resident #5's inappropriate behaviors of touching and kissing female residents.
-He had adjusted Resident #5's medications shortly after he was admitted, but that was due to Resident #5's anxiety

Interview with the Administrator on 01/24/20 at 5:41pm revealed:
-She did not know Resident #5 had inappropriately touched or kissed any female residents until earlier in the day on 01/24/20.
-Most people like touch and "holding hands and hugging was endearing."
-If a resident did not want to be touched, they would pull back and you could tell by their body language.
-Many of the residents in the special care unit can verbalize if they want to be touched.
-A resident kissing another resident on the lips "probably" would not be appropriate.
-A resident putting their hand down another resident's shirt, would not be appropriate.
-She did not know if Resident #5's PCP or the mental health provider (MHP) had been notified of his inappropriate touching and kissing of female residents on the unit.
-When Resident #5 had inappropriate behaviors, staff should have notified the physician, the SCC/MCC as well as herself.
-She would notify the family members of the

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residents who had been inappropriately touched and create a safety plan.

Based on observations, interviews, and record reviews, it was determined the female residents were not interviewable.

3. Review of Resident #1's current FL-2 dated 11/06/19 revealed:
-Diagnoses included unspecified dementia disorder with behavioral disturbances.
-Resident #1 was incontinent of bowel and bladder.
-Resident #1 was ambulatory.
-Resident #1 was disoriented intermittently.
-Resident #1's recommended level of care was secured memory care.

Review of Resident #1's care plan dated 12/10/19 revealed:
-Resident #1 was ambulatory and assistive device was needed.
-Resident #1 was always disoriented, had a significant loss of memory and must be directed.
-Resident #1 was nonverbal most of the time secondary to disease progression.
-Resident #1 had a history of wandering, being physically abusive, and resisting care.
-Resident #1 required extensive assistance from 2 staff members for all personal care.
-Resident #1 paced back and forth between the living room area and the lounge area and Resident #1 preferred to sleep in the living room on the couch or the recliner.
-Resident #1 was known to throw objects and be combative towards staff and Resident #1 preferred to be left alone.
-Resident #1 was admitted to hospice on 11/27/19 due to decreased food and fluid intake and concern that Resident #1 was in her final

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D 270	Continued From page 57 stages of the disease. Review of the facility's "Falls Management and Interventions" program revealed: -A resident is automatically placed on the program upon move in or any readmission from a hospital or rehab stay. -The resident may come off the program if he/she has not had a fall in 60 days. -Interventions should be developed to help manage the individual's risk of falling. -The Fall Risk Awareness and Interventions form will be completed and placed in the program binder, and also in the front of the personal care services (PCS)/activities of daily living (ADL) log book. -Staff on all three shifts are expected to check on residents proactively and regularly for any unmet need, and see that the resident is safe, has a call-pendent readily available, and that indicated interventions are in place. -Resident interventions will be reviewed during the Weekly Falls Management Meeting. Review of Resident #1's Incident and Accident reports revealed: -Resident #1 had 5 falls unwitnessed between 11/18/19 through 01/21/20. -Two of the unwitnessed falls were documented as occurring in Resident #1's bedroom. -One of the unwitnessed falls were documented as occurring in the activity room. -One of the unwitnessed falls were documented as occurring in the lounge area. -One of the unwitnessed falls were documented as occurring in the hallway. Review of Residents #1's Resident Notes dated 11/18/19 revealed Resident #1 had an unwitnessed fall in the activity room.	D 270		

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D 270	Continued From page 58 Review of Resident #1's Incident and Accident Report dated 11/18/19 at 10:30am revealed: -Staff heard a "bump" and found Resident #1 lying on the floor next to the couch in the activity room. -The resident was observed on the floor. -No injuries were noted on the report. -Emergency Medical Services (EMS) was not called, Resident #1 was not sent to the hospital, and Resident #1 remained in the facility. -Resident #1's primary care provider (PCP) and family member were notified. Interview on 11/27/19 at 9:02 with the medication aide (MA) who documented the Resident Note and the Incident and Accident Report dated 11/18/19 revealed: -She heard a noise and found Resident #1 sitting in front of the couch in the activity room. -She did not witness Resident #1 fall. -She saw Resident #1 five minutes before she heard Resident #1 fall. -Resident #1 needed more supervision at times because she was a fall risk, she was very active and would pace between rooms, and at times she would "run" into different rooms. -The policy was to check on residents at least every 2 hours, and after a fall, the policy was for staff to check on residents more often than every 2 hours. -The resident did not have an injury after her fall and she checked on the resident every 1 to 2 hours. Review of Residents #1's Resident Notes dated 11/19/19 revealed Resident #1 had an unwitnessed fall. Review of Resident #1's Incident and Accident	D 270		

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Report dated 11/19/19 at 10:50am revealed:
-Resident #1 was on her hands and knees in the lounge area.
-The resident as observed on the floor.
-No injuries were noted on the report.
-EMS was not called, Resident #1 was not sent to the hospital, and Resident #1 remained in the facility.
-Resident #1's PCP and family member were notified.

Interview on 01/24/20 at 10:00am with the MA who documented the Resident Note and the Incident and Accident Report dated 11/19/19 revealed:
-She was alerted by a personal care aide (PCA) that Resident #1 was on her hands and knees in the activity room.
-Neither she nor the PCA witnessed Resident #1 fall on 11/19/19.
-Resident #1 was on the "Falls Management and Intervention" program.
-Residents in the "Falls Management and Intervention" should be checked on more frequently.
-The policy was to check on residents at least every 2 hours.
-There was no policy on how often to check on a resident after a fall, except within a 2 hour period.

Review of Resident #1's mental health provider notes dated 11/26/19 revealed:
-Resident #1's mood stability and anti-anxiety medications were decreased due to family request because of Resident #1's recent fall and Resident #1's increased lethargy.
-Staff reported Resident #1 had increased anxiety, was exit seeking, wandered, and paced.

Review of Residents #1's Resident Notes dated

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D 270	Continued From page 60 11/27/19 revealed Resident #1 was admitted to hospice for frontotemporal dementia. Review of Residents #1's Resident Notes dated 01/08/20 revealed: -Resident #1 was discussed at the weekly "at risk" meeting due to a fall on 01/06/20. -Resident #1's intervention was to ensure she had proper footwear throughout the day and night. -There was no documentation in the resident notes for increased supervision checks. Review of Residents #1's Resident Notes dated 01/20/20 revealed: -Resident #1 was "pacing back and forth very fast". -Resident #1 had an unwitnessed fall in her bedroom. -The Hospice nurse arrived and "said to apply a cold pack when [Resident #1] calms down". -The Hospice nurse spoke with Resident #1's family member and the family member did not want Resident #1 to be sent to the hospital. Review of Resident #1's Incident and Accident Report dated 01/20/20 at 3:15am revealed: -Resident #1 was observed sitting on the floor in her bedroom. -The resident was observed on the floor. -Resident #1 was noted to have bruising to the right side of her face, right eye, right side nose, and right side swelling and hematoma. -EMS was not called, Resident #1 was not sent to the hospital, and Resident #1 remained in the facility. -Resident #1's Hospice staff and family member were notified. Interview on 01/27/20 at 9:45am with the MA who	D 270		

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documented the Resident Note and the Incident and Accident Report dated 01/20/20 at 3:15am revealed:
-Resident #1 had an unwitnessed fall in her bedroom.
-Resident #1 had bruising to the right side of her face.
-She called the hospice nurse and the nurse notified Resident #1's family member.
-Resident #1 family member did not want Resident #1 sent to the hospital.
-She checked on Resident #1 every 30 minutes after her fall.
-The policy was to check on residents at least every 2 hours, and after a fall, staff should check on the resident more frequently.
-Staff were able to watch Resident #1 because Resident #1 always slept in the living room and lounge area, she did not sleep in her apartment.

Review of Residents #1's Resident Notes dated 01/20/20 at 9:15am revealed Resident #1 had an unwitnessed fall and was found on the floor by staff.

Review of Resident #1's Incident and Accident Report dated 01/20/20 at 9:00am revealed:
-Staff heard a noise and found Resident #1 sitting on the floor in the hallway.
-The resident was observed on the floor.
-Resident #1 was noted to have a large knot above her right eye and an abrasion on her right knee.
-EMS was not called, Resident #1 was not sent to the hospital, and Resident #1 remained in the facility.
-Resident #1's PCP, Hospice staff, and family member were notified.

Interview on 01/27/20 at 9:02am with the MA who

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documented the Resident Note and the Incident and Accident Report dated 01/20/20 at 9:00am revealed:
-On 01/20/20, Resident #1 was in the dining room eating breakfast and she got up and slipped on the floor in the hallway.
-Resident #1's fall on 01/20/20 was not witnessed, but she heard the noise when Resident #1 fell.
-Resident #1's fall happened less than 5 minutes after she got up from the table in the dining room.
-Resident #1 repeatedly got up and down from the dining table during meal times.
-After the fall, she had the PCA sit with Resident #1 and put ice on her head until Resident #1's family member arrived.

Review of Resident #1's Resident Notes dated 01/21/20 revealed Resident #1 had an unwitnessed fall and was found by staff on her bedroom floor between the end of her bed and dresser.

Review of Resident #1's Incident and Accident Report dated 01/21/20 at 12:00pm revealed:
-A MA walked by Resident #1's bedroom and found Resident #1 sitting on the floor in her bedroom.
-The resident was observed on the floor.
-Resident #1 was noted to have no new injuries.
-EMS was not called, Resident #1 was not sent to the hospital, and Resident #1 remained in the facility.
-Resident #1's PCP, Hospice staff, and family member were notified.

Interview on 01/24/20 at 10:00am with the MA who documented the Resident Note and the Incident and Accident Report dated 01/21/20 revealed:

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-Resident #1 had an unwitnessed fall in her bedroom.
-Resident #1 was eating lunch, she got up from the table and walked to her bedroom.
-The MA thought Resident #1 was gone "too long" and she found Resident #1 sitting on the floor in her bedroom.
-Five minutes was usually "too long" for Resident #1 because she would have usually walked back to the dining room within that timeframe.
-There was no policy on how often to check on a resident after a fall, except within a 2 hour period.

Review of Residents #1's Resident Notes dated 01/22/20 revealed:
-Resident #1 was discussed at the weekly "at risk" meeting due to recent incidents.
-Resident #1's new interventions included a urinalysis to rule out a urinary tract infection (UTI), a mental health visit, and limiting visitors to 1-2 people at a time.
-There was no documentation in the resident notes for increased supervision checks.

Review of Resident #1's "Fall Risk Awareness and Interventions" form revealed:
-Resident #1 was on the "Falls Management and Intervention" program.
-Interventions for Residents #1 included: supervised for safe ambulation (11/13/19), ensured proper footwear at all times (11/13/19), reviewed and changed mental health medication (11/20/19), care plan meeting held with family member (11/20/19), reviewed and changed medications from PCP (11/26/19), admitted to hospice services (11/27/19), allowed resident to get up on her own from sitting (12/18/19), PCP & mental health medications reviewed (12/18/19), ensured "gripper" socks when shoes were not worn (01/08/20), urinalysis performed to rule out

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a urinary tract infection (01/20/20) and no antibiotic treatment was warranted (01/22/20), mental health evaluation (01/22/20), and limited visitors to 1-2 people per visit (01/22/20).
-There was no documentation on the form for increased supervision checks.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Interview with the Executive Director on 01/24/20 at 11:51am revealed:
-Resident #1 was on the "Falls Management and Intervention" program.
-Resident #1 had a fall assessment on admission.
-The Special Care Coordinator/Memory Care Coordinator (SCC/MCC) was responsible for the "Falls Management and Intervention" program in the Memory Care Cottage.

Interview with Resident #1's family member on 01/24/20 at 2:59pm revealed:
-Resident #1 was admitted to the facility on 11/07/19.
-He was aware of Resident #1's falls from 11/18/19 to 01/21/20.
-Resident #1 was "healthy physically" and liked to walk, but she was declining mentally because of dementia.
-Resident #1 was "almost too ambulatory" and sometimes tripped.
-Resident # 1 had one "bad fall" on 01/20/20 and the Hospice nurse followed up with Resident #1.

Interview with Resident #1's Hospice nurse on 01/24/20 at 4:13pm revealed:
-Resident #1 was admitted to hospice services on 11/27/19.

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D 270	Continued From page 65 -She knew Resident #1 had a history of falls and Hospice was notified of Resident #1's falls since her admission to Hospice in November 2019. -Resident #1's falls were because of declining health. -The goal for Resident #1 was comfort care, and after discussion with the family, they decided to not contact EMS or send Resident #1 to the hospital after her falls. -If Resident #1 had an injury from a fall, a Hospice nurse would be sent out to assess her and determine the severity and interventions. -On 01/20/20, Resident #1 was in a manic phase where she was awake for 24 hours and she had three falls. -Resident #1 had a head injury after the first fall on 01/20/20. -A Hospice nurse assessed Resident #1 after the first fall on 01/20/20 and spoke with her family member and no new orders were provided. -She assessed Resident #1 after the second fall on 01/20/20 and spoke with Resident #1's family member and no new orders were provided. -Resident #1's placement in the Memory Care Unit (MCU) was appropriate because the MCU was smaller, had fewer residents, and she would not be over stimulated in the environment. -The MCU was smaller and staff were able to supervise Resident #1 because Resident #1 mainly stayed in the common areas. -Resident #1 did not use an assistive device when ambulating and a walker would likely increase Resident #1's fall risk. -Resident #1 did not need additional one to one care; one to one contact "would likely agitate" Resident #1. Interview with the SCC/MCC on 01/27/20 at 8:30am revealed: -Resident #1 was on the "Falls Management and	D 270		

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Intervention" program.
-After a fall, the policy was to alert the residents responsible party, notify the PCP, and increase supervision.
-The policy did not have time requirements for increased supervision, and residents should be checked on "more frequently" after a fall.
-Residents should be supervised as needed, and at least every 2 hours.
-There was no documentation of "more frequent checks" on Resident #1.
-The facility previously used a 30-minute check form, but the form was not properly implemented, and staff stopped using the form.
-MAs were responsible for reporting if Resident #1 fell during their shift to the next shift.
-MAs documented shift checks on a resident post fall for 72 hours.
-Staff were able to supervise Resident #1 more frequently because she spent the "majority" of her time in common areas.
-Resident #1 slept in the living room or the lounge area and she paced in the common areas.
-Resident #1 did not stay in her bedroom except for short times and staff checked on her as they passed by her bedroom.
-He reviewed the Incident and Accident Reports completed by staff and signed and dated the reports; the reports were then turned into the Executive Director.
-Resident falls from the previous 24 hours were discussed at the "Stand-Up Meeting" that occurred Monday through Friday at 9:30am.
-The Monday "Stand-Up Meeting" included a weekly report on resident falls.
-When Resident #1 had a fall, she was discussed at the weekly "Stand-Up Meeting" and fall risk awareness and interventions were discussed.
-The in-house rehabilitation staff completed the fall risk assessment.

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D 270	Continued From page 67 Interview with the in-house Rehabilitation Director on 01/27/20 at 11:45am revealed: -Fall risk assessments were completed for residents upon admission to the facility, routinely every three months, if there was a resident concern, and after every fall. -If a resident was on Hospice, fall assessments were still completed. -Resident falls were reported at the Stand-Up Meeting. -Resident #1's fall risk assessment ranged from 18 to 26 and her current fall risk assessed on 01/21/20 was 22; a fall risk assessment score between 16 to 39 was considered higher risk of falls. -Resident #1 did not participate in rehabilitation therapy because she was on hospice. -There was "always something to be done" to decrease resident falls including care collaboration and implementing different interventions. -She did not know if Resident #1 needed additional supervision because she was not in the MCU all the time. Interview with the Executive Director on 01/27/20 at 4:08pm revealed: -The SCC/MCC was responsible for tracking residents falls in the MCU. -Resident #1 was frequently supervised because she spent her time in the common areas in the MCU. -She knew Resident #1 had a history of falls and she was in the "Falls Management and Intervention" program. -Per the fall policy, Resident #1 was supposed to be checked on "more frequently" after her falls, but the policy did not provide how often staff should increase their checks on a resident after a	D 270		

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fall.
-The SCC/MCC was responsible for ensuring Resident #1 was supervised.
-Resident #1 had frequent interventions, including medication adjustments in November 2019, to minimalize falls.

Interview with Resident #1's mental health provider on 01/27/20 at 4:33pm revealed:
-She was aware of Resident #1's falls from 11/18/19 to 01/21/20.
-She considered Resident #1 to be stable with her psychological medications and "unfortunately, titrating medications can cause a risk for falls".
-She did not know if Resident #1 needed more supervision.
-In January 2020, Resident #1 was not exit seeking, she was not combative, and she was not wandering.
-In order to treat Resident #1's behaviors with psychological medications, Resident #1 had an increased risk for falls.
-Resident #1 was in a "tricky situation" because there needed to be a balance of medications with her physical mobility.
-Resident #1's falls were related to her overall decline in health.
-She was concerned with Resident #1's falls because there was a risk for physical harm.
-The last time she saw Resident #1 was the week of 01/20/20.

Interview with Residents #1's PCP on 01/27/20 at 5:08pm revealed:
-She was notified of Resident #1's falls from November 2019 to January 2020.
-She was very concerned with Resident #1's falls because of the risk for her safety.
-Resident #1 had psychological issues and walked excessively.

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D 270	Continued From page 69 -Resident #1 would be safer if the family would provide a sitter. The facility failed to provide adequate supervision for 3 of 5 sampled residents (#3, #5, and #1) with diagnoses of dementia resulting in a resident who eloped without staffs knowledge and fell 19 times within 73 days (#3), a resident who eloped from the Special Care Unit 2 times (#5), a resident who fell 5 times within 65 days, with 2 falls in one day (#1), and a resident who inappropriately touched female residents (#5). This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/24/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2020.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 residents (Resident #7 and #8) were free of mental and physical abuse related to being inappropriately touched and kissed by a male resident in the Special Care Unit (SCU).	D 338		

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D 338	Continued From page 70 The findings are: 1. Review of Resident #7's current FL2 dated 01/15/20 revealed: -Diagnoses included dementia, muscle weakness, bone and cartilage disease, emphysema, and anxiety. -Resident #7 was constantly disoriented. -Resident #7 was non-ambulatory. Review of Resident #7's Care Plan dated 08/27/19 revealed: -Resident #7 was non-ambulatory and required a wheelchair. -Resident #7 had significant memory loss and had to be directed. Review of Resident #7's Incident Reports for December 2019 and January 2020 revealed there were no incident reports for her being inappropriately touched or kissed. Review of the Incident Reports for the named male resident for December 2019 and January 2020 revealed there were no reports for his inappropriate touching or kissing of Resident #7. Review of Resident #7's progress notes dated 12/01/19 through 01/23/20 revealed there were no progress notes regarding her being inappropriately touched or kissed by a male resident. Review of the named male resident's progress notes revealed: -There were 3 notes documenting in December 2019 of the resident inappropriately touching or kissing a female resident. -There were 10 notes documenting in January	D 338		

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2020 of the resident inappropriately touching or kissing a female resident.
-On 01/01/20, the named male resident was observed putting his hand down a female resident's shirt and after being redirected he was observed kissing the same female resident on the mouth two times.
-On 01/10/20, the named resident was observed kissing a female resident on the mouth.
-On 01/20/20, the named resident was observed holding a female resident's hand and he attempted to kiss her on the mouth and hands.
-On 01/21/20, the named male resident tried to kiss a female resident on the mouth.

Interview with a medication aide (MA) on 01/24/20 at 2:30pm revealed:
-On 01/10/20, the named male resident was observed kissing Resident #7 on the mouth; he became agitated when staff redirected him. Resident #7's power of attorney (POA) was notified via telephone message and they never returned the call to the facility. She did not document the incident in the female resident's record.
-On 01/20/20, the named male resident was observed holding Resident #7's hand and attempting to kiss her on her lips and hands while she sat at the dining table. She redirected him.
-On 01/21/20, the named resident was observed trying to kiss Resident #7 on her lips; she redirected him.
-She did not document the incidents of inappropriate touching or kissing Resident #7 in her record.
-The named male resident thought Resident #7 was his spouse as they looked similar.
-They sat the named male resident at a table with the other male residents for meals.
-The Special Care Coordinator (SCC)/Memory

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Care Coordinator (MCC) had been informed of each incident with a female resident, including touching a female resident's breast.
-When she had to leave the SCU, she made sure staff was in the common areas to watch the residents.
-She made rounds every 15-20 minutes.
-If the SCC/MCC wanted rounds completed every 15-30 minutes; it would had been written in the cottage update book.

Interview with the SCC/MCC on 01/24/20 at 5:10pm revealed:
-On 01/01/20, the named male resident put his hand down Resident #7's shirt and then kissed her on the mouth twice.
-Resident #7 had a similar hair color as his spouse.
-He did not know if family members had been notified each time the named male resident inappropriately touched or kissed Resident #7.

Attempted interview with Resident #7's family member on 01/27/20 at 11:35am was unsuccessful.

Refer to the interview with the named male residents MHP on 01/27/20 at 4:24pm.

Refer to the interview with the named male resident's PCP on 01/27/20 at 4:43pm.

Refer to the interview with a first shift MA on 01/27/20 at 1:20pm.

Refer to the interview with another MA on first shift on 01/27/20 at 1:45pm.

Refer to interview with a second shift MA on 01/27/20 at 10:40am.

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D 338	Continued From page 73 Refer to the interview with a third shift MA on 01/27/20 at 12:30pm. Refer to the interview with weekend MA on 01/27/20 at 1:07pm. Refer to interview with the SCC/MCC on 01/24/20 at 5:10pm. Refer to the second interview with the SCC/MCC on 01/27/20 at 2:05pm. Refer to the interview with the Resident Care Director (RCD) on 01/27/20 at 5:20pm. Refer to interview with the Administrator on 01/24/20 at 5:41pm Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. 2. Review of Resident #8's current FL2 dated 10/22/19 revealed: -Diagnoses included Alzheimer's dementia, non-insulin dependent Diabetes Mellitus, hypertension, chronic obstructive pulmonary disease, asthma, depression, hypothyroidism, and history of a stroke. -Resident #8 was constantly disoriented. -Resident #8 was non-ambulatory and required a wheelchair. Review of Resident #8's Care Plan dated 08/27/19 revealed: -Resident #8 was non-ambulatory and required a wheelchair. -Resident #8 had significant memory loss and had to be directed.	D 338		

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D 338	Continued From page 74 Review of Resident #8's progress notes dated 12/01/19 through 01/23/20 revealed there were no progress notes regarding her being inappropriately touched or kissed by a male resident. Review of the named male resident's progress notes revealed: -There were 3 notes documenting in December 2019 of the resident inappropriately touching or kissing a female resident. -There were 10 notes documenting in January 2020 of the resident inappropriately touching or kissing a female resident. -On 01/17/20, the named male resident was found in a female resident's bed laying beside the female resident and rubbing her hand. -On 01/17/20, the named male resident was rubbing on a female resident's hands and legs. Review of Resident #8's Incident Reports for December 2019 and January 2020 revealed there were no incident reports for her being inappropriately touched or kissed by a male resident. Review of the Incident Reports for the named male resident for December 2019 and January 2020 revealed there were no reports for his inappropriate touching or kissing of Resident #8. Telephone interview with Resident #8's family member on 01/27/20 at 11:25 am revealed; -He visited daily and had seen the named male resident pat Resident #8's hands. -Two staff members had tried to redirect him. -The facility had not notified him of any issues. Based on observations, interviews, and record	D 338		

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D 338	Continued From page 75 reviews, it was determined Resident #8 was not interviewable. Refer to the interview with the named male residents MHP on 01/27/20 at 4:24pm. Refer to the interview with the named male resident's PCP on 01/27/20 at 4:43pm. Refer to the interview with a first shift MA on 01/27/20 at 1:20pm. Refer to the interview with another MA on first shift on 01/27/20 at 1:45pm. Refer to interview with a second shift MA on 01/27/20 at 10:40am. Refer to the interview with a third shift MA on 01/27/20 at 12:30pm. Refer to the interview with weekend MA on 01/27/20 at 1:07pm. Refer to interview with the SCC/MCC on 01/24/20 at 5:10pm. Refer to the second interview with the SCC/MCC on 01/27/20 at 2:05pm. Refer to the interview with the Resident Care Director (RCD) on 01/27/20 at 5:20pm. Refer to interview with the Administrator on 01/24/20 at 5:41pm _____ Interview with the named male residents MHP on 01/27/20 at 4:24pm revealed: -The named male resident was very demented and severely confused.	D 338		

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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
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-She knew he held some of the female residents' hands.
-She did not know that he had inappropriately touched or kissed any of the female residents on the SCU.
-There were no medications that would help his inappropriate touching or kissing the female residents.
-The named male resident needed more redirection and supervision.

Interview with the named male resident's PCP on 01/27/20 at 4:43pm revealed:
-He did not know about the named male resident's inappropriate behaviors of touching and kissing female residents.
-Had adjusted the named male resident's medications shortly after he was admitted, but that was due to the named male resident's anxiety.

Interview with a first shift MA on 01/27/20 at 1:20pm revealed:
-On 01/02/20, the named male resident tried to kiss a female resident on the mouth, but was redirected by staff.
-Staff tried to make sure he did not get to close to the female residents.
-She only documented the incident in the named resident's record, but did not recall why.
-She did not notify the female resident's family member or the named male resident's physician.
-Staff did not do anything different after the incident to protect the female residents.

Interview with another MA on first shift on 01/27/20 at 1:45pm revealed:
-The named male resident thought the ladies were his spouse.
-She had observed the named male resident hold

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	HAL041074	A. BUILDING: _____ B. WING _____	01/27/2020

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the ladies' hands and sit beside them at meal times. It was not just one female. It was several.
-She tried to make sure he did not get to close to the female residents, but when he did, she took him to the dining room and worked a puzzle with him
-The MAs only documented in the named male resident's record and not the ladies, but she was not sure why.

Interview with a second shift MA on 01/27/20 at 10:40am revealed:
-The named male resident was adjusting to his recent move into the facility and he missed his spouse.
-She checked on residents constantly every 1 to 1 and ½ hours.
-Staff did not document when they checked on residents unless they were on the Falls Prevention Program; then they had to document every shift.
-A pink sheet in the personal care log listed interventions for the resident.
-The named male resident was very friendly, loving, and very affectionate as he liked the women.
-One lady would wave at the named male resident then he will go over and sit with her and hold her hand.
-He held their hands and gave them hugs.
-Staff had reported to her that he put his hand down a female resident's shirt, but she could not recall which female resident it was.
-She was not sure if the physician was notified or if the female residents' family were notified.
-She was instructed by the SCC/MCC to only document on the named male resident's behavior and not to notify the family because they were aware of his inappropriate behaviors.
-The named male resident had to constantly be

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redirected.
-Staff tried to get the named male resident involved in activities.
-She thought the Administrator knew of the named male resident's behavior as she had written notes on the back of the 24 hour report.
-The 24 hour report was slid under the SCC/MCC's office door and he filed them in a notebook.
-On 12/28/19, she redirected the named male resident as he was kissing a female resident's hands, but she could not recall which female resident.
-She did not recall the named male resident being overly affectionate with a female resident even though she had documented the incident in the named male resident progress notes.
-Interventions for the named male resident was in a notebook in the medication room.
-Staff had sat with the named male resident, but had not tried a sitter for him.

Interview with a third shift MA on 01/27/20 at 12:30pm revealed:
-The named resident had been observed multiple times touching female residents inappropriately on their hands and shoulders and kissing them on their lips and face.
-The named resident had been found in a female resident's room laying in the bed beside her.
-She did not think the families of the female resident had been notified.
-He touched the female residents nightly.
-It was impossible to watch him enough to prevent him from touching the female residents.

Interview with weekend MA on 01/27/20 at 1:07pm revealed:
-The named male resident tended to favor women as he thought they were his wife.

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-He had been observed hold holding a female resident's hands and rubbing them and hugging them.
-She did not tell the family members because she was told not to by another MA who was instructed by the SCC/MCC to only document in the named male residents record because they already knew about the inappropriate behaviors.

Interview with the SCC/MCC on 01/24/20 at 5:10pm.
-Normally, when a resident kissed another resident, staff would redirect the resident, then inform the family of the female resident to make sure that it was okay with the resident being kissed.
-Staff had let residents hold hands before, as if they were boyfriend and girlfriend, but staff made sure it did not go too far like going to the room and becoming intimate.
-Staff tried to keep affection between residents to a minimal.
-The named male resident thought several of the female residents were his wife and he would call them momma (an affectionate nickname he used for his wife).
-Rounds were made every 2 hours or as needed.
-When a resident had behaviors, they tried to keep them in the common areas so they could be watched constantly.
-They provided one on one activities for the named male resident but did not provide a sitter for around the clock or even on the shifts in which he was observed being inappropriate.
-Staff had provided a lot of one on one time and redirection with the named male resident.
-He knew a resident inappropriately touching another resident could violate residents' rights.
-Initially the named male resident was signed up to see the facility physicians and mental health

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providers.
-Upon admission, the family requested for the named male resident to keep his regular primary care physician (PCP).
-On 01/13/20, staff spoke with the named male resident's family members and obtained permission for him to be evaluated by mental health.
-On 01/14/20, the named male resident was evaluated by mental health.
-He had previously spoken to the named male resident's family member regarding his behavior and she was not upset and said, "he's always been a lady's man".
-When asked what had been put in place to protect the female residents, no answer was given.

Second interview with the SCC/MCC on 01/27/20 at 2:05pm revealed:
-Prior to 1/23/20, staff only documented in the named male residents record.
-As of 01/26/20, staff was required to document in both records if someone was touched inappropriately and both residents' family member as well as physicians had to be notified.
-He had never instructed staff not to document, inappropriately being touched or kissed, in the female resident's records.

Interview with the Resident Care Director (RCD) on 01/27/20 at 5:20pm revealed:
-She thought the named male resident perceived the female residents as his wife.
-Staff did not complete incident or behavior reports when the named male resident was inappropriate with the female residents.
-She had no answer as to why the incidents had not been documented in the female residents' records.

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D 338	Continued From page 81 -Usually the SCC/MCC was responsible for notifying residents' families when an incident occurred. Interview with the Administrator on 01/24/20 at 5:41pm revealed: -She did not know the named male resident had inappropriately touched or kissed any female residents until earlier in the day on 01/24/20. -Most people like touch and "holding hands and hugging was endearing." -If a resident did not want to be touched, they would pull back and you could tell by their body language. -Many of the residents in the special care unit can verbalize if they want to be touched. -A resident kissing another resident on the lips "probably" would not be appropriate. -A resident putting their hand down another resident's shirt, would not be appropriate. -She did not know if the primary care physician (PCP) or the mental health provider (MHP) had been notified of the named residents inappropriate touching and kissing of female residents on the unit. -When the named male resident had inappropriate behaviors, staff should notify the physician and then the SCC/MCC as well as herself. -She would notify the family members of the residents who had been inappropriately touched and create a safety plan. The facility failed to protect the residents from mental and physical abuse resulting in resident (#7 and #8) being inappropriately touched and kissed by a male resident. This failure was detrimental to the resident's health safety and welfare and constitutes a Type B violation.	D 338		

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D 338	Continued From page 82 The facility provided a plan of protection in accordance with G.S. 131D-34 on January 24, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2020.	D 338		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect and in compliance with federal and state laws and rules and regulations related to personal care and supervision and resident rights. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' needs and current symptoms for 3 of 5 sampled residents (#1, #3, and #5) including a resident who exhibited exit seeking behaviors (#5), a resident who eloped from the facility (#3), and two residents who had multiple falls which resulted in a knee injury (#1 and #3), a head contusion (#3) and a resident who inappropriately touched female residents (#5). [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B	D914		

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D914	Continued From page 83 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 residents (Resident #7 and #8) were free of mental and physical abuse related to being inappropriately touched and kissed by a male resident in the Memory Care Unit (MCU). [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		