Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029006	A. BUILDING: _____ B. WING _____	09/16/2019

RECEIVED
OCT 29 2019
ADULT CARE LICENSURE SECTION
RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LEXINGTON	161 YOUNG DRIVE LEXINGTON, NC 27292

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/12/19 through 09/13/19 and on 09/16/19.	D 000	The following is the Plan of Correction for Brookdale Lexington regarding the Statement of Deficiencies for the Annual Survey completed September 16, 2019. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, record reviews, and observations, the facility failed to assure 1 of 3 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled resident (Resident #2) with dementia, who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge. The findings are:	D 067		

Received and Accepted Keisha Banks 01/06/20

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D 067	Continued From page 1 Observations during the tour of the facility on 09/12/19 between 7:45am and 9:15am revealed: -At 7:45am, the door alarm to the front door of the main entrance did not sound upon entering the facility. -The front door was equipped with alarm keypads. Review of Resident #2's current FL2 dated 06/07/19 revealed: -Diagnoses included dementia. -Resident #2's current level of care was documented as domiciliary. -Resident #2 was documented as constantly disoriented Review of Resident #2's care plan dated 03/01/19 revealed: -Resident #2 was documented as having forgetfulness and short-term memory loss. -Resident #2 required limited assistance with bathing, but he was independent with all other activities of daily living. Review of Resident #2's Incident/Accident Reports revealed: -There was not a report dated 07/23/19. -There was a report dated 09/04/19 which indicated the nature of the incident was an elopement; the time of the incident was 7:15pm. -Resident #2 was observed outside in front of the building attempting to walk in the parking lot. -Resident #2 was redirected inside by a PCA after 5 to 10 minutes of redirection. Review of an Incident Investigation report dated 07/23/19 revealed: -The type of incident was documented as elopement.	D 067	Resident #2 was evaluated and transferred to a secure memory care unit on 9/16/19. A review of current residents was completed by the Health and Wellness Director (HWD) and Nurse Designees, and wander-guards were evaluated for effectiveness. Associates will be re-trained on the door alarms that must be alarmed at all times, the hours when the front door is to be alarmed, as well as care of the resident utilizing a wander-guard. This training will be provided by the Executive Director (ED), Health and Wellness Director (HWD) or Designee no later than 10/30/19. New hires will be instructed on this task as part of their orientation process. The Maintenance Tech was re-educated by the Executive Director on the requirement for exit door alarms to be checked weekly by the Maintenance Technician and/or designee to verify doors are operating correctly. Wander-guards will be checked by the Nurse/Med Tech for effectiveness prior to placing on the resident.	10-31-19

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D 067	Continued From page 2 -There was documentation Resident #2 was observed at 5:05pm on 07/23/19 outside in the front of the facility at the end of the sidewalk where the driveway began. -Resident #2 stated he was "walking his dog." -Resident #2 was encouraged to come inside the building and to go into the dining room for dinner. -A wanderguard was placed on Resident #2's left ankle. Interview with Resident #2's family member on 09/13/19 at 12:32pm revealed: -She was aware of 2 instances when Resident #2 exhibited wandering behaviors. -A few months ago, staff informed her Resident #2 eloped to the front of the facility and staff brought him back in the building. -A wanderguard was placed on Resident #2's ankle after he was brought back into the facility. -The Health and Wellness Director (HWD) called her about 2 weeks ago and informed her Resident had been taking off his wanderguard and eloped from the facility again. -Staff did not tell Resident #2 why he was wearing the wanderguard. -Resident #2 has had a decline in his mental state and had been more confused. -There was usually someone at the front desk when she visited Resident #2. -She visited Resident #2 on two occasions when Resident #2's wanderguard was laying in his room and she gave it to the HWD. -Staff told her Resident #2 had taken his wanderguard "off a lot more" than the two times she saw it off. -There was discussion with the previous Executive Director (ED) when Resident #2 was admitted regarding moving Resident #2 to the facility's Special Care Unit (SCU) when his	D 067	Wander-guards placed on residents will be checked for placement and functionality on each shift by Med-Tech and/or designee. This assignment will be added to the Medication Administration Record, and tracked for compliance by the HWD/Designee. Maintenance Tech records will be monitored for compliance on a monthly basis by the Executive Director (ED) or Designee.	10-31-19

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D 067	Continued From page 3 dementia worsened. -The current ED told her there was not a bed available in the SCU and she would have to find placement in a SCU in another facility within 60 days of the wanderguard initially being placed on Resident #2. Interview with the HWD on 09/13/19 at 1:00pm revealed: -Resident #2 had "gone outside" twice since July 2019. -She did not know if he was trying to leave the facility or not when he exited. -After Resident #2 exhibited wandering behaviors on 07/23/19, the facility implemented a wanderguard and contacted Resident #2's family. -The wanderguard caused an alarm to go off when Resident #2 attempted to exit, but he was able to take the wanderguard off. -She told staff to make more frequent checks, but did not indicate how often, to make sure Resident #2 had the wanderguard on due to him taking the wanderguard off. -Staff did not know how resident #2 took the wanderguard off, but they put it back on when it was taken off. -Resident #2 had taken his wanderguard off on 09/04/19 and he was observed outside by a PCA. -On 09/04/19, Resident #2 made it to the handicapped parking spaces before staff was able to stop him. -The facility implemented checking on Resident #2 every 2 hours to make sure he had the wanderguard on rather than just laying eyes on him every two hours. -There was staff at the front desk daily between 8:00am and 6:00pm to monitor who entered and exited the facility. -The front door alarm was automatically turned	D 067		

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D 067	Continued From page 4 on at 7:30pm nightly. -Staff in the area were responsible for monitoring the doors between 6:00pm and 7:30pm. Interview with the ED on 09/13/19 at 1:42pm revealed: -Resident #2 thought he was "walking his dog" a lot of the time. -On 07/23/19, Resident #2 was "walking his dog" when staff saw him walk through the front door and off the sidewalk. -A wanderguard was placed on Resident #2 on 07/23/19 and he was considered to have exit seeking behaviors at that point. -The staff provided intervention after Resident #2 eloped on 07/23/19 by checking every 2 hours to make sure his wanderguard was on his leg. -The Business Office Coordinator (BOC) was responsible for monitoring the front door entrance between 10:00am and 6:00pm -The 2nd shift MA was responsible for monitoring the front door between 6:00pm and 7:30pm. Interview with the Business Office Coordinator on 09/13/19 at 4:23pm revealed: -She worked at the front desk 5 days a week from 9:00am until 5:00pm or from 10:00am until 6:00pm. -The front door did not alarm during her work hours unless a resident had a wanderguard and was attempting to exit. -Resident #2 was the only resident in the facility with a wanderguard. -She had not, at any time, witnessed the front door alarm activated due to Resident #2 attempting to exit the facility with his wanderguard on nor had she witnessed Resident #2 attempting to exit the facility without his wanderguard on.	D 067		

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D 067	Continued From page 5 -The front door alarm automatically turned on at 7:30pm daily. -There was no one at the front desk between 5:00pm and 7:30pm or between 6:00pm and 7:30pm according to her work hours for that day. -She had never seen Resident #2 leave or attempt to leave out of the facility during her work hours. -No one was at the front desk after she left her shift. -There was usually a MA at the medication cart in the hallway where the front door could be seen between the time she left and 7:30pm and there was usually someone in the dining hall cleaning up and could see the front door. Interview with Resident #2 on 09/13/19 at 10:25am revealed: -Resident #2 had a wanderguard in place on his left leg. -He did not know why he had the wanderguard on or how long he had the wanderguard on. -He took the wanderguard off every now and then, but he did not know why. -"I just get it off." -He had left the building through the front door, but he did not remember when or if the alarm sounded when he left. Interview with a PCA on 09/13/19 at 12:08pm revealed: -She was working in the facility on 09/04/19 when Resident #2 walked out of the facility. -She was standing in the hall way outside of the dining hall when she saw Resident #2 exit the building. -She knew Resident #2 had exit seeking behaviors and wore a wanderguard. -She thought Resident #2 had the wanderguard	D 067		

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D 067	Continued From page 6 on when he exited the building on 09/04/15, but she did not remember hearing the alarm sound. -Resident #2 had not gotten off the porch yet because she got outside before he could go any further. -Resident #2 stated to her that he wanted to get some air so she walked him around the parking lot and brought him back into the facility and the ED put a different wanderguard on him. -She checked on Resident #2 every 15 minutes after he was brought back into the facility. Interview with the ED on 09/16/19 at 11:11am revealed: -A bed became available in the SCU over the weekend and she was going to offer it to Resident #2. -She had been trying to get in contact with Resident #2's family regarding the bed opening since 09/14/19, but she had not been able to. Attempted telephone interview with Resident #2's PCP on 09/16/19 at 2:35pm was unsuccessful. The facility failed to assure all exit doors were alarmed when there was at least one identified wanderer which resulted in a resident (#2) with a diagnosis of dementia, who exhibited exit seeking behaviors and eloped from the facility without staff's knowledge. 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 09/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 31,	D 067		

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D 067	Continued From page 7 2019.	D 067		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 2 of 6 sampled staff (Staff B and Staff F) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff B's, Special Care Unit (SCU) Program Coordinator, personnel record revealed: -Staff B was hired on 05/01/19. -Staff B started working on 05/13/19. -There was documentation the HCPR was checked on 05/29/19 with no substantiated findings. Observation of Staff B on 09/13/19 between 5:30pm and 5:45pm revealed: -Staff B assisted with serving the dinner meal to residents in the dining room. -Staff B interacted with residents regarding the dinner meal.	D 137	HCPR verification was completed by the Business Office Coordinator (BOC)/Designee on 9/16/19 for staff "B" & "F". The BOC will complete an audit of current associate files to verify compliance with in the area of Healthcare Personnel Registry no later than 10/31/19. The BOC and/or Designee will ensure that the Healthcare Personnel Registry is reviewed and no substantiated findings are listing for all new associates upon hire. The BOC and/or Designee will track this verification on the associate compliance tracking tool. The compliance tracking tool will be monitored by the ED to verify compliance on a monthly basis.	10-31-19

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D 137	Continued From page 8 Interview with Staff B on 09/16/19 at 3:17pm revealed: -She had worked at the facility since May 2019. -She worked as the SCU Program Coordinator and coordinating and leading activities for residents was a part of her job duties. -She did not know if the HCPR was checked on her upon hire. Interview with Executive Director (ED) on 09/16/19 at 4:01pm revealed: -The Business Office Coordinator (BOC) was responsible for maintaining employee records and for ensuring the HCPR was checked for new staff upon hire. -She did not know Staff B's HCPR was not checked until 05/29/19. -She expected the HCPR registry to be checked for new staff upon hire. 2. Review of Staff F's, Dietary Manager, personnel record revealed: -Staff F was hired on 12/13/18. -There was no documentation the HCPR was checked for Staff F. Observation of Staff F on 09/13/19 between 8:15am and 8:45am revealed: -Staff F assisted with serving the breakfast meal to residents in the dining room. -Staff F interacted with residents regarding the breakfast meal. Interview with Staff F on 09/16/19 at 2:22pm revealed he did not know if the HCPR was checked for him upon hire. Interview with the ED on 09/16/19 at 4:01pm revealed:	D 137		

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D 137	Continued From page 9 -She did not know prior to 09/16/19 there was no documentation of a HCPR check for Staff F. -She ran a HCPR check for Staff F on 09/16/19. -The Business Office Coordinator (BOC) was responsible for maintaining employee records and ensuring the HCPR was checked for new staff upon hire. -She thought the BOC coordinator may have some documents that were not filed in the personnel records and documentation of Staff F's HCPR check could possibly be in unfiled documents. -The BOC was not in the office on this date, 09/16/19, and she did not know where unfiled documents might be. -She expected the HCPR to be checked for new staff upon hire.	D 137		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after	D 150	Staff member "C" will receive retraining on "Personal Care" no later than 11/30/19. The BOC will complete an audit of current associate files to verify compliance with in the area of required training and competencies. A revised compliance tracking tool will be implemented upon completion for applicable associates, which includes 80-hour training for applicable associates that provide personal care.	11-30-19

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D 150	Continued From page 10 hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff C) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training. The findings are: Review of Staff C's, Supervisor, personnel record revealed: -Staff C was hired as a Personal Care Aide (PCA) on 05/05/16. -There was no documentation of completion of personal care training for Staff C. Interview with Staff C on 09/16/19 at 3:22pm revealed: -She was hired as a PCA in 2016 and became a MA and Supervisor in 2018. -Her job responsibilities included administering medication to residents and providing personal care as needed. -She had completed personal care training during her first few weeks of employment. -The Resident Care Coordinator (RCC) at her time of hire was responsible for ensuring personal care training was completed. -There was currently not an RCC employed at	D 150	The BOC and/or Designee will notify HWD, RCC and/or Designee if an associate has not met the required training rule requirement. The HWD, RCC and/or Designee will review the associate's needs schedule applicable training, and competency, or will take measures to remove associate from their assignment/position until the required training is complete. The BOC and/or Designee will monitor the tracking tool on a monthly basis for compliance. Records of training will be maintained in Business Office.	11-30-19

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D 150	Continued From page 11 the facility. Observations of Staff C on 09/16/19 between 3:25pm and 3:35pm revealed: -A PCA came to get Staff C to assist her with a resident who had fallen. -Staff C assisted the PCA with getting the resident up from the floor. Interview with the Executive Director (ED) on 09/16/19 at 4:01pm revealed: -The RCC and the Health and Wellness Director (HWD) were responsible for ensuring personal care training was completed for new staff. -There was not currently an RCC in place at the facility and the HWD was not employed when Staff C was hired. -She did not know if personal care training had been completed for Staff C because Staff C was hired prior to her becoming the ED. -The Business Office Coordinator (BOC) was responsible for maintaining employee records. -She thought the BOC coordinator may have some documents that were not filed in employee records and Staff C's 80 hour personal care training could possibly be in unfiled documents. -The BOC was not in the office on this date, 09/16/19, and she did not know where unfiled documents might be. -She expected the 80 hour personal care training to be completed for new staff within 6 months of hire. Documentation of completion of personal care training for Staff C was not provided prior to exit on 09/16/19.	D 150		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 12 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, record reviews, and interviews, the facility failed to provide supervision for 3 of 5 sampled residents (Residents #2, #3 and #4) who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge (#2) and who were disoriented and had repeated falls (#3 and #4). The findings are: 1. Review of Resident #2's current FL2 dated 06/07/19 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and macular degeneration. -Resident #2 was ambulatory and used a cane. -Resident #2 displayed constant disorientation. Review of Resident #2's care plan dated 03/019 revealed: -There was documentation Resident #2 required	D 270	Resident #2 was moved to a secure memory care unit on 9/16/19. The Executive Director/Designee has retrained the Maintenance Tech on the requirement that exit door alarms will be checked weekly by the Maintenance Technician and/or designee to verify doors are operating correctly. Wander-guards will be checked by the Nurse/Medication Tech/Designee for effectiveness prior to placing on the resident. Wander-guards placed on residents will be checked for placement on each shift by Med-Tech and/or designee. Associates will be re-trained on the door alarms including which doors are to be alarmed at all times and what hour the front door is to be alarmed. This training will take place on 10/30/19. Associates will be trained by the HWD/Designee on the policy and procedure for Missing Residents on 10/30/19.	10-31-19

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D 270	Continued From page 13 limited assistance with bathing. -There was documentation Resident #2 was independent with all other activities of daily living. Review of Resident #2's progress notes dated 07/23/19 revealed: -Resident #2 was observed outside in front of the facility at the end of the sidewalk where the driveway began. -Four staff went outside to get the resident. -Resident #2 stated he was "walking his dog." -A Medication Aide (MA) notified the Health and Wellness Director (HWD) and the Executive Director (ED). -The ED instructed the MA to put a wanderguard on Resident #2 and contact Resident #2's family member. -A wanderguard was placed on Resident #2's left ankle. Review of Resident #2's progress notes dated 07/24/19 revealed the wanderguard was intact. Review of Resident #2's progress notes dated 07/25/19 revealed the HWD put the wanderguard back on Resident #2's left ankle. Review of Resident #2's progress notes dated 07/27/19 the wanderguard was intact. Review of Resident #2's progress notes date 09/04/19 revealed: -Resident #2 was alert and confused. -Resident #2's wanderguard had been removed and he was observed outside of the facilty. -Resident #2 was redirected outside of the facility and his wanderguard was reapplied. -The MAs and Personal Care Aides (PCAs) were	D 270	An audit of FL'2's for current residents will be completed by the HWD/Resident Care Coordinator (RCC) or Designee no later than 10/31/19 to verify residents have been appropriately placed in Assisted Living or our secure memory care. Personal Service Plans (care plans) and Care Profiles for each resident will be reviewed by the Health and Wellness Director and Resident Care Coordinator by 10/31/19. Focus will be placed on assuring appropriateness for residents in the correct level of care and risk of elopement or exit seeking behavior. Personal Service Plan, Care Profile and Personalized Assignment Sheets will be based on both care and safety needs of current residents as identified by the Health and Wellness Director or designee through assessment, care oversight and associate supervision. FL2's will be monitored at least yearly or as needed on residents for accuracy. An in-service on reporting/identifying Changes in Condition will be conducted with associates on 10/30/19 by the Health and Wellness Director. Changes in resident needs identified through staff communication, nurse, physician or third party assessment will be followed up on a timely basis by the Health and Wellness Director and/or designee.	10-31-19

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D 270	Continued From page 14 aware to perform "frequent" checks for Resident #2's wanderguard placement. -Resident #2's family member was updated and an update was faxed to Resident #2's Primary Care Provider (PCP). Review of Resident #2's progress notes dated 09/05/19 at 9:22am revealed wanderguard was intact. Review of Resident #2's progress notes dated 09/06/19 revealed: -At 12:22am, there was documentation Resident #2's wanderguard was in place at 10:30pm. -At 10:56am, there was documentation Resident #2's wanderguard was in place on his right ankle and staff would continue frequent checks for placement. -At 2:03pm, there was documentation Resident #2's wanderguard was intact on every two hour check. -At 3:46pm, there was documentation Resident #2's wanderguard was removed and staff replaced the wanderguard on Resident #2's left ankle at 3:30pm. -At 10:40pm, there was documentation Resident #2's wanderguard was checked every 2 hours and the last check for 2nd shift was at 10:30pm with wanderguard in place. Review of Resident #2's progress notes dated 09/07/19 at 5:15am revealed Resident #2's wanderguard was checked every 2 hours and was last checked at 5:15am. Review of Resident #2's progress notes dated 09/07/19 at 9:26am revealed Resident #2's wanderguard was intact.	D 270	The HWD/Designee will be responsible for monitoring compliance.	10-31-19

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D 270	Continued From page 15 Review of Resident #2's progress notes dated 09/08/19 revealed: -At 6:58am, there was documentation Resident #2's wanderguard was checked every 2 hours and was last checked at 7:00am. -At 2:28pm, there was documentation Resident #2's wanderguard was intact at 2:30pm -At 10:46pm, there was documentation wanderguard placement was checked every 2 hours and the last check was at 10:30pm with wanderguard intact. Review of Resident #2's progress notes dated 09/09/19 revealed: -At 7:02am, there was documentation wanderguard was checked every 2 hours with the last check at 5:30am -At 9:48am, there was documentation Resident #2 was alert and confused and had removed his wanderguard. -At 10:09am, there was documentation Resident #2's wanderguard was reapplied and frequent checks would be continued for placement of the wanderguard. -At 11:48pm, there was documentation Resident #2's wanderguard was checked every 2 hours and the last check was at 10:30pm Review of Resident #2's progress notes dated 09/10/19 revealed: -At 1:17am, there was documentation Resident #2's wanderguard was checked at 1:00am and it was not in place. Resident #2 stated he had thrown it "over there." -At 1:26am, there was documentation Resident #2's wanderguard was located in a cabinet in his room. -At 8:35am, there was documentation Resident #2 removed his wanderguard and refused to	D 270		

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D 270	Continued From page 16 have it replaced. -At 2:16pm, there was documentation Resident #2 took his wanderguard off and staff tried to put it back on but Resident #2 refused to have it replaced. -At 2:32pm, there was documentation Resident #2 refused to have his wanderguard applied several times. The wanderguard was reapplied by the ED. -At 11:40pm, there was documentation Resident #2's wanderguard placement was checked every 2 hours with the last check being at 10:30pm. Review of Resident #2's progress notes dated 09/12/19 revealed: -At 12:22am, there was documentation the ED replaced Resident #2's wanderguard; The last wanderguard check was at 10:35pm with the wanderguard intact; Per ED, if Resident #2 removed his wanderguard during hours the doors were not locked and resident was not in bed, he was to go to the locked unit until the doors locked. -At 2:35pm, there was documentation Resident #2's wanderguard was in intact. Review of Resident #2's Incident/Accident Reports revealed: -There was not a report dated 07/23/19. -There was a report dated 09/04/19 which indicated the nature of the incident was an elopement; the time of the incident was 7:15pm. -Resident #2 was observed outside in front of the building attempting to walk in the parking lot. -Resident #2 was redirected inside by a PCA after 5 to 10 minutes of redirection. Review of an Incident Investigation report dated 07/23/19 revealed:	D 270		

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D 270	Continued From page 17 -The type of incident was documented as elopement. -There was documentation Resident #2 was observed at 5:05pm on 07/23/19 outside in the front of the facility at the end of the sidewalk where the driveway began. -Resident stated he was "walking his dog." -Resident was encouraged to come inside the building and to go into the dining room for dinner. -A wanderguard was placed on Resident #2's left ankle. Interview with Resident #2's family member on 09/13/19 at 12:32pm revealed: -She was aware of 2 instances when Resident #2 exhibited wandering behaviors. -Resident #2 exhibited wandering behaviors a few months ago; Staff informed her Resident #2 walked off the curb in front of the building and staff brought him back in the building. -A wanderguard was placed on Resident #2's ankle after he was brought back into the facility. -The facility called her about 2 weeks ago and informed her Resident had been taking off his wanderguard and had gotten out of the facility again. -Staff did not tell Resident #2 why he was wearing the wanderguard. -Resident #2 has had a decline in his mental state and had been more confused. -There was discussion with the previous ED regarding moving Resident #2 to the facility's Special Care Unit (SCU) when his dementia worsened. -The current ED told her there was not a bed available in the SCU and she would have to find placement in a SCU in another facility within 60 days of the wanderguard initially being placed on Resident #2.	D 270		

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D 270	Continued From page 18 Interview with the HWD on 09/13/19 at 1:00pm revealed: -Resident #2 had "gone outside" twice since she started working in the facility in July 2019. -She did not know if he was trying to leave the facility or not. -After Resident #2 eloped on 07/23/19, the facility implemented a wanderguard and contacted Resident #2's family. -She told staff to make more frequent checks to make sure Resident #2 had the wanderguard on due to him taking the wanderguard off. -Resident #2 took his wanderguard off on 09/04/19 and he was observed outside by a PCA. -On 09/04/19, Resident #2 had walked to the handicapped parking spaces (about 100 feet) in front of the the facility before staff was able to stop him. -The facility implemented checking on Resident #2 every 2 hours to make sure he had the wanderguard on rather than just laying eyes on him every two hours. There were no other interventions implemented. -The facility protocol was to check on all residents every 2 hours. Interview with the ED on 09/12/19 at 1:42pm revealed: -Resident #2 thought he was "walking his dog" a lot of the time. -On 07/23/19, Resident #2 was "walking his dog" when staff saw him walk through the front door and off the sidewalk. -A wanderguard was placed on Resident #2 on 07/23/19 and he was considered to have exit seeking behaviors at that point. -The staff provided intervention after Resident #2 eloped on 07/23/19 by checking every 2 hours to	D 270		

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D 270	Continued From page 19 make sure his wanderguard was on his leg. -Documentation of 2 hour checks for Resident #2 should be in Resident #2's progress notes. -The Business Office Coordinator was at the front desk daily from 10:00am until 6:00pm and the front door automatically alarmed at 7:30pm. -The 2nd shift MA watched the front door between 6:00pm and 7:30pm. -There was no other type of increased supervision implemented for Resident #2. Interview with the Business Office Coordinator on 09/12/19 at 4:23pm revealed: -She worked at the front desk 5 days a week from 9:00am until 5:00pm or from 10:00am until 6:00pm. -The front door alarm automatically turned on at 7:30pm daily. -There was no one at the front desk between 5:00pm and 7:30pm or between 6:00pm and 7:30pm according to her work hours for that day. -She had never seen Resident #2 leave or attempt to leave out of the facility during her work hours. -No one was at the front desk after she left her shift. -There was usually a MA at the medication cart in the hallway where the front door could be seen and there was usually someone in the dining hall cleaning up and could see the front door. Interview with Resident #2 on 09/13/19 at 10:25am revealed: -Resident #2 had a wanderguard in place on his left leg. -He did not know why he had the wanderguard on or how long he had the wanderguard on. -He took the wanderguard off every now and then, but he did not know why.	D 270		

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D 270	Continued From page 20 -"I just get it off." -He had left the building through the front door, but he did not remember when or if the alarm sounded when he left. Interview with a PCA on 09/13/19 at 12:08pm revealed: -She was working in the facility on 09/04/19 when Resident #2 eloped from the facility. -She was standing in the hall way outside of the dining hall when she saw Resident #2 exit the building. -She knew Resident #2 had exit seeking behaviors, had eloped from the facility and wore a wanderguard. -She thought Resident #2 had the wanderguard on when he exited the building, but she did not remember hearing the alarm sound. -Resident #2 had not gotten off the porch yet because she got outside before he could go any further. -Resident #2 stated to her that he wanted to get some air so she walked him around the parking lot and brought him back into the facility and the ED put a different wanderguard on him. -After Resident #2 came back into the facility, she was not told to increase supervision for Resident #2, but she checked on him every 15 minutes or so. -She did not document the 15 minute checks anywhere. -Typically, if there was a resident who eloped outside of the facility, the protocol was to stay with the resident until the resident was back in the building; if the resident had aggressive behaviors then the resident may be sent to the hospital for evaluation. -Increased supervision would differ from resident to resident.	D 270		

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D 270	Continued From page 21 Interview with the ED on 09/16/19 at 4:01pm revealed: -There was no policy regarding increase in supervision of residents after an incident or accident. -Increased supervision should be documented in resident progress notes. Attempted telephone interview with Resident #2's PCP on 09/16/19 at 2:35pm was unsuccessful. 2. Review of Resident 3's current FL2 dated 06/07/19 revealed: -Diagnoses included falls, muscle weakness, degenerative disk disease lumbar, Vitamin D deficiency, polyneuropathy, and chronic pain. -Resident #3 was documented as semi-ambulatory and used a walker. Review of Resident #3's care plan dated 02/17/19 revealed Resident #3 required limited assistance with toileting and bathing, but was independent with all other activities of daily living. Review of an Incident/Accident Report for Resident #3 dated 01/25/19 revealed: -Resident #3 had an unwitnessed fall in her bedroom at 2:45pm which resulted in bruising and puffiness to her left eye, area below the left eye and cheek. -Resident #3 was not sent to the emergency room (ER). -Resident #3 notified staff she had fallen earlier in the week as she lost her balance while getting something out of her closet. -The resident's walker was behind her and she was holding onto the wall as she was looking in	D 270		

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D 270	Continued From page 22 her closet. Review of a written intervention timeline provided by the Health and Wellness Director (HWD) on 09/15/19 revealed: -The intervention implemented after Resident #3's fall on 01/25/19 included encouraging Resident #3 to ask for assistance when she needed items at the top of the closet. -There was no documentation supervision was increased for Resident #3. Review of an Incident/Accident Report for Resident #3 dated 02/04/19 revealed: -Resident #3 had an unwitnessed fall in her bathroom at 2:00am which resulted in a cut to her left elbow, and bruising to her left forearm and left upper arm. -Resident #3 was sent to the emergency room (ER). -Resident #3 returned to the facility after having an x-ray which revealed she sustained a closed fracture of the medial portion of the lower left leg. Review of a written intervention timeline provided by the HWD on 09/15/19 revealed: -The intervention implemented after Resident #3's fall on 02/04/09 included ensuring Resident #3 had on proper footwear when toileting. -There was no documentation supervision was increased for Resident #3. Review of hospital ER provider notes dated 02/04/19 revealed: -Resident was seen in the ER after an unwitnessed fall. -The clinical impression included fall, left shoulder pain, and closed fracture of the medial	D 270		

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D 270	Continued From page 23 portion of the lower left leg. Review of an Incident/Accident Report for Resident #3 dated 03/10/19 revealed: -Resident #3 had an unwitnessed fall in her at 9:00pm which resulted in no injuries. -Resident #3 was not sent to the ER. -Resident #3 was found between her bed and her roommate's bed sitting on the floor. -The resident informed staff she was going to turn the light off. Review of a written intervention timeline provided by the HWD on 09/15/19 revealed: -The intervention implemented after Resident #3's fall on 03/10/19 included encouraging Resident #3 to ask for assistance when she needed items out of reach. -There was no documentation supervision was increased for Resident #3. Review of an Incident/Accident Report for Resident #3 dated 06/05/19 revealed: -Resident #3 had an unwitnessed fall at 2:40pm which resulted in no injuries. -Resident #3 was not sent to the ER. -Resident #3 stated she was walking in her room going to her wheelchair and her shoes made her trip. Review of a written intervention timeline provided by the HWD revealed the intervention implemented after Resident #3's fall on 06/05/19 included removing clutter from Resident #3's room. Review of the Incident/Accident Reports for Resident #3 revealed there was no report for 07/19/19.	D 270		

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D 270	Continued From page 24 Review of Resident #3's progress notes dated 07/19/19 revealed: -At 11:20pm, it was documented Resident #3 was found on the bathroom floor in her bedroom. -There were no apparent injuries. -Resident #3 was encouraged by the HWD, Medication Aide (MA), and Personal Care Aide (PCA) to notify staff before going to the restroom when she needed assistance. Interview with a Medication Aide (MA) on 09/16/19 at 4:46pm revealed: -She did not remember the details of Resident #3's fall on 07/19/19, but she remembered Resident #3 was found on her bathroom floor. -She did not remember any interventions being put in place after Resident #3's fall on 07/19/19. -Resident #3 was not sent out to the ER. -She had not been told to increase supervision for Resident #3 after her fall on 07/19/19, but she checked on Resident #3 every hour. -She did not document the hourly checks anywhere. -Resident #3 had "a lot of stuff" in her bedroom. -"It's tight in there." -She thought Resident #3's cluttered room could contribute to falls. -If a resident fell in the facility, staff would discuss the reason why the resident fell and how to prevent future falls. -Interventions were put in place depending on the resident and could include: placement of the resident's bed, decluttering the resident's room, proper footwear and keeping assistive devices near the resident. -Staff checked on residents more often after a fall and the frequency of the checks was decided by the HWD during day shifts and by the	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 25 supervisor during night shifts. -Staff did not document increased checks on residents after a fall. Review of a written intervention timeline provided by the HWD on 09/15/19 revealed: -There was no intervention or increased supervision documented as implemented after Resident #3's fall on 07/19/19. -There was no documentation supervision was increased for Resident #3. Review of an Incident/Accident Report for Resident #3 dated 08/29/19 revealed: -Resident #3 had an unwitnessed fall at 10:20am which resulted in a skin tear to her nose and right elbow and an abrasion to her forehead. -Resident #3 was sent to the ER. -Resident #3 tripped and fell while she was ambulating through the front entrance with her walker. Interview with a Supervisor on 09/16/19 at 11:28am revealed: -Resident #3 was a fall risk and had multiple falls. -She was working on 08/29/19 when Resident #3 had an unwitnessed fall at the door at the entrance to the facility. -A resident came to get her when Resident #3 fell. -Resident had a skin tear on her elbow and had been sent to the ER because she hit her head. -She did not think there was anyone at the front desk when Resident #3 fell at the front entrance. -Usually when a Resident had a fall, she assessed the situation, assessed if resident was bleeding or had any head injuries, asked what happened, talked to witnesses, completed an	D 270		

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D 270	Continued From page 26 incident report and faxed it to the physician and called the resident's family. -Usually after a fall, staff would document checking on that resident on each shift for 72 hours. -After Resident #3 fell on 09/04/19, she checked on her every 2 hours and sometimes more than every 2 hours, but she did not document it anywhere. -The facility protocol was to check on all residents every 2 hours. -Increasing supervision for a resident after a fall differed from resident to resident. -PT was providing services to Resident #3 prior to her fall on 08/29/19. -Staff reminded Resident to ask for help and encouraged her to use her gait belt when ambulating. -There was not much room in resident's bedroom between her bed and the window for the resident to ambulate and the lack of space could create fall risks. -She thought Resident #3 had had so many falls due to need for assistance with ambulation and transfers. -Resident #3 seldom requested assistance with ambulation and transfers. Review of a hospital After Visit Summary dated 08/29/19 revealed: -Resident #3 was seen in the ER due to a fall. -ER diagnoses included a concussion without loss of consciousness, strain of the neck muscle, an abrasion of the face, a contusion of the left hip, and a skin tear of the right elbow. Review of a written intervention timeline provided by the HWD on 09/15/19 revealed: -The intervention implemented after Resident	D 270		

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D 270	Continued From page 27 #3's fall on 08/29/19 included encouraging Resident #3 to wear her sneakers instead of slippers while ambulating. -There was no documentation supervision was increased for Resident #3. Review of Resident #3's Post Fall Evaluation Forms revealed: -There was a post fall evaluation form completed for Resident #3's fall on 02/04/19 and there was no intervention documented. -There was a post fall evaluation form completed for Resident #3's fall on 03/10/19 and the intervention included placement of a sign in Resident #3's room which read: Call Don't Fall; There were no other interventions noted. - There were no other Post Fall Evaluation Forms completed for Resident #3. Observation of Resident #3's room on 09/13/19 at 11:00am revealed: -Resident #3 shared her room with a roommate and her bed was close to the window in the room. -Resident #3 had a recliner chair in the left corner of the room directly beside the window with the left arm and seat portion of the chair extending about 2 feet in front of the window and pushed against the wall air conditioner/heating unit which extended from the wall directly below the window. -The right side front arm area of the recliner chair rested against the left side of the bed which sat diagonally towards the window the headboard touching the wall only on the left side of the bed. -The left side foot of the bed was less than a foot away from Resident #3's dresser drawer which was positioned halfway in front of the window and halfway on the wall. -Between Resident #3's recliner and her dresser	D 270		

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D 270	Continued From page 28 (4-5 feet tall) and between the bed and the air conditioner/heating unit was a side table, filled with personal hygiene products, positioned horizontally against the air conditioner/heating unit. -There was 1 foot of space between the recliner and the end of the side table, 1 foot of space between the bed and the side table, and less than a foot of space between the bed and the dresser. -The right side head of the bed was 1 foot from the left side head of Resident #3's roommate's bed. -The head of Resident #3's roommate's bed was flat against the wall. -The space between Resident #3's bed and her roommate's bed was in a V shape and increased from 1 foot at the head of the beds to 3 feet at the foot of the beds. -There was a large box on the floor between Resident #3's closet door and the foot of her bed and there was 1 foot of space between the foot of her bed and the box and 1 foot of space between the box and the closet door. -Resident #3's wheelchair was situated at the foot of her bed in an area beside her closet with the right front wheelchair wheel extending 1 foot from the right side foot of the bed. -The wheelchair was stacked with towels and books. -There was no sign in Resident #3's bedroom door or bathroom door regarding fall prevention. Interview with Resident #3 on 09/16/19 at 10:32am revealed: -She had resided at the facility for a little over a year. -She had multiple falls at the facility with the last 2 being "real bad" falls.	D 270		

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D 270	Continued From page 29 -When she fell in July 2019, she was in the bathroom and got tangled up in her walker. -She had been told by staff to ask for help, but she had not asked for help when she fell. -She did not remember how long it took for someone to come and assist her from the floor, but "it was a long time." -She was going in and out of consciousness. -She had a cut on her nose from her glasses, she hit her right forearm and elbow, and bruised her left hip. -Resident #3's most recent fall was at the door at the front entrance to the facility in August 2019. -She was going out the door to sit on the porch. -She hit her forehead during that fall and suffered a concussion, injured her left hip, and injured her left shoulder. -She also chipped a few teeth when she fell. -She started physical therapy (PT) after she fell in July 2019 and PT continued after her fall in August 2019. -She did not know of any other interventions that were put in place after her falls. -She did not have a lot of space in her room to ambulate and had to visit with her family member outside or in another common area. -She had fallen in her room before as well as in her bathroom. -She had concerns about ambulating in her room especially when she was on the left side of her bed by her recliner chair. Interview with a nurse at Resident 3's PCP's office on 09/16/19 at 2:35pm revealed: -Resident #3's PCP was aware of her multiple falls. -The PCP expected to be made aware of Resident #3's falls. -There were not any interventions ordered by the	D 270		

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D 270	Continued From page 30 PCP. Interview with Resident #3's physical therapist on 08/16/19 at 1:05pm revealed: -PT services for Resident #3 began on 07/22/19 after being in the hospital and continued to receive PT. -Resident #3 had an unsteady gait and was a high fall risk. -She worked with Resident #3 on how to use her walker, how to get in and out of chairs, and on gait training. -She conducted PT visits with Resident #3 in the library because there was more room in the library. -Resident #3's room was "really cluttered" and increased Resident #3's risk for falls. -She had discussed the condition of Resident #3's room with the facility staff. Interview with the HWD on 09/16/09 at 4:35pm revealed: -She knew about Resident #3's falls on 01/25/19 02/04/19, 03/10/19, 06/15/19, 07/19/19, and 08/29/19. -Staff had requested the PCP to order PT, worked on safety awareness, and decluttered Resident #3's room. -Resident #3's room was a lot less cluttered than what it used to be. -Resident #3 did not have a fall mat in her room. -Resident #3 had to wear her walking sneakers. -She thought if Resident #3 had on her walking sneakers she would be okay. -Staff checked on residents every 2 hours per facility protocol. -Staff should have increased supervision after falls. -Staff should have documented increased	D 270		

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D 270	Continued From page 31 supervision checks in the residents' progress notes. -She would expect for staff to check on a resident every hour after a fall, and the length of time between supervision checks may be different for each resident. -She did not know staff did not document increased supervision checks for residents. Interview with the ED on 09/16/19 at 4:00pm revealed: -Resident #3 was a high fall risk. -Interventions after a fall depended on the resident. -Resident #3 was evaluated by PT and occupational therapy (OT). -There was a "Call don't fall" sign posted in Resident #3's old room as a reminder to request assistance, but the sign was not posted in Resident #3's new room. -Staff tried to get Resident #3 to slow down, observed her getting up from the dining room table, and assisted her out of bed. -After Resident #3's fall in August, staff checked on her every hour "or so." -Increased checks on Resident #3 were not documented anywhere. -She knew Resident #3's room was cluttered and had spoken to Resident #3's family about the number of belongings in her bedroom. -Anything could present a fall risk for Resident #3. -When a resident had a fall, the MA checked the resident's vital signs, determined if the resident hit their head, called the nurse to decide whether to send the resident out to the ER, and called the ED. -The MA was to complete an incident report and submit it to the RCC or the HWD.	D 270		

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D 270	Continued From page 32 -The MA was to call the family, nurse, and the resident's physician. -The HWD and RCC were responsible for figuring out what preventions to put in place after the fall. -The facility's protocol was to check on all residents every 2 hours. -Increased supervision checks were not the same for each resident and depended on the resident. -She expected for staff to document increased safety checks after a fall in the resident's progress notes. Attempted telephone interview with Resident #3's family member on 09/16/19 at 3:35pm was unsuccessful. 3. Review of Resident #4's current FL2 dated 06/24/19 revealed: -Diagnoses included cognitive deficit, dysphagia, essential hypertension, atrophy of the thyroid, history of falls, anorexia, unspecified pneumonia, unspecified abdominal pain, and dysuria. -Resident #4 was intermittently disoriented, semi-ambulatory with assist, and incontinent of bowel and bladder at times. Review of Resident #4's current Care Plan dated 06/25/19 revealed Resident #4 required minimal assistance with transfers. Review of Resident #4's Incident/Accident reports revealed: -Resident #4 had 4 unwitnessed falls between 07/05/19 through 08/05/19. -One of the unwitnessed falls were documented as occurring in the resident's bathroom room. -Three of the unwitnessed falls were documented as occurring in the resident's room.	D 270		

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D 270	Continued From page 33 -All of Resident #4's falls occurred on third shift. Review of an Incident/Accident report for Resident #1 dated 07/05/19 at 11:15 pm revealed: -Resident #4 had an unwitnessed fall in her bedroom. -There was no injury noted. Review of Resident #4's post fall assessment form dated 07/05/19 revealed: -Resident #4 was found on her left side in the bathroom. -She attempted to get to the bathroom without assistance. -The sitter left the wheelchair by the residents' bed and she used the wheelchair to go to the bathroom unassisted instead of asking for staff assistance. -Resident required staff assistance to go to the bathroom. -Staff would perform frequent rounds and provide toileting assistance. Interview with a second shift medication aide (MA) on 09/16/19 at 9:50 am revealed: -She was the MA working on 07/05/19. -She did not remember Resident #4 falling on 07/05/19. -Resident #4 was considered a high fall risk. -Resident #4 would attempt to get up to the bathroom and transfer from the bed to the wheelchair without assistance. -After a fall, staff would increase supervision more frequently than every 2 hours. -Staff increased supervision based on each residents' needs. -Staff did not document increased supervision.	D 270		

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D 270	Continued From page 34 Review of Resident #4's progress notes dated 07/06/19 at 2:45 pm revealed: -Resident #4 had no complaints of pain post fall. -There was no documentation of increased supervision Review of Resident #4's progress notes dated 07/07/19 at 2:33 pm revealed: -Resident #4 had no complaints of pain post fall. -There was no documentation of increased supervision. Review of an Incident/Accident report for Resident #4 dated 07/13/19 at 6:20 am revealed: -Resident #4 had an unwitnessed fall in her bedroom. -Resident #4 was found sitting on the floor beside her bed. -Staff documented a left lower leg skin tear. Review of Resident #4's progress notes dated 07/13/19 revealed: -There was documentation of a fall with injury. -There was no documentation of increased supervision. Interview with another second shift MA on 09/13/19 at 6:00 pm revealed: -She was the MA on duty on 07/13/19. -On 07/13/19, Resident #4 was found on the floor by the bed. -The wheelchair was near the bed. -She thought she was attempting to go from the bed to the wheelchair without assistance. -Staff made sure the wheelchair was not left by the bed to discourage Resident #4 from getting up without assistance. -If Resident #4 had a fall, staff would increase supervision to more frequently than every 2	D 270		

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D 270	Continued From page 35 hours. -All residents were checked on every 2 hours. -Staff should document increased supervision but she was not sure if she documented the increased supervision checks. Review of an Incident/Accident report for Resident #4 dated 08/01/19 12:00 am revealed: -Resident #4 had an unwitnessed fall in her bedroom. -Staff documented Resident #4 attempted to use her wheelchair as a walker to get to the bathroom. -There was no injury noted. Review of Resident #4's progress notes dated 08/01/19 at 10:00 am revealed: -Resident #4 had no complaints of pain post fall. -There was no documentation of increased supervision. Interview with a third shift personal care aide (PCA) on 09/16/19 at 10:14 am revealed: -She was the PCA working on 08/01/19. -She checked on all residents every 2 hours. -She did not remember Resident #4 falling on 08/01/19. -Resident #4 did not fall often. -To prevent falls, staff checked on Resident #4 more frequently. -Staff checked Resident #4 every 1 hour, but did not document checks. Review of an Incident/Accident report for Resident #4 dated 08/05/19 at 4:15 am revealed: -Resident #4 had an unwitnessed fall in her bedroom. -Resident #4 was found sitting on the floor beside her bed.	D 270		

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D 270	Continued From page 36 -Staff documented a small left outer leg skin tear. Review of Resident #4's progress notes dated 08/05/19 at 5:29 am revealed: -Resident #4 was found lying on her back with her upper body under the bed. -A skin tear was documented on the left outer leg. -There was no documentation of increased supervision. Interview with a second PCA on 09/16/19 at 9:10 am revealed: -She was working as the PCA on 08/05/19. -On 08/05/19, Resident #4 was found on the floor in her room. -Resident #4 had her upper body under the bed and legs were visibly sticking out from under the bed. -Staff noticed a skin tear to Resident #4's left lower leg. -She checked on all residents at least every 2 hours. -She attempted to "lay eyes" on all residents every 15-30 minutes. -She only documented safety checks if there was a concern (fall, infection, recent hospital stay). -She did not know if the facility had a fall policy. Interview with the Special Care Unit (SCU) Program Director on 09/13/19 at 4:15 pm revealed: -Resident #4 required assistance with transfers. -All residents were checked on every 2 hours. -If a resident had falls staff would increase supervision from every 2 hours. -Supervision checks would depend on the residents individual needs.	D 270		

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D 270	Continued From page 37 -Staff did not document increased supervision. -There was no form or process established to document increased supervision. Interview with a second MA on 09/13/19 at 4:40 pm revealed: -She worked first and second shift as a MA. -The facility did not have a call bell system. -Resident #4 used a cow bell to call for assistance. -Staff stopped leaving the wheelchair by Resident #4's bed because she would try to get up without assistance. -She did not know if physical therapy was ordered for Resident #4. -Staff checked on all residents every 2 hours. -If Resident #4 had a fall she would increase safety supervision to every 1 hour. -She did not document increased supervision. -There was no form or process established to document increased supervision. -Most of Resident #4's falls occurred in her room. -Resident #4 did not have a fall mat. -She did not know of any additional interventions taken to prevent falls. Interview with a first shift MA on 09/16/19 at 11:10 am revealed: -She worked as a first shift MA on both the Assisted Living (AL) and SCU. -Staff checked on Resident #4 every 2 hours. -She did not consider Resident #4 a high fall risk because she used a wheelchair and staff assisted with transfers. -If staff increased supervision there was no documentation. Telephone interview with a contracted Home Health Nurse (HHN) on 09/16/19 at 12:20 pm	D 270		

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D 270	Continued From page 38 revealed: -Physical therapy (PT) was seeing Resident #4, but had to stop services due to a foot wound. -She considered Resident #4 a high risk for falls because she used a wheelchair and required assistance with all transfers. -She did not know Resident #4 had 4 falls from 07/05/19 through 08/05/19. Telephone interview with a contracted physical therapist on 09/16/19 at 1:00 pm revealed: -She was performing PT exercises with Resident #4. -She had to discharge Resident #4 from PT because of a lower extremity wound. -She initially admitted Resident #4 for PT services because she had transitioned from a skilled nursing facility. -She knew Resident #4 had 4 falls from 07/05/19 through 08/05/19. -She thought most falls were a result of Resident #4 trying to transfer from the bed to the chair. -She considered Resident #4 a high fall risk. Telephone interview with a representative at the contracted Home Health Agency on 09/16/19 at 2:10 pm revealed: -Resident #4 began PT services on 06/27/19 and discharged on 08/02/19. -Resident #4 was seen for PT twice a week and her gait did not improve. -Resident #4 began occupational therapy (OT) services on 06/28/19 and was discharged on 07/25/19. -Resident #4 was seen for OT twice a week. Interview with a MA on 09/16/19 at 4:46 pm revealed: -If a resident fell in the facility, staff would	D 270		

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BROOKDALE LEXINGTON	161 YOUNG DRIVE LEXINGTON, NC 27292

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D 270	Continued From page 39 discuss the reason why the resident fell and how to prevent future falls. -Interventions were put in place depending on the resident and could include: placement of the resident's bed, decluttering the resident's room, proper footwear and keeping assistive devices near the resident. -Staff checked on residents more often after a fall and the frequency of the checks was decided by the Health and Wellness Director (HWD) during day shifts and by the supervisor during night shifts. -Staff did not document increased checks on residents after a fall. Interview with the HWD on 09/16/19 at 3:50 pm revealed: -She knew Resident #4 had 4 falls from 07/05/19 through 08/05/19. -She remembered 2 falls occurred at night. -She knew Resident #4 attempted to go to the bathroom without assistance. -Staff no longer left Resident #4's wheelchair by the bed to encourage her to call for assistance when getting up. -Staff were to perform "more frequent checks" after falls and frequency would be based off each residents individual needs. -Frequent checks meant staff were to check on Resident #4 more often than every 2 hours. -Staff checked on all residents every 2 hours per facility protocol. -Staff should have documented increased supervision checks in the residents' progress notes. -She did not know staff did not document increased supervision checks for residents. Interview with the Executive Director (ED) on	D 270		

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D 270	Continued From page 40 09/16/19 at 4:00pm and 4:35 pm revealed: -She knew Resident #4 had a history of falls but she did not know there were 4 falls from 07/02/19 through 08/05/19. -She spoke with Resident #4's family regarding a halo or fall mat upon admission but they never revisited the discussion at a later date. -She felt Resident #4 did not have good balance and was a risk for falls. -Resident #4 received physical therapy upon admission. -The family provided a sitter for day and evening hours. -Resident #4 did not have a sitter at night. -The facility's protocol was to check on all residents every 2 hours. -She expected staff to check on Resident #4 at least every hour and document in the progress notes. -When a resident had a fall, the MA checked the resident's vital signs, determined if the resident hit their head, called the nurse to decide whether to send the resident out to the ER, and called the ED. -The MA was to complete an incident report and submit it to the RCC or the HWD. -The MA was to call the family, nurse, and the resident's physician. -The HWD and RCC were responsible for deciding what preventions to put in place after the fall. -Increased supervision checks were not the same for each resident and depended on the resident. -She expected for staff to document increased safety checks after a fall in the resident's progress notes. Attempted telephone interview with Resident #4's family member on 09/16/19 at 2:50 pm was	D 270		

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D 270	Continued From page 41 unsuccessful. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 09/13/19 at 3:12 pm 09/16/19 at 2:10 pm was unsuccessful. The facility failed to provide supervision for 3 of 5 sampled residents resulting in a resident eloping from the facility without staff's knowledge (#2); 2 residents who had multiple falls (#3 and #4) resulting in injuries of a fractured lower left leg and a concussion (#3). The facility's failure to provide supervision was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 09/16/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 31, 2019.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276	Resident #3: The HWD has reviewed the clinical record, notified the physician of any missed labs and will follow up on new orders received to address the missed lab order cited in the survey. An audit of current resident charts and physician orders will be completed by the HWD/RCC/Designee no later than 10/31/19 to verify /clarify current orders related to laboratory testing.	10-31-19

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D 276	Continued From page 42 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure laboratory orders for 1 of 5 sampled residents (Resident #1) were completed. The findings are: Review of Resident #1's current FL2 dated 02/13/19 revealed diagnoses included gastroesophageal disease, ulcer of the esophagus without bleed, unspecified atrial fibrillation, unspecified cystitis with hematuria, muscle weakness, dementia in other diseases classified elsewhere without behavioral disturbance, other abnormalities of gait and mobility, retention of urine, and unspecified hypercholesterolemia. Review of subsequent physician's orders for Resident #1 dated 08/21/19 revealed an order for labs including CMP (comprehensive metabolic panel), CBC (complete blood count) with differential, now and every 6 months. Review of subsequent physician's orders for Resident #1 dated 09/03/19 revealed an order for labs including BMP (comprehensive metabolic panel), CBC (complete blood count) with differential. Review of Resident #1's record revealed no labs results from labs ordered on 08/21/19 and 09/03/19.	D 276	The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) and/or Designee will monitor and follow up on new and recurring orders daily for residents requiring laboratory testing. Medication Administration Records will be reviewed by the HWD/Designee routinely to verify compliance. Medication Aides will receive re-training from the HWD/Designee on expectations of Medication Administration, with a focus on laboratory testing and documentation, no later than 10/31/19. Communication regarding prescribed laboratory testing and subsequent needs will be documented in the resident record. Communication will also include the Health and Wellness Director, Resident Care Coordinator and/or Designee for further follow up and review.	10-31-19

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D 276	Continued From page 43 Review of the transportation notebook on 09/16/19 at 4:00 pm revealed Resident #1 did not have appointments scheduled for August 2019 or September 2019.	D 276		
	Interview with the medication aide (MA) 09/16/19 at 2:15 pm revealed: -The MA was responsible for making a copy of the lab order and placing the order in the transportation notebook. -Transportation staff was responsible for scheduling the appointment and ensure labs were completed. -She did not know why the labs ordered on 08/21/19 and 09/03/19 were not completed. -It could take a few days to get an appointment scheduled. -Appointments had to be scheduled on Tuesdays and Thursdays. -She received the order for labs on 08/21/19 and placed the order in the transportation notebook. -She did not know about the labs ordered on 09/03/19. -She did not not check back to make sure the appointment was scheduled or the labs were completed.			
	Interview with the Health and Wellness Director (HWD) on 09/16/19 at 3:50 pm revealed: -The MA was responsible for placing lab orders in the transportation notebook to be scheduled. -Transportation staff was responsible for scheduling appointments Tuesday and Thursday. -She did not remember labs ordered on 08/21/19 and 09/03/19. -She did not know why labs were not completed on 08/21/19 and 09/03/19. -No one checked behind transportation staff to ensure labs were completed.			

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D 276	Continued From page 44 -She did not know for sure if the lab orders were placed in the transportation folder to be scheduled. Interviews with Resident #1's family member on 09/13/19 revealed: -She requested labs on 08/21/19 because Resident #1 was experiencing lower extremity edema. -She requested labs again on 09/03/19 because labs on 08/21/19 were not completed. -She was concerned about Resident #1's lower extremity edema. Interview with the Executive Director (ED) on 09/16/19 at 4:35 pm revealed: -The staff that received the order for labs would be responsible for placing the order in the transportation book. -The HWD or the transportation staff was responsible for scheduling an appointment for the labs and making sure the labs are completed. -The HWD was responsible for following up to ensure labs were completed. -She did not know Resident #1 had labs ordered on 08/21/19 and 09/03/19. Attempted telephone interview with Resident #1's Primary Care Physician on 09/13/19 at 3:12 pm and 09/16/19 at 2:10 pm was unsuccessful. Transportation Staff was not available for interview on 09/13/19 and 09/16/19.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310	Resident 3 and 6: HWD reviewed current orders and clarified physician orders regarding dietary need and resident choices.	11-30-19

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D 310	Continued From page 45 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure therapeutic diets were served as ordered for 2 of 5 sampled residents (#3 and #6) with physician's orders for carbohydrate controlled diets. The findings are: 1. Review of Resident #3's current FL2 dated 06/07/19 revealed: -Diagnoses included encephalopathy, metabolic hypertension, type II diabetes mellitus, and chronic obstructive pulmonary disease, polyneuropathy, edema, and bronchitis. -There was an order for a regular diet -There was a physician's order attached to the FL2 dated 06/07/19 with orders for a carbohydrate controlled diet and an order to monitor fingerstick blood sugars (FSBS) three times daily after meals. Review of a subsequent physician's order dated 08/06/19 revealed an order for a carbohydrate controlled diet. Review of Resident #3's electronic Medication Administration Record (eMAR) for July 2019 revealed Resident #3's FSBS ranged from 73 to 363. Review of Resident #3's electronic (eMAR) for August 2019 revealed Resident #3's FSBS ranged from 76 to 282.	D 310	An audit of all diets was completed by the HWD/Designee to verify that diet orders are present and that there is a corresponding therapeutic diet menu for each diet. The Diet Manual has been updated to reflect all current diets, alternatives and therapeutic needs. Staff received will receive re-training from the HWD/Designee regarding requirements for therapeutic diets available in community. This training includes Carbohydrate Controlled Diets, appropriate substitutions, and communication when resident's request and alternative diet. This training will be completed on 10/30/19. Menus will be monitored weekly by the Dining Services Coordinator to ensure that meals are healthy, balanced and meet rule requirements. Substitutions will be documented accordingly. The Nutrition Tracker has been updated by the HWD/Designee. An updated Nutrition Tracker has been reviewed with Dining Services to verify each residents diet order, preferences, and therapeutic needs. This tracker will be updated monthly, and upon change in diet orders, by the Health and Wellness Director, and posted in the kitchen for utilization by the Dining Services staff.	11-30-19

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D 310	Continued From page 46 Review of Resident #3's electronic (eMAR) for September 2019 revealed Resident #3's FSBS ranged from 95 to 326. Review of the therapeutic diet list dated 02/08/19 posted in the kitchen revealed Resident #3 was listed to be served a carbohydrate controlled diet. Review of the carbohydrate controlled diet menu for the lunch meal service on 09/12/19 revealed residents had a choice of sautéed pork chop with a starch/potato and bread, chef salad with a roll, , cottage cheese and fresh fruit plate without a potato/starch or a roll, tossed salad, sugar free cookies, mandarin oranges, low fat milk or a sugar free beverage. Observation of the lunch meal service on 09/12/19 between 12:00pm and 1:00pm revealed: -There were printed copies of the regular menu for the 09/12/19 lunch meal at each place setting which included fluffy rice, vegetable salad. -There was not a therapeutic menu available for Resident #3 to choose her meal from. -Resident #3 ordered from the regular menu. -Resident #3 was served beef and broccoli, rice, vegetable salad (The vegetable salad should have been substituted with tossed salad according to the carbohydrate controlled diet menu.), watermelon, orange sherbet (The dessert should have been substituted with sugar free cookies according to the carbohydrate controlled diet menu.), coffee, and water. -Resident #3 consumed 75% of the meal. Review of the carbohydrate controlled diet menu	D 310		

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D 310	Continued From page 47 for the dinner meal service on 09/12/19 revealed residents had a choice of Tuscany soup, egg salad plate with a roll, chicken salad with a roll, cottage cheese and fresh fruit plate without a starch or a roll, chef salad with a roll, green peas and herbs salad, 1 slice of reduced sugar chocolate mousse layer cake, or fresh fruit, milk or a sugar free beverage. Observation of the dinner meal service on 09/12/19 between 5:00pm and 6:00pm revealed: -Resident #3 was served a grilled cheese sandwich, 3 slices of tomatoes, watermelon, key lime pie (The dessert should have been substituted with 1 slice of reduced sugar chocolate mousse layer cake according to the carbohydrate controlled diet menu.), coffee, water, and sweet tea (A sugar free beverage should have been served according to the carbohydrate controlled diet menu.). -Resident #3 ate 100% of her meal. Observation in the kitchen on 09/12/19 at 6:14 pm revealed: -The orange sherbet list of ingredients included 21 grams of sugar and 23 grams of carbohydrates. -The key lime pie list of ingredients included 52 grams of sugar and 67 grams of carbohydrates. -There were no sugar free or reduced sugar desserts in the pantry, walk-in refrigerator or the freezer. Interview with a Medication Aide (MA) on 09/12/19 at 5:32pm revealed: -He worked in the dining hall during meals on his shift. -He served plates and beverages to residents. -All residents were served the same meals	D 310		

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D 310	Continued From page 48 except for residents on pureed diets and those on thickened liquids. -He did not know Resident #3 was on a carbohydrate controlled diet. Interview with a Personal Care Aide (PCA) on 09/12/19 at 5:35pm revealed: -She worked in the dining hall during meals on her shift. -She served plates and beverages to residents. -Resident #3 was diabetic, but she preferred sweet tea. -"As long as her sugar levels were okay, she could have it." -The MA let her know if Resident #3's blood sugars were okay to receive sweet tea. -Resident #3 was served regular desserts as everyone was served the same desserts. -She had not been told Resident #3 was to have different desserts or beverages. Interview with a cook on 09/12/19 at 6:05pm revealed: -She prepared the dinner meal plate for Resident #3 for on 09/12/19. -She knew Resident #3 was on a carbohydrate controlled diet. -She did not use the carbohydrate controlled diet menu for guidance to prepare the dinner meal for Resident #3 on 09/12/19. Interview with the Dietary Manager (DM) on 09/13/19 at 11:00am revealed: -He prepared the lunch meal plate for Resident #3 on 09/12/19. -He knew Resident #3 was on a carbohydrate controlled diet. -He did not give Resident #3 bread with her lunch meal because she was on a carbohydrate	D 310		

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D 310	Continued From page 49 controlled diet. -He did not know Resident #3 could be served a roll with her meal according to the carbohydrate controlled diet menu. Interview with Resident #3 on 09/16/19 at 10:32am revealed: -She was diabetic, but she did not think she was on a special diet. -She was served sweetened and unsweetened beverages. -She was always served the same desserts as the other residents were served. Interview with Resident #3's Primary Care Physician (PCP) on 09/16/19 at 2:35pm revealed: -Resident #3 was on a carbohydrate controlled diet due to her diagnoses of diabetes. -The PCP did not know Resident #3 was not served meals according to the carbohydrate controlled diet menu. -Not serving Resident #3 the ordered carbohydrate controlled diet could possibly cause elevated blood sugar readings. Refer to interview with a cook on 09/12/19 at 6:10pm. Refer to interview with a second cook on 09/13/19 at 10:57am. Refer to interview with the DM on 09/13/19 at 11:03am. Refer to interview with the HWD on 09/13/09 at 11:22am. Refer to interview with the ED on 09/13/19 at	D 310		

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D 310	Continued From page 50 11:31am. 2. Review of Resident #6's current FL2 dated 12/28/18 revealed: -Diagnoses included abnormal weight loss, muscle weakness, chronic obstructive pulmonary disease, bronchitis, and neuroleptic induced Parkinson's disease. -There was an order for a carbohydrate controlled diet with cut meats. Review of Resident #6's subsequent physician's order dated 08/01/19 revealed an order for a carbohydrate controlled diet with cut meats. Review of the therapeutic diet list dated 02/08/19 posted in the kitchen revealed Resident #6 was listed to be served a carbohydrate controlled diet with cut meats. Review of the carbohydrate controlled diet menu for the lunch meal service on 09/12/19 revealed residents had a choice of sautéed pork chop with a starch/potato and bread, chef salad with a roll, , cottage cheese and fresh fruit plate without a potato/starch or a roll, tossed salad, sugar free cookies, mandarin oranges, milk or a sugar free beverage. Observation of the lunch meal service on 09/12/19 between 12:00pm and 1:00pm revealed: -There were printed copies of the regular menu for the 09/12/19 lunch meal at each place setting which included fluffy rice, vegetable salad. -There was not a therapeutic menu available for Resident #6 to choose her meal from. -Resident #6 ordered from the regular menu. -Resident #6 was served chopped beef and	D 310		

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D 310	Continued From page 51 broccoli, rice, vegetable salad (The vegetable salad should have been substituted with tossed salad according to the carbohydrate controlled diet menu.), pimento cheese sandwich (It could not be determined if the pimento cheese sandwich was appropriate to serve because it was not listed to be served on the carbohydrate controlled diet menu.), orange sherbet (The dessert should have substituted with sugar free cookies according to the carbohydrate controlled diet menu.), coffee, water and and unsweetened tea. -Resident #6 consumed 100% of the meal. Review of the carbohydrate controlled diet menu for the dinner meal service on 09/12/19 revealed residents had a choice of Tuscany soup, egg salad plate with a roll, chicken salad with a roll, cottage cheese and fresh fruit plate without a starch or a roll, chef salad with a roll, green peas and herbs salad, 1 slice of reduced sugar chocolate mousse layer cake, or fresh fruit, milk or a sugar free beverage. Observation of the dinner meal service on 09/12/19 between 5:00pm and 6:00pm revealed: -Resident #6 was served a pimento cheese sandwich (It could not be determined if the pimento cheese sandwich was appropriate to serve because it was not listed to be served on the carbohydrate controlled diet menu.), 3 slices of tomatoes, water, and sweet tea (A sugar free beverage should have been served according to the carbohydrate controlled diet menu.). -Resident #6 ate 100% of her meal. Observation in the kitchen on 09/12/19 at 6:14 pm revealed: -The orange sherbet list of ingredients included	D 310		

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D 310	Continued From page 52 21 grams of sugar and 23 grams of carbohydrates. -There were no sugar free or reduced sugar desserts in the pantry, walk-in refrigerator or the freezer. Interview with a Medication Aide (MA) on 09/12/19 at 5:32pm revealed: -He worked in the dining hall during meals on his shift. -He served plates and beverages to residents. -All residents were served the same meals except for residents on pureed diets and those on thickened liquids. -He thought Resident #6 was diabetic, but was not on a therapeutic diet. -He served Resident #6 regular meals, desserts, and beverages. Interview with a Personal Care Aide (PCA) on 09/12/19 at 5:35pm revealed: -She worked in the dining hall during meals on her shift. -She served plates and beverages to residents. -Resident #6 was diabetic, but she preferred sweet tea. -Resident #6 was served regular meals, desserts, and beverages. Interview with a cook on 09/12/19 at 6:05pm revealed: -She prepared the dinner meal plate for Resident #6 for on 09/12/19. -She knew Resident #6 was on a carbohydrate controlled diet. -She did not use the carbohydrate controlled diet menu for guidance to prepare the dinner meal for Resident #6 on 09/12/19.	D 310		

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D 310	Continued From page 53 Interview with the Dietary Manager (DM) on 09/13/19 at 11:00am revealed: -He prepared the lunch meal plate for Resident #6 on 09/12/19. -He knew Resident #6 was on a carbohydrate controlled diet. -He prepared a pimento cheese sandwich for Resident #6 for her lunch meal on 09/12/19, but he did not know if it was on the carbohydrate controlled diet menu. -Resident #6 requested and was served a pimento cheese sandwich for a lot of her meals. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Attempted interview with Resident #6's Primary Care Physician (PCP) on 09/16/19 at 2:27pm was unsuccessful. Refer to interview with a cook on 09/12/19 at 6:10pm. Refer to interview with a second cook on 09/13/19 at 10:57am. Refer to interview with the DM on 09/13/19 at 11:03am. Refer to interview with the HWD on 09/13/09 at 11:22am. Refer to interview with the ED on 09/13/19 at 11:31am. Interview with a cook on 09/12/19 at 6:10pm revealed: -Residents who were on a carbohydrate	D 310		

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D 310	Continued From page 54 controlled diet did not receive a roll if they ordered the main meal. -Residents who were on a carbohydrate controlled diets were served regular desserts, but also had the option of watermelon and other available fruit. -There were rarely any sugar free desserts available and there were no sugar free desserts currently available to serve. -She did not know what type of beverages residents on a carbohydrate controlled diet were to be served. -She did not follow the carbohydrate controlled diet menu. -Residents were able to choose their meals from the menu on their dining tables and she served them what they wanted. -"It is their choice." Interview with a second cook on 09/13/19 at 10:57am revealed: -She was not sure how many residents were on a carbohydrate controlled diet. -She did not use the carbohydrate controlled menu. -She used the regular menu for guidance, but usually, she would not serve bread or starches to residents on a carbohydrate controlled diet. -Sometimes dietary staff would serve fruit, applesauce, or watermelon as desserts. Interview with the Dietary Manager (DM) on 09/13/19 at 11:03am revealed: -He did not serve bread to residents on carbohydrate controlled diets. -He tried to serve fresh fruit as desserts for residents on a carbohydrate controlled diet. -There were no other sugar free desserts available besides fruit.	D 310		

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D 310	Continued From page 55 -Residents on a carbohydrate controlled diet should be served unsweetened beverages, most of the times resident's beverages depended upon their preference. -"Residents know their diets and are allowed to choose what they want." -If residents on a carbohydrate controlled diet wanted regular desserts they could have it. -Dietary staff did not document when regular desserts were served to residents who were on carbohydrate controlled diets. -He was responsible for making sure diets were served as ordered. Interview with the Health and Wellness Director (HWD) on 09/13/19 at 11:22am revealed: -She had worked at the facility since 07/18/19. -She did not know carbohydrate controlled diets were not being served as ordered. -The DM was responsible for ensuring therapeutic diets were served as ordered. Interview with the Executive Director (ED) on 09/13/19 at 11:31am revealed: -Staff who worked in the dining hall "memorized" residents' diets for the most part. -The DM was responsible for making sure diets were served as ordered. -The DM was responsible for ordering foods to match the menus for each ordered diet. -She did not know there were no sugar free desserts available for residents on carbohydrate controlled diets. -She did not know residents on a carbohydrate controlled diet were supposed to be served sugar free beverages, but were served regular beverages. -She expected for therapeutic diets to be served as ordered by the physician.	D 310		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered by a licensed practicing practitioner for 1 of 5 sampled residents (Residents #4) related to antibiotic medications. The findings are: Review of Resident #4's current FL2 dated 06/24/19 revealed diagnoses included cognitive deficit, dysphagia, essential hypertension, atrophy of the thyroid, history of falls, anorexia,	D 358	Medication Technicians will be responsible for administering medications and treatments as ordered by a licensed prescribing practitioner and in accordance with state regulations and the policies of the community. Medication Aides will receive re-training from the HWD/Designee on expectations of Medication Administration, with a focus on new order follow-up, antibiotics, Rights of Medication Administration, and new order tracking and documentation no later than 10/31/19. Off-going Medication Technicians will complete a MAR Audit at the end of each shift to verify compliance at the end of their shift. Communication and documentation related to resident medication or care needs will be reflected on the Shift Change Report each shift. Monitoring of the New Order Tracking form will be reviewed for accuracy and completion of orders and appropriate follow-up by the Executive Director and/or designee daily for one month and will continue weekly thereafter. Monitoring includes proper administration of medications, review of new orders and medications and documentation on the Medication Administration Record (MAR).	10-31-19

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D 358	Continued From page 57 unspecified pneumonia, unspecified abdominal pain, and dysuria. a. Review of Resident #4's physician's order dated 07/16/19 revealed an order for Macrobid (a medication used to treat infection) 100 mg twice a day for 7 days. Review of Resident #4's record revealed: -On 07/15/19, a MA contacted the Primary Care Provider (PCP) via fax and requested an order for a urinalysis and culture sensitivity (UA and C/S) due to Resident #4 was experiencing increased confusion, increased urination, and she experienced a fall. -On 07/15/19, the PCP ordered a UA and C/S. -On 07/16/19 staff obtained a urine specimen and results were positive for a urinary tract infection (UTI) . -On 09/09/19, the Health and Wellness Director (HWD) contacted the PCP and obtained a telephone order for a UA and C/S due to blood noted in Resident #4's urine. Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for Macrobid 100 mg twice a day for 7 days. Observation of Resident #4's medications on hand on 09/13/19 at 4:30 pm revealed there was no Macrobid available to be administered. Telephone interview with a representative from the contracted pharmacy on 09/13/19 at 2:56 pm revealed: -The pharmacy did not receive an order dated 07/16/19 for Macrobid 100 mg twice a day x 7 days.	D 358	An audit of all medication carts, resident charts and physician orders will be completed by 10/31/19 to verify current medication and treatment orders. This will be completed monthly and as needed thereafter by the Health and Wellness Director, Resident Care Coordinator, and/or Designee(s).	10-31-19

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D 358	Continued From page 58 -The pharmacy had not filled or dispensed Macrobid for Resident #4. Interview with the medication aide (MA) on 09/16/19 at 10:40 am revealed: -She did not remember Resident #4 having a urinary tract infection in July 2019. -She did not remember Resident #4 having an order for Macrobid. -The Macrobid should have also been documented on the shift report. -Staff should have also completed a new order tracking form for the Macrobid. -She did not know why the Macrobid was not sent to the pharmacy and the medication was not administered in July 2019. Interview with a second MA on 09/16/19 at 11:05 am revealed: -She remembered Resident #4 having a urinary tract infection in July 2019. -She did not remember Resident #4 being prescribed Macrobid in July 2019. -She did not know why the Macrobid order was not sent to the pharmacy or administered. Interview with the HWD on 09/16/19 at 3:50 pm revealed: -She did not remember Resident #4 having a urinary tract infection or having an order for Macrobid in July 2019. -She was unable to locate the shift reports or the new order tracking form for 09/16/19 with the Macrobid order. Interview with the Executive Director (ED) on 09/16/19 at 4:30 pm revealed: -She did not know Resident #4 had a urinary tract infection in July 2019	D 358		

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D 358	Continued From page 59 -She did not remember Resident #4 having an order for Macrobid in July 2019. -She was unable to locate the shift reports or the new order tracking form for 09/16/19 with the Macrobid order. Attempted telephone interview with Resident #4's PCP on 09/13/19 at 3:12 pm 09/16/19 at 2:10 pm was unsuccessful. Refer to interview with the medication aide (MA) on 09/16/19 at 10:45 am. Refer to interview with a second MA on 09/16/19 at 11:15 am. Refer to interview with the HWD on 09/16/19 at 3:55 pm. Refer to interview with the Executive Director (ED) on 09/16/19 at 4:40 pm. b. Review of Resident #4's physician's order dated 07/25/19 revealed: -On 07/25/19, the Health and Wellness Director (HWD) contacted the Primary Care Provider (PCP) via fax regarding Resident #4's lower leg and foot (near foot wound) with redness, swelling, warm to touch, and resident complaining of pain. -An order for Levaquin (a medication used to treat infection) 250 mg daily x 10 days. Review of an Incident/Accident report for Resident #4 dated 07/13/19 at 6:20 am revealed: -Resident #4 had an unwitnessed fall in her bedroom. -Resident #4 was found sitting on the floor beside her bed.	D 358		

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D 358	Continued From page 60 -Staff documented a lower leg skin tear. Review of Resident #4's progress notes dated 07/13/19 revealed there was documentation of a fall with injury. Review of Resident #4's shift report notes revealed: -On 07/13/19, staff noted resident had a fall and staff noted a skin tear to the right shin. -On 07/15/19, staff noted "area on right foot burst". -On 07/27/19, all three shifts documented the Levaquin was not in the facility. Review of Resident #4's record revealed a medication aide (MA) contacted the Primary Care Provider (PCP) on 07/13/19 to report Resident #4 hit her leg on the wheelchair getting out of bed and had a skin tear noted to the right shin. Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for Levaquin 250 mg daily x 10 days. Observation of Resident #4's medications on hand on 09/13/19 at 4:30 pm revealed there was no Levaquin available to be administered. Telephone interview with a representative from the contracted pharmacy on 09/13/19 at 2:56 pm revealed: -The pharmacy did not receive an order dated 07/25/19 for Levaquin 250 mg daily x 10 days. -The pharmacy had not filled or dispensed Levaquin for Resident #4.	D 358		

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D 358	Continued From page 61 Interview with a second shift MA on 09/13/19 at 4:40 pm revealed: -She did not remember an order for Levaquin in July 2019. -She remembered Resident #4 was receiving home health services for wound care and the nurse was not able to discharge the resident in July 2019 because of a lower extremity wound. Interview with a third shift MA on 09/16/19 at 10:16 am revealed: -She remembered Resident #4 having lower extemity cellulitis in July 2019. -She did not remember an order for Levaquin in July 2019. -She did not remember documenting Levaquin was not in the facility on 07/27/19. -The MA was responsible for sending orders to the pharmacy and was expected to call the pharmacy and make sure they received the order. -The MA was responsible for making sure the medication was received from the pharmacy. -If there were any issues getting the medication, the MA should report this information off to the next shift. -She did not remember Resident #4 receiving Levaquin in July 2019 for cellulitis. -She did not know why Levaquin was not administered. Interview with a first shift MA on 09/16/19 at 10:40 am revealed: -She remembered Resident #4 having cellulitis in her lower extremity in July 2019. -She remembered the HWD had the order and was going to fax over a request for an antibiotic for the lower leg wound. -The MAs were responsible for sending over new	D 358		

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D 358	Continued From page 62 orders to pharmacy. -The Levaquin should have been put on a new order tracking form. -The Levaquin should have also been documented on the shift report. -She did not know why the Levaquin order was not sent to the pharmacy or administered to Resident #4. Interview with another first shift MA on 09/16/19 at 11:10 am revealed: -She remembered Resident #4 had cellulitis in her lower extremity in July 2019. -In the past the MA was responsible for sending orders to the pharmacy but recently the HWD preferred to send all orders. -She remembered the Levaquin order was found well after the order date in a stack of papers. -She remembered the HWD had the order for Levaquin and was going to fax the order to the pharmacy. -She never heard anything else about the Levaquin. -She did not ask about the Levaquin. -She felt the Levaquin order was not administered because it was lost in paperwork. Telephone interview with a contracted Home Health Nurse (HHN) on 09/16/19 at 12:20 pm revealed: -She treated Resident #4 for her bilateral lower extremity wounds. -She provided wound care to Resident #4 at least weekly. -She remembered she was planning to discharge Resident from nursing services but she went for a routine visit and Resident #4 had a trauma wound to her right foot. -Staff did not make her aware Resident #4 had a	D 358		

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D 358	Continued From page 63 new wound from a trauma (wheelchair hit right lower extremity on 07/13/19). -The HWD would attend at least one visit a week during dressing changes to assess the wound. -Resident #4 developed a hematoma to the right foot wound and it burst. -On 07/17/19, the wound was noted to be worse and she noted swelling of the right foot and toes. -She reported the assessment to the PCP and felt the PCP needed to assess the wound. -On 07/22/19, she asked the HWD to have the PCP assess the wound. -The wound was almost healed as of 09/13/19. -The facility staff did not inform her they had received an order for Levaquin. -She did not have Levaquin listed on her medication list. Review of Physician visit notes revealed on 07/17/19 the PCP made a face to face visit to assess Resident #4's right leg wound. Interview with the HWD on 09/16/19 at 3:50 pm revealed: -She remembered Resident #4 having cellulitis in the lower extremity in July 2019. -She assessed wounds with the contracted HHN at least once a week. -In July 2019, she noticed the right lower extremity wound appeared to have cellulitis. -She contacted the PCP the following day requesting an antibiotic but never followed up to make sure the order was sent to the pharmacy or was received to be administered. -The Levaquin order dated 07/25/19 was found at a later date not processed. -She remembered a MA having the Levaquin order. -She was not given the Levaquin order.	D 358		

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D 358	Continued From page 64 -The MA was responsible for faxing the Levaquin order to the pharmacy. -She did not follow up to make sure the Levaquin was administered or the PCP was notified the Levaquin was not administered. -She was unable to locate the shift reports or the new order tracking form for 09/16/19 with the Levaquin order. Interview with the Executive Director (ED) on 09/16/19 at 4:35 pm revealed: -She did not remember Resident #4 having cellulitis in July 2019. -She did not know Resident #4 was prescribed Levaquin for cellulitis in July 2019. -If there was an order for Levaquin, she expected staff to administer the Levaquin as ordered. -She did not know what happened to cause the Levaquin order to not be processed and not administered. -She was unable to locate the shift reports or the new order tracking form for 09/16/19 with the Levaquin order. Attempted telephone interview with Resident #4's PCP on 09/13/19 at 3:12 pm 09/16/19 at 2:10 pm was unsuccessful. Refer to interview with a first shift MA on 09/16/19 at 10:45 am. Refer to interview with another first shift MA on 09/16/19 at 11:15 am. Refer to interview with the HWD on 09/16/19 at 3:55 pm. Refer to interview with the ED on 09/16/19 at 4:40 pm.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 65 Interview with a first shift medication aide (MA) on 09/16/19 at 10:45 am revealed: -The MAs were responsible for sending orders to the pharmacy. -The Health and Wellness Director (HWD) was supposed to review the new order tracking book. -Once the medication is received from the pharmacy the order was moved to the back of the book. -At the end of each month the HWD would take the orders from the entire month. -The HWD were expected to review the new order tracking book every 2-3 days to make sure the order was sent to the pharmacy and follow up to make sure the medication had arrived at the facility. Interview with another first shift MA on 09/16/19 at 11:15 am revealed: -The MA/Supervisor was responsible for sending orders to the pharmacy. -There have been recent changes with the order process. -Recently the HWD had been receiving all orders and not all orders were completed. Interview with the HWD on 09/16/19 at 3:55 pm revealed: -The MAs were responsible for sending all new or changed orders to the pharmacy. -The MAs were responsible for completing a new order tracking form for all new or changed orders. -She did not review the new order tracking book. -No one completed eMAR to cart audits or eMAR to record audits. Interview with the Executive Director (ED) on	D 358		

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	HAL029006	A. BUILDING: _____ B. WING _____	09/16/2019

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D 358	Continued From page 66 09/16/19 at 4:40 pm revealed: -MA/HWD was responsible for faxing orders to the pharmacy. -A new order tracking form should be completed for all new or changed orders. -The shift reports and the new order tracking forms should be kept in the HWD office. _____ The facility failed to administer medications as ordered for 1 of 5 residents (#4) including antibiotics placing the resident at an increased risk for continued infection. This failure was detrimental to the health, welfare, and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 09/16/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 31, 2019.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents	D912	Resident 2, 3, and 4: HWD/Nurse Designee has re-assessed the residents for current needs and has updated each service plan to reflect the personalized care, preferences, and safety needs of each resident, including physical environment and medication administration. Re-training on the community's policies regarding Resident Rights, care, communication, and responding to resident needs will be provided to applicable associates by 10/30/19. In addition, the local Ombudsman will do an in-service on 11/26/19.	10-31-19

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D912	Continued From page 67 received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment, personal care and supervision and medication administration. The findings are: 1. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 3 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled resident (Resident #2) with dementia, who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge. [Refer to Tag 0067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 3 of 5 sampled residents (Residents #2, #3 and #4) who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge (#2) and who were disoriented and had repeated falls (#3 and #4). [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered by a licensed practicing practitioner for 1 of 5 sampled residents (Residents #4) related to antibiotic medications. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912	Medication Administration re-training with a focus on Rights of Medication Administration and following directions indicated on the Medication Administration Record will be offered to applicable associates by the HWD or DDCS no later than 10/31/19. Medication Administration classes will continue monthly and as needed thereafter. Care and safety needs of residents will be determined through personal service assessment, collaboration of care associates, community management, and third parties as indicated. Personal care will be provided according to the Personal Service Plan and will be monitored and supervised by Health and Wellness Director, Resident Care Coordinator, Executive Director, and/or Designee(s). The community shall verify that residents receive appropriate care and services in accordance with federal and state laws, rules and regulations through oversight, supervision, training and assessment/identification of care, medication, nutritional and/or safety needs. Oversight and supervision will be provided by Executive Director, Health and Wellness Director, Resident Care Coordinator, and/or Designee(s).	10-31-19

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D934	Continued From page 68	D934	Infection Control training was located for staff member "E" and has been placed in the associate's training file.	11-30-19
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 6 Medication Aides sampled (Staff A, C and E) had completed the mandatory annual infection control training. The findings are: 1. Review of Staff A's, Medication Aide (MA)/Supervisor, personnel record revealed:	D934	Staff member "A" & "C" will receive retraining from the HWD/Designee on Infection Control no later than 10/31/19. The BOC will complete an audit of current associate files to verify compliance with in the area of Continuing Education (CEs) hours. A revised compliance tracking tool was implemented upon completion for applicable associates, which includes Annual Infection Control Training. The BOC and/or Designee will monitor the tracking tool on a monthly basis for compliance. Records of training will be maintained in Business Office. The HWD and/or Designee will coordinate monthly in-services for applicable associates to obtain required CE hours, including Infection Control. The BOC and/or Designee will notify HWD, RCC and/or Designee if an associate has not met the required Continuing Education hour rule requirement.	

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D934	Continued From page 69 -Staff A was hired in 09/22/08 as a Personal Care Aide (PCA) and later became a MA and Supervisor in 2014. -There was documentation Staff A had completed the annual infection control training on 04/23/14, 11/13/15, and 12/14/16. -There was no documentation Staff A had completed infection control training since 12/14/16. Interview with Staff A on 09/16/19 at 3:02pm revealed: -She had worked at the facility for 11 years. -She administered medications, checked fingerstick blood sugars, and gave insulin injections. -She did not remember when she last had infection control training. Interview with the Executive Director (ED) on 07/26/19 at 5:15pm revealed: -The Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) were responsible for making sure infection control training was completed yearly for staff. -She thought there had been an infection control training at the end of last year, but she did not know if Staff A participated. -She did not know there was no documentation of a current infection control training in Staff A's personnel record. 2. Review of Staff C, Medication Aide (MA)/Supervisor, personnel record revealed: -Staff C was hired on 05/05/16 as a Personal Care Aide (PCA) and later became a MA and Supervisor 2018. -There was documentation Staff C completed infection control training on 08/08/18.	D934	The HWD, RCC and/or Designee will review the associate's needs, schedule applicable training, and competency, or will take measures to remove associate from their assignment/position until the required training is complete.	11-30-19

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D934	Continued From page 70 -There was no documentation Staff C completed infection control training in 2019. Interview with Staff C on 07/26/19 at 11:55am revealed: -She had worked at the facility since 2016. -She administered medications, checked fingerstick blood sugars, and gave insulin injections. -She had not completed infection control training after she became a MA, and did not remember if she had another infection control training. Interview with the Executive Director (ED) on 07/26/19 at 5:15pm revealed: -The Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) were responsible for making sure infection control training was completed yearly for staff. -She thought there had been an infection control training at the end of last year, but she did not know if Staff C participated. -She did not know there was no documentation of a current infection control training in Staff C's personnel record. 3. Review of Staff E's Medication Aide (MA) personnel record revealed: -Staff E was hired on 05/09/19. -There was no documentation Staff E had completed infection control training. Attempted telephone interview with Staff E on 09/16/19 at 5:54pm was unsuccessful. Interview with the Executive Director (ED) on 07/26/19 at 5:15pm revealed: -The Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) were	D934		

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D934	Continued From page 71 responsible for making sure infection control training was completed yearly for staff. -She did not know there was no documentation of infection control training in Staff E's personnel record or if Staff E had initial infection control training.	D934		