STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	C 08/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Davidson County Department of Social Services conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 07/16/20 and a desk review survey on 07/17/20 to 08/07/20 with a telephone exit on 08/07/20.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 7 of 42 shifts sampled	D 167	The Administrator reviewed the rule .0507 training on CPR with the Director on 8/7/20 to ensure understanding. Director reviewed employee files on 08/07/20 to obtain accurate list of employees who had completed CPR. Director reviewed schedules to make sure each shift has at least one person with CPR training on each shift. CPR class was scheduled for additional staff to be trained on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver. 8/12/2020 - 9/1/2020 multiple staff members were trained in CPR with cards on file at facility. Employee files will be reviewed by the Director/Administator for CPR training to ensure adequate training to include one staff member per shift. Staff Schedules will be monitored by the Director/ Administrator to ensure one staff member per shift is trained in CPR. Monitoring will be done biweekly x 3, monthly x 3, then quarterly thereafter using a monitoring tool designed by the Administrator. Monitoring will be kept at the facility for review.	9/21/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Garner — TITLE: ADMINISTRATOR — (X6) DATE: 09/21/2020

Received 11/18/20
Reviewed and accepted 11/19/20 Jo Scarlett, RN

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D 167	Continued From page 1 for 14 days from May 2020 through July 2020. The findings are: Review of 6 personnel records revealed: -Six of 6 staff (Staff A, B, C, D, E, and F) had no documentation of completing a course in CPR in the past 24 months. -Three of 6 staff (Staff B, C, and D) worked on shifts where there was no other CPR certified staff coverage during the sampled days in May 2020, June 2020, and July 2020. Review of staffing time cards for 05/1/20, 05/12/20, 06/15/20, 06/16/20, 06/19/20, 06/26/20, 06/29/20, and 07/03/20 through 07/09/20 revealed: -The facility had 3 shifts: first shift was 7:00 am-3:00 pm, second shift was 3:00 pm-11:00 pm, and third shift was 11:00 pm-7:00 am. -There were no staff on each shift per day who had training on cardio-pulmonary resuscitation (CPR) and choking management for 7 of 42 shifts. 1. Review of Staff B, personal care aide's (PCA) personnel record revealed: -Staff B was hired on 08/14/19. -There was no documentation Staff B had completed training on CPR within the last 24 months. Review of staffing time cards dated 05/01/20, 06/15/20, 06/26/20, 06/29/20, and 07/04/20 revealed: -Staff B worked 8 hours on third shift (11:00 pm-7:00 am) on all 5 dates. -There was no staff who worked with Staff B on third shift who had current CPR training.	D 167	**** **** **** **** **** **** THIS PAGE INTENTIONALLY LEFT BLANK **** **** **** **** **** **** ****	

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D 167	Continued From page 2 Telephone interview with Staff B on 08/06/20 at 9:32 am revealed: -She had CPR training prior to working at the facility. -Her CPR certification had expired, but she did not know when. -She had not had CPR training since she started working at the facility. Telephone interview with the Director on 08/07/20 at 1:15 pm revealed: -She talked to Staff B and B and found out her CPR certification expired in 2018. -She had never had a copy of Staff B's CPR card, but she thought Staff B had CPR certification. -She was responsible for ensuring staff had CPR certification. -Staff B was scheduled for in-house CPR training prior to the COVID-19 outbreak, but the facility postponed the training. -Staff B was scheduled on shifts as the staff with CPR certification. Telephone interview with the Administrator on 08/07/20 at 3:51 pm revealed: -She took Staff B's word that she had current CPR certification when she was hired in August 2019. -She never received a copy of Staff B's CPR card. -She did not know Staff B did not have current CPR certification. Refer to telephone interview with the Director on 08/06/20 at 1:46 pm. Refer to telephone interview with the Director on 08/07/20 at 11:25 am. Refer to telephone interview with the	D 167	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 167	Continued From page 3 Administrator on 08/06/20 at 5:05 pm Refer to telephone interview with the Administrator on 08/07/20 at 3:52 pm. 2. Review of Staff C, medication aide's (MA) personnel record revealed: -Staff C was hired on 03/14/19. -There was no documentation Staff C had completed training on CPR within the last 24 months. Review of staffing time cards dated 06/29/20, and 07/09/20 revealed: -Staff C worked 3.5 hours on second shift (3:00 pm-11:00 pm) on 06/29/20. -There was no staff who worked on second shift (the whole shift) who had current CPR training. -Staff C worked 3 hours on second shift (3:00 pm-11:00pm) on 07/09/20. -There was no staff who worked on second shift (the entire shift) who had current CPR training. Telephone interview with Staff C on 08/07/2020 at 9:28 am revealed: -She had CPR training before, but she did not remember when or if it was expired. -She had not had CPR training since she started working at the facility, 03/14/19. -She had signed up for a CPR class at the facility in 2020 before COVID-19 hit, but the class was canceled. -The Director or the Administrator were responsible for creating the schedule and making sure staff had CPR certification. Telephone interview with the Director on 08/07/20 at 1:15 pm revealed: -She knew Staff C did not have CPR certification. -Staff C was scheduled to take a CPR class, but	D 167	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 167	Continued From page 4 the facility did not conduct the training due to COVID-19. Refer to telephone interview with the Director on 08/06/20 at 1:46 pm. Refer to telephone interview with the Director on 08/07/20 at 11:25 am. Refer to telephone interview with the Administrator on 08/06/20 at 5:05 pm. Refer to telephone interview with the Administrator on 08/07/20 at 3:52 pm. 3. Review of Staff D, medication aide's (MA) personnel record revealed: -Staff D was hired on 01/10/20. -There was no documentation Staff D had completed training on CPR within the last 24 months. Review of staffing time cards dated 06/29/20, and 07/09/20 revealed: -Staff D worked 8 hours on second shift (3:00 pm-11:00 pm) on 06/29/20. -There was no staff who worked on second shift (the entire shift) who had current CPR training. -Staff D worked 8 hours on second shift (3:00 pm-11:00pm) on 07/09/20. -There was no staff who worked on second shift (the entire shift) who had current CPR training. Telephone interview with Staff D on 08/06/20 at 4:15 pm revealed: -She was hired in January of 2020 as a personal care aide (PCA) and became a MA in June 2020. -Her CPR certification expired in 2018. -She was not told she needed to complete CPR certification when she was hired.	D 167	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 167	Continued From page 5 -She had signed up for the CPR class that was scheduled for March or April, but it was canceled due to the COVID-19 outbreak. -She thought MAs were supposed to be CPR certified. -The Director was responsible for scheduling staff on each shift with CPR certification. Telephone interview with the Director on 08/07/20 at 1:15 pm revealed: -She knew staff D did not have CPR certification. -Staff D was scheduled to take a CPR class, but the facility did not conduct the training due to the COVID-19 outbreak. Refer to telephone interview with the Director on 08/06/20 at 1:46 pm. Refer to telephone interview with the Director on 08/07/20 at 11:25 am. Refer to telephone interview with the Administrator on 08/06/20 at 5:05 pm Refer to telephone interview with the Administrator on 08/07/20 at 3:52 pm. _____ Telephone interview with the Director on 08/06/20 at 1:46 pm revealed: -She was responsible for creating the schedules. -She was aware there needed to be at least one person on every shift who was CPR certified. -She was responsible for ensuring there was one staff on every shift with CPR certification. -CPR trainings were scheduled quarterly and were conducted by the Administrator. -The last in-house CPR training was in 2018 and the Administrator taught the class. Telephone interview with the Director on 08/07/20	D 167	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 167	Continued From page 6 at 11:25 am revealed: -She made the staff work schedules to include a staff on each shift that had current CPR training. - A copy of their new CPR card was placed in their personnel folder after each training. -She made an audit of the personnel records quarterly and was responsible for keeping them up to date. -She did the last quarterly review in April or March of this year but did not notice if any staff CPR cards were missing. -One staff that was scheduled for 3rd shift CPR coverage on 05/01/20, 06/15/20, 06/16, 06/26/20 and 06/29/20 had a CPR card but she was not sure if the training had expired. -After checking with Staff B, the expiration date on her card was August 13, 2018. -She did not check Staff B's personnel file to see if her CPR training was up to date. -She kept an itemized list of staff that had CPR training; she needed to have more staff CPR certified. -It had been difficult to have CPR classes because of the COVID-19 outbreak. -The Administrator was responsible for scheduling the CPR classes. -She was responsible for assuring staff CPR records were up to date. Telephone interview with the Administrator on 08/06/20 at 5:05 pm revealed: -The requirement for CPR coverage was to have 1 staff on each shift inside the building. -The Director made the schedules and she checked them about every other cycle. -Discussions were held with the Director and staff personnel folders were reviewed every 4-5 months. -The staff folders have not been reviewed since March.	D 167	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 167	Continued From page 7 -She was not notified by the Director of any current staff that do not have current CPR certification or she would have sent them to a class. -She was responsible for assuring staff were currently CPR certified and there were CPR trained staff scheduled on all shifts. Telephone interview with the Administrator on 08/07/20 at 3:52 pm revealed: -She conducted CPR classes at the facility for staff. -She had planned to conduct a CPR class at the beginning of 2020, but it was canceled due to COVID-19. -The last CPR class she conducted was in 2018. -She did not know of any staff who had expired CPR certifications. _____ The facility failed to assure there was staff on duty who had training on CPR and choking management in the last 24 months for 7 of 42 shifts sampled for 14 days from May 2020 through July 2020, resulting in there being no staff available to perform lifesaving measures in the event of an emergency. The 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 for this violation on on 08/03/20 . CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2020.	D 167	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing	D 188	*** SEE NEXT PAGE FOR POC ***	

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D 188	Continued From page 8 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff	D 188	The Administrator/Director has reviewed staffing guidelines per DHSR rules and regulations. The Administrator/Director has reviewed current schedules/staffing availability at the facility both in the ACH and the SCU. Schedules will be prepared to ensure staffing per DHSR Rules and Regulations. The Administator/Director will monitor staffing in the adult care assisted living side of the facility to ensure adequate staffing per DHSR regulations. Schedules and staffing will be reviewed by the administrator to ensure adequate staffing weeking x 3, biweekly x 3, monthly x 3 then quarterly therafter using a monitoring form and will be kept at the facility for review.	09/06/2020

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D 188	Continued From page 9 if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 5 of 42 shifts sampled for 14 days from May 2020 through July 2020. The findings are: Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living (AL) with a capacity of 75 beds and a Special Care Unit (SCU) with a capacity of 16 beds. 1. Review of the Resident Daily Census report dated 05/01/20 revealed there was a census of 38 residents, which required 16 aide hours on third shift. (There was a Supervisor/MA within 500 feet of the facility.) Review of the individual time cards dated 05/01/20 revealed there were 8 total aide hours provided on third shift. There was a shortage of 8 aide hours. Refer to telephone interview with a Personal Care Aide (PCA) on 08/03/20 at 11:48 am.	D 188	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 188	Continued From page 10 Refer to telephone interview with a PCA on 08/04/20 at 2:55 pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:08 pm. Refer to telephone interview with the Director on 08/07/20 at 1:09 pm. Refer to telephone interview with the Administrator on 08/07/20 at 4:06 pm. 2. Review of the Resident Daily Census Report dated 06/16/20 revealed there was an AL census of 38 residents, which required 16 staff hours on third shift. Review of individual time cards dated 06/16/20 revealed 8 staff hours were provided on third shift, leaving the shift short 8 hours. Refer to telephone interview with a Personal Care Aide (PCA) on 08/03/20 at 11:48 am. Refer to telephone interview with a PCA on 08/04/20 at 2:55 pm. Refer to telephone interview with the resident care coordinator (RCC) on 08/03/20 at 2:08 pm. Refer to telephone interview with the Director on 08/07/20 at 1:09 pm. Refer to telephone interview with the Administrator on 08/07/20 at 4:06 pm. 3. Review of the Resident Daily Census report for July 2020 revealed there was a census of 37 residents in the Assisted Living (AL) on 07/04/20 and 07/05/20 which required 16 aide hours on	D 188	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 188	Continued From page 11 second shift and 16 aide hours on third shift. Review of staff timecards for second shift on 07/04/20 revealed: -A personal care aide (PCA) worked six hours. -A medication aide (MA) worked six hours. -There was 10 total aide hours for the AL unit. -There was a shortage of 6 aide hours. Review of staff timecards for third shift on 07/04/20 revealed: -There was 8 total aide hours for the AL unit. -There was a shortage of 8 aide hours. Telephone interview with a PCA on 08/04/20 at 2:51 pm revealed: -She worked third shift on 07/04/20. -She was the only PCA on the AL unit that night. Review of staff timecards for third shift on 07/05/20 revealed: -There was 11.75 total aide hours for the AL unit. -There was a shortage of 4.25 aide hours. Telephone interview with a PCA on 08/04/20 at 2:55 pm revealed: -She worked the night of 07/05/20 and there were 3 other staff members working. -There was one PCA in the SCU that had stayed over from second shift and 2 PCA's for the AL unit. -The PCA on the SCU had to leave emergently prior to the end of the shift. -When the PCA who had been assigned to the SCU left, there was only one PCA for each unit. -She went to the SCU and the other PCA stayed on the AL unit. Telephone interview with another PCA on 08/06/20 at 11:50 am revealed:	D 188	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 188	Continued From page 12 -She worked on third shift on 07/05/20. -There were 3 PCAs in the building, one on the SCU and 2 on the AL unit. -The PCA on the SCU had to leave during the middle of the shift. -After she left there were 2 PCAs in the building: one on AL and one in the SCU. Refer to telephone interview with a Personal Care Aide (PCA) on 08/03/20 at 11:48 am. Refer to telephone interview with a PCA on 08/04/20 at 2:55 pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:08 pm. Refer to telephone interview with the Director on 08/07/20 at 1:09 pm. Refer to telephone interview with the Administrator on 08/07/20 at 4:06 pm. _____ Telephone interview with a Personal Care Aide (PCA) on 08/03/20 at 11:48 am revealed: -She has worked short staffed on first and second shift on both units. -When staff called out the medication aide (MA) on duty had to fill the call out. -She did not know what happened if the MA could not find coverage. -The MA's are responsible for reporting the call out to the RCC and the Director. Telephone interview with a PCA on 08/04/20 at 2:55 pm revealed: -Sometimes halls were left unattended when there was only 1 staff working on each unit because some residents were a 2 person assist. -When there were only 2 PCAs on third shift,	D 188	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 188	Continued From page 13 sometimes she could not get around to check restraints every 30 minutes because of helping another resident. -She would check restraints as soon as she had finished providing care to the resident she was currently working with. -Sometimes it would be 45 minutes between checks. -There was no PCA to cover the halls on third shift when you had to do a 2 person assist with a shower. Interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:08 pm revealed: -MA's were responsible for filling call-outs, and if they could not find coverage then a staff member (PCA or MA) had to stay: a PCA usually volunteered to stay and work the next shift. -She had worked short on second and third shifts and it happened more than once. -A month or so ago it was frequent to be short staffed. -She was on call and if staff needed anything, she was available. Telephone interview with the Director on 08/07/20 at 1:09 pm revealed: -She was responsible for making the staff schedules. -She knew the facility had been short staffed some shifts but there were other shifts that were short staffed that no one let her know until after the fact. -The MAs took the calls when staff called out. -MAs were responsible to fill the shift in which a PCA had called out: they had to call other PCAs to find coverage; if no one was available a PCA or MA from the current shift had to stay to work as a PCA. -She posted the schedule a week in advance.	D 188	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 188	Continued From page 14 -She made the schedule according to what the administrator told her, based on the current census. -She had worked many shifts in which they were short including third shift. -The Administrator reviewed her schedule about every 2 weeks. -She tried to schedule 5 PCA's on first and second so that they would still be covered if someone called out. -The RCC and herself were on call. -When she had problems, she would go to the Administrator, but she was still ultimately responsible for staffing. Telephone interview with the Administrator on 08/07/20 at 4:06 pm revealed: -The Director was responsible for making the schedule. -She periodically reviewed the schedule (every other schedule). -She discussed any concerns with the Director. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. The facility failed to assure the minimum number of staff were present at all times to meet the needs of residents for 5 of 42 shifts sampled for 14 days from May 2020 through July 2020 resulting in the death of a resident by her falling into the half bed rail and asphyxiated and a resident having multiple falls resulting in hematoma's on his head and a skin tear. This failure resulted in death and serious physical harm and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/20 for	D 188	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 188	Continued From page 15 this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED September 6, 2020.	D 188		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to provide adequate supervision for 5 of 5 sampled residents who had half bed rails (Residents #1, #2, #3, #4, and #5) and 3 of 5 residents (Resident #1, #3, and #4) with a history of falls. The findings are: 1. Review of Resident #1's current FL2 dated 01/03/20 revealed: -Diagnoses included dementia, stroke, hypertension, and osteoporosis. -The resident was semi-ambulatory with a wheelchair. -The resident was intermittently disoriented. Review of Resident #1's physician's order for restraints dated 03/03/20 revealed: -The reason for the restraint was documented as	D 270	Facility Director will provide training to staff on personal care and supervision, emphasizing importance on rounds, 2 hour checks, 30 min checks, and the importance of responding to accidents and incidents involving residents and providing care and intervention (even with those involving DNRs). Initial training done with staff 7/24/2020. Facility will arrange training with outside provider to train staff on Personal care and supervision emphasizing checking on residents frequently and importance of responding to accident and incidents involving a resident and providing care and intervention. Facility will develop a system to monitor the staff and will monitor weekly x 3, biweekly x 3, monthly x 3, then quarterly thereafter. Documentation will be kept at the facility for review.	09/06/2020

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D 270	Continued From page 16 mobility enhancement and fall prevention. -The type of restraint to be used was half bed rails. -The time period for the restraint to be used was documented as while in bed. -The time interval for the restraint to be checked was every 30 minutes and loosened and released every 2 hours. Review of Resident #1's Resident Register revealed an admission date of 01/03/20. Review of Resident #1's assessment and care plan dated 05/13/20 revealed: -It was a significant change assessment in which the resident no longer qualified for Hospice. -The resident was sometimes disoriented. -The resident had significant memory loss, required direction, and was non-verbal. -The resident was ambulatory with a wheelchair with assistance by staff. -The resident had limited range of motion in her upper extremities. -The resident was totally dependent on staff for all activities of daily living. -Half bed rails and wheelchair were written in the "Other section" without any corresponding days of use or level of assistance required. Review of Resident #1's Hospice care plan update dated 07/03/20 revealed: -The start of care date was 06/11/20. -The primary diagnosis was dementia with expressive aphasia. -Level of care was domiciliary. -The resident was wheelchair bound. -The resident was dependent for all activities of daily living (ADLs). -The resident had loss of trunk control and was not able to hold herself erect in a wheelchair.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 17 -The resident was sleeping 20+ hours per day. -The resident often fell asleep when not stimulated. Review of Resident #1's Hospice service note dated 06/30/20 revealed: -The resident usually stayed awake a few moments then fell back to sleep. -The resident was unable to make her needs known so staff had to anticipate her needs. Review of Resident #1's Restraint Care Plan dated 01/03/20 revealed: -Alternatives had failed. -The least restrictive type of restraint that would provide safety was half bed rails. -Care to be provided to the resident during the time the resident was restrained was left blank. -Time checks should be every 30 minutes loosening every 2 hours. -Special instructions remained blank. -The family member's name was written in attesting she had been informed of the recommendations of the use of a physical restraint and she had a right to refuse such treatment. -The " I agree" statement had been circled. -There were 3 signatures: The Director, Resident #1's family member, and the physician. a. Review of Resident #1's Accident/Incident report dated 07/06/20 revealed: -A first shift medication aide (MA) completed the report. -The date of accident/incident was documented as 07/06/20. -There was not a time documented for the incident. -A personal care aide (PCA) had come to her and told her that the resident had fell out of bed.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 18 -The resident's head was wedged between the bed and the rails. -The resident did not have a pulse. -She notified Hospice and the Director of what happened. Review of the facility's video footage on the night of 07/05/20 - the morning of 07/06/20 revealed: -The facility's camera time stamp was 19 minutes fast. -At 2:03 am 2 staff, both PCAs, entered Resident #1's room. -At 2:03:32 am one of the PCAs left Resident #1's room and went into the hallway and entered the laundry room, located on the same side of the hallway. -At 2:06:20 am one PCA re-entered Resident #1's room. -At 2:08:13 am one PCA left Resident #1's room again and threw something away, then left the hallway. -At 2:13:34 am the other PCA left Resident #1's room and threw something away then re-entered at 2:13:45 am. -At 2:15:13 am the PCA walked out of Resident #1's room on her cell phone. -The PCA remained on her cell phone in Resident #1's doorway until she re-entered Resident #1's room at 2:18 am. -At 2:32:21 am the second PCA returned to and entered Resident #1's room. -Both PCAs left Resident #1's room at 2:37:57 am and left the hallway. -One PCA was observed on video in the day area from 2:41 am until 3:09 am. -At 6:51:34 am the assisted living (AL) PCA stuck her head inside of Resident #'1 room and continued to look until 6:51:45 am when she turned around stepped back into the hallway and closed the door then paused.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 19 -The AL PCA went into the room directly across from Resident #1 and remained in their until 7:03:51 am. -At 7:04:11 the AL PCA returned to Resident #1's room. She was observed turning on the light and stepping partially into the room. -At 7:04:11 the AL PCA went to get help and returned with 2 other staff at 7:06:00 am. -At 7:06:57 a staff was seen running from the room. -At 7:12:04 am all staff members were seen walking out of Resident #1's room shutting the door behind them. Observation on 07/16/20 of Resident #1's room at 11:22 am revealed: -A hospital bed with half bed rails attached to both sides, of the head of the bed, in an up position. -The bed was next to the wall separated by the heating/air conditioning unit. -There was a soiled stain approximately 2 feet in diameter on the bottom sheet midway to the left side of the mattress. -There were small smeared blood stains just below the pillow and at the foot of the bed. -There were 5 inches between the mattress and the half bed rail with the bed rails in the up position. Telephone interview with a PCA on 08/06/20 at 11:50 am revealed: -She worked on third shift the night of 07/05/20 and morning of 07/06/20. -She and one other staff worked together until around 3:00 am when the Special Care Unit (SCU) staff had to leave emergently. -The other staff went to work in the SCU around 3:00 am and she remained in the AL unit by herself. -She was trained to do rounds at 1:00 am, 3:00	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 20 am, and 5:00 am. -Sometimes she made rounds at 2:15 am and not again until 5:00 am. -When she was trained, she was told she could watch movies to help her stay awake. -The bed rails were up the night of Resident #1's death on 07/05/20. -On the night of 07/05/20 she had gone to the television area and watched a movie on her phone. -She was doing rounds, but could not recall the time, when she entered Resident #1's room and observed her head wedged between the half bed rail and bed frame and her bottom and legs on the floor. -She got scared and walked out, without calling for assistance, then assisted the resident across the hall. -She then went back into Resident #1's room and then went to get help. -She made her last rounds when the other staff had patched Resident #1's knee (did not recall the time). -On her next round around 5:45 am she found the resident with her head wedged in the bed rail. -She was told she did not check on Resident #1 for 4 hours and 15 minutes, but it did not seem like that much time to her. -She had never worked on the assisted living (AL) unit by herself until the night of 07/05/20. -She had worked at the facility about 3 weeks. -Resident #1 had the strength to pull herself up in bed and turn herself using the half bed rails. Telephone interview with PCA on 08/04/20 at 2:55 pm revealed: -She worked third shift the night of 07/05/20. -She and another PCA worked on the AL unit until around 3:00 am when the PCA in the SCU had to leave emergently.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 21 -She then went to finish her shift in the SCU, which left one PCA by herself on the AL unit. -The AL unit PCA had worked at the facility about 1 month. -She had trained the AL unit PCA, a total of 4 nights and someone else trained AL unit PCA on her first night. -The AL unit PCA was instructed and trained to make rounds every 2 hours on everyone and then every 30 minutes for residents with half bed rails. -Sometimes halls were left unattended when there was only 1 PCA working on each unit because some residents were a 2 person assist. -Another staff informed her Resident #1 was found deceased at 7:00 am on 07/06/20. -When she was cleared to leave the SCU after her shift, she went to AL unit and saw Resident #1 with her neck embedded in the half bed rail and her head wedged between the half bed rail and the bed frame with her bottom and legs on the floor. Interview with a medication aide (MA) on 07/16/24 at 1:46 pm revealed: -She wrote the incident report for Resident #1 on 07/06/20. -On her way to work on the morning of 07/06/20, her phone kept ringing, but she could not answer it as she was driving. -When she arrived at the facility, a staff came running out of the building and told her Resident #1 was not breathing. -She ran to Resident #1's room and checked her pulse at her neck and her wrist. -Resident #1's bottom was on the floor while her head was wedged between the half bed rail and the bed frame. -She called the Director and informed her, but then recalled Resident #1 was on hospice services, so she notified Hospice of her death.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 22 Hospice notified the family of her death. -She took a picture of Resident #1 before she and 3 PCAs put her back in the bed. -She had to remove the half bed rail to get the resident back into bed. -She moved her because she did not want Resident #1's family to see her with her head wedged between the bedrail and the bed frame. -Resident #1's feet had a bluish tint to them. -The Hospice nurse called the police while attempting to contact the coroner. -She did not know if an internal investigation was completed. Interview with the Director on 07/16/20 at 2:11 pm revealed: -Resident #1's death occurred on 07/06/20. -She received a text from staff at 6:55 am stating Resident #1 was found without a pulse so she advised them to contact hospice. -She instructed the staff not to move the resident. -She then received a phone call at 7:45 am from staff advising her that Hospice was on their way and had notified the family. -The Hospice nurse called the medical examiner after staff had showed her the picture of how Resident #1 was found. -She believed Resident #1 died while sitting on the side of the bed because her feet and hands were purple and then she fell into the rail. -The day shift MA had arrived at the facility, so the on-call MA was not notified of the incident. -Staff A had found Resident #1. -Rounds were supposed to be made every 2 hours on all residents. -Residents with half bed rails or other restraints were supposed to be checked every 30 minutes. -A second shift PCA had stayed over on third shift because they were short staffed. -The Detective showed her the long period in	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 23 which no one checked on Resident #1. -The Detective made her aware of Staff B pre-documenting the restraint check logs for 1 day. -Staff B was just tired and pre-documented unknowingly. -Resident #1 required assistance with dressing. -Resident #1 was heavy and did not like to bare weight. Interview with a detective with the local law enforcement office on 07/21/20 at 2:24 pm revealed: -Resident #1 was found deceased in her room at the facility. -She appeared to have been hung/strangulated by a half bed rail in which her neck had became wedged between the half bed rail and bed frame with her bottom and lower extremities on the floor. -Staff did not call 911 because Resident #1 was a Hospice resident. -Staff notified the Hospice nurse of Resident #1's death and Hospice notified the residents' family. -Staff moved Resident #1's body prior to Hospice arriving because they did not want Resident #1's family to see her in the half bed rail. -Staff took a picture of Resident #1 with her head wedged between the half bed rail and the bed frame with her bottom and legs on the floor prior to putting her back on the bed. -When the Hospice nurse arrived and staff showed her the picture of how Resident #1 was found, she called the local medical examiner. -There were 3 staff who had worked on third shift the night of 07/05/20 and one staff had to leave emergently around 3:00 am leaving only 2 staff present in the building. - One staff finished the night out in the locked unit and the other staff worked on the assisted living	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 24 unit. -The detectives reviewed the camera footage and determined the video footage was 19 minutes fast. -Two staff left Resident #1's room at 2:37 am and no one returned to her room until the AL staff stuck her head inside Resident #1's room at 6:51 am and looked inside for 11 seconds then she turned around stepped back into the hallway then went into the room directly across from Resident #1. -The AL staff stayed in the room across the hallway until 7:03 am. -After 14 minutes the AL staff returned to Resident #1's room at 7:04 am and turned on the light and stepped partially into the room. -At 7:04 am she then left and went to get help and brought 2 other staff to Resident #1's room at 7:06 am. -At 7:06 am one staff member immediately ran from the room. -At 7:12 am all staff were seen walking out of Resident #1's room closing the door behind them. -The facility should had called 911 and should not have moved the body. -The medical examiner believed the resident tried to get out of bed and fell into the rail hanging/strangulating herself while trying to get up. -Resident #1 had a deep indentation in her right neck (ligature marks) from being embedded in the half bed rail and extensive bruising was present. Telephone interview with the local Medical Examiner on 08/03/20 at 3:41 pm revealed: -He had been notified of Resident #1's death by the Hospice nurse who told him the resident was hung/strangled on the half bed rail. -When he arrived at Resident #1's room he saw	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 25 definite impression of the bed rails on the right side of her neck with bruising present. -He reviewed the video footage, and no one had checked on Resident #1 for 4 hours and 15 minutes. -He filled out the death certificate with asphyxia being the immediate cause of death and under description he listed hung/strangulated while getting/falling out of bed. Interview with the Administrator on 08/07/20 at 4:06 pm revealed: -She had received a text around 8:00 am that Resident #1 had passed away. -She then received another text stating the Resident #1 had fell. -Then she received a third text stating staff had placed Resident #1 back on the bed. -After that she received a phone call from the Director who was "hysterical" stating that the MA had sent her a photo of Resident #1 with her head/neck caught between the half bed rail and the bed frame. -Resident #1 appeared in the photo as having been hung on the half bed rail. -Staff did not call 911 because Resident #1 was on Hospice. -The MA called Hospice. -She was informed that when hospice arrived at the facility and saw the photo, she called 911 with the Director. -If the Director saw the picture first, she would had called 911 immediately. -The officers made her aware there was 4 hours and 15 minutes that Resident #1 was not checked on. -Resident #1 should have been checked on every 30 minutes because she had a half bed rail. -The Director or herself were not notified when one staff had to leave emergently.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 26 -Staff could have their phone on their person so they could easily call other staff for help in the middle of the night. -She had never given staff permission to use their phones to stay awake on third shift. -She expected staff to make 30-minute rounds on residents who had half bed rails. Attempted interview with Resident #1's family on 07/22/20 at 1:35 pm was unsuccessful. b. Review of Resident #1's Restraint Check Log between 05/01/20 and 05/04/20 revealed: -Resident #1 was to be checked every 30 minutes. -On 05/01/20 there were no documented 30-minute checks for sixteen hours on first and second shifts. -On 05/02/20 and 05/03/20, there were no documented 30-minute checks for 8 hours on first shift. Resident #1's Restraint Check Log between 07/03/20 and 07/05/20 was not made available for review. Review of Resident #1's Restraint Check Log on 07/06/20 - 07/08/20 revealed: -On 07/06/20 documentation had been completed for all shift by staff, a personal care aide (PCA) who worked on the assisted living (AL) unit until 3 am at which time she was moved to the special care unit (SCU) to complete her shift. -On 07/07/20 and 07/08/20 the restraint check log documentation had been pre-charted for third shift by a PCA. Telephone interview with a PCA on 08/06/20 at 11:50 am revealed: -She worked with Resident #1 on the night of	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 27 07/05/20 and the morning of 07/06/20. -Resident #1 held to the bed rail when staff provided personal care. -She did not recall how long the resident had half bed rails. -The bed rails were up the night of 07/05/20 and morning of 07/06/20 when Resident #1 died. -She was not "really" trained on the use of bed rails. -She did not know to check on Resident #1 every 30 minutes. -She was trained for 3 days when she was hired. -She had never signed a restraint check log and had never seen it. -She was never trained on restraints by the facility. -She did not know who was responsible to fill out the restraint check log. -After the incident she knew to check on the residents more often. Telephone interview with a PCA on 08/04/20 at 2:55 pm revealed: -She was "kind of, sort of trained on restraints" at the facility. -She was previously trained on restraints while working at another facility. -She knew she was supposed to check on the resident with half bed rails every 30 minutes or as soon as she could get there. -The PCAs were responsible for checking on the residents. -The staff that worked on the AL unit the night of 07/05/20 had been trained 5 days. -She trained the other PCA how to check Resident #1 every 30 minutes. -She filled out the restraint check logs when she and the other PCA worked together because the other PCA said she did not know how to do them, but she had been trained to do them.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 28 -On the night of 07/05/20 and morning of 07/06/20 she had taken the restraint check logs back to the SCU with her to do them because the AL staff again said she did not know how to do them. -She had filled out the documentation for Resident #1's restraint check log 1 day in advance the night she had passed away. -She knew she was not supposed to fill out documentation in advance (but did not give a reason as to why she did). Interview with the Director on 07/16/20 at 2:11 pm revealed: -Rounds were supposed to be made every 2 hours on all residents and residents with half bed rails or other restraints were supposed to be checked every 30 minutes. -The Detective made her aware of Staff B pre-documenting the restraint check logs for 1 day after Resident #1 passed away. -The SCU PCA was just tired and pre-documented unknowingly. Telephone interview with the Director on 08/06/20 at 10:25 am revealed: -The PCAs were responsible for completing and documenting restraint checks. -The PCAs were trained on how to complete the form by senior PCAs and herself when hired. -There was no policy and procedure in place for documenting restraint checks. -It was her responsibility to ensure the restraint checks were being completed and documented. -If a PCA did not complete the restraint check log she addressed it with the responsible PCA and disciplinary procedures were taken when needed. -If the restraint check log was not signed it meant the restraint check was not done.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 29 Telephone interview with Resident #1's Hospice nurse on 08/06/20 at 12:42 pm revealed: -Resident #1 had a regular bed when she was admitted to Hospice on 06/11/20. -An electric hospital bed was delivered to the resident at the facility on 06/12/20. -Resident #1's family member had requested bed rails on 07/02/20. -Half bed rails were placed on Resident #1's bed on 07/03/20. -Hospice did not assess the resident for the ability to put the rails up and down. -Hospice did not assess for the ability of the resident to extricate herself from the half bed rails should she become entangled. Telephone interview with Resident #1's primary care provider (PCP) on 08/06/20 at 11:26 am revealed: -She did not know half bed rails were a physical restraint. -She expected staff to complete the restraint checks as ordered. Telephone interview with the Administrator on 08/07/20 at 4:06 pm revealed: -She did not know Resident #1 had been on a regular bed between 05/04/20 and 06/12/20. -She believed the resident had continued to have the same bed and half bed rails as when she was on Hospice the first time. -PCAs should have checked on residents with bedrails every 30 minutes and documented the 30-minute checks in the restraint check log notebook. -There was a sample restraint log in the front of the restraint log notebook that the PCAs should have used as a guide. -Instead of documenting where the resident was if the resident was not in the bed, PCAs were	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 30 leaving the 30-minute restraint log blank for the time when the residents were not in bed. -Staff should have documented 30-minute checks at the end of their shift or at the beginning of their shift. -She had instructed staff to review the 30-minute restraint check logs and fill them in if they were missing documentation from previous days. -The Director was ultimately responsible for ensuring staff was checking on residents. Attempted interview with Resident #1's family on 07/22/20 at 1:35 pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 09/20/19 revealed: -Diagnoses included dementia, dysphagia, symbolic dysfunction, depression, anxiety, and osteoarthritis. -The resident's level of care was Special Care Unit (SCU). -The resident was semi-ambulatory with a walker. -The resident was constantly disoriented. -The resident required total care for her personal care. -There was no physician's order for bed rails. Review of Resident #2's Care Plan dated 04/10/20 revealed: -It was a significant change assessment and care plan due to the resident transitioning to Hospice. -Resident #2 had limited range of motion and limited strength in her upper extremities. -Resident #2 was a fall risk. -Resident #2 required extensive to total assistance with all activities of daily living except with transferring in which she only required supervision. Review of Resident #2's physician's order for	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 31 restraints dated 03/03/20 revealed: -The reason for the restraint was documented as mobility enhancement and fall prevention. -The type of restraint to be used was half bed rails. -The time period for the restraint to be used was documented as while in bed. -The time interval for the restraint to be checked was every 30 minutes and loosened and released every 2 hours. -The primary care provider (PCP) signed the order on 03/03/20. Review of Resident #2's PCP orders dated 07/09/20 revealed: -There was an order to discontinue half bed rails. -There was an order that read "may use concave mattress and/or fall alarm as needed" (neither were obtained). Observations of Resident #2's room on 07/16/20 at 12:41 pm revealed: -Resident #2 had half bed rails (one on both sides) on the top half of her bed in the up position. -Resident #2 was lying in her bed. Review of Resident #2's Restraint Check Log on 07/01/20 - 07/16/20 revealed: -On 07/06/20, there were no documented 30-minute checks for eight hours on first shift. -There were no documented 30-minute checks after 07/07/20 at 6:30 am. Interview with the Special Care Unit Coordinator (SCUC) on 07/16/20 at 12:42 pm revealed: -Restraints had not been used since 07/08/20. -She had given medications to Resident #2 in her room after receiving the order to discontinue the half bed rails.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 32 -She did not know Resident #2 still had half bed rails. -She thought maintenance staff had removed the bed rails after receiving the order to discontinue half bed rails after the incident on the assisted living unit. Interview with the Director on 07/16/20 at 1:25 pm revealed: -The facility no longer used half bed rails. -All half bed rails were discontinued on 07/09/20 due to the incident that occurred on the assisted living unit on 07/06/20. -She did not know Resident #2 still had half bed rails. -Maintenance staff was supposed to have removed them last Tuesday or Wednesday (07/07/20 or 07/08/20). -She did not know why maintenance had not removed Resident #2's half bed rails. -The PCAs who worked with Resident #2 would not have been able to fill out the restraint check log because she had taken the restraint check log book from the SCU and had it in her office since 07/07/20 or 07/08/20. Observation via video conference on 07/27/20 at 3:35 pm revealed that Resident #2's half bed rails had been removed from her bed. Telephone interview with the Director on 07/29/20 at 10:49 am revealed: -The SCUC knew Resident #2's half bed rails were discontinued and were supposed to be removed. -Resident #2's half bed rails were overlooked. -Resident #2's half bed rails should had been removed on 07/07/20 or 07/08/20 by maintenance staff because she had instructed him to remove all half bed rails.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 33 Telephone interview with Resident #2's PCP on 08/04/20 at 2:15 pm revealed: -He gave an order to discontinue half bed rails on 07/09/20. -He did not know Resident #2 continued to have half bed rails after he wrote the discontinue order. -He did not know that half bed rails could be considered restraints, but he always ordered them for the residents' mobility. -He did not know if the resident was able to put the rails up and down. -He never considered that someone could be entrapped in half bed rails. -He would had expected the 30-minute checks to continue until the half bed rails were removed from Resident #2's bed. Telephone interview with the Administrator on 08/07/20 at 4:06 pm revealed: -Maintenance staff was supposed to have removed the half rails from Resident #2's bed. -There must had been some miscommunication. -The SCUC should have known the half bed rails were still on Residents #2's bed as she made daily rounds. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. 3. Review of Resident #3's FL2 dated 12/23/19 revealed: -Diagnoses included benign prostrate hyperplasia (prostate gland enlargement), cognitive decline, frequent falls, hypertension, hypothyroidism, type II diabetes mellitus, and urinary retention. -Resident #3 was semi-ambulatory and used a wheelchair. -Resident #3 required total care.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 34 -There was no information regarding Resident #3's orientation. a. Review of Resident #3's Care Plan dated 12/23/19 revealed: -Resident #3 had limited strength in his upper extremities. -Resident #3 was a fall risk. -Resident #3 required limited assistance with transferring and extensive assistance with ambulation. Review of Resident #3's Licensed health Professional Support (LHPS) review dated 07/06/20 revealed: -Resident #3 used a wheelchair for ambulation and required staff assistance with transfers. -LHPS personal care tasks provided included transferring semi-ambulatory residents and ambulation using assistive devices. There was no Fall Policy provided after requests on 07/17/20, 07/24/20, and 08/03/20. Review of the facility's policy on Safety Measures revealed: -If a fall occurred, the staff person present was to immediately assess the resident for signs of trauma. -If signs of trauma are present, staff member immediately called Emergency Medical Services (EMS) and had the Special Care Unit resident sent to the local emergency room (ER) for evaluation. -The resident's responsible party was notified. -If falls were recurrent for an individual resident then additional safety precautions were individualized and implemented for each specific resident. -The additional safety measures were included in	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 35 the resident's care plan in attempt to eliminate falls. -There was no documentation of how staff would respond to residents on the assisted living (AL) side of the facility. Review of Resident #3's Home Health notes revealed: -He was evaluated for physical therapy (PT) services on 01/03/20. -He required assistance with mobility and all activities of daily living (ADLs). -He required maximum assistance physically as well as for safety purposes. -He was impulsive at times, required moderate to maximum verbal cues for safety, and was forgetful at times. -Resident #3 was seen by PT on 01/06/20, 01/13/20, 01/15/20, 01/20/20, 01/22/20, and 01/23/20. -On 01/15/20, Resident #3 refused activity after ambulating. -On 01/20/20, Resident #3 became agitated towards the therapist after using a pedal assistant and refused further activities. -On 01/22/20 and 01/23/20, Resident #3 was easily agitated, used significant profanity, and was resistant with any therapeutic activity. -On 01/28/20, Resident #3 was discharged from PT services due to his refusal to participate with PT in physical activity, ambulation or exercise. Review of Resident #3's Resident Care Notes and Accident/Incident reports revealed Resident #3 had 5 falls in June 2020. Review of Resident #3's Resident Care Notes dated 06/15/20 (no time indicated) revealed: -Resident #3 fell trying to get out of bed unassisted.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 36 -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/15/20. Review of the Accident/Incident Report for Resident #3 dated 06/15/20 at 7:10 pm revealed: -Resident #3 was trying to put himself to bed and he fell. -Resident #3 was "fine." -The medication aide (MA) helped the personal care aide (PCA) pick up the resident and put him to bed. -Resident #3's family was notified. -There was no documentation Resident #3's primary care physician (PCP) was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/15/20. Telephone interview on 08/04/20 at 4:29 pm with the MA who documented the Resident Care Note on 06/15/20 revealed: -Resident #3 was a fall risk and had multiple falls. -Resident #3 fell because "he thought he was very independent and liked to get up on his own." -She did not remember the details of Resident #3's fall on 06/15/20. -She had not been told to do anything differently for Resident #3 after his falls. Review of Resident #3's Resident Care Notes dated 06/16/20 (no time indicated) revealed: -Resident #3 was found lying on his side taking a nap. -There was no documentation Resident #3 fell on 06/16/20. Review of the Accident/Incident Report for Resident #3 dated 06/16/20 (no time indicated) revealed:	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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	HAL029010	A. BUILDING: _____ B. WING _____	C 08/07/2020

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D 270	Continued From page 37 -A PCA walked into Resident #3's room to check on him and found him laying in the floor. -There were no visible cuts or bruises. -Resident #3's family member was notified. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/16/20. Telephone interview on 08/03/20 at 10:26 am with the MA who completed the Accident/Incident Report dated 06/16/20 revealed: -Resident #3 was a fall risk. -Resident #3 needed assistance with toileting, bathing, dressing, ambulation and transfers. -She thought resident #3 continued to fall because he tried to do things by himself instead of ringing his call bell for help. -"He is going to do something regardless of what you ask him not to do." -She did not remember the details of Resident #3's fall on 06/16/20. -She did not know if there was any increased supervision or interventions put in place after Resident #3's fall on 06/16/20 to help prevent further falls. -The PCAs were constantly going to check on Resident #3, but she did not how often or if the frequent checks were documented. Review of Resident #3's Resident Care Notes dated 06/19/20 (no time indicated) revealed there was no documentation Resident #3 fell on 06/19/20. Review of the Accident/Incident Report for Resident #3 dated 06/19/20 at 5:45 am revealed: -A PCA found Resident #3 on the floor while doing rounds.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 38 -Resident #3 had been trying to transfer to his wheelchair by himself. -There was no visible bruising or cuts. -Resident #3's family member was notified. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/19/20. Telephone interview on 08/03/20 at 10:26 am with the MA who completed the Accident/Incident Report dated 06/19/20 revealed: -She did not remember the details of Resident #3's fall on 06/19/20. -She did not know if there was increased supervision or interventions put in place after Resident #3's fall on 06/19/20 to help prevent further falls. Review of Resident #3's Resident Care Notes dated 06/26/20 (no time indicated) revealed: -Resident #3 fell around 9:00am. -Resident #3's family member was called. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/26/20. Review of the Accident/Incident Report for Resident #3 dated 06/26/20 (no time indicated) revealed: -Resident #3 was found on the floor of the bathroom. -There were no cuts or visible bruising. -Resident #3's family member was notified. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 39 supervision or interventions provided to Resident #3 after his fall on 06/26/20. Telephone interview on 08/03/20 at 10:26 am with the MA who completed the Accident/Incident report dated 06/26/20 revealed: -She did not remember the details of Resident #3's fall on 06/26/20. -She did not know if there was increased supervision or interventions put in place after Resident #3's fall on 06/26/20 to help prevent further falls. Review of Resident #3's Resident Care Notes dated 06/29/20 (no time indicated) revealed there was no documentation Resident #3 fell on 06/29/20. Review of the Accident/Incident Report for Resident #3 dated 06/29/20 at 6:10 (a.m. or p.m. was not indicated) revealed: -Resident #3 was going to the bathroom and fell on the floor. -Resident #3 had a skin tear on his right arm, a "knot" on the right side of his head and a "knot" on his forehead. -Resident #3's family member was notified. -There was no documentation Resident #3's PCP was notified or Resident #3 was sent out to the hospital. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/29/20. Attempted interview with the MA who completed the incident accident report on 06/29/20 was unsuccessful. Review of Resident #3's Resident Care Notes and Accident/Incident reports revealed Resident	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 40 #3 had 4 falls in July 2020 between 07/01/20 and 07/23/20. Review of Resident #3's Resident Care Notes dated 07/05/20 revealed: -Resident #3 slid out of his chair. -Resident #3's family member was contacted. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 06/29/20. Review of the Accident/Incident Report for Resident #3 dated 07/05/20 at 7:30 am revealed: -A PCA left Resident #3 to get help to sit him in his wheelchair so he would not fall out. -The MA and PCA walked in Resident #3's room to find him sliding into the floor. -The MA and PCA made sure Resident #3 was not hurt, checked him for blood or bruising and got him back up in his chair. -Resident #3's responsible person was notified. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 07/05/20. Telephone interview on 08/03/20 at 11:48am with the PCA who found Resident #3 on 07/05/20 revealed: -Resident #3 needed assistance with toileting, dressing, bathing, transferring, and ambulation. -Resident #3 has had a lot of falls. -On 07/05/20, she was going to take Resident #3 to the bathroom, and he started sliding out of his chair. -She left Resident #3 to go get a MA and when she and the MA got back, Resident #3 was sliding	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 41 out of his chair but had not made it onto the floor. -She and the MA lifted Resident #3 back into the wheelchair. -Resident #3 had fallen about 3 other times during her shift. -She had been told to keep an eye on Resident #3, but she had not been told how often. -She checked on Resident #3 about every 2 hours after a fall. -She did not know of any interventions put in place to prevent falls after Resident #3's fall on 07/05/20. Review of Resident #3's Resident Care Notes dated 07/09/20 revealed there was no documentation Resident #3 had a fall on 07/09/20. Review of the Accident/Incident Report for Resident #3 dated 07/09/20 at 6:45 am revealed: -Resident #3 fell out of bed trying to go to the restroom. -Resident #3 had a skin tear on the left side of his arm and "knot" on the left side of his head. -The MA on first shift notified Resident #3's family member. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 07/09/20. Telephone interview on 08/04/20 at 2:54pm with the PCA who found Resident #3 on 07/09/20 at 6:45 am revealed: -Resident #3 was a high fall risk and needed assistance with transfers and ambulation. -She found Resident #3 on the floor on 07/19/20 of his room and there were no injuries. -She had not been told to increase supervision	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 42 after any of Resident #3's falls and she did not know if there were any interventions put in place to prevent further falls. -She checked on residents randomly every 2 hours. Review of Resident #3's Resident Care Notes dated 07/19/20 revealed there was no documentation Resident #3 fell on 07/19/20. Review of the Accident/Incident Report for Resident #3 dated 07/19/20 at 6:15 am revealed: -Resident #3 fell out of bed trying to get dressed by himself. -There were no visible bruises or scratches. -Resident #3's responsible party was notified on 07/20/20. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 07/19/20. Telephone interview on 08/04/20 at 2:54 pm with the PCA who found Resident #3 on 07/19/20 at 6:15 am revealed: -She found Resident #3 on the floor on 07/19/20 and there were no injuries. -She had not been told to increase supervision after any of Resident #3's falls and she did not know if there were any interventions put in place to prevent further falls. Resident #3's Resident Care Notes for 07/21/20 were not provided. Review of the Incident Accident Report for Resident #3 dated 07/21/20 at 6:20am revealed: -Resident #3 fell around 6:20am. -His call bell had been pulled and Resident #3	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 43 was found laying on the floor beside his roommate's bed. -Resident #3 had no visible bruises. -Resident #3's responsible party was notified on 07/21/20. -There was no documentation Resident #3's PCP was notified. -There was no documentation of any increased supervision or interventions provided to Resident #3 after his fall on 07/19/20. Telephone interview on 08/04/20 at 2:54pm with the PCA who found Resident #3 on 07/21/20 revealed: -She found resident #3 on the floor in his bedroom on 07/21/20 and he had no injuries. -She had not been told to increase supervision after any of Resident #3's falls and she did not know if there were any interventions put in place to prevent further falls. Telephone interview with Resident #3's responsible party on 07/24/20 at 11:37 am revealed: -The facility called her every time Resident #3 fell. -Resident #3 was evaluated for physical therapy (PT) and occupational therapy (OT), but she did not remember when. -She knew Resident #3 hit his head during falls, but she requested the facility to not send Resident #3 out to the hospital due to COVID-19. -She did not know if any other interventions were put in place by the facility or any increase in supervision after Resident #3's falls. Telephone interview with a MA on 07/24/20 at 3:06 pm revealed: -Resident #3 was a high fall risk. -Resident #3 needed assistance with transferring, ambulating, bathing, and dressing	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 44 -Resident #3 would not pull his call bell to ask for help. -All residents were checked on every 2 hours. -It depended on who the resident was as to whether the resident received an increase in safety checks. -She did not know the frequency of increased safety checks. -She was not sure if Resident #3 had increased safety checks, but she knew that increased safety checks were not documented. -She did not know of any interventions put in place for Resident #3. Telephone interview with a second MA on 08/03/20 at 10:26 am revealed: -If a resident had a fall, the MA was to go check the resident out and then help get them up from the floor. -If the resident was a hospice patient, she would contact Hospice. -If the resident was not a Hospice patient, she would notify the residents family, the Resident Care Coordinator (RCC), and the Director and send the resident out to the Hospital if necessary. -She normally did not notify the resident's PCP after a fall. -She did not know if any other staff notified the physician regarding resident falls. -She looked in on residents as she walked up and down the halls. -If residents were not visible from the door, she would check for the resident in their bathroom. -She had not been told to increase supervision or do anything differently for residents after they fell. Telephone interview with the RCC on 08/03/20 at 2:09 pm revealed: -Resident #3 needed quite a bit of assistance with transferring, ambulation, bathing, and dressing.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 45 -Resident #3 was considered a high fall risk. -She knew Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -Resident #3 was unable to, but tried to do things himself such as get in and out of bed and go to the bathroom -Staff checked on Resident #3 and all other residents every 2 hours. -Staff looked in Residents #3's room to see what he was doing every time they went down the hall. -Staff did not document when they "checked on" residents anywhere. -She did not know of any interventions put in place for Resident #3 after his falls to prevent further falls. Telephone interview with the Home Health PT Clinical Manager on 08/04/20 at 9:14 am revealed: -Resident #3 received PT services beginning on 01/06/20 to address functional mobility. -Resident #3 was discharged from PT services on 01/18/20 with his goals partially met due to refusal of services and due to him becoming agitated. -There had been no other referrals received by home health for PT services. Telephone interview with the Director on 08/06/20 at 1:46 pm revealed: -The facility could not prevent residents from falling. -If a resident fell often, the resident would be put on more frequent checks. -She would let the PCAs know to check on the residents who fell every 15 to 30 minutes. -Staff also requested a referral from residents' physician for PT and if PT did not help, staff would request an order for a fall alarm. -Staff knew to check on Resident #3 every 15 to	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 46 20 minutes, but increased checks were not documented anywhere. -Resident #3 did not have a fall alarm, a fall mat, or any other safety device. Telephone interview with the Director on 08/07/20 at 1:15 pm revealed: -The MAs discussed the residents during daily shift reports and came to her daily with any identified issues. -If the MAs reported a resident had falls, she would address the falls with the PCP when he came in the facility each week on Wednesday. -She felt Resident #3's falls had decreased after his bedrails were removed on 07/09/2020. Telephone interview with the Administrator on 08/07/20 at 3:51 pm revealed: -The facility did not have a Fall Policy. -The facility's policy was to notify the resident's family and physician after a fall. -She knew Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -Staff moved Resident #3's wheelchair away from his bedside at the request of his family member as an intervention. -She did not know of any other interventions put in place after each of Resident #3's falls. -Staff checked on all residents at least every 2 hours. -She expected staff to check on Resident #3 more often, but the increased checks were not documented by staff. -Resident #3 was able to get out of bed using his bedrails, but his falls have decreased since his bedrails were removed on 07/09/20. -Resident #3 did not have a fall mat or fall alarm. Telephone interview with Resident #3's PCP on 08/04/20 at 9:51 am revealed:	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 47 -He did not know Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -He expected the facility to notify him when a resident had a fall. -He would generally recommend an intervention after being notified of a fall. -On almost each occasion after a fall that was reported to him, he would order physical therapy to strengthen the resident. b. Review of Resident #3's FL2 dated 12/23/19 revealed: -Resident #3 was admitted to the facility on 12/24/20. -Diagnoses included benign prostrate hyperplasia, cognitive decline, frequent falls, hypertension, hypothyroidism, type II diabetes mellitus, and urinary retention. -Resident #3 was semi-ambulatory and used a wheelchair. -Resident #3 required total care. -There was no order for bed rails. Review of a physician's restraint order for Resident #3's dated 12/23/19 revealed: -There was an order for half bed rails for mobility enhancement and fall prevention. -The restraint was to be used while in bed. -The restraint was to be checked every 30 minutes, loosened every 2 hours, and removed every 2 hours. Review of Resident #3's physician's orders dated 07/09/20 revealed: -There was an order to discontinue half bed rails. -There was an order Resident #3 may use a concave mattress and or fall alarm as needed. Review of Resident #3's current Care Plan dated 12/23/19 revealed:	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 48 -Resident #3 was new to the facility and was admitted after he fell at home during the first week of December 2019. -Resident #3 was ambulatory with a walker and a wheelchair. -Resident #3 had limited strength in his upper extremities. -Resident #3 was forgetful. -Resident #3 required extensive assistance with toileting, ambulation (fall risk noted), bathing, dressing, grooming/personal hygiene and limited assistance with transferring (fall risk noted). -Half bed rails were listed as a restraint. Review of Resident #3's Restraint Assessment and Care Plan dated 12/23/19 revealed: -Resident #3 had confusion with the risk of falls. -Resident #3 had minor injuries from falling multiple times. -Alternatives that had been provided included physical therapy, increased staff monitoring, family involvement, and increased communication, and alternatives had failed. -The least restrictive restraint was half bed rails. -The responsible party consented to the use of bed rails. -There were no subsequent quarterly restraint assessments completed for Resident #3. Review of Resident #3's Licensed Health Professional (LHPS) review dated 01/27/20, 04/17/20, and 07/06/20 revealed: -Resident #3 had bed rails for safety. -The half bed rails were noted to be on Resident #3's bed during each LHPS assessment. Review of the 30-minute check log for half bed rails were initialed daily for 05/01/20 through 05/31/20 revealed: -There was a space for the date to be inserted, a	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 49 column with preprinted times from 12:00 am to 11:30 pm, and a column for staff initials. -There was no documentation Resident #3's bed rails were checked for 28 of 30 days from 7:00 am to 2:30pm on 05/01/20 through 05/30/20. -There was no documentation Resident #3's bed rails were checked for 8 of 30 days from 3:00 pm to 10:30pm. -There was no documentation of any bed rail checks on 05/31/20. Review of the 30-minute check log for half bed rails were initialed daily for 06/01/20 through 06/30/20 revealed: -There was a space for the date to be inserted, a column with preprinted times from 12:00 am to 11:30 pm, and a column for staff initials. -There was a line drawn from 12:00 am to 6:00 am with an initial at 6:30 am for 18 of 30 days. -There was a line drawn from 12:30 am to 6:00 am with an initial at 6:30 am for 1 of 30 days. -There was a line drawn from 1:00 am to 5:30 am with an initial at 6:00 am and 6:30 am for 3 of 30 days. -There was no documentation Resident #3's bed rails were checked for 1 of 30 days from 12:00 am to 6:30 am on 06/18/20. -There was no documentation Resident #3's bed rails were checked for 30 of 30 days from 7:00 am to 3:00 pm on 06/01/20 through 06/30/20. -There was no documentation Resident #3's bed rails were checked for 26 of 30 days from 3:00 pm to 10:30pm on 06/01/20 through 06/30/20. Review of the 30-minute check log for half bed rails were initialed daily for 07/01/20 through 07/09/20 revealed: -There was a space for the date to be inserted, a column with preprinted times from 12:00 am to 11:30 pm, and a column for staff initials.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 50 -Resident #3's bed rail was discontinued on 07/09/20. -There was a line drawn from 12:00 am to 6:00 am with an initial at 6:30 am for 1 of 9 days. -There was a line drawn from 12:30 am to 6:00 am with an initial at 6:30 am for 2 of 9 days. -There was no documentation Resident #3's bed rails were checked for 8 of 8 days from 7:00 am to 2:30 pm on 07/01/20 through 07/08/20. -There was no documentation Resident #3's bed rails were checked for 3 of 8 days from 3:00 am to 10:30 pm on 07/01/20 through 07/08/20. Telephone interview with Resident #3's responsible party on 07/24/20 at 11:37 am revealed Resident #3 had bed rails, but she did not know why. A second telephone interview with Resident #3's responsible party on 08/04/20 at 10:42 am revealed: -She signed initial paperwork for Resident #1 to have bed rails. -She did not know if Resident #3 was able to raise and lower his bed rail. Telephone interview with a medication aide (MA) on 07/24/20 at 3:06 pm revealed: -Resident #3 had bed rails which were removed in July 2020. -She did not know if Resident #3 was able to raise or lower his bed rails. -Personal care aides (PCAs) were responsible for checking on residents with bed rails every 30 minutes and documenting on the bed rail check log. -She did not know if PCAs checked on residents and documented 30-minute checks. -She never saw the restraint log book until after restraints were discontinued in the facility in July	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 51 2020 and the restraint log books were taken away. Telephone interview with the Director on 07/31/20 at 11:40 am revealed: -Staff were trained by other PCAs how to fill out the Restraint Check Log. -The MAs turned in the Restraint Check Logs monthly to the RCC to be reviewed and filed. -Blank spaces with no initials indicated the restraint was not being used. -Drawing a line down the spaces was not the correct way to document. -She did not know if there was incomplete documentation on the Restraint Check Logs. -She tried to review the logs weekly, looking for empty spaces. Telephone interview with the RCC on 08/03/20 at 2:09 pm revealed: -Resident #3 had bed rails, but she did not know why. -Resident #3's bed rails were discontinued in July 2020 when all bed rails in the facility were removed. -The PCAs were responsible for completing 30-minute checks for residents with bed rails. -PCAs should have documented 30-minute bed rail checks when the residents were in the bed. -She did not know how PCAs were to document 30-minute check log when residents were not in the bed. -The 30-minute bed rail check logs were removed from a notebook by the MAs and given to her at the end of the month. -She did not review the 30-minute bed rail logs to ensure they were completed correctly. Telephone interview with a PCA on 08/04/20 at 2:54pm revealed:	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 52 -She did not know why Resident #3 had a bed rail. -She did not know if Resident #3 could raise or lower the bed rail. -Resident #3 had fallen multiple times trying to get out of bed. -She checked on Resident #3 every 30 minutes during her shift and documented it in the 30-minute check log. Telephone interview with the Director on 08/06/20 at 10:25 am revealed: -The PCAs were responsible for completing and documenting restraint checks. -The PCAs were trained on how to complete the form by senior PCAs and herself when hired. -There was no policy and procedure in place for documenting restraint checks. -It was her responsibility to ensure the restraint checks were being completed and documented. -If a PCA did not complete the restraint check log she addressed it with the PCA responsible and disciplinary procedures were taken when needed. -If the restraint check log was not signed it meant the restraint check was not done. Telephone interview with Resident #3's primary care provider (PCP) on 08/06/20 at 4:11 pm revealed: -He was not aware half bedrails were a physical restraint. -He expected staff to complete the restraint checks as ordered. Telephone interview with the Administrator on 08/07/20 at 3:51 pm revealed: -Resident #3 had bed rails, but they were discontinued in July 2020. -PCAs should have checked on residents with bedrails every 30 minutes and documented the	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 53 30-minute checks in the restraint log notebook. -There was a sample restraint log in the front of the restraint log notebook that the PCAs should have used as a guide. -Instead of documenting where the resident was if the resident was not in the bed, PCAs were leaving the 30-minute restraint log blank for the time when the residents were not in bed. -Staff should have documented 30-minute checks at the end of their shift or at the beginning of their shift. -She had instructed staff to review the 30-minute restraint logs and fill them in if they were missing documentation from previous days. 3. Review of Resident #5's current FL2 dated 03/17/20 revealed: -Diagnoses included mental retardation, chronic lymphatic leukemia, and Zenker's diverticulotomy. -He was intermittently disoriented. -He was continent of bladder and bowel. -He was ambulatory with a walker. Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 12/16/19 revealed: -He used a walker independently. -He had half bed rails for safety. Review of Resident #5's care plan dated 02/18/20 revealed: -He required supervision for ambulation and transfers. -He was a fall risk. -He had half bed rails. Review of Resident #5's physician orders dated 06/26/20 revealed: -He was to have half bed rails while in bed for mobility enhancement and fall prevention.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 54 -His restraints were to be checked every 30 minutes. Review of Resident #5's Restraint Check Log between 05/01/20 and 05/31/20 revealed: -Resident #5 was to be checked every 30 minutes. -There were no documented restraint checks between 05/06/20 and 05/31/20. -On 05/01/20, 05/03/20, and 05/04/20, there were no documented 30-minute checks for 16 hours on first and second shifts. -On 05/02/20, there were no documented 30-minute checks between 8:30 pm and 10:30 pm. -On 05/05/20, there were no documented 30-minute checks for 8 hours on second shift. Review of Resident #5's Restraint Check Log between 06/01/20 and 06/30/20 revealed: -Resident #5 was to be checked every 30 minutes. -There were 4 days with no documented 30-minute checks for 16 hours on first and second shifts on 06/03/20, 06/04/20, 06/07/20, and 06/18/20. -On 06/28/20 there were no documented 30-minute checks for 8 hours on first shift. -There were 19 days with no documented 30-minute checks for 8 hours on second shift including on 06/02/20, 06/20/20 and 06/30/20. -On 06/01/20 and 06/09/20, there were no documented 30-minute checks between 12:00 am and 6:30 am and between 3:00 pm and 10:30 pm. -On 06/08/20, there were no documented 30-minute checks between 3:00 pm and 11:30 pm. Review of Resident #5's Restraint Check Log	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 55 between 07/01/20 and 07/08/20 revealed: -Resident #5 was to be checked every 30 minutes. -On 07/02/20 and 07/05/20, there were no documented 30-minute checks for 16 hours on first and second shifts. -There were 6 days with no documented 30-minute checks for 8 hours on second shift on 07/01/20, 07/03/20, 07/04/20, and 07/06/20 through 07/08/20. Review of Resident #5's Restraint Check Log and employee timecards between 06/10/20 and 07/07/20 revealed: -There were two PCAs who documented as performing restraint checks who did not work that shift. -There were 7 shifts the PCAs documented on the restraint logs when they were not working. Review of Resident #5's Restraint Check Log on 07/06/20 revealed it was pre-documented for third shift on 07/06/20, 07/07/20, and 07/08/20 by Staff B, a personal care aide (PCA). Observation on 07/09/20 at 1:15 pm revealed: -Resident was in his room, sitting in a chair watching television. -A walker was in front of him. -There were no bed rails on his bed. Interview with Resident #5 on 07/09/20 at 1:15 pm revealed: -He did not know what happened to the bed rails. -He was able to get up from his bed and chair using his walker. -He had not had a fall in a while and could not give more details. -Staff checked on him, but he did not know how often.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 56 Telephone interview with Staff B on 08/04/20 at 2:51 pm revealed: -Restraints used in the facility were bed rails and a lap belt. -The PCAs were responsible to check the residents with restraints every 30 minutes. -The PCAs were responsible to document restraint checks on the resident's Restraint Check Log. -She was trained on how to fill out the Restraint Check Log by another PCA when she was hired. -She usually signed the book after completing the 30-minute check, as the shift went along. -She did not know why she pre-documented the log for Resident #5 between 07/06/20 and 07/08/20. -She did not remember pre-documenting the log other than between 07/06/20 and 07/08/20. -If the log was not filled out either the medication aide (MA) or the Director brought it to the PCA's attention. -She thought the Director was ultimately responsible for making sure the restraint logs were completed. Telephone interview with a MA on 08/03/20 at 10:25 am revealed: -Restraints used in the facility were bed rails and lap belts. -She was trained on restraints by the facility but could not remember when she was trained or who did the training. -The PCAs were responsible for completing and documenting the restraint checks. -She thought it was the Resident Care Coordinator's (RCC) responsibility to ensure the restraint checks were completed and documented. -She was not told the MAs were responsible to	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 57 ensure the restraint checks were completed and documented. Telephone interview with the RCC on 08/03/20 at 2:08 pm revealed: -Restraints used in the facility were bed rails and lap belts. -She did not consider half bed rails a restraint because the resident was still able to get out of bed. -The PCAs were responsible for completing and documenting the restraint checks. -She thought the MAs were responsible to make sure the restraint check logs were completed but she was not sure. -The MAs gave the restraint check logs to her at the end of each month and she was responsible to put them in the resident record. -She never reviewed them for gaps and never looked at them, other than the front page when she put them in the resident record. -She was not aware there were gaps in the restraint check log for Resident #5. -She was never notified she needed to look at the restraint logs for the residents. Telephone interview with the Director on 08/06/20 at 10:25 am revealed: -The PCAs were responsible for completing and documenting restraint checks. -The PCAs were trained on how to complete the form by senior PCAs and herself when hired. -There was no policy and procedure in place for documenting restraint checks. -It was her responsibility to ensure the restraint checks were being completed and documented. -If a PCA did not complete the restraint check log she addressed it with the PCA responsible and disciplinary procedures were were taken when needed.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 58 -She tried to complete audits weekly but did not always get to it, but she completed monthly audits. -She noticed there were many gaps in the restraint check logs at the end of April 2020. -There was a meeting with the PCAs after she noticed the gaps but could not remember when it was. -She revised her policy and restraint log audits were being completed by her daily. -If the restraint check log was not signed it meant the restraint check was not done. -Staff was never told they could pre-document. -She was not aware staff had documented on shifts they did not work. Telephone interview with Resident #5's responsible party on 08/03/20 at 3:34 pm revealed: -She thought she requested the half bed rails because Resident #5 had several falls getting out of bed, although she could not remember when that was. -The need for half bed rails ended when they repositioned Resident #5's bed and he stopped falling. -She thought the last conversation with the facility about half bed rails was a year or more ago. Telephone interview with primary care provider (PCP) on 08/06/20 at 4:11 pm revealed: -He was not aware half bed rails were a physical restraint. -He expected staff to complete the restraint checks as ordered. -He knew Resident #5 had a diagnosis of mental retardation but did not know if Resident #5 would be mentally aware enough to free himself if caught in the bed rail.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 59 5. Review of Resident #4's current FL2 dated 12/05/19 revealed: -Diagnoses included dementia, abnormal gait with tremor, transient ischemic attacks, artery stenosis, depressive disorder and osteoporosis. -The resident was constantly disoriented and semi-ambulatory using a wheelchair. Review of Resident #4's Care Plan dated 02/19/20 revealed: -Resident #4 continued to show cognitive decline, had a lap belt to prevent falls from her wheelchair, and bed rails for mobility enhancement and fall protection. -The resident needed total assistance toileting, ambulation with wheelchair (needed pushing), bathing, dressing, grooming, transferring and extensive assistance with eating. Review of Incident/Accident Reports for Resident #4 revealed: -On 05/01/20 at 7:25 am, Resident #4 was found lying on the floor, she slid out of her wheelchair, no documentation of injuries. -On 06/12/15 at 6:40 pm, Resident #4 was found lying on the floor, in her room by her wheelchair, no documentation of injuries. On 06/15/15 at 12:15 pm, Resident #4 Resident #4 slid to the floor in the bathroom while having toileting assistance by 1 staff, no documentation of injuries. Review of Resident #4's Progress Notes revealed: -There was no documentation of a fall in May 2020. -On 06/12/15 Resident #4 slid out of her chair, "POA (power of attorney) is bringing another strap tomorrow so (Resident #4 does not slide out of chair'.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 60 -On 6/15/20 Resident #4 slid to the floor while staff was providing toileting care. Review of the Resident Notes for Resident #4 revealed: -There was no documentation for 05/01/20. -On 06/12/20, Resident #4 slid out of her wheelchair, (POA) was called. -On 06/12/20, Resident #4 slipped in restroom while a personal care aide (PCA) was assisting with hygiene. Telephone interview with a first shift PCA on 07/29/20 at 1:50 pm revealed: -Resident #4 needed extensive assistance, 2-person assist with bathing and transferring. -Resident #4 had a lap belt attached to her wheelchair to keep her from falling out. -Each shift was to complete lap belt checks and document on the Restraint Check Log with initials every 30 minutes because Resident #4 was a falls risk. -Some staff on first shift did not complete the checks and she did not know why. -The log was kept in the staff lounge and the shift supervisor/ medication aide (MA), was supposed to check that staff documented the checks. -The Restraint Check Log would be given to the Director once a month, for review, to make sure the checks were done for all residents with restraints. -After Resident #4 had her first fall (05/01/20), nothing different was put in place for supervision. -The Resident Care Coordinator (RCC) had a communication book in the staff lounge for notifications of changes for residents. -The PCAs would check the book for changes for resident care. -After Resident #4 had her second fall (06/12/15), the POA brought in another lap belt that was	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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	HAL029010	A. BUILDING: _____ B. WING _____	C 08/07/2020

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D 270	Continued From page 61 stronger and had an adhesive closure. -She was not aware of any other changes made for fall prevention for Resident #4. -She documented in the Restraint Check Log that she did every 30 minutes checks for Resident #4. Telephone interview with a second shift PCA on 07/29/20 at 3:23 pm revealed: -She checked on the residents when she first came on duty, toileting and getting ready for dinner. -Resident #4 was weak, needed a 2-person assist, and needed to be toileted in bed because the resident could not stand on her own. -Resident #4 had a half bed rail attached to her bed and a lap belt attached to her wheelchair to keep her from sliding out of the wheelchair. -She was not aware of any changes made for Resident #4 after her fall on 05/01/20. -She was not aware of Resident #4's fall on 06/12/20; there was no documentation of supervision changes in the communication book. -Rounds were made every 2 hours to check on the residents. -Thirty minutes checks were made for residents with half bed rails and lap belts. Resident was the only resident with a lap belt. -When documenting the Restraint Check Log, staff was to initial after each observation. -Staff were to go into the room and look at the resident. -The Restraint Check Log list was kept in the staff lounge midway down the hall. -Staff walked by it when they walked up and down the hall. -If there was only one set of initials on the Restraint Check Log for the shift, the resident was observed only once during the shift. -Blanks in the boxes meant staff did not complete the checks on the Restraint Check Log.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 62 -She was not aware of anyone on her shift that pre-documented the times; she was not sure if other staff pre-documented the Restraint Check Log. Telephone interview with a third shift PCA on 08/04/20 at 3:36 pm revealed: -Resident #4 slept during the night, she toileted her in the bed because she was a 2-person assist and it took longer to get her up to the bathroom. -Resident #4 was on every 30 minutes Restraint Check Log checks. -Staff was supposed to observe the residents and initial beside the documented time on the form. -On 07/06/20, in the facility, she was doing the Restraint Check Log checks for the AL and SCU. -She pre-documented the 30 minutes Restraint Check Log maybe a day ahead for Resident #4. -She did not remember if she pre-documented for 07/07/20 and 07/08/20 for Resident #4. -Sometimes she got busy assisting another resident and could not observe Resident #4 every 30 minutes. -She did not remember how many days she pre-documented the 30 minutes Restraint Check Log for Resident #4. Telephone interview with a first shift medication aide (MA) on 07/27/20 at 1:55 pm revealed: -Resident #4 needed a 2-person assist for bathing, toileting and transfer needs; the resident could not stand on her own weight. -Resident #4 could sit in her wheelchair using a lap belt. -When Resident #4 fell out of her wheelchair on 06/12/20 and 06/16/20, there were no new changes or alternatives put in place for her for supervision. -PCAs were supposed to observe residents with half bed rails and lap belts using the Restraint	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 63 Check Log. -The Restraint Check Log was kept in the break room on a table. -PCAs were to observe the resident and come in and initial the time of the observation. -The Restraint Check Log sheets were filed in the front office with the RCC. Review of the May 2020 Restraint Check Log for Resident #4 revealed: -There were 29, eight hour shifts from 05/01/20 to 05/30/20 having no initials documented for checking the resident. -There were 2, eight hour shifts with one set of initials for the entire shift for checking the resident. -On 05/01/20, the resident was found lying on the floor having fallen out of her wheelchair at 7:25 am, there were no restraint checks documented between 7:00 am to 11:00 pm. Review of the June 2020 Restraint Check Log for Resident #4 revealed: -There were 36, eight hour shifts from 06/01/30 to 06/30/20 having no initials documented for checking Resident #4. -There were 30, eight hour shifts (3rd shift) with a line drawn from the beginning of the shift to the end and having initials at the start and the end of the shift. -On 06/12/20, the resident was found lying on the floor by her wheelchair at 6:40 pm, there were no 30 minutes checks documented between 12:00 am to 6:30 am. Review of the July 2020 Restraint Check Log for Resident #4 revealed there were 5, eight hour shifts from 07/01/20 to 07/04/20 with no initials documented for checking Resident #4.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 64 Telephone interview with the RCC on 07/30/20 at 9:49 am revealed: -Resident #4 was provided Hospice services. -When an incident occurred, the MA would call the family and Hospice. -On 05/01/20 Resident #4 fell out of her wheelchair. -She was not aware of any changes made for supervision after 05/01/20. -On 06/12/20 Resident #4 fell out of her wheelchair. -The lap belt was changed by the POA only because the adhesive fastener was worn; there were no other changes put in place. -On 06/15/20 Resident #4 fell onto the bathroom floor while being assisted by 1 staff. -Resident #4 was an extensive assist for toileting and there should have been 2 staff assisting her. -The RCC "had no idea" if the facility had a falls policy. -There was a every 30 minutes Restraint Check Log the PCAs were responsible for completing for residents having bed rails and lap belt. -The Director was responsible for training the PCAs on filling out the forms and the more experienced PCAs would train each other. -The PCA's initials would be documented in the time blocks. -If there were no initials, the PCA did not do the check or forgot to sign the form. -Each month the Restraint Check Logs were given to the MA and the MA gave them to her. -The RCC did not review the Restraint Check Logs. - Restraint Check Logs were given to the Director to review and file. -The RCC had not been told, by the Director, of any blank spaces or concerns regarding the Restraint Check Logs.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 65 Telephone interview on 07/24/20 with Resident #4's power of attorney (POA) revealed: -Resident #4 had a half bed rail attached to her bed and used a lap belt attached to her wheelchair to prevent falling out of the wheelchair. -Resident #4 became weaker, would not eat well and started with Hospice on 05/07/20. -Resident #4 could not stand and was a 2-person assist for transferring and activities of daily living. -For toileting, staff would check on Resident #4 every 2 hours. -If the staff had a schedule for checking on Resident #4, she was not aware of it. Telephone interview with Resident #4's primary care provider (PCP) on 07/27/20 at 9:40 am revealed: -Resident #4 was often trying to get up and transfer. -Resident #4 "had a lap belt because she could not remember to not get up for her own safety". -The lap belt was reversed; the adhesive fastener would be placed at the back of the wheelchair instead of in the front of Resident #4. -The lap belt was to be released every 30 minutes when up in the wheelchair. -He was not aware there were numerous blank spaces on the Restraint Check Logs for Resident #4. -His expectation was for the staff to make the checks for Resident #4's bed rail and lap belt every 30 minutes, as directed on the Restraint Check Logs. Review of the Policy On Safety Measures document, Falls section, revealed "If falls are recurrent, for an individual resident then additional safety precautions will be individualized and implemented for each specific resident.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 66 Those additional safety measures in an attempt to eliminate falls will be included in the resident's care plan." Review of Resident #4" Care Plan dated 02/19/20 revealed: -There was no reassessment documentation after the original assessment date for Resident #4. -There were no additional safety measures to eliminate falls documented in the Care Plan for Resident #4's falls on 05/01/20, 06/12/20 or 06/15/20. Telephone interview with Resident #4's Hospice nurse on 7/22/20 revealed: -Resident #4 started with Hospice care on 05/07/20. for signs of decline and was seen every 21 days or as needed by the Registered Nurse (RN). -The last visit by the RN was on 07/07/20 when the RN observed Resident #4 slumped in her chair, pushing herself out of the wheel chair with her feet. -Resident #4 was not able to follow one-step commands, she was weak all over and could not stand on her own. -Resident #4 had a lap belt, and she would be able to release it because the adhesive closure was placed behind her at the back of the chair. -Having the lap belt did not seem to hinder her attempt to get out of the wheelchair. -The lap belt was not issued by Hospice as the agency did not use restraints. -There were no changes documented on her Care Plan after 02/19/20. Telephone interview with the Director on 07/31/20 at 10:56 am revealed: -Staff made rounds, checking on the residents	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 67 every 2 hours. -Staff were constantly walking up and down the hall. -Resident #4 had lap belt checks every 30 minutes when she was in her wheelchair. -After the fall on 05/01/20, nothing new was put into place for Resident #4. -Physical therapy was requested for Resident #4 about 2 years ago but had not been effective. -After the fall on 06/12/20, the adhesive fastener for the lap belt on Resident #4's wheel chair was worn. -Staff would take the resident to the medication room to watch her while waiting for the POA to replace the worn lap belt. - On 06/15/20, 1 PCA was assisting Resident #4 to the bathroom when the resident let go of the handrail and fell. - Because of her decline and weakness Resident #4 was a 2 person assist. -Two staff were needed to assist Resident #4 in the bathroom. Telephone interview with the Administrator on 08/07/20 at 2:35 pm revealed: -After Resident #4's fall on 05/01/20 she did not know if any new precautions were put in place. -After Resident #4's fall on 06/12/20, nothing new was put in place for the resident for the prevention of falls. -After Resident #4's fall on 06/15/20, nothing new was put in place. -The facility did not have a falls policy. -Obtaining and documenting assessments for Resident #4 were the responsibility of the Director. Telephone interview with the Director on 07/31/20 at 11:40 am revealed: -Staff were trained" over and over" on how to fill	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 270	Continued From page 68 out the Restraint Check Log. -The PCAs documented on the form, they were trained by the experienced PCA staff. -The MAs turned in the Restraint Check Logs monthly to the RCC to be reviewed and filed. -Blank spaces with no initials indicated the restraint was not being used. -Drawing a line down the spaces was not the correct way to document. -She did not know if there was incomplete documentation on the Restraint Check Logs. -She tried to review the logs weekly, looking for empty spaces. -If there was a problem with documentation on the logs, she would discuss with the PCA. _____ The facility failed to provide adequate supervision for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) who had half bed rails resulting in a resident becoming entangled in the half bed rail and died (Resident #1); and 3 residents (#1, #3, and #4) who had a history of falls with a resident (#3) resulted in multiple hematoma's in his head and a skin tear on his right arm. This failure resulted in death and serious physical harm which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2020.	D 270	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***SEE NEXT PAGE FOR POC ***	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 69 of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #3) related to falls. The findings are: Review of Resident #3's FL2 dated 12/23/19 revealed: -Diagnoses included benign prostrate hyperplasia (prostate gland enlargement), cognitive decline, frequent falls, hypertension, hypothyroidism, type II diabetes mellitus, and urinary retention. -Resident #3 was semi-ambulatory and used a wheelchair. -Resident #3 required total care. -There was no information regarding Resident #3's orientation. Review of Resident #3's Care Plan dated 12/23/19 revealed: -Resident #3 had limited strength in his upper extremities. -Resident #3 was a fall risk. -Resident #3 required limited assistance with transferring and extensive assistance with ambulation. Review of Resident #3's Licensed health Professional Support (LHPS) Review dated 07/06/20 revealed: -Resident #3 used a wheelchair for ambulation and required staff assistance with transfers. -LHPS personal care tasks provided included transferring semi-ambulatory residents and ambulation using assistive devices.	D 273	The Administrator /Director shall ensure the facility shall assure referral and follow-up to meet the routine and acute health care needs of the residents. Administrator/Director assessed all residents in facility to determine who were considered fall risk. New policy was implemented to assess residents on admission and ongoing to determine if they become a fall risk. New form implemented by director to monitor residents who are a fall risk that require 30 min checks by staff. Director monitors staff to ensure 30 min checks are being done. Monitoring to be done weekly x 3 , biweekly x 3 , monthly x 3 then quarterly thereafter.	09/21/2020

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D 273	Continued From page 70 No Fall Policy was provided after requests on 07/17/20, 07/24/20, and 08/03/20. Review of Resident #3's Resident Care Notes and Accident/Incident Reports revealed: -Resident #3 had 5 falls in June 2020 on 06/15/20, 06/16/20, 06/19/20, 06/26/20, and 06/29/20. -Resident #3 had 4 falls in July 2020 on 07/05/20, 07/09/20, 07/19/20, and 07/21/20. -Resident #3 had a skin tear on his right arm, a hematoma on the right side of his head, and a hematoma on his forehead on 06/29/20. -Resident #3 had a skin tear on the left side of his arm and a hematoma on the left side of his head on 07/09/20. -There was no documentation Resident #3's Primary Care Physician (PCP) had been contacted after any falls. Interview with a Medication Aide (MA) on 07/24/20 at 3:06 pm revealed: -Resident #3 was a high fall risk. -She had not contacted Resident #3's PCP regarding Resident #3's falls and had never been instructed to contact the PCP. -She thought the Resident Care Coordinator (RCC) or the Administrator notified Resident #3's physician. Telephone interview with a second MA on 08/03/20 at 10:26 am revealed: -If a resident had a fall, the MA was to go check out the resident and help get them up from the floor. -If the resident was a hospice patient, she would contact hospice. -If the resident was not a hospice patient, she would notify the residents family, the RCC, and	D 273	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 273	Continued From page 71 the Director and send the resident out to the hospital if necessary. -She "normally" did not notify the resident's PCP after a fall. -She did not know if any other staff notified the physician regarding resident falls. -She had not notified Resident #3's physician of Resident #3's falls. -She had not been told to contact a resident's physician if they had a fall. Telephone interview with the RCC on 08/03/20 at 2:09 pm revealed: -She knew Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -Resident #3 was unable to, but he tried to do things himself such as get in and out of bed and go to the bathroom. -She had never contacted Resident #3's physician to report falls. -She did not know if anyone else notified Resident #3's physician of his falls. Telephone interview with the Director on 08/06/20 at 1:46 pm revealed: -The facility could not prevent residents from falling. -Increased checks were not documented anywhere. -Staff also tried to get the resident on PT and if PT did not help, staff would get an order for a fall alarm. -Resident #3 was a fall risk and she was aware Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -Resident #3 had falls at home before being admitted to the facility and was known to be a fall risk prior to admission. -Staff knew to check on Resident #3 every 15 to 20 minutes.	D 273	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 273	Continued From page 72 -Resident #3's roommate let staff know when Resident #3 was trying to get up by himself. -Resident #3 did not have a fall alarm, a fall mat, or any other safety device. Telephone interview with the Director on 08/07/20 at 1:15 pm revealed: -The MAs discussed the residents amongst themselves daily and came to her daily with any identified issues. -MAs were expected to follow up with a resident's physician and responsible party after a resident had a fall. -Staff were not required to document contact with a resident's physician. -If the MAs reported to her a resident had falls, she would address the falls with the PCP when he came in the facility each week on Wednesday. -Resident #3's PCP knew about Resident #3's falls. -She had not documented her contacts with Resident #3's physician regarding falls. Telephone interview with the Administrator on 08/07/20 at 3:51 pm revealed: -The facility did not have a Fall Policy. -The facility's policy was to notify the resident's family and physician after a fall. -The MA's or the Director were responsible for making sure the family and physician were notified of falls. -She knew Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -She did not know if staff had notified Resident #3's PCP regarding his falls. -She expected staff to notify Resident #3's PCP after each fall. Telephone interview with Resident #3's PCP on 08/04/20 at 9:51 am revealed:	D 273	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 273	Continued From page 73 -He did not know Resident #3 had 5 falls in June 2020 and 4 falls in July 2020. -He expected the facility to notify him when a resident had a fall. -He would generally recommend an intervention after being notified of a fall. -On almost each occasion after a fall that was reported to him, he would order physical therapy to strengthen the resident.	D 273	The Administrator shall ensure that the facility shall follow the recommendations and guidance issued by the CDC and NCDHHS regarding infection prevention and control related to the COVID-19 pandemic. All staff shall wear a face mask over the mouth and nose while inside the facility. All staff shall be screened for symptoms of respiratory illness and temperature taken at the beginning of each shift and the screening shall be documented. Staff who exhibit symptoms and/or a temperature of 99.5 degrees or more shall be prohibited from working. All residents shall be screened for symptoms of respiratory illness and temperature taken at the beginning of each shift and the screening shall be documented. Any resident who exhibits symptoms and/or a temperature of 99.5 degrees or more shall be reported immediately to the resident's physician. Facility will screen all non-employee visitors, including taking the individual's temperature as well as asking the recommended screening questions per CDC guidelines. Facility will ask to record the name, address, and telephone number of every visitor allowed to enter the facility. Non-employee visitors who exhibit symptoms or respond affirmatively to any of the screening questions shall be prohibited from entering the facility. ·Clean face coverings shall be provided for all residents and residents shall be encouraged to wear face coverings when outside of their rooms or within 6 feet of another resident in their room. ·The facility shall develop and implement an infection prevention protocol and plan to address the needs of residents who are quarantined due to recent hospitalizations or absences from the facility. The plan shall include: Quarantine protocols for a resident upon return from the hospital; Practices to protect other residents regarding remaining in their room and social distancing protocols while out of their room; Wearing face masks whenever outside of their resident room and when needed inside a shared room; A pre-determined date and time the quarantine can be lifted. The facility Administrator/Director shall ensure the implementation of all other recommendations included in the guidance for long term care facilities and any recommendations from the Davidson County Health Department.	9/30/2020
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening of visitors and use of personal protective equipment (PPE) by staff and residents to reduce the risk of transmission and infection. The findings are: Review of the CDC guidelines for Considerations for Preventing Spread of COVID-19 in Assisted	D 338		

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D 338	Continued From page 74 Living Facilities revealed: -Personnel should wear a facemask at all times while they are in the facility. -Encourage residents to wear a cloth face covering (if tolerated) whenever they are around others, including when they leave their rooms and when they leave the facility. -Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) before starting each shift/when they enter the building. -Remind residents to remain at least 6 feet apart from others when they are outside their room. -Remind personnel to practice social distancing while in break rooms and common areas. Review of the resident roster dated 07/16/20 revealed there were 50 residents on the roster with 37 residents residing on the assisted living (AL) and 13 residents residing in Special Care Unit (SCU) of the facility. Review of the facility's amended Infection Control Plan related to COVID-19 policy dated 03/16/20 revealed: -Visitors will be limited except for end of life situations. -In an end of life situation, visitors will be screened prior to entry and restricted to their loved one's room or another designated area within the facility. -The facility was conducting health screenings on anyone who came into the facility. -The facility implemented daily health screenings	D 338	Residents and Staff signed form stating they are supplied masks. Residents signed form stating they are aware they are encouraged to wear in halls at all times and in their room if they have a roommate but know that it is their right not to wear it. Signage was put up throughout building in residents rooms and in halls as a reminder to residents and staff. New COVID 19 screening station put in front lobby, with new non-employee visitor screening forms, new temp/o2 machine, handouts on hand washing and proper use on hand sanitizer and face masks made available to all non employee visitors. Director is monitoring screening station at least every other day to ensure proper set up to ensure non employee screening forms, temp/o2 machine is available with alcohol prep pads for cleaning, hand sanitizer, handouts, and face masks are available at all times. Spot monitoring of staff to ensure masks are worn is being done by the director weekly x 3, biweekly x 3, weekly x 3 then quarterly thereafter. Documentation of this monitoring shall be kept at the facility for review. ***** ***** ***** ***** *****	

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D 338	Continued From page 75 for all residents including checking their temperature and O2 saturation. -The facility implemented daily health screenings of staff as they report to work daily. -Federal and state protocols were already implemented into their processes. -Their experienced clinical team was actively reviewing updates from the CDC, local public health authorities, and large reputable hospital sources. -They require anyone entering the facility to wash/sanitize their hands upon entrance into the facility and require them to wear a mask. -They educated their residents on social distancing and health practices set forth by the CDC and local government officials. Observation of the front lobby upon entrance to the facility on 07/16/20 between 11:50 am and 11:59 am revealed: -A staff member opened the door for surveyors to enter the front lobby. -Surveyors entered the facility with masks and gloves on. -The staff member told surveyors she needed to measure their oxygen saturation and then took the surveyors' temperatures. -Surveyors were not asked to remove their gloves to measure their blood oxygen levels. -Surveyors were not asked any screening questions. Interview with the front desk staff on 07/16/20 at 1:40 pm revealed: -She "usually" asked COVID-19 screening questions to visitors. -She did not ask COVID-19 screening questions to surveyors because surveyors were "from the state." -She did not screen surveyors blood oxygen	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 76 levels because surveyors had gloves on. Interview with the Director on 07/16/20 at 2:11 pm revealed: -There were no screening questions for residents because residents did not leave the facility. -There were no screening questions for staff because staff were encouraged to call in prior to their shift if they experienced signs or symptoms of COVID-19 and they were still paid if they did not work due to having symptoms. -There were screening questions for visitors who visited residents outside the facility. -There were no screening questions for visitors (facility physician, facility nurse, hospice nurse, home health nurse, or the psychiatrist). -The home health nurse was not screened with screening questions by the facility because the nurse was screened by the home health agency. -The facility physician, facility nurse, hospice nurse, and the psychiatrist were not screened with questions because they were tested for COVID-19 weekly. -The staff who screened surveyors today, 07/16/20, did not screen surveyors because she did not usually work up front. Observation of the special care unit (SCU) on 07/16/20 at 12:00 pm revealed: -A personal care aide (PCA) was standing in the doorway of a resident room and was talking to the resident who was standing in his room less than 6 feet away in front of her. -The resident did not have a mask on. -The PCA had a mask on, but it was resting below her mouth and nose. -The PCA pulled her mask up to cover her mouth and nose after she turned from the resident and started talking to surveyors.	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 77 Observation of the area outside of the medication room on the Assisted Living (AL) side of the facility on 07/16/20 at 12:30 pm revealed: -A resident was seated outside the medication room. -The resident was not wearing a mask. -A medication aide (MA) came out of the medication room with no mask on and administered medication to the resident seated outside the medication room. -After administering medication to the resident, the MA went back into the medication room and came back out wearing a mask. Interview with the MA on 07/16/20 at 12:39 pm revealed: -She realized she did not have a mask on after administering medication to the resident. -She had just eaten her lunch, sanitized her hands and without thinking, she went out and administered medication to the resident. -Staff were required to wear masks while in the facility and she usually wore her mask. Observation of the SCU on 07/16/20 between 12:00 pm and 12:30 pm revealed: -At 12:06 pm a PCA came up to the work desk on the SCU and pulled her mask down under her chin, she was 3 feet in front of the RCC. -After a few seconds she pulled her mask up just under her nose leaving her nose exposed. -At 12:08 the same PCA was observed adjusting her face mask. -At 12:10 the PCA again came to the work desk with her mask down. Interview with a PCA on 07/16/20 at 12:47 pm revealed: -She usually wore her mask because it was mandatory.	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 78 -She thought it was okay to pull the mask down at the desk because there were not any residents around. -She sanitized her hands before adjusting her mask. -She changed masks daily. Observations of the AL side of the facility on 07/16/20 between 12:04 pm and 12:30 pm revealed: -No residents in the SCU had a face mask on. -At 12:04 pm, a resident was observed walking down the hallway with no face mask on. -At 12:18 pm, a resident was observed walking down the hallway with no face mask on. -At 12:30 pm, three residents were observed sitting in a common area with no face masks on. Staff was nearby and did not encourage residents to wear face masks. Interviews with 5 residents at various times on 07/16/20 between 12:00 pm and 2:00 pm revealed: -One resident did not wear a mask and had never been offered a mask. -The only resident who received masks were the ones who had to go out of the facility for appointments. -Masks were only offered if there was a group meeting. -One resident left her room to go outside to smoke several times a day and did not wear a face mask when outside of her room. -Residents did not wear masks in the facility and staff did not encourage the residents to wear face masks. Interview with a MA on 07/16/20 at 12:39 pm revealed: -She had training on personal protective	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 79 equipment a few months ago. -Residents had visitors outside and were required to wear a face mask, stay 6 feet apart and limit visitation to 15 minutes. -Residents did not wear masks while outside of their rooms. -If a resident wanted a face mask, the resident could get the face mask from the medication room or from the front office. -Staff and visitors entered the facility through the front door where they had their temperature and blood oxygen levels checks. (The MA had her face mask on her chin at the start of the interview (12:39 pm) and pulled the face mask up over her mouth and nose at 12:42 pm.) Telephone interview with a PCA on 08/03/20 at 12:30 pm revealed: -She did not know who the facility contact person was for questions or issues related to COVID-19. -If a resident had symptoms of COVID-19, she would tell a MA. -Residents did not have to wear face masks when they were out of their rooms. -Masks were kept in the medication room. -All staff were required to wear masks which were disposed of in the nearest trash can. -There was no designated receptacle for PPE. Telephone interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:09 pm revealed: -The Director was responsible for answering questions and addressing issues in the facility related to COVID-19. -She remembered having COVID-19 infection control training since May, but she did not remember exactly when. -The COVID-19 infection control training covered	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 80 the use of PPE. -Residents were not required to wear face masks while out of their rooms in the facility, but they could get face masks from the medication room. -Residents were only required to wear face masks when they were visiting outside with their families. Telephone interview with the Director on 08/06/20 at 1:46 pm revealed: -The Administrator was responsible for making sure the facility was up to date with COVID-19 infection control policy and protocols. -She was the COVID-19 contact person in the facility, and she was responsible for making sure staff followed the COVID-19 infection control policy. A second telephone interview with the Director on 08/07/20 at 1:15 pm revealed: -She was aware of the CDC guidelines regarding use of face masks. -Residents were told there were face masks available if they wanted one, but staff did not encourage residents to wear face masks. -Staff were required to wear face masks when they walked through the door of the facility, when they were around residents, and when they were around other staff members. -Staff were not required to wear face masks when they were in the break room. Telephone interview with the facility physician's assistant on 08/06/20 at 4:11 pm revealed: -He visited the facility every Wednesday afternoon. -Residents should wear face masks when they are not in their rooms. -He did not know residents were not routinely wearing masks while outside of their rooms.	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 81 -He expected staff to encourage residents to wear face masks when they are outside of their rooms. -He had discussed the used of face masks for staff and residents with facility staff. Telephone interview with the Administrator on 08/07/20 at 3:51 pm revealed: -Staff were instructed they had to wear face masks when they were with residents. -Staff did not have to wear face masks when they were at the nurse's desk, in the break room, or around multiple staff as long as they stayed 6 feet apart. -She did not know residents were supposed to wear masks when they were out of their rooms. -Residents were not wearing face masks when they were out of their rooms and staff did not encourage residents to wear face masks. Interview with the Special Care Unit Coordinator (SCUC) on 07/16/20 at 12:10 pm revealed: -Staff were supposed to wear their mask while at work unless staff were in the break room. -Staff get a new mask daily. -The facility did not have a designated trash receptacle to dispose of their masks and gloves so she disposed of hers in the medication room trash can. -Their infection control policy included: frequent washing of hands especially before and after wearing gloves, staff wears face mask and restrict visitation. -If staff or their family members tested positive for COVID-19 staff were not allowed to work for a minimal of 14 days and then had to have a negative test before returning to work. -All staff had their temperature and oxygen saturation checked prior to clocking in and must have a mask on before entering the building.	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 338	Continued From page 82 -Staff checked the resident's temperature and oxygen saturation as well as asked them how resident felt on all shifts. -The MAs notify the primary care provider for residents with a temperature over 99.5 F or higher or oxygen level less than 93%. -Staff did not encourage residents to wear masks in the SCUC because the residents were easily agitated with masks on their face. -Should the facility have an outbreak there was a plan to move the residents to a sister facility and would have staff from here with them. -The facility also had some rooms on 400 hall designated as quarantine rooms. _____ The facility failed to ensure staff were following infection control guidelines during a viral pandemic including wearing face masks and screening visitors for the presence of illness or symptoms in the facility with 50 residents which placed the residents at risk of contracting a serious viral illness. This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on on 08/03/20 . CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2020.	D 338	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** *****	
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and	D 438	****see next page for POC***	

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D 438	Continued From page 83 supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to complete and submit the Health Care Personnel Registry (HCPR) initial and 5-day investigation reports in a timely manner for 1 of 4 sampled residents (#1), who was found with her face and neck pressed against the lower bar of the one-half bed rail attached to her bed, with her legs and feet on the floor and having no pulse and to report allegations of not checking on Resident #1 for 4 hours and 15 minutes (Staff A) and signing/completing bed rail logs in advance (Staff B). The findings are: Telephone interview with Staff A, personal care aide (PCA) on 08/06/20 at 11:50 am revealed: -She worked on 07/06/20, 3rd shift, for 2-3 weeks. -She made rounds with other staff and was in training for 3 days. -She was trained to do rounds at 1:00 am, 3:00 am, and 5:00 am. -She was "not really trained on bed rails" and did not know to check on Resident #1 every 30 minutes until the investigation. -She went in the television room to watch movies on her phone to help stay awake. -She never worked on the assisted living (AL) by herself. -She did not know bed rails could be restraints. -Resident #1 had the strength to turn and pull herself up in bed using the bed rail. -She did not know how long Resident #1 had bed	D 438	Administrator completed and faced 24 hour working report on 2 employees on 7/22/2020. [redacted] Employees were suspended until investigation is complete. The Administrator shall ensure reporting of all allegatrions against healthcare personnel as defined in GS 131E-256(1) shall be done within 24 hours of the healthcare facility becoming aware of the incident. The results of the healthcare facility investigation shall be submitted to the department in the accordance with GS 131E-256.	9/21/2020

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D 438	Continued From page 84 rails. -She never signed the restraint checklist. -She did not know what she was signing in the PCA book (Restraint Check Log), another PCA told her what it was. -She was told supervisors on the day shift looked at the restraint log, but she never saw anyone check it. -She did not know who was responsible for ensuring restraint checks were completed. -She was "doing rounds, don't remember the time, walked into Resident #1's room, saw her head wedged between the half rail and the bed, got scared, did not tell anyone and walked out to assist another resident. -She last made rounds at 5:45 am; she was told 4 hours and 15 minutes went by between 1st seeing Resident #1 and going back to her room. Telephone Interview with Staff B, PCA on 08/04/20 at 3:55 pm revealed: -She worked as a PCA at the facility on the 11:00 pm to 7:00 am (3rd shift). -On 07/06/20 there were 3 staff working, 1 in the special care unit (SCU), and 2 on the assisted living (AL) side -At 3:30 am, one staff left to go home, leaving Staff A on the AL and she went to the SCU. -She initialed and completed the Restraint Check Logs for Staff A, in advance, for the 3rd shift on 07/06/20. -Staff A told her she did not know how to document on the Restraint Check Logs so Staff B did it for her. -She did not know if Staff A observed the residents with restraints every 30 minutes as per the Restraint Check Logs. -She was aware she was not to document the Restraint Check Logs in advance, but she documented she observed residents with	D 438	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 438	Continued From page 85 restraints, every 30 minutes, a day ahead. -She did not remember if she pre-signed the Restraint Check Logs in advance for 07/07/20 and 07/08/20. -"No one said anything about not pre-signing the Restraint Check Logs in advance before the incident on 07/06/20. Telephone interview with a representative from the Health Care Personnel Registry (HCPR) on 08/05/20 at 11:34 am revealed: -Reports were due to the HCPR within 24 hours of an incident. -The report for the incident on 07/06/20, sent by the Administrator, was received by the HCPR on 07/23/20. -The allegations for Staff A and Staff B on 07/06/20 were not reported to the HCPR by the facility until 07/23/20. -The HCPR's fax was available 24 hours a day to accept facility reports; a report could have been sent anytime to the office. -The Administrator or Director of the facility should have sent in a report within 24 hours of the incident. Telephone interview with a nurse investigator from the HCPR on 08/06/20 at 10:28 am revealed: -The HCPR had not received a report from the facility for Staff A and Staff B and the incident on 07/06/20. -The HCPR investigation started due to the county Department of Social Services (DSS) sending the HCPR the report. Telephone Interview with the Director on 08/05/20 at 2:50 pm revealed: -The timeline for reporting to the HCPR within 24 hours.	D 438	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 438	Continued From page 86 -A report was sent to the HCPR, but it was sent "over a week later." -The Administrator was responsible for generating and sending reports to the HCPR. Telephone Interview with the Administrator on 08/08/20 at 2:58 pm revealed: -There was so much going on the day of the incident (07/06/20); it did not occur to me to make a report to the HCPR. -On 07/22/20 Staff A and Staff B were suspended; the report was sent to the HCPR on 07/23/20. -It was the Administrator's responsibility to send the report to the HCPR within 24 hours _____ The facility failed to complete and submit HCPR reports of Staff A allegedly for not checking on Resident #1 for 4 hours and 10 minutes on 3rd shift with Resident #1 being found with her face and neck pressed against the lower bar of the half bedrail attached to her bed, with her legs and feet on the floor and having no pulse, and of Staff B allegedly signing/completing bedrail checks in advance. The facility's failure to provide timely checks on Resident #1 and to document correctly on bedrail checks 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 08/03/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2020.	D 438	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** ***** ***see next page for POC	
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff	D 465		

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D 465	Continued From page 87 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 6 of 42 shifts sampled for 14 days from May 2020 through July 2020. The findings are: Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 75 beds and a Special Care Unit (SCU) with a capacity of 16 beds. 1. Review of the Resident Daily Census Report dated 06/15/20 revealed there was an SCU census of 13 residents, which required 10.4 personal care staff hours on third shift. Review of individual time cards dated 06/15/20 revealed 9.25 personal care staff hours were provided on third shift, leaving the shift short 1.4	D 465	The Administrator/Director has reviewed the staffing guidelines Rule .1308(a) to ensure understanding 8/7/2020. The Administrator/ Director has reviewed the current schedules/staffing availability at the facility both in the ACH and the SCU. Schedules will be prepared to ensure staffing per DHSR Rules and Regulations. (One staff member for eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.) The Administrator/ Director will monitor staffing in the Alzheimer's unit (SCU) to ensure adequate staffing per DHSR Regulations . Schedules/Staffing Availability will be reviewed by the Administrator with the Director in weekly meetings to ensure adequate staffing per DHSR rules and regulations. Staffing will be monitored by the Director using a monitoring tool designed by the administrator. Monitoring will be done biweekly x 3, monthly x 3, and quarterly thereafter. Monitoring will be available at the facility for review.	9/21/2020

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D 465	Continued From page 88 personal care staff hours. Review of the Resident Daily Census Report dated 06/16/20 revealed there was an SCU census of 13 residents, which required 10.4 personal care staff hours on third shift. Review of individual time cards dated 06/16/20 revealed 8 personal care staff hours were provided on third shift, leaving the shift short 2.4 personal care staff hours. Review of the Resident Daily Census Report dated 06/29/20 revealed there was an SCU census of 13 residents, which required 10.4 personal care staff hours on third shift. Review of individual time cards dated 06/29/20 revealed 8.25 personal care staff hours were provided on third shift, leaving the shift short 2.15 personal care staff hours. Refer to telephone interview with a Personal Care Aide (PCA) on 08/03/20 at 11:48 am. Refer to telephone interview with the RCC on 08/03/20 at 2:08 pm. Refer to telephone interview with the Director on 08/07/20 at 1:09 pm. Refer to telephone interview with the Administrator on 08/07/20 at 4:06 pm. 2. Review of the Resident Daily Census report for July 2020 revealed: -There was a census of 12 residents in the Special Care Unit (SCU) on 07/04/20 and 07/05/20, which required 12 staff hours on second shift and 9.6 staff hours on third shift.	D 465	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 465	Continued From page 89 -There was a census of 13 residents in the SCU on 07/09/20, which required 13 staff hours on second shift. Review of staff timecards for third shift on 07/04/20 revealed: -There were no staff hours for the SCU. -There was a shortage of 9.6 staff hours. Telephone interview with a PCA on 08/04/20 at 2:51 pm revealed: -She worked third shift on 07/04/20. -She was the only PCA on the AL unit that night. -Another PCA worked on the SCU but she could not remember who it was. Review of staff timecards for third shift on 07/05/20 revealed: -There was 8.25 total staff hours for the SCU. -There was a shortage of 1.35 hours. Review of staff timecards for second shift on 07/09/20 revealed: -There were 8 total staff hours for the SCU. -There was a shortage of 5 hours. Refer to telephone interview with a Personal Care Aide (PCA) on 08/03/20 at 11:48 am. Refer to telephone interview with the RCC on 08/03/20 at 2:08 pm. Refer to telephone interview with the Director on 08/07/20 at 1:09 pm. Refer to telephone interview with the Administrator on 08/07/20 at 4:06 pm. _____ Telephone interview with a Personal Care Aide	D 465	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 465	Continued From page 90 (PCA) on 08/03/20 at 11:48 am revealed: -She has worked short staffed on first and second shift on both units. -The Director made the schedule and posted it every Monday. -When staff called out the medication aide (MA) on duty had to find coverage for the shift. -She did not know what happened if the MA could not find coverage. -The MA's were responsible for reporting the call out to the Resident Care Coordinator (RCC) and the Director. Interview with the RCC on 08/03/20 at 2:08 pm revealed: -The Director was responsible for making the schedule which covered a 2-week time track. -MA's were responsible for finding coverage for call-outs and if they could not find coverage then a staff member had to stay, a PCA usually volunteered. -She had worked short on second and third shifts and it happened more than once. -A month or so ago it was frequent to be short staffed. -She was on call and if staff needed anything, she was available. Telephone interview with the Director on 08/07/20 at 1:09 pm revealed: -She was responsible for making the staff schedules. -She kept up with call outs. -She knew the facility had been short staffed some shifts but there were other shifts that were short staffed that no one let her know until after the fact. -She posted the schedule a week in advance. -She made the schedule according to what the administrator told her based on the current	D 465	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 465	Continued From page 91 census. -She had worked many shifts in which they were short including third shift. -The Administrator reviewed her schedule about every 2 weeks. -She tried to schedule 5 PCA's on first and second so that they would still be covered if someone called out. -The RCC and herself were on call. -When she had problems, she would go to the Administrator, but she was still ultimately responsible for staffing. Telephone interview with the Administrator on 08/07/20 at 4:06 pm revealed: -The Director was responsible for making the schedule. -She periodically reviewed the schedule (every other schedule). -She discussed any concerns with the Director. _____ The facility failed to ensure aide hours met the minimum requirements for a special care unit (SCU) and staff on duty were present at all times for 6 of 42 shifts sampled for 14 days from May 2020 through July 2020 . The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU 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 for this violation on on 08/28/20 . CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2020.	D 465	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 92	D 482	The Administrator/Director shall ensure the use of physical restraints per rule 10A NCAC 13F .1501(a) is followed. The facility has located the policy and procedures for physical restraints that could not be located during this survey and it is at the facility for review. The Facility Director checked each resident bed for rails/restraint and each chart for orders . If restraint is being used, order will be obtained from MD or restraint will be discontinued if MD decides restraint is no longer needed. BED RAILS OF ANY KIND WILL NO LONGER BE USED AT GRAYSON CREEK. Alternatives to be used in place of half rails. Halo Device (alternative to 1/2 bed rail) was purchased by the facility to attach to hospital bed to assist resident who needed for mobility) Staff meeting held on 7/24/2020 emphasizing importance of no longer using half rails and alternatives to restraints, meeting also covered restraint logs, 2hour checks, 30min checks, and documentation associated with restraints. Director began reviewing restraint logs 8/17/2020 at least 3 times weekly to ensure accuracy and completeness. Monitoring to ensure orders are being obtained by the physician quarterly with alternatives will be done. Monitoring of restraints will be done by the director weekly x 3, biweekly x 3, monthly x 3 then quarterly thereafter. Monitoring will be kept at the facility for review.	9/6/2020
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a	D 482		

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D 482	Continued From page 93	D 482		

device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure physical restraints were used only after an assessment, care and team planning, and use of alternatives were tried and documented for 4 of 5 sampled Residents (#1, #3, #4, #5) who had half bed rails attached to both sides of the bed.

The findings are:

There was no written restraint policy provided upon request prior to exit on 08/07/20.

Review of the facility's Consent for Physical Restraint Use revealed:
-Effective 01/01/01, the following restraint requirements shall apply:
-The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to one's

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D 482	Continued From page 94 body and includes bed rails when used to keep the resident from voluntarily getting out of bed as opposed to enhancing the mobility of the resident while in bed. -The facility shall prohibit the use of physical restraints for discipline or convenience and limit restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. -Medical symptoms may include, but are not limited to, the following: confusion with risk of falls; and risk of abusive or injurious behaviors to self or others. Review of the facility's Restraint Assessment revealed: -Assessments consisted of: medical conditions that warranted the restraint. -How the medical symptoms affected the resident. -When medical symptoms were first observed. -How often the medical symptoms occurred. -Alternatives that had been provided with the resident's response. Review of the facility's Restraint Care Plan revealed: -Alternatives and how the alternatives will be used. -The least restrictive type of restraint that would provide safety. -Care to be provided to the resident during the time the resident was restrained. -Time checks should be every 30 minutes loosening every 2 hours. -Special instructions had blank spaces to fill in. -There was a blank space to fill in the responsible persons name attesting they had been informed of the recommendations of the use of a physical restraint and they had a right to refuse such	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 95 treatment. -There was " I agree" and "I disagree" statement with instructions to circle one with the use of physical restraints and sign below. -There were 3 blanks for signatures of the Director, the resident or family member, and the physician. 1. Review of Resident #1's current FL2 dated 01/03/20 revealed: -Diagnoses included dementia, stroke, hypertension, and osteoporosis. -The resident was semi-ambulatory with a wheelchair. -The resident was intermittently disoriented. -There was no physician's order for half bed rails. Review of Resident #1's Resident Register revealed an admission date of 01/03/20. Review of Resident #1's Hospice order dated 05/01/20 revealed an order to discharge the resident from Hospice services due to no longer being Hospice appropriate. Review of Resident #1's primary care provider (PCP) order dated 06/11/20 revealed an order to refer to Hospice for evaluation due to advanced Alzheimer's dementia and cardiac issues. Review of Resident #1's Hospice invoice dated 06/12/20 revealed a charge for an electric hospital bed with a mattress. Review of Resident #1's Hospice orders dated 07/02/20 revealed an order for bed rails. Review of Resident #1's Guardian's Request revealed: -The resident's family member had signed the	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 96 form on 01/03/20 when the resident was admitted. -There was not a new request for half bed rails signed when the resident was re-admitted to Hospice on 06/11/20 and had been in a regular bed. Review of the Resident #1's Restraint Assessment dated 01/03/20 revealed: -Medical symptoms that warranted the use of physical restraints: confusion with the risk of falls. -How the medical symptoms affected the resident: minor injury from falling multiple times. -Medical symptoms were first observed: was left blank. -How often the medical symptoms occurred: daily. -Alternatives that had been provided: physical therapy, devices that assist, increased staff monitoring, and family involvement. No responses were listed for either alternative. Additional review of the Resident #1's Restraint Assessment dated 01/03/20 revealed: -There was no quarterly assessment or new assessment when half bed rails were delivered and placed on her new hospital bed on 07/03/20. -There was no assessment for the resident's ability to put the half bed rail up and down nor an assessment that indicated whether or not the resident had the capability of removing themselves from the half bed rail in the event of the resident becoming entangled in the bed rails. There were no quarterly Restraint Assessments for Resident #1 provided for March and June 2020 prior to 08/07/20. Review of Resident #1's Restraint Care Plan dated 01/03/20 revealed:	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 97 -Alternatives had failed. -The least restrictive type of restraint that would provide safety was half bed rails. -Care to be provided to the resident during the time the resident was restrained was left blank. -Time checks should be every 30 minutes loosening every 2 hours. -Special instructions remained blank. -The family member's name was written in attesting she had been informed of the recommendations of the use of a physical restraint and she had a right to refuse such treatment. -The " I agree" statement had been circled. -There were 3 signatures: The Director, Resident #1's family member, and the physician. -There was no quarterly care plan or new care plan after the resident received half bed rails on 07/03/20. Review of Resident #1's Accident/Incident report dated 07/06/20 revealed: -A first shift medication aide (MA) completed the report. -A personal care aide (PCA) had came to her and told her that the resident had fell out of bed. -The resident's head was wedged between the bed and the bed rails. -The resident did not have a pulse. -She notified Hospice and the Director of what happened. Observation on 07/16/20 of Resident #1's room at 11:22 am revealed: -A hospital bed with half bed rails attached to both sides, of the head of the bed, in an up position. -The bed was next to the wall separated by the heating/air conditioning unit. -There was a soiled stain approximately 2 feet in diameter on the bottom sheet midway to the left	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 98 side of the mattress. -There were small smeared blood stains just below the pillow and at the foot of the bed. -There were 5 inches between the mattress and the half bed rail with the half bed rails were in the up position. Interview with the Director on 07/16/20 at 2:11 pm revealed: -Staff had notified her about 6:55 am that Resident #1 was found without a pulse in her room on the morning of 07/06/20. -Resident #1's Hospice nurse had called the medical examiner due to the resident being found with her neck wedged between the half bed rail and the bed frame. Interview with a representative from the local sheriff's office on 07/21/20 revealed: -Resident #1 was found deceased in her room with her head wedged between the half bed rail and the bed frame. -The local medical examiner had notified his office of the incident and provided a picture that staff had taken before moving the resident's body. -It appeared as if the weight of her body pulling on her neck cut off the resident's airway so that she could not breathe, and she laid there without oxygen until she died. Telephone interview with the Director on 07/29/20 at 10:49 am revealed: -Resident #1 was not physically able to put the half bed rails up or down. -She used the half bed rails to help pull herself up in bed. Telephone interview with a PCA on 08/03/20 at 11:48 am revealed:	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 99 -She had worked with Resident #1. -Resident #1 used the half bed rail to hold herself over during personal care. -Resident #1 did not have the ability to think how to get herself out of the half bed rails if she became entangled, due to her dementia. -Resident #1 did not have the strength to get herself out of the bedrails if she became entangled. -She did not know if anyone had assessed Resident #1 for the ability to extricate herself if she became entangled. Telephone interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:08 pm revealed: -She did not consider half bed rails a restraint because most of the residents were still able to to get out of bed. -She did not know why Resident #1 had half bed rails because she could still get out of bed by herself. -She did not know if an assessment for the half bed rails had been completed or who was responsible for assessing the resident. Telephone interview with the local Medical Examiner on 08/03/20 at 3:41 pm revealed: -He had been contacted by Resident #1's Hospice nurse on the morning of 07/06/20. -The Hospice nurse had informed him that the resident had been entangled in a half bed rail and had strangled and passed away. -Upon his arrival to Resident #1's room, he could see a definite impression with bruising on the right side of the resident's neck. -The resident was deceased, and he believed it was due to asphyxiation from becoming entangled in the half bed rail and unable to extricate herself.	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 100 Telephone interview with Resident #1's Hospice physician on 08/06/20 at 11:21 am revealed: -She knew bed rails could be used as restraints. -Hospice did not assess the resident for the ability to put the rails up and down. -Hospice did not assess for the ability of the resident to extricate herself from the half bed rails should she become entangled. Telephone interview with the personal care aide (PCA) on 08/06/20 at 11:50 am revealed: -She worked with Resident #1 on the night of 07/05/20 and the morning of 07/06/20. -Resident #1 held to the bed rail when staff provided personal care. -She did not recall how long the resident had half bed rails. -The half bed rails were up the night of Resident #1's death on 07/05/20. Telephone interview with Resident #1's Hospice nurse on 08/06/20 at 12:42 pm revealed: -Resident #1 had a regular bed when she was admitted to Hospice on 06/11/20. -An electric hospital bed was delivered to the resident at the facility on 06/12/20. -Resident #1's family member had requested bed rails on 07/02/20. -Half bed rails were placed on Resident #1's bed on 07/03/20. -Hospice did not assess the resident for the ability to put the rails up and down. -Hospice did not assess for the ability of the resident to extricate herself from the half bed rails should she become entangled. Telephone interview with Resident #1's Primary Care Provider on 08/06/20 at 4:11 pm revealed: -He did not know that half bed rails could be	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 101 considered a restraint. -When he gave an order for half bed rails it was to mobilize the resident by holding onto the rail to get out of bed. -The facility would call and tell him who needed half bed rails and he gave them an order. -He did not do any assessments for the half bed rails. -He did not know an assessment needed to be done or how often it needed to be done. -He expected staff to complete any required assessments. Telephone Interview with the Director on 08/07/20 at 1:09 pm revealed: -She was responsible for completing the restraint assessments, on all residents who had half bed rails and lap belts every 3 months. -She did not assess any of the residents for the ability to raise and lower the half bed rails or for the ability to extricate themselves in the event they became entangled. -She was responsible for completing the restraint assessments and consents every 3 months. -Resident #1's assessment and consent were received at the beginning of COVID-19 in January, March, and June 2020. They were unsigned and laying in the medication room (assessments and consents were requested but not provided prior to 08/07/20). The family was notified of the continued use of half bed rails -Resident #1 had a new hospital bed and should have had a new assessment for half bed rails and a new consent. -She was told Resident #1 had a new assessment and consent, so she did not do a new assessment or new consent for half bed rails. -It must have been a breakdown in communication on her end.	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 102 Telephone interview with the Administrator on 08/07/20 at 3:52 pm revealed: -Assessments for half bed rails and lap belts were completed every 3 months and should be documented in the records. -The Director was responsible for completing quarterly assessments for half bed rails and lap belts every 3 months. -She believed Resident #1 continued to have the same bed with half bed rails as when she was on Hospice the first time, so she thought her assessment would have been good. -She did not know Resident #1 had been on a regular bed between 05/04/20 and 06/12/20. -She did not assess Resident #1 for the ability to raise and lower the half bed rails or for the ability to extricate herself in the event she became entangled. Attempted interview with Resident #1's family member on 07/22/20 at 1:35 pm was unsuccessful. 2. Review of Resident #3's FL2 dated 12/23/19 revealed: -Resident #3 was admitted to the facility on 12/24/20. -Diagnoses included benign prostrate hyperplasia, cognitive decline, frequent falls, hypertension, hypothyroidism, type II diabetes mellitus, and urinary retention. -Resident #3 was semi-ambulatory and used a wheelchair. -Resident #3 required total care. -There was no order for bed rails. Review of a physician's restraint order for Resident #3 dated 12/23/19 revealed: -There was an order for half bed rails for mobility	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 103 enhancement and fall prevention. -The restraint was to be used while in bed. -The restraint was to be checked every 30 minutes, loosened every 2 hours, and removed every 2 hours. Review of Resident #3's physician's orders dated 07/09/20 revealed: -There was an order to discontinue half bed rails. -There was an order Resident #3 may use a concave mattress and or fall alarm as needed. Review of Resident #3's current Care Plan dated 12/23/19 revealed: -Resident #3 was new to the facility and was admitted after he fell at home during the first week of December 2019. -Resident #3 had limited strength in his upper extremities. -There was documentation Resident #3 had half bed rails. Review of Resident #3's Restraint Assessment and Care Plan dated 12/23/19 revealed: -Resident #3 had confusion with the risk of falls. -Resident #3 had minor injuries from falling multiple times. -Alternatives that had been provided included physical therapy, increased staff monitoring, family involvement, and increased communication, and alternatives had failed. -The least restrictive restraint was half bed rails. -The responsible party consented to the use of bed rails. -There were no subsequent quarterly restraint assessments completed for Resident #3. Review of Resident #3's Licensed Health Professional (LHPS) review dated 01/27/20, 04/17/20, and 07/06/20 revealed:	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 104 -Resident #3 had bed rails for safety. -The half bed rails were noted to be on Resident #3's bed during each LHPS assessment. Telephone interview with Resident #3's responsible party on 07/24/20 at 11:37 am revealed Resident #3 had bed rails, but she did not know why. A second telephone interview with Resident #3's responsible party on 08/04/20 at 10:42 am revealed: -She signed initial paperwork for Resident #3 to have bed rails. -She did not know if quarterly assessments for bed rails were completed. Telephone interview with a medication aide (MA) on 07/24/20 at 3:06 pm revealed: -She was not sure if Resident #3 could raise and lower his bed rail. -She did not know any bed rail assessments had been completed for Resident #3. Telephone interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:09 pm revealed: -She did not know why Resident #3 had bed rails because she did not process his order for bed rails. -The Director was responsible for completing quarterly bed rail assessments. -She did not know if quarterly assessments had been completed for Resident #3. Telephone interview with the Director on 08/06/20 at 1:26 pm revealed: -She was responsible for completing bed rail assessments. -She knew bed rail assessments should have	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 105 been completed quarterly. -Resident #3 only had 1 bed rail assessment completed. -Quarterly assessments were completed for Resident #3 (The quarterly assessments were not provided by the facility.) -Resident #3's quarterly assessment were not signed by his responsible party due to visitor restrictions at the facility. Telephone interview with Resident #3's primary care physician (PCP) on 08/04/20 at 9:51 am revealed: -If Resident #3 had a bed rail, he wrote the order for it. -He was not aware bed rails were considered a restraint. -He thought of a half bed rail as something a resident could hold on to when trying to stand or pivot. -A half bed rail may keep a resident from falling out of bed, but not keep them in bed. Interview with the Administrator on 08/07/20 at 3:51 pm revealed: -Resident #3 had bed rails, but they were discontinued in July 2020. -Bed rail assessments should have been completed quarterly for residents with bed rails. -The Director was responsible for completing quarterly bed rail assessments. -She did not know quarterly assessments had not been completed for Resident #3. 3. Review of Resident #5's current FL2 dated 03/17/20 revealed: -Diagnoses included mental retardation, chronic lymphatic leukemia, and Zenker's diverticulotomy. -He was intermittently disoriented. -He was ambulatory with a walker.	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 106 Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 12/16/19 revealed: -He used a walker independently. -He had half bed rails for safety. Review of Resident #5's care plan dated 02/18/20 revealed he was a fall risk and had half bed rails. Review of Resident #5's physician orders, dated 06/26/20 revealed Resident #5 was to have half bed rails while in bed for mobility enhancement and fall prevention. Review of Resident #5's most recent restraint assessment, dated 03/20/19, revealed: -He had confusion with the risk for falls. -He sustained minor injuries from falling multiple times. -He had sustained injuries that required a trip to the emergency room or physician's office. -Alternatives had been attempted including physical therapy, assistive devices, increased staff monitoring, pain management, family involvement, and increased communication. Review of Resident #5's restraint care plan, dated 03/20/19 revealed: -Alternatives for bed rails for Resident #5 had failed. -The least restrictive type of physical restraint that would provide safety was half bed rails. Telephone interview with personal care aide (PCA) on 08/04/20 at 2:51 pm revealed Resident #5 had bed rails until they were all recently discontinued. Telephone interview with a medication aide (MA)	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 107 on 08/03/20 at 10:25 am revealed: -She did not know how often the restraint assessments and care planning needed to be completed. -The Director was responsible for completing the restraint assessments. Telephone interview with the Resident Care Coordinator (RCC) on 08/03/20 at 2:08 pm revealed: -She did not know why Resident #5 had half bed rails or when they were put on his bed. -The Director was responsible for completing quarterly bed rail assessments and care planning. Telephone interview with the Director on 07/23/20 at 11:08 am revealed: -Resident #5 had bed rails put on his bed in March 2019 due to falling when getting out of bed. -He had additional falls while getting out of bed after the bed rails were put on the bed. -In April 2019, it was concluded he was falling because of getting caught in the blanket when getting out of bed. -The bed was repositioned at that time and Resident #5 has had no more falls getting out of bed. -The bed rails were not removed after repositioning the bed as the responsible party wanted them left on. -The most recent restraint assessment for Resident #5 was 03/20/19. -Restraint assessments and care planning were to be completed every three months. -She was responsible for completing resident restraint assessments. Telephone interview with Resident #5's responsible party on 08/03/20 at 3:34 pm	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 108 revealed: -She thought she requested the bed rails because Resident #5 had several falls getting out of bed, although she could not remember when that was. -The need for bed rails ended when they repositioned Resident #5's bed and he stopped falling. -She did not remember the facility contacting her about removing the half bed rails after Resident #5 stopped falling. -She thought the last conversation with the facility about bed rails was a year or more ago. Telephone interview with the primary care provider (PCP) on 08/06/20 at 4:11 pm revealed: -He was not aware half bed rails were a restraint. -He did not know an assessment for bed rails had to be completed. -The facility called him when they wanted a bed rail order and he gave the order. -He knew Resident #5 had a diagnosis of cognitive disability but did not know if Resident #5 would be cognitively aware enough to extricate himself if he became entangled in the bed rail. 4. Review of Resident #4's current FL2 dated 12/05/19 revealed: -Diagnoses included dementia, abnormal gait with tremor, transient ischemic attacks, artery stenosis, depressive disorder and osteoporosis. -The resident was constantly disoriented and semi-ambulatory using a wheelchair. -There were no physician's orders for half bed rails or a lap belt. Review of Resident #4's assessment and care plan dated 02/19/20 revealed: -Resident #4 continued to show cognitive decline, had a lap belt to prevent falls from her	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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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 482	Continued From page 109 wheelchair, and a half bed rail for mobility enhancement and fall protection. -The resident needed extensive assistance with eating. -The resident needed total assistance with toileting, ambulation with wheelchair (needed pushing), bathing, dressing, grooming, and transferring. -The resident had a lap belt (for the wheelchair) to prevent falls. -The resident had a half bed rail for mobility enhancement and fall prevention. Review of Resident #4's record revealed: -A Physician Restraint Order, dated 03/01/19, for a half bed rail restraint, while in bed, for mobility, repositioning and fall prevention for Resident #4. -A Consent for Physical Restraint Use document dated 03/01/19 for one-half rails for mobility and fall prevention signed by the Director on 03/01/19 and Resident #4's Power of Attorney on 03/08/19. -A Physician Restraint Order, dated 03/01/19, for a lap belt restraint, while up in w/c (wheelchair) for Resident #4. -A Consent for Physical Restraint Use document dated 03/01/19 for a lap belt for fall prevention signed by the Director on 03/01/19 and Resident #4's Power of Attorney on 03/08/19. -There was no documentation of Resident #4 having a medical need or symptoms for the use of a half bed rail or the lap belt. Review of the Restraint Assessment and Care Plan document for Resident #4 dated 03/01/19 revealed: -There was no documentation of medical symptoms for the use of a half bed rail for Resident #4. -There was no "agree" documented, for the use of physical restraints, for Resident #4, by her	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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	HAL029010	A. BUILDING: _____ B. WING _____	C 08/07/2020

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D 482	Continued From page 110	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

representative.
-There was a primary care provider (PCP) signature on the document, but no date was given.

There were no subsequent assessments, care plans, or medical need or symptoms provided for Resident #4 for the use of a half bed rail restraint or the lap belt restraint after the physician's orders on 03/01/19.

Telephone interview on 07/29/20 at 1:50 pm with a personal care aide (PCA) revealed:
-Resident #4's bed was against the wall on one side and had a half bed rail on the open side.
-She did not know why Resident #4 had the half bed rail, it was just a part of the bed, the resident had not fallen out of bed since she was admitted 2 years ago.
-She thought the half bed rail was just part of the bed for the resident to feel more secure.
-Resident #4 slept in place, she did not move while sleeping.

Telephone interview on 07/29/20 at 3:23 pm with a second PCA revealed:
-Resident #4 was weak, she could not stand and required a 2-person assist to toilet her in bed.
-It was harder to change her without having the half bed rail to place the resident's hand on to turn her.
-Staff did not know why Resident #4 had the half bed rail, she did not fall out of bed.

Telephone interview on 07/27/20 at 1:55 pm with the first shift Medication aide (MA) revealed:
-Resident #4's bed had a half bed rail and her wheel chair had a lap belt attached.
-The half bed rail and lap belt were in place when she began employment at the facility over a year

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D 482	Continued From page 111 ago. -The MA never asked why the resident had the half bed rail or the lap belt. -The MA was not aware of any assessment, planning, or alternatives used for Resident #4. Review of Licensed Health Professional Support (LHPS) quarterly reviews revealed: -On 04/20/20, the LHPS nurse documented Resident #4 required extensive assistance for transferring and had orders for half bed rails for mobility and fall prevention. -On 05/13/20, the LHPS nurse noted Resident #4 had extensive assist for transfers and had orders for half bed rails for mobility and fall prevention. Telephone interview on 07/23/20 at 3:18 pm with the LHPS nurse revealed: -The LHPS nurse started working with Resident #4 about a year ago and the resident had the half bed rail attached to the bed and had a lap belt attached to her wheelchair. -Staff told the LHPS nurse they helped the resident to hold onto the bed rail to assist them with positioning her in bed (could not remember the date). -Resident #4 did not have the strength to hold onto the half bed rail and pull herself up or to get out of bed on her own. -Resident #4 could not participate in transferring herself to the wheelchair and needed extensive (more than 1) staff assistance; she could not get up on her own. -The LHPS nurse was not aware of any process for the assessment or use of restraints for Resident #4. Telephone interview on 07/31/20 at 9:42 am with the Resident Care Coordinator (RCC) revealed: -The half bed rail was attached to Resident #4's	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 112 bed and the lap belt was attached to Resident #4's wheel chair more than a year ago as per the Director. -The RCC was not aware of any assessment, discussion, or medical need for the half bed rail. -Resident #4 had "not ever fallen out of bed; I have no idea why she had the half bed rail". Telephone interview on 07/24/20 at 1:17 pm with Resident #4's Power of Attorney (POA) revealed: -Resident #4 was afraid of falling out of bed and had become weaker and was not eating well. -The POA made a telephone request to the Director on 03/01/19 for a bed rail for the resident. -The Director obtained a bed with bed rails for Resident #4 to use. -The POA ordered a lap belt, with an adhesive clasp, on the internet, to use on Resident #4's wheelchair so Resident #4 would not slip out of the wheelchair. -The POA was not aware of a process for using bed rails and lap belt. - She expected the Director would have told her of a process and use of alternatives, but was only made aware there were times the half bed rail and lap belt were to be taken off. -She did not talk with Resident #4's primary care provider (PCP) about the use of restraints for Resident #4. -There had been no meeting with or calls from the Director or the PCP about the use of the bed rail or lap belt for Resident #4. -She had not been requested to sign documents for the use of the one-half bed rail or lap belt restraints since last year. Telephone interview on 07/27/20 at 9:30 am with the PCP's nurse revealed: -There was no documentation of an assessment,	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 113 medical need or care planning for the use of a half bed rail or lap belt while sitting in the wheelchair for Resident #4. -There was no 03/01/19 physician's order filed in Resident #4's records for the use of half bed rails or for a lap belt. -There was no documentation of communication with Resident #4's POA concerning the use of a half bed rail or lap belt. Telephone interview on 07/27/20 at 9:40 am with the PCP revealed: -There was no medical need documented on the 03/01/19 restraint orders for the half bed rail and the lap belt. -There were no staff reported falls out of bed for Resident #4. -Resident #4 "was often trying to get up and transfer, it was a safety thing, she could not remember to not get up". -Since 03/01/19 he did routine assessments for Resident #4 every 6 months; he did not do assessments every 3 months for the half bed rail and lap belt. Telephone interview on 07/31/20 with the Director revealed: -There was no medical need or symptoms documented for the use of the half bed rail or the lap belt for Resident #4, only for mobility and repositioning. -Resident #4 did not fall out of bed, the half bed rail was used to keep the resident from sliding while sitting on the bed when staff were dressing her. -No alternatives were tried for the half bed rail. -A chair alarm was tried 2 years ago before the lap belt was obtained for use while sitting in the wheelchair. -No alternatives were tried before the 03/01/19	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 114 physician's orders for the half bed rail or the lap belt. -There were no every 3 months assessments for the use of the half bed rail and the lap belt for Resident #4 since the physician's order on 03/01/19. -The Director was responsible for making sure an assessment, care planning, and the use of alternatives were tried and documented for the use of restraints for Resident #4. Telephone interview on 08/07/20 at 2:35 pm with the Administrator revealed: -There was no medical need or symptoms documented for the use of the half bed rail or the lap belt for Resident #4. -There was no documentation of an assessment being done for Resident #4 for the use of the one-half bedrail or the lap belt. -There was no documentation of alternatives being tried for the half bedrail or the lap belt for Resident #4. -There was no documentation of every 3 months assessments for the use of restraints for Resident #4. -The Director was responsible for ensuring every 3 months assessments, use of alternatives, and care planning documentation were complete for the use of restraints for Resident #4. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. _____ The facility failed to ensure quarterly assessments, care and team planning, bed rail safety checks, and use of alternatives were attempted prior to using half bed rails as physical restraints for 4 of 5 residents including Resident #1 who had dementia and was found without a	D 482	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 482	Continued From page 115 pulse with her head wedged between the bed mattress and the half bed rail with her body on the floor. The facility's failure resulted in death and serious physical harm and neglect to the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on on 07/09/20 . CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2020.	D 482	The Administrator/Director shall ensure the use of physical restraints per rule 10A NCAC 13F .1501 (d) is followed referring to the the restraint order. The facility has located the policy and procedures for physical restraints that could not be located during this survey and it is at the facility for review. The Facility Director checked each resident bed for rails/restraint and each chart for orders . If restraint is being used, order will be obtained from MD or restraint will be discontinued if MD decides restraint is no longer needed. BED RAILS OF ANY KIND WILL NO LONGER BE USED AT GRAYSON CREEK. Alternatives to be used in place of half rails. Halo Device (alternative to 1/2 bed rail) was purchased by the facility to attach to hospital bed to assist resident who needed for mobility) Staff meeting held on 7/24/2020 emphasizing importance of no longer using half rails and alternatives to restraints, meeting also covered restraint logs, 2hour checks, 30min checks, and documentation associated with restraints. Director began reviewing restraint logs 8/17/2020 at least 3 times weekly to ensure accuracy and completeness. Monitoring to ensure orders are being obtained by the physician quarterly with alternatives will be done. Monitoring of restraints will be done by the director weekly x 3, biweekly x 3, monthly x 3 then quarterly thereafter. Documentation of monitoring shall be kept at the facility for review.	9/6/2020
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall	D 485		

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D 485	Continued From page 116 update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an order for a restraint was current and complete as required for 1 of 5 sampled residents (Residents #2) with half bed rails. The findings are: Review of Resident #2's current FL2 dated 09/20/19 revealed: -Diagnoses included dementia, dysphagia, symbolic dysfunction, depression, anxiety, and osteoarthritis. -The resident's level of care was special care unit. -The resident was semi-ambulatory with a walker. -The resident was constantly disoriented. -The resident required total care for her personal care. -There was no physician's order for bed rails. Review of Resident #2's Physician order for restraints dated 03/03/20 revealed: -The reason for the restraint was documented as mobility enhancement and fall prevention. -The type of restraint to be used was half bed	D 485	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 485	Continued From page 117 rails. -The time period for the restraint to be used was documented as "while in bed". -The time interval for the restraint to be checked was every 30 minutes and loosened and released every 2 hours. -The primary care provider (PCP) signed the order on 03/03/20. Review of Resident #2's PCP orders dated 07/09/20 revealed: -There was an order to discontinue half bed rails. -There was an order that read "may use concave mattress and/or fall alarm as needed". Observations of Resident #2's room (302) on 07/16/20 at 12:41 pm revealed: -Resident #2 had half bed rails (one on both sides) on the top half of her bed in the up position. -Resident #2 was lying in her bed. Interview with the Special Care Unit Coordinator (SCUC) on 07/16/20 at 12:42 pm revealed: -Restraints had not been used "in a while". -She had given medications to Resident #2 in her room after receiving the order to discontinue the half bed rails. -She did not know Resident #2 still had half bed rails. -She thought maintenance staff had removed the bed rails after receiving the order on 07/09/20. Interview with the Director on 07/16/20 at 1:25 pm revealed: -The facility no longer used half bed rails. -All half bed rails were discontinued on 07/09/20. -She did not know that Resident #2 still had half bed rails. -Maintenance staff was supposed to had	D 485	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 485	Continued From page 118 removed them on 07/07/20 or 07/08/20. -She did not know why maintenance had not removed Resident #2's half bed rails. -Resident #2 did not have a current order for half bed rails. Observation via video conference on 07/27/20 at 3:35 pm revealed that Resident #2's half bed rails had been removed from her bed. Telephone interview with the Director on 07/29/20 at 10:49 am revealed: -The SCU Coordinator knew Resident #2's half bed rails were discontinued and were supposed to be removed. -Resident #2's half bed rails should had been removed on 07/07/20 or 07/08/20 by maintenance staff because she had instructed him to remove all half bed rails. Telephone interview with Maintenance Staff on 08/06/20 at 10:13 am revealed: -All half bed rails were removed by 07/08/20. -He was responsible for removing all half bed rails. -There was 1 set of half bed rails that he could not remove because the resident was in her bed. -The half rails were attached to the underneath of the bed. -He had asked a staff member to let him know when the resident was out of bed so he could remove her half bed rails. -He had gone back to the Special Care Unit (SCU) several times, but he did not say anything because he did not want to bother Resident #2 while she was resting. -He knew that half rails required a physician's order. Telephone interview with the Administrator on	D 485	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D 485	Continued From page 119 08/07/20 at 4:06 pm revealed: -Maintenance staff was supposed to have removed the half rails from Resident #2's bed. -There must had been some miscommunication. -She knew Resident #2 did not have a current order for half bed rails. -The SCUC should have known the half bed rails were still on Residents #2's bed as she did rounds daily. -The Director was ultimately responsible for ensuring the half bed rails were removed from Resident #2's bed. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 485		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents were free from physical abuse and neglect related to Use of Physical Restraints and Alternatives, Personal Care and Supervision, Implementation, Personal Care and Other Staffing, Resident Rights, and Health Care Personnel Registry (HCPR). The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure physical restraints were used only after an assessment,	D914	Refer to Tag 465 Page 83-85	9/21/2020

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D914	Continued From page 120 care and team planning, use of alternatives were tried and documented, and a written order by a physician was obtained, for 5 of 5 sampled Residents (#1, #2, #3, #4, #5) who had half bed rails attached to both sides of the bed resulting in Resident #1 becoming entrapped and asphyxiated [Refer to Tag 482 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A1 Violation)]. 2. Based on record reviews and interviews the facility failed to provide adequate supervision for 5 of 5 sampled residents who had half bed rails (Residents #1, #2, #3, #4, and #5) and 3 of 5 residents (Resident #1, #3, and #4) with a history of falls. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were maintained and implemented to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to the use of physical restraints, personal care and supervision, resident rights, cardiopulmonary resuscitation, health care personnel registry, personal care and other staffing, and Special Care Unit staffing. [Refer to Tag 980 G.S. 131D-25 Implementation (Type A1 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented	D914	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D914	Continued From page 121 and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening of visitors and use of personal protective equipment (PPE) by staff and residents to reduce the risk of transmission and infection. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 5. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 5 of 42 shifts sampled for 14 days from May 2020 through July 2020. [Refer to Tag 0188 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type A1 Violation)]. 6. Based on interviews and record reviews the facility failed to ensure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 7 of 42 shifts sampled for 14 days from May 2020 through July 2020. [Refer to Tag 0167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 7. Based on record reviews and interviews, the facility failed to complete and submit the Health Care Personnel Registry (HCPR) initial and 5-day investigation reports in a timely manner for 1 of 4 sampled residents (#1), who was found with her face and neck pressed against the lower bar of the half bed rail attached to her bed, with her legs and feet on the floor and having no pulse and to report allegations of not checking on Resident #1 for 4 hours and 15 minutes (Staff A) and signing/completing bed rail logs in advance (Staff	D914	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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	HAL029010	A. BUILDING: _____ B. WING _____	C 08/07/2020

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D914	Continued From page 122 B). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 8. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 6 of 42 shifts sampled for 14 days from May 2020 through July 2020. [Refer to Tag 0465 10A NCAC 13F. 1308(a) Special Care Unit Staffing (Type B Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were maintained and implemented to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to the use of physical restraints, personal care and supervision, resident rights, cardiopulmonary resuscitation, health care personnel registry, personal care and other staffing, and Special Care Unit staffing. The findings are:	D980	Refer to Tags D167, D188, D270, D273, D338, D438, D465, D482, D485, & D914 Director will monitor to ensure compliance in all rule areas, documentation will be available at facility for review at indicated in each tag.	9/20/20

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D980	Continued From page 123 Telephone interview with a medication aide (MA) on 08/04/20 at 4:29 pm revealed: -She usually went to the Resident Care Coordinator (RCC) if she needed anything. -The RCC worked every day at the facility. -The Administrator was responsible for the total operations of the facilty. -The Administrator worked at the facility about 3 days a week. -The Director worked every day, but her hours in the facility varied. Telephone interview with the RCC on 08/07/20 at 10:40 am revealed: -She went to the Director for any problems she had. -The Director was ultimately responsible for running the facility. Telephone interview with the Director on 08/07/20 at 1:09 pm revealed: -She was at the facility 40 plus hours per week and sometimes as much as 60 hours per week. -Her hours were flexible, and she came in on all shifts. -The Administrator was at the facility 2-3 days per week. -She went to the Administrator when she had any problems. -She was responsible for running the day to day operations of the facility and the Administrator was responsible for the policies and procedures. Interview with the Administrator on 08/07/20 at 4:06 pm revealed: -The Director was responsible for over seeing staff, physician orders, medication administration and day to day operations of the facility. -The Director was in the facility a minimum of 40	D980	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D980	Continued From page 124 hours per week. -She worked at the facility at least 30 hours per week and was in charge of the Director and ensured she did her job and ensured overall operation of the facility and compliance with all rules and regulations. Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews and record reviews, the facility failed to assure physical restraints were used only after an assessment, care and team planning, use of alternatives were tried and documented, and a written order by a physician was obtained, for 5 of 5 sampled Residents (#1, #2, #3, #4, #5) who had half bed rails attached to both sides of the bed resulting in Resident #1 becoming entrapped and asphyxiated [Refer to Tag 482 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A1 Violation)]. 2. Based on record reviews and interviews the facility failed to provide adequate supervision for 5 of 5 sampled residents who had half bed rails (Residents #1, #2, #3, #4, and #5) and 3 of 5 residents (Resident #1, #3, and #4) with a history of falls. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were maintained and implemented to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to the use of physical restraints, personal care and supervision,	D980	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D980	Continued From page 125 resident rights, cardiopulmonary resuscitation, health care personnel registry, personal care and other staffing, and Special Care Unit staffing. [Refer to Tag 980 G.S. 131D-25 Implementation (Type A1 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening of visitors and use of personal protective equipment (PPE) by staff and residents to reduce the risk of transmission and infection. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 5. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 5 of 42 shifts sampled for 14 days from May 2020 through July 2020. [Refer to Tag 0188 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type A1 Violation)]. 6. Based on interviews and record reviews the facility failed to ensure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 7 of 42 shifts sampled for 14 days from May 2020 through July 2020. [Refer to Tag 0167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B	D980	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D980	Continued From page 126 Violation)]. 7. Based on record reviews and interviews, the facility failed to complete and submit the Health Care Personnel Registry (HCPR) initial and 5-day investigation reports in a timely manner for 1 of 4 sampled residents (#1), who was found with her face and neck pressed against the lower bar of the half bed rail attached to her bed, with her legs and feet on the floor and having no pulse and to report allegations of not checking on Resident #1 for 4 hours and 15 minutes (Staff A) and signing/completing bed rail logs in advance (Staff B). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 8. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 6 of 42 shifts sampled for 14 days from May 2020 through July 2020. [Refer to Tag 0465 10A NCAC 13F. 1308(a) Special Care Unit Staffing (Type B Violation)]. _____ The Administrator failed to ensure the facility's infection control policy was maintained, and staff adhered to the guidelines and recommendations established by the Centers for Disease Control (CDC) to protect the residents from infection and transmission of Coronavirus (COVID-19) during a global pandemic, use of physical restraints resulting in a resident becoming entangled in the half bed rails and passed away, personal care and supervision with resident's falling with multiple injuries, staffing, and reporting to the HCPR. The Administrator's failure resulted in serious neglect, physical harm, and death of a resident which constitutes a Type A1 Violation.	D980	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	

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D980	Continued From page 127 _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2020.	D980	***** ***** ***** ***** ***** ***** THIS PAGE INTENTIONALLY LEFT BLANK ***** ***** ***** ***** ***** *****	