From: Franks, James <JFranks@5SSL.COM>
Sent: Thursday, January 28, 2021 3:03 PM
To: Nielsen, Tina B <tina.nielsen@dhhs.nc.gov>
Cc: tworek, dai <dai.tworek@dhhs.nc.gov>; Williams, Wendy <wendy.williams@dhhs.nc.gov>; Hill, Nakea R <nakea.hill@dhhs.nc.gov>; Lloyd, Theresa A <theresa.lloyd@dhhs.nc.gov>; Goldman, Catherine E <Catherine.Goldman@wakegov.com>; DHSR.AdultCare.Star <DHSR.AdultCare.Star@dhhs.nc.gov>; dhsr.adultcare.email7 <dhsr.adultcare.email7@dhhs.nc.gov>
Subject: [External] RE: Morningside of Raleigh 2021-01-15 SODL F6N011

Good afternoon

I've attached a copy of the Statement of Deficiencies, along with the Plan of Correction.

2 Page Plan of Correction Attached.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: ______ B. WING ______	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 12/15/20 and a desk review survey on 12/15/20 - 12/18/20 and 12/21/22 - 12/22/20 and a telephone exit on 12/22/20.	D 000		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 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 188		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 1/28/21

01/28/21 — Reviewed & Accepted Iria B Nielsen RN MSN

Morningside of Raleigh Plan of Correction from Survey completed 1/27/2021

Responses to cited deficiencies does not constitute an admission or agreement by the facility of the truth of alleged or conclusions set forth in this statement of deficiencies of Corrective Action Report; the plan is solely as a matter of compliance with state law.

- **MEASURES TO CORRECT THE IDENTIFIED DEFICIENT PRACTICE**
- **MEASURE TO PREVENT RECURRENCE**
- **WHO WILL MONITOR**
- **HOW OFTEN WILL MONITORING BE DONE**
- **DATE CERTAIN**

188 10A NCAC 13F .0604(e) Personal Care and Other Staffing

- ED adjusted staffing based on state regulations and resident needs completed 12/22/20.
- DRC and/or designee will review staffing and assignments and adjust based on census and/or resident needs.
- ED and/or designee will monitor the daily assignment sheets in accordance to the schedule above weekly for twelve weeks.
- Correction date completion 2/5/21

270 10A NCAC 13 F .0901 (b) Personal Care and Supervision

- Res #3 care plan was reviewed on 12/18/20 by ADRC. 24 hour sitters put in place by family on 12/18/20. Care needs and fall risk re-evaluated the residents fall risk and other care needs on 12/18/20. Staff were re-educated on the Falls Management Policy by Regional Director of Health by 1/21/21.
- The Director of Resident Care or designee will review incident reports for completion, intervention, notification, and follow up to ensure interventions are in place at least weekly.
- ED will review all incident reports weekly for 12 weeks during the At Risk Meeting to ensure incident report is complete with interventions listed and that county has been notified as appropriate.
- Correction date completion 1/21/2021

367 10A NCAC 13F. 1004(j) Medication Administration

- DRC and/or designee re-educated Medication Technicians on resident rights, requirements for medication administration and timely MAR documentation. This will be completed by 2/5/21.
- MAR audits will be completed once weekly for each med cart for twelve weeks by DRC and/or designee.
- Off-going and on-coming med aide will review the mars page by page for omissions.
- Correction date completion 2/5/21.

James Franks ED 1/28/21 Reviewed + Accepted
Dnia B Nielsen RN MSN 1 of 2
01/28/21

451 10A NCAC 13F. 1212(a) Reporting of Accidents and Incidents

- RDH notified county monitor, on 12/22/20 of referenced incidents. .
- Re-education of incident reporting to be conducted with all staff, including managers by Executive Director and Regional Director of Health to be completed by 2/5/21.
- DRC or designee to review all incident reports for proper reporting to the county monitor daily.
- ED or designee has initiated 1/4/21 and will audit all incident reports for proper reporting to the county monitor weekly for 12 weeks.
- Correction date completion 2/5/2021

465 10A NCA 13F .1308(a) Special Care Unit Staff

- ED adjusted staffing based on state regulations and resident needs completed 12/22/20.
- DRC and/or designee will review staffing and assignments and adjust based on census and/or resident needs.
- ED and/or designee will monitor the daily assignment sheets in accordance to the schedule above weekly for twelve weeks.
- Correction date completion 2/5/21

914 GS 131D-21(4) Declaration of Resident Rights

- Res #3 care plan was reviewed on 12/18/20 by ADRC. 24 hour sitters put in place by family on 12/18/20. Care needs and fall risk re-evaluated the residents fall risk and other care needs on 12/18/20. Staff were re-educated on the Falls Management Policy by Regional Director of Health by 1/21/21.
- The Director of Resident Care or designee will review incident reports for completion, intervention, notification, and follow up to ensure interventions are in place at least weekly.
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- Correction date completion 1/21/2021

1/28/21

James Franks ED

Reviewed + Accepted
Dria B Nicholson RN MSN
01/28/21

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D 188	Continued From page 2 to cover the shortage in the AL area. Review of the employee time cards dated 12/08/20 (Tuesday) revealed: -There was a total of 16.03 staff hours provided on second shift in the AL area with a shortage of 3.97 hours. -There was also a shortage on second shift for the SCU so there was no additional staff in the facility to cover the shortage in the AL area. Review of the employee time cards dated 12/09/20 (Wednesday) revealed: -There was a total of 15.22 staff hours provided on third shift in the AL area with a shortage of 0.78 hours. -There was also a shortage on third shift for the SCU so there was no additional staff in the facility to cover the shortage in the AL area. Telephone interview with a personal care aide (PCA) on 12/22/20 at 2:02pm revealed: -When the facility was short staffed, it was hard to get the 2-hour checks done and assist residents with baths. -They used to have 2 medication aides (MAs) and 2 PCAs working in the AL area of the facility during first shift. -For the last 1 to 2 months, there had only been 3 staff working in the AL area on first shift. -Some staff had been fired or had quit so the MAs and PCAs did the best they could when they were short staffed. Telephone interview with a MA on 12/22/20 at 3:23pm revealed: -The facility never had enough staff. -There was usually 1 MA and about 9 PCAs for both the AL area and the SCU on third shift. -When they were short staffed, they might not get	D 188		

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D 188	Continued From page 3 a resident changed as often as needed and it was hard to monitor the residents. Telephone interview with the Wellness Coordinator (WC) on 12/21/20 at 6:00pm revealed: -She recently started completing the staff schedule and she was still in training with learning how to do it. -She used a master schedule and a formula that the Regional Nurse was teaching her to make the schedule based on the resident census. -The Director of Resident Care (DRC) and the Assistant of Director of Resident Care (ADRC) usually checked the schedule behind her. -If staff called out, she was responsible for getting coverage for that shift. -The supervisor on duty was supposed to call her if they were short staffed and she could come into work if needed to cover the shift because she only lived 10 minutes from the facility. -She sometimes worked double shifts because they were short staffed. -They were usually short staffed because of call outs, holidays with paid time off, and some new hires came for orientation but did not come back to work. Telephone interview with the DRC on 12/22/20 at 2:23pm revealed: -The WC was responsible for doing the staffing schedule. -The WC was trained to do staffing by the Regional Nurse. -There was a model based on the census and how many they could staff based on that model. -She did not check the schedule but she would verbally ask the WC how the schedule was looking and encouraged the WC to stay ahead on the schedule.	D 188		

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D 188	Continued From page 4 -She was not aware of the facility being short staffed and they had just hired 3 new staff. -The WC was responsible for call outs and making sure they had coverage. -The ADRC was the back up for helping the WC with the schedule. Telephone interview with the Regional Nurse on 12/22/20 at 4:09pm revealed: -She had gone over staffing requirements with the facility staff in November 2020. -The facility was supposed to have enough staff scheduled to cover any break time and to cover all shifts based on the current census. -She was not aware the facility had been short staffed because she was not at the facility every day. -If the facility was short staffed, they could call her and she could help if needed. Telephone interview with the Interim Administrator on 12/22/20 at 4:09pm revealed: -He was not aware of any issues with the facility being short staffed on some shifts from 12/05/20 - 12/09/20. -There had been some issues with the facility being short staffed since he started in October 2020 during the pandemic. -The WC was responsible for making the staffing schedule. -He had not been checking the schedule. Attempted interview with the ADRC on 12/22/20 at 2:21pm was unsuccessful.	D 188		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 270		

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D 270	Continued From page 5 Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 2 residents (#3) sampled with a history of multiple falls with injuries including abrasions, bruises, hematoma, bleeding from the right eyebrow, a possible rib fracture, and a head injury with a laceration requiring stitches. The findings are: Review of the facility's Falls Management and Investigation Policy revealed: -The facility used all reasonable efforts to provide a system to review residents' potential risk for falls and provide a proactive program of supervision, assistive devices, and interventions to manage and minimize falls and identify residents' continued needs. -All residents were assessed prior to, or shortly after, move-in or admission for fall risk, which included history of falls. -Fall interventions were documented in the resident's service plan. -A fall risk evaluation tool was completed and a service plan regarding falls was developed within 8 hours of move-in, an updated with level of care and significant change in status, post fall, or otherwise required by state law or regulation, addressing potential risk factors and suggested interventions. - Some of the post fall procedures included: the	D 270		

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D 270	Continued From page 6 service plan was reviewed and revised with resident/family participation; fall interventions were reviewed for continued effectiveness and communicated to staff, family and the resident. -Post fall investigations were completed using the Post Fall Investigation Form. Review of Resident #3's FL-2 dated 10/08/20 revealed: -Diagnoses included dementia, overactive bladder, hypothyroidism, major depressive disorder, and hyperlipidemia. -The resident was intermittently disoriented. -The resident was documented as semi-ambulatory and used a wheelchair. -The resident was incontinent of bladder and bowel. -The resident needed assistance with bathing and dressing. Review of Resident #3's current assessment and care plan dated 12/01/20 revealed: -The assessment was marked as a significant change assessment and it was dated by the assessor on 12/01/20 but it had not been signed by a physician. -The resident was ambulatory with a wheelchair and had limited strength in her upper extremities. -The resident was occasionally incontinent of bowel but documentation for bladder function was blank. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required limited assistance by staff with grooming/personal hygiene. -The resident required extensive assistance by staff with eating, toileting, ambulation, bathing, dressing, and transferring. -The resident had a significant falls history and had a private duty sitter Mondays through Fridays	D 270		

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D 270	Continued From page 7 from 7:00pm - 7:00am. -The resident needed reminders not to transfer on her own. -There was no other documentation regarding interventions for falls. Review of Resident #3's licensed health professional support (LHPS) review dated 10/07/20 revealed: -The resident needed assistance with bathing, dressing, and toileting. -The resident's only LHPS task documented was transferring. -The resident transferred to wheelchair with 2-person assist and mechanical lift. -The resident was able to self-propel the wheelchair. -There was no documentation related to the resident's falls or the resident receiving physical therapy (PT) and occupational therapy (OT) services. Review of Resident #3's incident/accident (I/A) reports, resident care notes, communication notes, and hospital visit notes revealed: -From 09/03/20 - 12/21/20, there was documentation Resident #3 was found on the floor or fell on 24 occasions. -The resident required evaluation by emergency medical services (EMS) on 3 falls including 1 of the 3 occasions requiring a visit to the emergency room (ER) resulting in a diagnosis of a head injury with a laceration requiring stitches. -The resident's other injuries included abrasions, bruises, hematoma (pocket of blood under the skin), bleeding from the right eyebrow, and a possible rib fracture. Review of a fax communication note to Resident #3's primary care provider (PCP) dated 09/02/20	D 270		

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D 270	Continued From page 8 revealed: -Facility staff requested an order for a bed alarm due to ambulatory issues. -The PCP signed the order and documented "ok". Review of Resident #3's resident service notes dated 09/03/20 revealed: -At 2:30am, the resident was found on the floor by her bed. -The resident had no complaints of pain and no injury was noted. -The resident would not stay in bed or call for assistance. -The resident was taken to the TV room for a while to monitor. -The resident's family and PCP were made aware. -There was no staff signature with the note dated 09/03/20 at 2:30am. -At 2:30pm, the resident was very agitated and would not stay seated. -The resident was walking "back & forward". Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/03/20. Review of Resident #3's PCP visit notes dated 09/03/20 revealed: -The resident had gait impairment and debility. -The PCP ordered PT and OT. Review of Resident #3's home health (HH) resident service notes dated 09/03/20 revealed: -There was a referral for PT and OT. -The resident was seen by PT and presented with generalized weakness and limited standing tolerance. -PT recommended 2-person assist with transfers for safety. -The resident was confused and kept trying to get	D 270		

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D 270	Continued From page 9 out of the chair. -The resident was a fall risk and a chair alarm was in place. Review of Resident #3's HH resident service notes dated 09/04/20 revealed: -The resident was seen by OT for evaluation. -Facility staff reported the resident fell out of bed last night (09/03/20) trying to get out of bed. -OT discussed with facility staff about falls safety and use of chair alarm in bed and in recliner. Review of Resident #3's resident service notes dated 09/04/20 revealed: -At 2:00pm, the resident said she wanted to get in bed and rest. -The resident was checked on every 2 hours. -At 8:00pm, the resident was asleep most of the day and checked on every 2 hours. -At 10:00pm, the resident was found lying on the floor in front of her bed. -"Non-injury" fall at this time. -The resident's family, PCP, and the Assistant Director of Resident Care (ADRC) were notified. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/04/20. Review of Resident #3's resident service notes dated 09/05/20 (no time specified) revealed: -The resident fell "back to back". -The resident would not stay in the bed or the chair. -Even when supervised, the resident tried to get up and walk. Review of Resident #3's I/A reports revealed no report was provided for the incidents on 09/05/20. Review of Resident #3's resident service notes	D 270		

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D 270	Continued From page 10 dated 09/08/20 at 4:27pm revealed: -The resident was found lying on the floor by her bed yelling. -The resident was checked but she had no pain at this time. -The resident had a small red abrasion under her left knee. -The resident refused to go to bed. -The resident's family and PCP were notified. -Staff would continue to monitor. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/08/20. Review of Resident #3's resident service notes dated 09/09/20 (no time specified) revealed the resident received a new order for a prn (as needed) medication for anxiety and agitation. Review of Resident #3's resident service notes dated 09/10/20 at 10:31pm revealed: -The resident was found sitting on the floor in the middle of her room. -There were no bruises or pain at this time. -The resident was given her prn medication. -The resident's family and PCP were notified. -Staff would continue to monitor. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/10/20. Telephone interview on 12/22/20 at 3:23pm with the medication aide (MA) who wrote the resident service note dated 09/10/20 revealed: -For the fall on 09/10/20, she found the resident on the floor. -Sometimes the bed and chair alarms worked and sometimes the alarms did not work because the resident knew how to turn off the alarms.	D 270		

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D 270	Continued From page 11 Review of Resident #3's PCP visit dated 09/10/20 revealed: -The resident had gait impairment and recurrent falling fortunately with no injury. -The resident's falls were due to poor safety awareness. -The resident as working with PT. -The PCP would continue to monitor. Review of Resident #3's resident service notes dated 09/12/20 at 12:30pm revealed: -The resident was found on the floor in her room between the bed and the air conditioner. -The resident had no complaints of pain and no bruises at this time. -The resident's family and PCP were notified. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/12/20. Review of Resident #3's resident service notes dated 09/22/20 at 9:00am revealed: -The resident was found on the floor in front of her bed. -Range of motion was performed and the resident denied pain. -The resident was seen by her PCP today, 09/22/20. -The resident's family was notified. -Staff would continue to monitor. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/22/20. Review of Resident #3's resident service notes dated 09/28/20 revealed: -At 7:00am, the resident was found on the floor by her bed. -No injury was noted at this time. -The resi	D 270		

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D 270	Continued From page 12 aware. -At 2:20pm, the resident was observed to be okay with no complaints of pain or discomfort from early morning fall. -Staff would continue to monitor the resident during the shift. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/28/20. Review of Resident #3's HH resident service notes dated 09/30/20 revealed the resident was seen by PT who worked on trunk/core/leg exercises with minimal participation by the resident. Review of Resident #3's HH resident service notes dated 10/01/20 revealed the resident was seen by OT and the resident participated well today. Review of Resident #3's resident service notes dated 10/01/20 at 6:30pm revealed: -The resident was sitting in a chair in the dayroom and kept moving the chair after the resident was told several times to be still. -The resident disregarded what staff told her until the resident slid out of the chair and landed on her buttocks. -There were no injuries. -All necessary parties were called to report the fall. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/01/20. Review of Resident #3's resident service notes dated 10/03/20 at 1:30am revealed: -The resident was found on the floor by her bed. -No injury was noted.	D 270		

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D 270	Continued From page 13 -The resident's family was made aware. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/03/20. Review of Resident #3's resident service notes dated 10/04/20 at 9:40am revealed: -The resident was in the lobby trying to transfer from the wheelchair to another chair. -The wheelchair rolled out from under the resident and the resident fell to the floor. -The resident's family and PCP were notified. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/04/20. Telephone interview on 12/22/20 at 1:13pm with the MA who wrote the resident service note dated 10/04/20 revealed: -For the fall on 10/04/20, Resident #3 was in the lobby and probably forgot to lock her wheelchair. -The resident would try to transfer herself from the wheelchair to another chair without assistance. Review of Resident #3's resident service notes dated 10/06/20 revealed: -The resident was found on the floor by her bed (no time specified). -No injury was noted. -The resident's family and PCP were notified. -At 3:00pm, the resident was observed to be okay with no complaints of pain or discomfort from fall. -The resident was resting in the lobby where staff could monitor her. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/06/20. Review of Resident #3's resident service notes	D 270		

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D 270	Continued From page 14 dated 10/07/20 at 9:30am revealed: -Staff was walking by the TV room and observed the resident trying to transfer from her wheelchair to another chair without assistance. -The resident slid off the chair and onto the floor. -There were no injuries to report. -The resident's family and PCP were notified. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/07/20. Telephone interview on 12/22/20 at 1:13pm with the MA who wrote the resident service note dated 10/07/20 revealed: -For the fall on 10/07/20, she was walking past the TV room and saw Resident #3 in the midst of transferring herself and the resident hit the floor. -There were no staff in the TV room at that time. Review of Resident #3's HH resident service notes dated 10/07/20 revealed the resident was seen by OT and OT would follow up to see if the resident was eligible for a wheelchair cushion. Review of Resident #3's HH resident service notes dated 10/08/20 revealed the resident was seen by PT and the resident was maximum assist with sit to stand transfers. Review of Resident #3's resident service notes dated 10/10/20 at 10:40am revealed: -The resident sustained a fall today. -The fall was unwitnessed with no injuries. -The resident's vital signs were taken. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/10/20. Review of Resident #3's HH resident service notes dated 10/12/20 revealed the resident was	D 270		

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D 270	Continued From page 15 seen by OT and facility staff reported the resident had an unwitnessed fall 2 days ago with no injury. Review of Resident #3's resident service notes dated 10/19/20 at 10:00am revealed the resident was seen by her PCP and observed to be okay with no complaints of pain or discomfort. Review of Resident #3's resident service notes dated 10/23/20 revealed: -At 3:00pm, the resident was found on the floor in her room. -Staff heard her chair alarm. -Staff asked the resident if she was hurt or if she bumped her head and the resident said "no". -The resident had no complaints and said she was okay. -The resident's family and PCP were notified. -At 8:55pm, the resident was observed to be okay with no complaints of pain or discomfort from the fall. -Staff continued to "keep a close eye" on the resident while awake. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/23/20. Telephone interview on 12/22/20 at 1:13pm with the MA who wrote the resident service note dated 10/23/20 revealed: -For the fall on 10/23/20, the PCAs heard Resident #3's alarm and let her know. -The resident was found on the floor in her room. Review of Resident #3's resident service notes dated 10/31/20 revealed: -At 6:00am, the resident was found on the floor by the bed. -The resident was bleeding from her right eyebrow.	D 270		

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D 270	Continued From page 16 -The area was cleaned and EMS was called. -EMS said it was an abrasion and if it was okay with the resident's family/power of attorney (POA), the resident would not be taken to the hospital. -The resident's family/POA did not want the resident taken to the hospital. -The resident's PCP and the facility's ADRC were made aware. -At 10:30pm, staff kept a close eye on the resident during day/evening shift. -The resident had an injury on the right side of her eye but the resident had not complained of pain or discomfort from the fall. -Staff would continue to monitor. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/31/20. Review of Resident #3's resident service notes dated 11/01/20 (no time specified) revealed: -The resident continued to get in and out of bed. -The resident was found on the floor. -There were no skin tears, bruising, or complaints of pain. -The resident was extremely confused. -Staff helped the resident get dressed and they would continue to monitor the resident. Review of Resident #3's I/A reports revealed no report was provided for the incident on 11/01/20. Review of Resident #3's resident service notes dated 11/03/20 revealed: -At 6:00am, the resident was up and down most of the shift. -The resident was very unsteady when getting up. -At 8:30pm, the resident had been getting up out of the recliner and the wheelchair during the shift and putting herself into bed.	D 270		

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D 270	Continued From page 17 -Staff would continue to monitor. Review of Resident #3's resident service notes dated 11/03/20 revealed staff monitored the resident closely by keeping the resident in "eye sight" and assisting frequently. Review of Resident #3's resident service notes dated 11/08/20 at 5:55pm revealed: -The resident was bringing out her dinner plate and the resident said she lost her balance and fell. -There was no injury. -The resident's family, PCP, and the facility's Director of Resident Care (DRC) were notified. Review of Resident #3's I/A reports revealed no report was provided for the incident on 11/08/20. Review of Resident #3's PT discharge instructions and visit notes dated 11/09/20 revealed: -The resident was discharged from PT as the resident was a maximum potential. -The resident was able to ambulate using a rolling walker with minimal assistance and verbal cues in walker management and directional changes. -The resident was able to transfer with minimal assistance. -The resident had improved balance but due to impaired cognition and safety awareness, the resident continued to be at a high falls risk. -No further PT services were recommended at this time. -Safety precautions to be continued including keeping chair/bed alarms in place. -Encourage increased fluid intake to prevent dehydration. -Report to the physician any falls, skin tears, skin breakdown, pain, change in mental	D 270		

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D 270	Continued From page 18 status/physical functions form discharge. Review of Resident #3's PCP visit dated 11/09/20 revealed: -The resident had gait impairment and recurrent falling. -The resident continued to work with PT. -The PCP was concerned about the resident's medication causing bone mineral loss and with frequent falls there was a concern for fractures. Review of Resident #3's resident service notes dated 11/10/20 at 1:40pm revealed staff kept the resident close by to prevent further falls. Review of Resident #3's resident service notes dated 11/17/20 revealed: -At 6:30am, the resident was found on the floor by her bed with a hematoma and a 2cm laceration to the left eyebrow area. -EMS was called to evaluate the resident and EMS said the resident possibly needed sutures. -EMS took the resident to the hospital for evaluation. -The resident's family, PCP, and the facility's DRC were notified. -At 12:50pm, the resident returned from the hospital. -The resident had a laceration with stitches in her left lower eyebrow. -The resident was placed in her recliner and she was trying to get up out of the recliner. -The resident's chair alarm continued to sound off due to the resident getting up. -At the beginning of second shift, the resident was trying to get up and walk without assistance. -The "head nurse" explained to the resident's family that the resident would need one-on-one supervision. -The resident's family would have a sitter to come	D 270		

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D 270	Continued From page 19 in the morning. Review of Resident #3's accident/incident report dated 11/17/20 revealed: -The resident was found on the floor at 5:40am. -The resident had a laceration and EMS was called. -The resident's family and PCP were notified. Telephone interview on 12/22/20 at 1:13pm with the MA who wrote the resident care note dated 11/17/20 revealed: -For the fall on 11/17/20, that was the second time the resident had hit her face from a fall. -The resident hit the left side of her face one week and the right side the next week. Review of Resident #3's after visit summary from the hospital dated 11/17/20 revealed: -The resident was seen for a fall and diagnosed with a head injury. -A laceration repair with stitches was completed. Review of Resident #3's HH resident service notes dated 11/17/20 revealed: -The resident was seen by OT who was planning to discharge the resident but the resident had a new fall early that morning on 11/17/20. -The resident was sent to the ER and got 3 stitches over her left eye and had a bruise over her left eye. Review of Resident #3's resident service notes dated 11/18/20 at 4:30pm revealed staff observed a sitter with the resident during the shift and had no problems. Review of Resident #3's HH resident service notes dated 11/28/20 revealed: -The resident was seen by OT for reassessment.	D 270		

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D 270	Continued From page 20 -There were no new falls reported. -The resident had met goals and was discharged from OT services. Telephone interview with a representative from the HH therapy provider's office on 12/22/20 at 2:16pm revealed: -Resident #3 was discharged from PT services on 11/09/2020 and OT services on 11/30/2020. -Resident #3 needed a lot of help when she was discharged from therapy services. -Staff were to reinforce fall prevention by assuring chair and bed alarms were in place. Review of Resident #3's resident service notes dated 12/08/20 at 10:45pm revealed: -The resident complained to the sitter that she was having pain on the left side and the left lower back. -Staff would let the next shift know and continue to monitor the resident throughout the shift. Review of Resident #3's resident service notes dated 12/09/20 at 6:30pm revealed: -The resident still complained of having left lower side pain leading to severe hip pain. -The resident's PCP was faxed to get an order for an x-ray to be done. Review of Resident #3's x-ray report dated 12/10/20 revealed there was an acute non-displaced fracture laterally to the left rib #9. Review of Resident #3's PCP visit dated 12/10/20 revealed: -The resident had gait impairment and remained a fall risk. -The resident had left hip and side pain and she already ordered x-rays which showed a fracture of the left ninth rib.	D 270		

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D 270	Continued From page 21 -The resident was going to continue with PT. Review of Resident #3's resident service notes dated 12/11/20 at 6:30pm revealed: -The resident was found on the floor in her room on her buttocks. -The sitter came in (sitter hours were 7:00pm - 7:00am) and found the resident on the floor. -The resident said she was getting ready for bed. -Range of motion was done without complaint of pain and there were no bruises at this time. -The resident's family and PCP were notified. Review of Resident #3's I/A reports revealed no report was provided for the incident on 12/11/20. Review of Resident #3's resident service notes dated 12/13/20 at 4:30pm revealed: -Staff was walking by the resident's room and heard the resident yelling for help. -Staff observed the resident on the floor sitting on her bottom. -The resident said that she just fell and did not know why she fell. -EMS was called to assist/assess the resident due to rib fracture. -EMS evaluated the resident and assisted the resident into the wheelchair. -The resident's PCP was called by EMS for further advice about taking the resident to the hospital. -The PCP declined the resident going to the hospital and the PCP would see the resident on 12/14/20. -The resident's family was notified that the resident had been falling again. -The resident was experiencing some pain on her left side area. -Staff would continue to monitor the resident.	D 270		

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D 270	Continued From page 22 Review of Resident #3's I/A reports revealed no report was provided for the incident on 12/13/20. Telephone interview on 12/22/20 at 1:13pm with the MA who wrote the resident service note dated 12/13/20 revealed:: -For the fall on 12/13/20, she walked by the resident's room and heard the resident say "help, help". -Neither the bed alarm or chair alarm were sounding. -The resident was on the floor in the middle of the room so she called EMS because she knew the resident already had a broken rib. Review of Resident #3's PCP visit dated 12/14/20 revealed: -The resident had several recent falls. -The resident's injuries to her head were resolving from falls weeks ago. -No new injuries were reported or identified today. Review of Resident #3's electronic incident report form dated 12/19/20 revealed: -The resident was found on the floor in her room at 5:04am. -There was no injury. -The resident's family and PCP were notified. Review of Resident #3's electronic communication form dated 12/21/20 at 10:49am revealed: -The resident's family member was called to make her aware of the resident's fall that morning, 12/21/20. -There were no other details documented about the incident. Telephone interview with the facility's Regional Nurse on 12/22/20 at 11:02am revealed:	D 270		

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D 270	Continued From page 23 -Resident #3 had dementia with periods of paranoia and confusion. -The resident did not remember her falls or being found on the floor. -The resident had received PT/OT services from an outside agency in the past. -The resident just started PT services with the facility's in-house provider on 12/17/20. Telephone interview with a MA on 12/22/20 at 1:13pm revealed: -Resident #3 had frequent falls. -Resident #3 did not understand that she could not walk independently so the resident tried to get up and go and do whatever she wanted to. -The resident was provided with a wheelchair 2.5 to 3 months ago and the resident's room was near the elevator. -The resident's family bought bed and chair alarms. -She checked on the resident multiple times but the resident still tried to get up on her own. -Staff would put the resident in high traffic areas but as soon as staff turned their backs, the resident would try to transfer from the wheelchair to a standard chair by herself. -The resident never remembered to lock the wheelchair so the resident had fallen a couple of times when trying to transfer from the wheelchair by herself. -Staff could go to the resident's room, assist her to the bathroom, and the resident would still try to get up and fall after staff had left the room. -If a resident fell, they were supposed to check on the resident every 30 minutes for 5 days and document it in the resident's record. -She could not recall if 30-minute checks were documented for Resident #3. -She had not been instructed to check on Resident #3 more frequently than every 30	D 270		

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D 270	Continued From page 24 minutes. -The 30-minute checks for the resident was not working so she tried to keep the resident with her when she was working. -Other residents were checked on either every 1 hour or every 2 hours. -For Resident #3, they were constantly trying to keep her busy or hanging out with staff. -Resident #3 had a wheelchair but the resident also had a walker she tried to use. -Even when Resident #3 was in the common areas, staff could not supervise the resident 24 hours a day because staff had to do other tasks. -If staff was in the common area, they sometimes had their backs to Resident #3 because staff was helping other residents. -The resident knew how to disengage the bed alarm so staff changed the position of the bed alarm so the resident could not reach it. -There was a delay in the resident's chair alarm; it sounded after the resident had already gotten up (could not say how long). -She let the family know on Friday, 12/18/20, and the family was supposed to get a new one. -The resident had a sitter at night from 7:00pm to 7:00am through an outside agency she thought 7 days a week. -The resident last had a sitter on 12/19/20 but the sitter left that evening and had not been back to her knowledge. -She spoke with the resident's family member last night and was told the sitter was not coming back and the family was trying to find another sitter. -She let the DRC know about the sitter this morning on 12/22/20. -The resident's family was trying to get a 24-hour sitter for the resident. Telephone interview with a second MA on 12/22/20 at 3:23pm revealed:	D 270		

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D 270	Continued From page 25 -She usually monitored residents every hour and she tried to check on residents with frequent falls more often (could not give a set time frame). -Resident #3 had a bed and a chair alarm since September 2020. -The bed and chair alarms both worked but you had to be quick enough to get to the resident once the alarms sounded. -The resident had a sitter every day but that stopped this past weekend when the sitter quit. -Even with the sitter, the resident continued to fall because the sitter only came at night and not during the day when the resident was most active. Telephone interview with a personal care aide (PCA) on 12/22/20 at 2:02pm revealed: -Resident #3 had anemia and she was very weak and did not have enough strength to walk. -The resident would take enough steps to get out of her room but once she was in the hallway, she would either fall or go right back in the room. -The resident had a walker but had been using a wheelchair for a couple of months. -She found the resident a couple of times when the resident had fallen. -The resident would get out of the bed and fall right beside the bed. -The resident had a pendant necklace and a call bell by her bed but the resident never used either one. -Staff usually checked on residents every 2 hours. -She tried to keep Resident #3 with her as much as possible and let the resident sit in the common areas. -If she had to go to another room to help another resident then Resident #3 was left unattended. -When Resident #3 was in her room, she tried to check on the resident every 15 minutes because	D 270		

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D 270	Continued From page 26 the resident was so quick and could get up fast. -The resident had a sitter at night from 7:00pm to 7:00am and she thought it was for 7 days a week but she was not sure. Telephone interview with the Wellness Coordinator (WC) on 12/21/20 at 6:00pm revealed: -Staff usually checked on residents, including Resident #3 every 2 hours but there was usually always staff walking in the hallways. -There were no current residents who required to be supervised more frequently than every 2 hours to her knowledge. -For residents with falls, they put bed alarms in place. -For residents with frequent falls, staff tried to keep the residents with them and keep the residents "entertained". -If a resident had frequent falls, they may need a sitter. -Resident #3 had a part-time sitter and she last saw the sitter a couple of days ago. -Resident #3 did not sit still and the resident was always saying she had to go somewhere. -The PCAs and MAs tried to take Resident #3 with them when they went from room to room. -Less than a month ago, she exited the elevator and saw Resident #3 on the floor in her room. -She heard the resident's alarm but the resident was already on the floor and the sitter was in the room. -Resident #3 was confused and not oriented to self or time. -Prior to having a sitter, Resident #3 was on 2-hour checks and she was in the common areas a lot. -The facility's nurses were responsible for contacting a resident's PCP and putting interventions in place, such as bed alarms, for	D 270		

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D 270	Continued From page 27 falls. Telephone interview with Resident #3's PCP on 12/22/20 at 10:00am revealed: -Resident #3 was a frequent faller and she was aware of the resident's falls. -The resident had a couple of head injuries from her falls and possibly a fractured rib. -It was difficult to tell if the resident's fractured rib came from the fall on 11/17/20 (the fall prior to x-ray on 12/10/20) because it could take several weeks for a fractured rib to heal and sometimes it could take a while for a fractured rib to show up. -She had checked the resident for orthostatic blood pressure concerns for potential cause of the falls. -Resident #3 had a bed/chair alarm but she was not sure if the resident could disarm the alarms. -She had staff trying to keep the resident hydrated because the resident was falling a lot when she first got up in the mornings and had altered mental status. -The resident had a sitter but she thought that was only for a few hours each day. -She had recommended 24-hour supervision for Resident #3 (could not recall date) to the facility. -The facility was trying to get a 24-hour sitter for the resident but there were staffing and financial issues with that. -She last saw the resident during a tele-visit yesterday (12/21/20) and she was doing well at that time. -The injuries to her face from a previous fall were almost resolved. -The resident did not remember the falls and could not voice any details about the falls. Telephone interview with the DRC on 12/22/20 at 2:23pm revealed: -When she started working at the facility 5 weeks	D 270		

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D 270	Continued From page 28	D 270		

ago, Resident #3 already had bed and chair alarms in place.
-The resident could not remember she required staff assistance to get up.
-She contacted the resident's family after she started working at the facility 5 weeks ago because the resident was going to injure herself due to the falls.
-When the resident injured her head from a fall and went to the hospital on 11/17/20, the family got a private duty sitter for the resident.
-The private duty sitter was quarantined with the resident for about 7 days when the resident returned from the hospital on 11/17/20 and the resident had no falls during that time.
-The resident's family then decided to change the private duty sitter to 7:00am - 7:00pm.
-The resident began falling again during the day after the private duty sitter's hours were changed to 7:00pm - 7:00am.
-She called the resident's family on 12/07/20 to see about moving the resident to their special care unit (SCU) for more oversight but the family was not ready to move the resident.
-The resident fell again yesterday, 12/21/20, so she called the resident's family again yesterday (12/21/20).
-The PCP had checked the resident's blood pressure and it was low while lying and sitting.
-There was one occasion (could not recall date) when the resident's private duty sitter left early but a replacement was found after 2 hours.
-She received an email from the homecare agency this morning that they were unable to find a sitter for the resident last night.
-The facility staff did not do anything differently if the resident's private sitter was not at the facility.
-Staff would check on the resident during their routine rounds (no set schedule) and staff was in the halls at all times providing personal care and

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D 270	Continued From page 29 passing medications. -If a resident fell, staff would check on them every 30 minutes. -For Resident #3, the MAs kept the medication cart outside the resident's room so they could keep an eye on the resident. -She put 24-hour supervision in place for the resident weeks ago (after the fall on 11/17/20) when she had the family to get a 24 hour sitter but the family decided to change it to 12 hours. -The resident then started falling again after that change. -The resident needed around the clock supervision but the facility did not have enough staff to provide 24-hour supervision for the resident. -She was responsible for documenting fall interventions on a resident's care plan. Interview with Resident #3's POA on 12/18/20 at 10:55am revealed: -The resident was falling at home before she ever went to the facility. -The resident had an increase in dementia and increase in her fall risks prior to admission. -The resident had alarms on her bed and chair but she could disarm them. -The facility staff notified her of every fall the resident had. -Around the end of November 2020 or the first of December 2020, the resident fell and hit her head above her eye. -The resident was quarantined when she returned from the hospital and the family had a sitter come in from 7:00pm to 7:00am to make nighttime a little less eventful. -The family committed to having the sitter until the end of December 2020. -The family had considered moving the resident downstairs to the special care unit but it was a	D 270		

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D 270	Continued From page 30 difficult decision to move the resident. -The family was still considering moving the resident to the special care unit. A second telephone interview with the Regional Nurse on 12/22/20 at 4:09pm revealed: -Resident #3 had a lot of falls in September 2020 and October 2020 and had continued to fall into December 2020. -The resident was "impulsive" but the facility could not provide 24 hour one-on-one supervision for the resident. -Staff would check on the resident frequently but they did not have eyes on her all the time. -They were currently looking into finding a skilled nursing facility for the resident but it was difficult to find a facility that would take new residents due to the pandemic. -The facility had a separate care plan for at risk meeting for falls that was an internal document for quality assurance purposes that should have fall interventions documented. -The resident's current assessment and care plan should also have fall interventions documented on it. -Resident #3 should have a fall risk assessment in her record. Resident #3's fall risk assessment and pos t fall risk evaluations were requested on 12/22/20 at 11:02am and 4:09pm but not provided. Based on interviews and record reviews, it was determined Resident #3 was not interviewable. The facility failed to provide supervision for Resident #3 who was found on the floor or fell on 24 occasions from 09/03/20 - 12/21/20 with injuries including abrasions, bruises, hematoma (pocket ob blood under the skin), bleeding from	D 270		

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D 270	Continued From page 31 the right eyebrow, and a head injury with a laceration requiring stitches. The failure of the facility to provide supervision resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/18/20 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 21, 2021.	D 270		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 32 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records (MARs) were accurate and complete for 3 of 5 residents (#1, #2 and #4) sampled for review. The findings are: 1. Review of Resident #1's current FL-2 dated 03/05/20 revealed diagnoses included Parkinson's dementia, Parkinson's disease, hypertension, benign prostatic hyperplasia, atrial fibrillation, coronary artery disease and Vitamin d deficiency. Review of Resident #1's dated on 04/15/20 revealed: -There was an order for Atorvastatin 20mg tablet every evening. (Atorvastatin is used to lower cholesterol.) -There was an order for Clonazepam 0.5mg take half tablet at bedtime. (Clonazepam is used for anxiety.) -There was an order for Seroquel 25mg tablet to be administered with Seroquel 50mg tablet for a total dose of 75mg at bedtime. (Seroquel is used to treat mood disorders.) -There was an order for Trazodone 50mg take half tablet at bedtime. (Trazodone is used for insomnia.) -There was an order for Rytary 48.75mg/195mg two capsules four times daily. (Rytary is a medication administered for Parkinson's disease.) -There was an order for Seroquel 50mg tablet to be administered with Seroquel 25mg tablet for a total dose of 75mg at bedtime. -There was an order for Biotene Mouthwash to	D 367	Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records (MARs) were accurate and complete for 3 of 5 residents (#1, #2 and #4) sampled for review. The findings are: 1. Review of Resident #1's current FL-2 dated 03/05/20 revealed diagnoses included Parkinson's dementia, Parkinson's disease, hypertension, benign prostatic hyperplasia, atrial fibrillation, coronary artery disease and Vitamin d deficiency. Review of Resident #1's dated on 04/15/20 revealed: -There was an order for Atorvastatin 20mg tablet every evening. (Atorvastatin is used to lower cholesterol). -There was an order for Clonazepam 0.5mg take half tablet at bedtime. (Clonazepam is used for anxiety). -There was an order for Seroquel 25mg tablet to be administered with Seroquel 50mg tablet for a total dose of 75mg at bedtime. (Seroquel is used to treat mood disorders). -There was an order for Trazodone 50mg take half tablet at bedtime. (Trazodone is used for insomnia). -There was an order for Rytary 48.75mg/195mg two capsules four times daily. (Rytary is a medication administered for Parkinson's disease). -There was an order for Seroquel 50mg	

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D 367	Continued From page 33 rinse for 30 seconds twice daily. (Biotene is a moisturizing mouthwash.) -There was an order for Chlorhexidine Gluconate Mouthwash 1.25mg twice daily. (Chlorhexidine Gluconate Mouthwash is used to reduce the amount of bacteria in the mouth.) -There was an order for Eliquis 5mg tablet twice daily. (Eliquis is an anticoagulant used to prevent blood clots.) Review of Resident #1's October 2020 medication administration record (MAR) revealed: -There was an entry for Atorvastatin 20mg scheduled every evening at 8:00pm. -Documentation for Atorvastatin was blank on 10/04/20 with no reason for the omission documented. -There was an entry for Clonazepam 0.5mg half tablet at bedtime scheduled at 8:00pm. -Documentation for Clonazepam was blank on 10/04/20 with no reason for the omission documented. Review of Resident #1's November 2020 MAR revealed: -There was an entry for Seroquel 25mg to be administered in addition to Seroquel 50mg for a total dose of 75mg at bedtime scheduled at 8:00pm. -Documentation for Seroquel 25mg was blank on 11/21/20 with no reason for the omission documented. -There was an entry for Trazodone 50mg take half tablet at bedtime scheduled at 8:00pm. -Documentation for Trazodone was blank on 11/21/20 with no reason for the omission documented. -There was an entry for Rytary 48.75mg/195mg two capsules four times a day scheduled for 7:00am, 11:00am, 4:00pm and 7:00pm.	D 367	tablet to be administered with Seroquel 25mg tablet for a total dose of 75mg at bedtime. -There was an order for Biotene Mouthwash to rinse for 30 seconds twice daily. (Biotene is a moisturizing mouthwash). -There was an order for Chlorhexidine Gluconate Mouthwash 1.25mg twice daily. (Chorhexidine Gluconate Mouthwash is used to reduce the amount of bacteria in the mouth). -There was an order for Eliquis 5mg tablet twice daily. (Eliquis is an anticoagulant used to prevent blood clots). Review of a physician's order for Resident #1 dated on 11/30/20 revealed: -There was an order for Vancomycin 125mg one capsule every six hours for ten days. (Vancomycin is an antibiotic). Review of Resident #1's October 2020 medication administration record (MAR) revealed: -There was an entry for Atorvastatin 20mg scheduled every evening at 8:00pm. -Documentation for Atorvastatin was blank on 10/04/20 with no reason for the omission documented. -There was an entry for Clonazepam 0.5mg half tablet at bedtime scheduled at 8:00pm. -Documentation for Clonazepam was blank on 10/04/20 with no reason for the omission documented. Review of Resident #1's November 2020 MAR revealed: -There was an entry for Seroquel 25mg to	

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D 367	Continued From page 34 -Documentation for Rytary was blank on 11/14/20 for the 4:00pm dose with no reason for the omission documented. -There was an entry for Seroquel 50mg to be administered in addition to Seroquel 25mg for a total dose of 75mg at bedtime scheduled at 8:00pm. -Documentation for Seroquel 50mg was blank on 11/20/20 with no reason for the omission documented. Review of Resident #1's December 2020 MAR revealed: -There was an entry for Biotene Mouthwash twice daily scheduled for 8:00am and 8:00pm. -Documentation for Biotene Mouthwash was blank on 12/12/20 for the 8:00pm dose with no reason for the omission documented. -There was an entry for Chlorhexidine Gluconate 1.25mg Mouthwash twice daily scheduled for 8:00am and 8:00pm. -Documentation for Chlorhexidine Gluconate was blank on 12/14/20 for the 8:00pm dose with no reason for the omission documented. -There was an entry for Eliquis 5mg tablet twice daily scheduled for 8:00am and 8:00pm. -Documentation for Eliquis was blank on 12/14/20 for the 8:00pm dose with no reason for the omission documented. Based on interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to telephone interview with a medication aide (MA) on 12/18/20 at 4:15pm. Refer to telephone interview with a second MA on 12/22/20 at 12:41pm. Refer to telephone interview with the Wellness	D 367	be administered in addition to Seroquel 50mg for a total dose of 75mg at bedtime scheduled at 8:00pm. -Documentation for Seroquel 25mg was blank on 11/21/20 with no reason for the omission documented. -There was an entry for Trazodone 50mg take half tablet at bedtime scheduled at 8:00pm. -Documentation for Trazodone was blank on 11/21/20 with no reason for the omission documented. -There was an entry for Rytary 48.75mg/195mg two capsules four times a day scheduled for 7:00am, 11:00am, 4:00pm and 7:00pm. -Documentation for Rytary was blank on 11/14/20 for the 4:00pm dose with no reason for the omission documented. -There was an entry for Seroquel 50mg to be administered in addition to Seroquel 25mg for a total dose of 75mg at bedtime scheduled at 8:00pm. -Documentation for Seroquel 50mg was blank on 11/20/20 with no reason for the omission documented. Review of Resident #1's December 2020 MAR revealed: -There was an entry for Vancomycin 125mg one capsule every six hours for ten days. -Vancomycin was scheduled to be administered at 8:00am, 2:00pm and 8:00pm. -Documentation for Vancomycin was blank on 12/08/20 for the 8:00pm dose with no reason for the omission documented. -There was an entry for Biotene	

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D 367	Continued From page 35 Coordinator/MA on 12/21/20 at 4:53pm. Refer to telephone interview with the Director of Resident Care (DRC) on 12/22/20 at 2:23pm. Refer to telephone interview with the Regional Nurse on 12/22/20 at 4:09pm. 2. Review of Resident #4's current FL-2 dated 04/06/20 revealed: -Diagnoses included right hip fracture, hypertension, anemia, history of pulmonary embolism and benign prostatic hypertrophy. -There was an order for Myrbetriq 50mg once daily. (Myrbetriq relaxes the muscles of the urinary bladder.) -There was an order for Vitamin B-12 500mcg two tabs once daily. (Vitamin B-12 is a vitamin that assists in red blood cell formation.) -There was an order for Pradaxa 150mg twice daily. (Pradaxa is used to treat and prevent blood clots.) -There was an order for Lopressor 25mg take half tablet twice daily. (Lopressor is used to lower the blood pressure.) -There was an order for Ramipril 5mg once daily. (Ramipril is used to lower blood pressure.) Review of Resident #4's physician's orders dated on 09/17/20 revealed there was an order for Primidone 250mg scheduled daily at 8:00 am. (Primidone is used to control seizures.) Review of Resident #4's October 2020 Medication Administration Record (MAR) revealed: -There was an entry for Myrbetriq 50mg scheduled daily at 8:00am. -Documentation for Myrbetriq was blank on 10/09/20 with no reason for the omission	D 367	Mouthwash twice daily scheduled for 8:00am and 8:00pm. -Documentation for Biotene Mouthwash was blank on 12/12/20 for the 8:00pm dose with no reason for the omission documented. -There was an entry for Chlorhexidine Gluconate 1.25mg Mouthwash twice daily scheduled for 8:00am and 8:00pm. -Documentation for Chlorhexidine Gluconate was blank on 12/14/20 for the 8:00pm dose with no reason for the omission documented. -There was an entry for Eliquis 5mg tablet twice daily scheduled for 8:00am and 8:00pm. -Documentation for Eliquis was blank on 12/14/20 for the 8:00pm dose with no reason for the omission documented. Telephone interview with a medication aide (MA) on 12/22/20 at 12:41pm revealed: -Medications were signed off on after residents took their medications. -If a medication was not administered, MAs would write their initials in the spot for that medication, circle their initials and write on the back of the MAR why the medication was not given. -The blanks on the MARs were likely due to documentation errors and not related to residents not getting their medications. -There were other MAs that would flag the MARs that were missing documentation. -The MAs would review the flagged MARs and sign if it was their missed documentation. -The boxes on the MAR where they placed their initials were tiny and was hard	

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D 367	Continued From page 36 documented. -There was an entry for Vitamin B-12 1000mcg daily at 8:00am. -Documentation for Vitamin B-12 was blank on 10/09/20 with no reason for the omission documented. -There was an entry for Pradaxa 150mg scheduled to be administered at 8:00am and 6:00pm. -Documentation for Pradaxa was blank on 10/09/20 for the 8:00am dose with no reason for the omission documented. -There was an entry for Lopressor 25mg half tablet scheduled to be administered at 8:00am and 8:00pm. -Documentation for Lopressor was blank on 10/09/20 for the 8:00am dose with no reason for the omission documented. -There was an entry for Ramipril 5mg scheduled daily at 8:00am. -Documentation for Ramipril was blank on 10/09/20 with no reason for the omission documented. -There was an entry for Primidone 250mg scheduled daily at 8:00am. -Documentation for Primidone was blank on 10/09/20 with no reason for the omission documented. Review of Resident #4's December 2020 MAR revealed: -There was an entry for Pradaxa 150mg scheduled to be administered at 8:00am and 6:00pm. -Documentation for Pradaxa was blank on 12/14/20 for the 6:00pm dose with no reason for the omission documented. -There was an entry for Lopressor 25mg half tablet scheduled to be administered at 8:00am and 8:00pm.	D 367	to tell if they have signed in that place already. Based on interviews and record reviews, Resident #1 was not able to be interviewed. 2. Review of Resident #4's current FL-2 dated 04/06/20 revealed: -Diagnoses included right hip fracture, hypertension, anemia, history of pulmonary embolism and benign prostatic hypertrophy. -There was an order for Myrbetriq 50mg once daily. (Myrbetriq relaxes the muscles of the urinary bladder). -There was an order for Vitamin B-12 500mcg two tabs once daily. (Vitamin B-12 is a vitamin that assists in red blood cell formation). -There was an order for Pradaxa 150mg twice daily. (Pradaxa is used to treat and prevent blood clots). -There was an order for Lopressor 25mg take half tablet twice daily. (Lopressor is used to lower the blood pressure). -There was an order for Ramipril 5mg once daily. (Ramipril is used to lower blood pressure). Review of Resident #4's physicain's orders dated on 09/17/20 revealed: -There was an order for Primidone 250mg scheduled daily at 8:00 am. (Primidone is used to control seizures). Review of Resident #4's October 2020 Medication Administration Record (MAR) revealed: -There was an entry for Myrbetriq 50mg	

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D 367	Continued From page 37 -Documentation for Lopressor was blank on 12/14/20 for the 8:00pm dose with no reason for the omission documented. Refer to telephone interview with a medication aide (MA) on 12/18/20 at 4:15pm. Refer to telephone interview with a second MA on 12/22/20 at 12:41pm. Refer to telephone interview with the Wellness Coordinator/MA on 12/21/20 at 4:53pm. Refer to telephone interview with the Director of Resident Care (DRC) on 12/22/20 at 2:23pm. Refer to telephone interview with the Regional Nurse on 12/22/20 at 4:09pm. 3. Review of Resident #2's current FL-2 dated 10/08/20 revealed: -Diagnoses included Alzheimer's dementia, diabetes mellitus type 2, hypertension, colon cancer, and fatigue. -There was an order for Tylenol ES 500mg once daily. (Tylenol is a pain reliever/fever reducer.) -There was an order for Aspirin 81mg chew 1 tablet once daily. (Aspirin may be used to prevent heart disease.) -There was an order for Bystolic 10mg once daily. (Bystolic lowers blood pressure.). -There was an order for Fiberlax 500mg 2 tablets once daily. (Fiberlax is a laxative for constipation.) -There was an order for Bacid 1 tablet once daily. (Bacid is a probiotic used to improve digestion.) -There was an order for Miralax 17 grams in water once daily. (Miralax is a laxative for constipation.)	D 367	scheduled daily at 8:00am. -Documentation for Myrbetriq was blank on 10/09/20 with no reason for the omission documented. -There was an entry for Vitamin B-12 1000mcg daily at 8:00am. -Documentation for Vitamin B-12 was blank on 10/09/20 with no reason for the omission documented. -There was an entry for Pradaxa 150mg scheduled to be administered at 8:00am and 6:00pm. -Documentation for Pradaxa was blank on 10/09/20 for the 8:00am dose with no reason for the omission documented. -There was an entry for Lopressor 25mg half tablet scheduled to be administered at 8:00am and 8:00pm. -Documentation for Lopressor was blank on 10/09/20 for the 8:00am dose with no reason for the omission documented. -There was an entry for Ramipril 5mg scheduled daily at 8:00am. -Documentation for Ramipril was blank on 10/09/20 with no reason for the omission documented. -There was an entry for Primidone 250mg scheduled daily at 8:00am. -Documentation for Primidone was blank on 10/09/20 with no reason for the omission documented. Review of Resident #4's December 2020 MAR revealed: -There was an entry for Pradaxa 150mg scheduled to be administered at 8:00am and 6:00pm. -Documentation for Pradaxa was blank on 12/14/20 for the 6:00pm dose with no reason for the omission documented.	

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D 367	Continued From page 38 -There was an order for Travatan 0.004% instill 1 drop in each eye once daily. (Travatan is for glaucoma.) -There was an order for Calcium with Vitamin D 600mg/200IU once daily. (Calcium with Vitamin D is a vitamin supplement.) -There was an order for Vitamin D3 25mcg once daily. (Vitamin D3 is used to treat Vitamin D deficiency.) -There was an order for Zocor 40mg at bedtime. (Zocor lowers cholesterol.) -There was an order for Januvia 50mg once daily. (Januvia lowers blood sugar.) -There was an order for Zinc Oxide ointment to buttocks twice daily. (Zinc Oxide ointment is a topical skin protectant.) -There was an order for Eucerin cream to legs twice a day. (Eucerin cream is used to treat dry skin.) Review of Resident #2's October 2020 medication administration record (MAR) revealed: -There was an entry for Tylenol ES 500mg once daily scheduled at 6:00am. -There was an entry for Aspirin 81mg chew 1 tablet once daily scheduled at 8:00am. -There was an entry for Bystolic 10mg once daily scheduled at 8:00am. -There was an entry for Fiberlax 500mg 2 tablets once daily scheduled at 8:00am. -Documentation for Tylenol, Aspirin, Bystolic, and Fiberlax was blank for each medication on 10/07/20 with no reasons for the omissions documented. -There was an entry for Januvia 50mg once daily scheduled at 8:00am. -Documentation for Januvia was blank on 10/06/20 and 10/07/20 with no reasons for the omissions documented. -There was an entry for Zinc Oxide ointment to	D 367	-There was an entry for Lopressor 25mg half tablet scheduled to be administered at 8:00am and 8:00pm. -Documentation for Lopressor was blank on 12/14/20 for the 8:00pm dose with no reason for the omission documented. Telephone interview with a Medication Aide on 12/18/20 at 4:15pm revealed: -Documentation on MARs was to be documented after resident was observed taking all medications. -MAs should sign and circle their initials when a medication was not administered and write the reason a medication was not administered on the back of the MAR. -Blanks on the MARs meant there was no proof or documentation the medications were administered. Telephone interview with the Wellness Coordinator/MA on 12/21/20 at 4:53pm revealed: -She was aware of the resident's MARs having blanks. -Blanks on the MARs had improved since the facility nurses started working at the facility about two-three months ago. -She monitored the MARs and notified the nurses of any blanks. -The nurses would then notify the MA to get the documentation completed. -It was the nurses' responsibility to ensure the MARs were completed.	

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D 367	Continued From page 39 buttocks 3 times daily scheduled at 6:00am, 2:00pm, and 8:00pm. -Documentation for Zinc Oxide ointment was blank for 6:00am on 10/26/20 and at 2:00pm on 10/08/20 and 10/09/20 with no reasons for the omissions documented. -There was an entry for Eucerin cream to legs twice a day scheduled at 6:00am and 6:00pm. -Documentation for Eucerin cream was blank at 6:00am on 10/26/20 with no reason for the omission documented. Review of Resident #2's November 2020 MAR revealed: -There was an entry for Aspirin 81mg chew 1 tablet once daily scheduled at 8:00am. -There was an entry for Bystolic 10mg once daily scheduled at 8:00am. -There was an entry for Fiberlax 500mg 2 tablets once daily scheduled at 8:00am. -There was an entry for Bacid 1 tablet once daily scheduled at 8:00am. -There was an entry for Miralax 17 grams, mix with 4 - 8 ounces of fluid and take every day scheduled at 8:00am. -There was an entry for Januvia 50mg once daily scheduled at 8:00am. -Documentation for Aspirin, Bystolic, Fiberlax, Bacid, Miralax, and Januvia was blank for each medication on 11/27/20 with no reasons for the omissions documented. -There was an entry for Travatan 0.004% instill 1 drop in each eye once daily scheduled at 8:00am. -Documentation for Travatan was blank on 11/08/20 and 11/13/20 with no reasons for the omissions documented. -There was an entry for Vitamin D3 25mcg once daily scheduled at 8:00pm. -Documentation for Vitamin D3 was blank on 11/08/20, 11/09/20, and 11/26/20 with no reasons	D 367		

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D 367	Continued From page 40 for the omissions documented. -There was an entry for Zocor 40mg at bedtime scheduled at 8:00pm. -Documentation for Zocor was blank on 11/08/20, 11/24/20, and 11/26/20 with no reasons for the omissions documented. -There was an entry for Zinc Oxide ointment to buttocks 3 times daily scheduled at 6:00am, 2:00pm, and 8:00pm. -Documentation for Zinc Oxide ointment was blank on 23 occasions, including 12 times for 6:00am, 3 times for 2:00pm, and 8 times for 8:00pm with no reasons for the omissions documented. -There was an entry for Eucerin cream to legs twice a day scheduled at 6:00am and 6:00pm. -Documentation for Eucerin cream was blank on 18 occasions, including 12 times for 6:00am and 6 times for 6:00pm with no reason for the omission documented. Review of Resident #2's December 2020 MAR revealed: -There was an entry for Vitamin D3 25mcg once daily scheduled at 8:00pm. -Documentation for Vitamin D3 was blank on 12/07/20 and 12/14/20 with no reasons for the omissions documented. -There was an entry for Eucerin cream to legs twice a day scheduled at 6:00am and 6:00pm. -Documentation for Eucerin cream was blank on 7 occasions, including 5 times for 6:00am and 2 times for 6:00pm with no reason for the omission documented. Telephone interview with a medication aide (MA) on 12/21/20 at 5:33pm revealed: -She thought there were "holes" on the MARs for Resident #2 because the MAs sometimes forgot to write their initials on the MARs.	D 367		

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D 367	Continued From page 41 -If a medication was not administered, the MAs would document the reason on the MARs. Based on interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to telephone interview with a medication aide (MA) on 12/18/20 at 4:15pm. Refer to telephone interview with a second MA on 12/22/20 at 12:41pm. Refer to telephone interview with the Wellness Coordinator/MA on 12/21/20 at 4:53pm. Refer to telephone interview with the Director of Resident Care (DRC) on 12/22/20 at 2:23pm. Refer to telephone interview with the Regional Nurse on 12/22/20 at 4:09pm. Telephone interview with a medication aide (MA) on 12/18/20 at 4:15pm revealed: -Documentation on MARs was to be documented after resident was observed taking all medications. -MAs should sign and circle their initials when a medication was not administered and write the reason a medication was not given on the back of the MAR. -Blanks on MARs meant there was no proof or documentation that the medication was administered. Telephone interview with a second MA on 12/22/20 at 12:41pm revealed: -Medications were signed off on after residents took their medications. -If a medication was not administered, MAs would write their initials in the spot for that medication,	D 367		

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D 367	Continued From page 42	D 367		

circle their initials and write on the back of the MAR why the medication was not given.
-The blanks on the MARs were likely due to documentation errors and not related to residents not getting their medications.
-There were other MAs that would flag the MARs that were missing documentation.
-The MAs would review the flagged MARs and sign if it was their missed documentation.
-The boxes on the MAR where they placed their initials were tiny and was hard to tell if they have signed in that place already.

Telephone interview with the Wellness Coordinator/MA on 12/21/20 at 4:53pm revealed:
-She was aware of the residents' MARs having blanks on them.
-Blanks on the MARs had improved since the facility nurses started working at the facility about 2 to 3 months ago.
-She monitored the MARs and notified the nurses of any blanks.
-The nurses would then notify the MA to get the documentation completed.
-It was the nurses' responsibility to ensure the MARs were completed.

Telephone interview with the Director of Resident Care (DRC) on 12/22/20 at 2:23pm revealed:
-The MAs were supposed to initial the MARs as soon as they passed the medication and observed the resident take the medication.
-If a medication was not administered, the MAs were supposed to circle their initials and document the reason on the back of the MAR.
-There should not be any blanks on the MARs.
-Since she started working at the facility 5 weeks ago, she had been checking MARs and she would let the MAs know when she saw errors.
-The Assistant Director of Resident Care (ADRC)

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D 367	Continued From page 43 checked the MARs weekly. -She had noticed an improvement in the documentation on the MARs since they had been checking behind the MAs. Telephone interview with the Regional Nurse on 12/22/20 at 4:09pm revealed: -The MAs should initial the MARs when they administered and observed a resident take their medication. -If a medication was not administered, the MAs should circle their initials and document the reason on the back of the MAR. -Some of the MAs thought they could sign the MARs the next day within 24 hours if they forgot to document when the medication was administered.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of incidents resulting in injury requiring emergency medical evaluation and medical treatment at a hospital for 1 of 2 residents sampled (#3).	D 451		

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D 451	Continued From page 44 The findings are: Review of Resident #3's FL-2 dated 10/08/20 revealed diagnoses included dementia, overactive bladder, hypothyroidism, major depressive disorder, and hyperlipidemia. Review of Resident #3's incident/accident (I/A) reports, resident care notes, communication notes, and hospital visit notes revealed the resident required evaluation by emergency medical services (EMS) for 3 incidents including 1 of the 3 incidents requiring a visit to the emergency room (ER) resulting in a diagnosis of a head injury with a laceration requiring stitches. Review of Resident #3's resident service notes dated 10/31/20 revealed: -At 6:00am, the resident was found on the floor by the bed bleeding from her right eyebrow. -The area was cleaned and EMS was called. -EMS stated it was an abrasion and if it was okay with the resident's family/power of attorney (POA), the resident would not be taken to the hospital. -The resident's family/POA did not want the resident taken to the hospital. Review of Resident #3's I/A reports revealed no report was provided for the incident on 10/31/20 and no documentation the county Department of Social Services (DSS) was notified. Review of Resident #3's resident service notes dated 11/17/20 revealed: -At 6:30am, the resident was found on the floor by her bed with a hematoma and a 2cm laceration to the left eyebrow area. -EMS was called to evaluate the resident and EMS stated the resident possibly needed sutures.	D 451		

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D 451	Continued From page 45 -EMS took the resident to the hospital for evaluation. Review of Resident #3's after visit summary from the hospital dated 11/17/20 revealed: -The resident was seen for a fall and diagnosed with a head injury. -A laceration repair with stitches was completed. Review of Resident #3's I/A report dated 11/17/20 revealed: -The resident was found on the floor at 5:40am. -The resident had a laceration and EMS was called. -The resident's family and primary care provider (PCP) were notified. -There was no documentation the report was sent to the local county DSS. Review of Resident #3's resident service notes dated 12/13/20 at 4:30pm revealed: -Staff was walking by the resident's room and heard the resident yelling for help. -Staff observed the resident on the floor sitting on her bottom. -The resident stated that she just fell and did not know why she fell. -EMS was called to assist/assess the resident due to rib fracture. -EMS evaluated the resident and assisted the resident into the wheelchair. Review of Resident #3's I/A reports revealed no report was provided for the incident on 12/13/20 and no documentation the county DSS was notified. Telephone interview with the Adult Services Supervisor at the county DSS on 12/22/2020 at 11:48am revealed:	D 451		

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D 451	Continued From page 46 -Her office last received an I/A report from the facility for Resident #3 in 2019. -Her office had not received any I/A reports dated 10/30/2020, 11/17/2020 and 12/13/2020 for Resident #3. Telephone interview with a medication aide (MA) on 12/22/20 at 1:13pm revealed: -For Resident #3's fall on 12/13/20, she walked by the resident's room and heard the resident say "help, help". -The resident was on the floor in the middle of the room so she called EMS because she knew the resident already had a broken rib. -She thought she completed an I/A report for the fall on 12/13/20 but she could not recall. -The MAs filled out the report and then gave the report to the Director of Resident Care (DRC) or the Assistant Director of Resident Care (ADRC). -She did not know who was responsible for sending the reports to DSS. Telephone interview with the Regional Nurse on 12/22/20 at 4:09pm revealed: -For Resident #3's falls on 10/31/20 and 12/13/20, staff did not realize an I/A report needed to be sent to DSS. -They completed an internal report but it was not sent to DSS. -For the fall on 11/17/20, there was no confirmation the I/A report was sent to DSS. -The Administrator, DRC, or ADRC were responsible for sending I/A reports to DSS. Attempted interview with the ADRC on 12/22/20 at 2:21pm was unsuccessful. Telephone interview with the DRC on 12/22/20 at 2:23pm revealed: -The MAs were responsible for completing an I/A	D 451		

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D 451	Continued From page 47 report for any fall whether there was an injury or not. -The MAs were supposed to put I/A reports in her box for review. -She made sure the I/A reports were complete then she signed them and gave them to the Administrator. -The Administrator was responsible for sending I/A reports to DSS. -She could not recall if she had received I/A reports for Resident #3 since she started working at the facility 5 weeks ago. Telephone interview with the Interim Administrator on 12/22/20 at 4:09pm revealed he had not sent any I/A reports to DSS and he was not aware he was responsible for sending those reports.	D 451		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 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: Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the special care unit (SCU) with a census of 32 residents were met for 7 of 15 shifts sampled from 12/05/20 - 12/09/20.	D 465		

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	HAL092217	A. BUILDING: _____ B. WING _____	12/22/2020

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D 465	Continued From page 48 The findings are: Review of the facility's current license effective January 1, 2020 revealed the facility was licensed for a capacity of 110 beds including a special care unit (SCU) with a capacity of 53 beds. Review of the facility's resident census reports dated 12/05/20 - 12/09/20 revealed there was a SCU census of 32 residents on each of those dates, which required 32 staff hours on first and second shift and 25.6 staff hours on third shift. Review of the employee time cards dated 12/05/20 revealed there was a total of 21.83 staff hours provided on first shift in the SCU with a shortage of 10.17 hours. Review of the employee time cards dated 12/06/20 revealed there was a total of 21.77 staff hours provided on second shift in the SCU with a shortage of 11.23 hours. Review of the employee time cards dated 12/07/20 revealed: -There were 21.38 staff hours provided on second shift in the SCU with a shortage of 10.62 staff hours. -There were 22.82 staff hours provided on third shift in the SCU with a shortage of 2.78 staff hours. Review of the employee time cards dated 12/08/20 revealed: -There were 26.48 staff hours provided on second shift in the SCU with a shortage of 5.52 staff hours. -There were 22.85 staff hours provided on third shift in the SCU with a shortage of 2.75 staff hours.	D 465		

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D 465	Continued From page 49 Review of the employee time cards dated 12/09/20 revealed there was a total of 23.15 staff hours provided on third shift in the SCU with a shortage of 2.75 hours. Telephone interview with a personal care aide (PCA) on 12/22/20 at 2:02pm revealed: -When the facility was short staffed, it was hard to get the 2-hour checks done and assist residents with baths. -Some staff had been fired or had quit so the medication aides (MAs) and PCAs did the best they could when they were short staffed. Telephone interview with a MA on 12/22/20 at 3:23pm revealed: -The facility never had enough staff working. -There was usually 1 MA and about 9 PCAs for both the assisted living (AL) area and the SCU on third shift. -When they were short staffed, they might not get a resident changed as often as needed and it was hard to monitor the residents. Telephone interview with the Wellness Coordinator (WC) on 12/21/20 at 6:00pm revealed: -She recently started completing the staff schedule and she was still in training with learning how to do it. -She used a master schedule and a formula that the Regional Nurse was teaching her to make the schedule based on the resident census. -The Director of Resident Care (DRC) and the Assistant Director of Resident Care (ADRC) usually checked the schedule behind her. -If staff called out, she was responsible for getting coverage for that shift. -The supervisor on duty was supposed to call her	D 465		

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D 465	Continued From page 50 if they were short staffed and she could come into work if needed to cover the shift because she only lived 10 minutes from the facility. -She sometimes worked double shifts because they were short staffed. -They were usually short staffed because of call outs, holidays with paid time off, and some new hires came for orientation but did not come back to work. Telephone interview with the DRC on 12/22/20 at 2:23pm revealed: -The WC was responsible for doing the staffing schedule. -The WC was trained to do staffing by the Regional Nurse. -There was a model based on the census and how many they could staff based on that model. -She did not check the schedule but she would verbally ask the WC how the schedule was looking and encouraged the WC to stay ahead on the schedule. -She was not aware of the facility being short staffed and they had just hired 3 new staff. -The WC was responsible for call outs and making sure they had coverage. -The ADRC was the back up for helping the WC with the schedule. Telephone interview with the Regional Nurse on 12/22/20 at 4:09pm revealed: -She had gone over staffing requirements with the facility staff in November 2020. -The facility was supposed to have enough staff scheduled to cover any break time and to cover all shifts based on the current census. -She was not aware the facility had been short staffed because she was not at the facility every day. -If the facility was short staffed, they could call her	D 465		

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D 465	Continued From page 51 and she could help if needed. Telephone interview with the Interim Administrator on 12/22/20 at 4:09pm revealed: -He was not aware of any issues with the facility being short staffed on some shifts from 12/05/20 - 12/09/20. -There had been some issues with the facility being short staffed since he started in October 2020 during the pandemic. -The WC was responsible for making the staffing schedule. -He had not been checking the schedule. Attempted interview with the ADRC on 12/22/20 at 2:21pm was unsuccessful.	D 465		
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 interviews and record reviews, the facility failed to assure Resident #3 was free of neglect as related to supervision of the resident. The findings are: Based on interviews and record reviews, the facility failed to provide supervision for 1 of 2 residents (#3) sampled with a history of multiple falls with injuries including abrasions, bruises, hematoma, bleeding from the right eyebrow, a possible rib fracture, and a head injury with a laceration requiring stitches. [Refer to Tag D270,	D914		

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D914	Continued From page 52 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		