Division of Health Service Regulation

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ADULT CARE LICENSURE SECTION
RALEIGH

PRINTED: 10/23/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: ______ B. WING ______	09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 09/04/20 and a desk review survey on 09/04/20, 09/08/20 - 09/11/20, 09/14/20 - 09/18/20, 09/21/20 - 09/25/20, and 09/28/20 and a telephone exit on 09/28/20.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure staff provided personal care assistance for 1 of 5 sampled residents (#3) as related to Foley catheter care. The findings are: Review of Resident #3's current FL-2 dated 03/19/20 revealed: -Diagnoses included diabetes mellitus type 2, atrial fibrillation, hyperlipidemia, and cellulitis of left foot. -The resident was documented as intermittently disoriented. -The resident was documented as semi-ambulatory with a walker. -The resident was documented as incontinent of bladder and bowel. -The resident needed assistance with bathing and	D 269		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Burrell

TITLE: Owner

(X6) DATE: 11/13/20

STATE FORM 6899 ZXNG11

Reviewed and accepted with Revisions.
WW 11/25/20

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D 269	Continued From page 1 dressing. Review of Resident #3's current assessment and care plan dated 03/19/20 revealed: -The resident's diagnoses included primary mental retardation, hearing impairment, visual impairment, speech impairment, hypothyroidism, diabetes, chronic obstructive pulmonary disease, and anemia. -The resident was ambulatory with a walker and had limited strength in upper extremities. -The resident was occasionally incontinent of bowel. -The resident had an indwelling urinary catheter. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident's vision was limited (sees large objects) and he could hear loud sounds/voices. -The resident's speech was slurred. -The resident required supervision for ambulation and transferring. -The resident required limited assistance with eating and toileting. -The resident required extensive assistance with bathing and dressing. -The resident required total assistance with grooming/personal hygiene. -Other personal care tasks listed for the resident included urinary catheter care. -There was no details provided regarding urinary catheter care. Review of Resident #3's licensed health professional support (LHPS) review dated 09/07/20 revealed: -The resident had left arm sling, status post urinary tract infection with history of fall. -The resident had a long term indwelling urinary catheter managed by home health. -The resident used a leg bag during the day and a	D 269	It is the policy of Wilson Assisted Living that staff provide the necessary personal care for all residents. All staff are oriented to catheter care upon hire and with RN as she completes LHPS check offs. Current staff have been In-serviced on catheter care by facility RN. Additional training will be scheduled in 6 months. Catheter care has been added to MAR for staff signoff. Administrator, RCC, SCC or designee will monitor monthly to ensure compliance.	11/13/20

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D 269	Continued From page 2 bedside drainage bag at night. -The facility staff assisted the resident with emptying and placement of the urinary catheter. -The resident's urine was clear and straw colored. -The LHPS nurse noted one of the resident's LHPS tasks was indwelling urinary catheter and staff were competency validated. Review of Resident #3's July 2020 - September 2020 treatment administration records revealed no documentation of urinary catheter care being provided to the resident. Telephone interview with LHPS nurse on 09/25/20 at 1:33pm revealed: -She visited the facility weekly on Mondays and conducted trainings for staff at the facility. -All staff were trained on Resident #3's catheter care. -Training for staff on Resident #3's catheter care was part of the LHPS tasks. -Staff were trained and knew how to change his catheter bag from the bedside drainage bag at night to the leg bag. -The LHPS task for catheter care targeted all staff including personal care aides (PCAs) and medication aides (MAs). -Staff were expected to report discolored urine or strong odors to the home health provider. -The home health provider saw Resident #3 monthly and they were responsible for changing the catheter bag. Review of Resident #3's home health nurse (HHN) skilled visit form dated 08/12/20 revealed: -The HHN received a call from facility staff stating the resident was having an issue with his Foley catheter. -The resident was sitting in his room in a chair and the HHN performed an assessment.	D 269		

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D 269	Continued From page 3 -The Foley catheter was draining well and the resident had no complaints at this time. Review of Resident #3's HHN skilled visit form dated 08/21/20 revealed: -The facility staff called the HHN to assess the resident's Foley catheter. -The resident had urine in the catheter bag and the urine was cloudy. -The HHN changed the catheter and there was very little urine return, just a tiny amount at the base of the catheter bag. -The HHN informed the MA that the resident appeared to have a urinary tract infection. -The primary care provider's (PCP) office was closed at the time so facility staff would have to send the resident out to the emergency room (ER). -The MA stated she would check the resident's catheter to see what the urine looked like in the bag when the resident's bag filled with some urine and the MA would send the resident out if the urine was dark and cloudy with the catheter bag change. -The HHN reminded staff to call the HHN with issues and 911 in cases of emergency. Review of Resident #3's ER summary report dated 08/22/20 - 08/23/20 revealed: -The resident arrived to the ER on 08/22/20 at 9:54pm. -The reason for visit was fall and right side head laceration. -The resident had an indwelling catheter and upon exam, the leg bag had dark brown urine and odor was noted from the urine. -The catheter was emptied and dark brown sludge was noted to be coming from the urine as well. -The nurse confirmed with staff at the facility that	D 269		

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D 269	Continued From page 4 the resident had "brown color urine for a while" but no fever. -The urinalysis was abnormal and indicated the resident had blood, bacteria, and mucus in his urine. Telephone interview with a MA on 09/25/20 at 4:24pm revealed: -She was working on another hall on third shift on 08/22/20 when Resident #3 fell. -The other MA reported the resident slipped on his urine in the bathroom. -She did not know if his catheter bag was leaking. -The HHN would come to the facility and check the catheter. -She switched the resident's night bedside drainage bag for his catheter to the leg bag in the mornings. -She rinsed the leg bag out and used the same one over and changed to a new one about 3 times a week. -She did not recall getting any instructions about the catheter from the HHN. Review of Resident #3's HHN skilled visit form dated 08/24/20 revealed: -The resident was in need of HHN visits for monthly Foley catheter changes. -When HHN arrived, facility staff stated the resident had a fall on 08/21/20 and was sent to the ER. -The resident was diagnosed with a urinary tract infection while at the ER and was sent back to the facility with a prescription for antibiotics. -The resident was lying in bed and staff stated the resident had been lying in bed all day. -The HHN educated staff to continue to monitor the resident and call the HHN or PCP with further concerns. -The HHN reminded staff to watch for	D 269		

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D 269	Continued From page 5 pain/burning/dark/cloudy urine and change the catheter bags daily. -Staff should change bags with clean, washed hands and gloves on to prevent infection. -The HHN informed staff that the resident allowed the HHN to help and staff should at least go in and try to help the resident daily to prevent future infections. Review of Resident #3's HHN skilled visit form dated 09/07/20 revealed: -Facility staff called and reported the resident was not having much urine output and was complaining of pain. -The HHN called staff back and asked the MA if staff had checked for kinks or other issues with the resident's catheter bag. -The MA stated she had not checked the catheter but was basing this information on what the previous MA stated during shift change. -When the HHN arrived to the facility, 400ml of clear yellow urine was observed in the catheter bag and the resident was currently urinating and the tubing was filled with urine. -The resident denied pain and continued to urinate without difficulty. -The bag filled quickly and the HHN emptied 1400ml of urine from the bag. -The HHN reinforced with facility staff to please check catheter for kinks and to change from the leg bag to the large drainage bag at bedtime to prevent complications with flow. Review of Resident #3's HHN skilled visit form dated 09/17/20 revealed: -The HHN went to see the resident after facility staff called stating the resident was uncomfortable and he had no urine in the catheter leg bag. -The resident was in bed with the leg bag	D 269		

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D 269	Continued From page 6	D 269		

attached when the HHN arrived.
-There was no kinking in the tubing so the HHN removed the catheter and prepared for sterile insertion of a new catheter.
-The catheter was secured to the leg bag over the top of the leg bag cap preventing the urine from flowing.
-This was shown to the MA who stated the leg bag was in place when she arrived and she had not noticed the cap.
-The HHN also noted the bedside drainage bag was laying on the floor with the connector laying on the floor.
-Both the bedside drainage bag and the leg bag were thrown in the trash.
-The HHN educated the MA on the need to keep the catheter bag in clean area and capped when not in use.
-A new catheter was inserted and drained 600cc of light, yellow urine immediately.
-The MA stated she would let her supervisor know of the issue.
-The HHN reinforced staff calling the HHN for all questions/concerns and to dial 911 for all life-threatening emergencies.

Telephone interview with a second MA on 09/18/20 at 3:44pm revealed:
-Resident #3 needed help with switching his catheter leg bag to the night bedside drainage bag.
-The resident fell "a month ago or more" while trying to pull his pants down and got tangled in the leg bag of his catheter.

Telephone interview with a third MA on 09/25/20 at 11:09am revealed:
-She sometimes provided care to Resident #3 when she worked on the assisted living (AL) side on third shift.

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D 269	Continued From page 7	D 269		

-The resident would ring his call bell about 5:00am or 5:30am.
-She would change his catheter bag from the night bedside drainage bag to the leg bag.
-She would put on gloves, unhook the tubing from the bedside drainage bag and connect the tubing to the leg bag.
-She used the same leg bag from the previous day but changed to a new leg bag about every 2 or 3 days.
-Resident #3's urine was always cloudy and dark yellow.
-She had not reported it to anyone because she did not know if that was normal or not.
-She had training on catheters when she started as a new employee but none recently.
-If there was an issue with the catheter, like when the resident could not urinate, she would call the home health provider.
-The home health provider supplied leg bags for the resident's catheter and they had never run out of them.
-The HHN had instructed staff on what to do about the resident's catheter like if the tubing kinked up, they should call the HHN.
-The resident usually let staff know when the catheter bag needed emptying.
-Staff would help empty the catheter bag but the resident could also go to the bathroom, hold his leg up and drain the bag in the toilet.

Telephone interview with a PCA on 09/25/20 at 11:45am revealed:
-Resident #3 sometimes needed assistance with emptying his catheter bag.
-In the mornings, she removed his night bedside drainage bag and reattached a leg bag to the catheter.
-The resident had a drawer full of leg bags so she used a new leg bag each time.

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D 269	Continued From page 8 -The resident's urine was usually a yellowish orange color. -She had not seen blood in his urine and she had not seen any dark brown urine. -The resident tried to do his own catheter care but staff tried to help him because his hands were shaky. Telephone interview with a second;PCA on 09/25/20 at 12:04pm revealed: -She usually checked Resident #3's catheter bag every day when she worked. -When the resident got up in the mornings, she unhooked and emptied his night bedside drainage bag and put a new bag on the catheter. -The facility's registered nurse (RN) had observed her providing catheter care but she could not recall when. -Another PCA and Resident #3 showed her how to change Resident #3's catheter bag. -The resident could also do his own catheter care. -About 2 months ago (could not recall date), the resident's urine was "really dark", a rust color. -She was not sure how long the resident's urine was rust colored. -She reported it to the MA (could not recall when or which MA). -The resident went to the hospital on 08/22/20 and was diagnosed with a urinary tract infection. Telephone interview with a fourth MA on 09/25/20 at 3:52pm revealed: -Staff assisted Resident #3 with his urinary catheter bag. -She switched his catheter leg bag to the night bedside drainage bag when the resident was going to bed. -If the leg bag was dirty or smelly, she threw it away otherwise she would sometimes reuse the	D 269		

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D 269	Continued From page 9 same leg bag. -She washed her hands and used gloves when she provided catheter care. Telephone interviews with the Special Care Coordinator (SCC) on 09/24/20 at 2:54pm and 09/28/20 at 10:27am revealed: -Staff did not document catheter care they provided to Resident #3. -Catheter care was not included on the medication or treatment administration records or the personal care logs. -Staff were supposed to empty, clean, and switch Resident #3's urinary catheter bags. Telephone interview with Resident #3's PCP on 09/23/20 at 4:22pm revealed: -Resident #3 wanted to be as independent as possible and he knew how to drain his catheter bag. -Facility staff should be monitoring the resident's catheter and making sure there were no problems on a daily basis. -Facility staff should at least check the catheter to make sure it was intact and there was no blood in his urine. Telephone interviews with Resident #3's HHN on 09/25/20 at 9:20am and 09/28/20 at 1:17pm revealed: -She went to the facility on 08/24/20 and changed the resident's catheter. -She sometimes had problems with the facility staff regarding Resident #3's catheter because staff would call and say something was wrong with the catheter but once she got to the facility, the staff on duty could not tell her what was wrong with the resident or the catheter. -She took 30 leg bags to the facility each month so staff could use a new leg bag each day but	D 269		

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D 269	Continued From page 10 facility staff were putting the same leg bag back on the resident's catheter without changing to a new one. -Not changing to a new bag each day could contribute to the resident's urinary tract infections because the used bags could have bacteria where it was reconnected. -The resident liked to be very independent in doing things and he tried to provide his own catheter care at times but he was unsteady with his hands. -The resident always let the HHN nurse help him and change his catheter. -She told facility staff "all the time" to make sure they helped the resident with his catheter care and checked it every day. -She was concerned the resident was not washing his hands when providing his own catheter care and that could also contribute to urinary tract infections. -She went to the facility on 08/21/20 because facility staff called her to assess the resident's catheter because he was not urinating. -When she changed the resident's catheter, there was a little urine in the bag and it was cloudy. -It was after 5:00pm on a Friday afternoon, so she would not be able to get an order for a urinalysis. -She told the MA (could not recall her name) to check the resident within the next hour and if the resident's urine was cloudy or dark to send the resident to the ER. -She did not hear anything else from the facility that day, 08/21/20, or over the weekend. -She called the facility on Monday, 08/24/20, to follow up to see the resident but the SCC told the HHN the resident had been to the ER over the weekend for a fall and was diagnosed with a urinary tract infection.	D 269		

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D 269	Continued From page 11 Telephone interview with the facility's Owner on 09/25/20 at 1:10pm revealed: -Staff should provide catheter care for Resident #3. -She would have staff in-serviced on catheter care. -The resident should not be teaching staff how to provide catheter care.	D 269		
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 observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #3, #4) with histories of multiple falls with injuries including multiple facial fractures, hematomas, and bruising (#1); bruising, multiple head injuries and lacerations requiring staples on two occasions (#4); and three falls in two weeks with one fall resulting in a broken collarbone (#3). The findings are: Review of the facility's falls management program revealed: -The falls management program included two primary approaches for the management of falls and injuries.	D 270		

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D 270	Continued From page 12 -The first approach was through immediate response to a resident fall, by careful evaluation and investigation of the fall, along with immediate intervention during the first 24 hours after the fall to help identify the fall risk and prevent future incidents. -The second approach was through long-term management for screening as needed for changes in conditions to identify residents who have a high risk of falls. -For both approaches, a fall assessment should be developed with individualized care interventions for the resident. -Staff should monitor and manage the resident's response, making care plan revisions as needed. -The falls management program included a falls intervention plan and a fall tracking record. Review of the facility's supervision policy revealed: -If a resident was identified as having frequent falls, the staff would provide increased supervision to assist with the resident's safety every fifteen minutes for 60 days. -The Resident Care Coordinator/Unit Coordinator would complete an assessment for further risks after the initial 60 days, as well as implement any other safety needs for the resident. 1. Review of Resident #1's current FL-2 dated 08/25/20 revealed: -Diagnoses included dementia, muscle weakness, traumatic subdural hemorrhage with loss of consciousness, repeated falls, and history of other specified skull and facial bone fractures. -Resident #1 was constantly disoriented and semi-ambulatory with a walker. -Resident #1's recommended level of care was the Special Care Unit (SCU).	D 270	Fall assessments were completed on residents . Residents at risk for falls have been identified and are on increased supervision checks every 15 minutes for 60 days. At the end of that time a re-evaluation for appropriate precautions will be made. A Falls Tracking Sheet is in place and Will be updated by Administrator weekly. Every other week a team (Administrator, RCC/SCC, RN & Therapy) will meet to Identify any changes/concerns with residents and implement any necessary changes. In-services on Fall Prevention have been conducted with more scheduled.	

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 Review of Resident #1's previous FL-2 dated 05/20/20 revealed: -Diagnoses included dementia and Alzheimer's disease. -Resident #1 was constantly disoriented and semi-ambulatory with a wheelchair. -Resident #1's recommended level of care was the SCU. Review of Resident #1's current care plan dated 08/25/20 revealed: -Resident #1 was always disoriented and had significant memory loss which necessitated direction from others. -She was ambulatory with a wheelchair and had limited strength to her upper extremities. -Resident #1 required limited assistance with eating and extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -There was no assessment of Resident #1's needs related to fall precautions. Review of Resident #1's previous care plan dated 05/20/20 revealed: -Resident #1 was always disoriented and had significant memory loss which necessitated direction from others. -She was ambulatory with a wheelchair and the assistance of staff. -Resident #1 had limited strength to her upper extremities. -Resident #1 required limited assistance with eating; extensive assistance with toileting, ambulation, bathing, and transferring; and was totally dependent for bathing and grooming. -There was no assessment of Resident #1's needs related to fall precautions. Review of a physician's order for Resident #1	D 270	15 min/2 hr checks are monitored by Med aides daily and RCC/SCC monitor weekly and notify Administrator of any issues or concerns. Management will continue to monitor Staffing to ensure appropriate supervision of residents.	10/28/20

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dated 02/26/20 revealed an order for physical therapy (PT) to evaluate and treat Resident #1 due to decreased gait and strength.

Review of an accident/injury report for Resident #1 dated 02/27/20 revealed:
-Resident #1 was found lying on the floor by her bed at 4:15pm and the fall was not witnessed by staff.
-Resident #1 was sent to the emergency room (ER) for swelling to an undocumented area of her body and there no documentation that first aid was administered.
-Resident #1's physician and responsible party were notified.
-There was no documentation of any increased supervision by staff of Resident #1.

Review of Resident #1's ER summary notes dated 02/27/20 revealed:
-Resident #1 was seen in the ER for a head injury and traumatic hematoma of the forehead.
-Resident #1 was advised to alternate taking ibuprofen and acetaminophen as needed for pain.

Review of a PT note for Resident #1 dated 03/05/20 revealed:
-Resident #1 was referred to PT as a result of fall on 02/27/20 due to weakness and gait instability.
-Resident #1 presented with bruising over her left eye.
-Resident #1 required supervision by staff with transfers and used a rollator for ambulation.
-Resident #1 needed partial assistance for staff for self-care activities and ambulation.
-Resident #1 was dependent on staff to climb stairs.
-Resident #1 demonstrated gait deviations with right-sided weakness noted; running into walls; and right lower extremity with some "scissoring"

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D 270	Continued From page 15 when ambulating. -Resident #1 was a fall risk. Review of a facility's provider notification form for Resident #1 dated 03/09/20 revealed: -There was a request made by the Special Care Coordinator (SCC) for a wheelchair for Resident #1 related to Resident #1 "having trouble ambulating" described as "scissor walking" -There was an order written for a wheelchair related to Resident #1's mobility, irregular and unsteady gait, and history of repeated falls. Review of an accident/injury report for Resident #1 dated 03/18/20 revealed: -Resident #1 was found on the floor in her bedroom at 10:30pm and the fall was not witnessed by staff. -There was no documentation Resident #1 suffered an injury or required first aid from staff. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #1. Review of an accident/injury report for Resident #1 dated 03/19/20 revealed: -Resident #1 was found on the floor by her bed when staff went to give medications at 5:30am and the fall was not witnessed by staff. -Resident #1 denied any pain at that time. -Resident #1 was sent to the ER for swelling to an undocumented area of her body and there no documentation that first aid was administered. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #1. Review of an accident/injury report for Resident	D 270		

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D 270	Continued From page 16 #1 dated 03/21/20 revealed: -Resident #1 was found on the floor between her bed and her bathroom at 11:00pm and the fall was not witnessed by staff. -Resident #1 denied any pain at that time. -There was no documentation Resident #1 suffered an injury or required first aid from staff. -Resident #1 was sent to the ER and Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #1. Review of Resident #1's ER summary notes dated 03/21/20 revealed: -Resident #1 was seen in the ER for an unwitnessed fall and had a hematoma to her forehead. -She complained about pain to her forehead and had bruising to her cheek (which cheek not specified). -Resident #1 was treated for contusions and acute pain and released on 03/22/20. Review of a facility's provider notification form for Resident #1 dated 03/23/20 revealed the SCC notified the primary care provider (PCP) of Resident #1's ER visit on 03/22/20. Review of a PT note for Resident #1 dated 04/03/20 revealed: -Resident #1 continued to have deficits in balance and functional strength which limited her ability to safely transfer and ambulate within the facility. -Due to safety reasons, the resident continued to require the maximum visual, verbal, and tactile cues for all transfers and gait exercises. -Resident #1 was a fall risk. Review of an accident/injury report for Resident	D 270		

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D 270	Continued From page 17 #1 dated 04/05/20 revealed: -Resident #1 was found on the floor in the doorway of her bedroom at 1:40pm and the fall was not witnessed by staff. -There was no documentation Resident #1 suffered an injury or required first aid from staff. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #1. Review of Resident #1's ER summary notes dated 04/06/20 revealed: -Resident #1 was brought to the ER for a bruised right knee after a fall on 04/05/20 at the assisted living (AL) facility. -She complained of pain to her knee; was treated for bilateral knee contusions; and was to take acetaminophen as needed for pain. Review of a facility's provider notification form for Resident #1 dated 04/07/20 revealed: -The SCC notified the PCP of Resident #1's ER visit on 04/06/20 and inquired about the recommendation for acetaminophen as needed for pain. -There was an order signed by the PCP on the order request form on 04/08/20 for acetaminophen 325mg - 2 tablets three times a day for seven days. Review of a PT note for Resident #1 dated 05/29/20 revealed: -Resident #1 continued to be assessed at high risk for fall due to impaired balance. -Resident #1 continued to require assistance with all gait tasks. -Her participation in PT varied based on her cognitive status. -Resident #1 continued to have a "high burden of	D 270		

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care" due to her high fall risk and issues with decreased safety.

Review of an accident/injury report for Resident #1 dated 06/05/20 revealed:
-Resident #1 had a fall on the dining room floor and hit her head at 5:30pm.
-She suffered a skin tear above her eye (which eye was not specified) and was sent to the ER.
-Resident #1's physician and responsible party were notified.
-There was no documentation of any increased supervision by staff of Resident #1.

Review of Resident #1's ER summary notes dated 06/05/20 revealed:
-Resident #1 presented to the ER with a small laceration to the right side of her head after a fall at the assisted living facility.
-It was documented by report, Resident #1 hit her head on a door when she fell at the AL facility.
-Resident #1 was alert with altered mental status and altered gait.
-Resident #1 was assessed to be at high risk for falls.
-Resident #1 was treated for facial laceration and facial contusions and Resident #1 was to follow-up with her primary care provider in two days.
-Resident #1 was released from the ER on 06/06/20.

Review of a facility's provider notification form for Resident #1 dated 06/08/20 revealed the SCC notified the PCP of Resident #1's ER visit on 06/05/20.

Review of a PT discharge summary note for Resident #1 dated 07/07/20 revealed:
-Resident #1 had made some progress toward

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her goals since the start of care, however not all her goals were met due to her changing cognitive status.
-It was questionable if Resident #1 would be able to retain the education provided to her regarding safety with transfers and gait tasks due to her cognitive status.
-Resident #1 continued to have a "high burden of care" due changing cognitive status and level of alertness as well as safety implications.
-Precautions continued to include Resident #1 was a fall risk and had decreased safety.
-Discharge recommendations included continued staff support as necessary to reduce falls.

Review of a physician communication report for Resident #1 dated 07/08/20 revealed Resident #1 had a fall (location not specified) and was sent to the ER for an injury (not specified).

Review of Resident #1's ER summary notes dated 07/09/20 revealed:
-Resident #1 arrived at the ER at 12:23am by ambulance.
-It was documented Resident #1 was found on the floor at the AL facility with a large bleeding hematoma on her left side of her forehead and staff at the AL facility were unsure how Resident #1 fell.
-Resident #1 suffered a subdural hemorrhage, left maxillary fracture, left orbital fracture, a laceration to the forehead, an open wound to the tongue secondary to a bite, and had a urinary tract infection.
-Resident #1 was transferred from this hospital to another local hospital for services.

Review of a facility's provider notification form for Resident #1 dated 08/20/20 revealed:
-Resident #1 transferred back to the facility from

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D 270	Continued From page 20 a rehabilitation facility. -Notifications were made for clarifications for five of Resident #1's medications. -There was no request for any fall precautions to be put in place for Resident #1 when she returned to the facility. Review of an accident/injury report for Resident #1 dated 08/22/20 revealed: -Resident #1 was found on the hallway floor at 12:26pm and complained of right hip pain. -There was no documentation Resident #1 required first aid from staff. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #1. Review of facility's 15-minute check sheet for Resident #1 dated 08/22/20 revealed: -Staff provided supervision of Resident #1 every 15 minutes on 08/22/20. -Staff documented Resident #1 was in her bedroom from 12:00pm to 1:00pm. Review of an accident/injury report for Resident #1 dated 08/23/20 revealed: -Resident #1 was found on her bedroom floor at 2:20pm. -There was no documentation Resident #1 suffered an injury or required first aid from staff. -Resident #1's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #1. Review of facility's 15-minute check sheet for Resident #1 dated 08/23/20 revealed: -Staff provided supervision of Resident #1 every 15 minutes on 08/23/20.	D 270		

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D 270	Continued From page 21 -Staff documented Resident #1 was in the hallway of the SCU from 2:00pm to 2:45pm. Review of Resident #1's licensed health professional support (LHPS) review dated 08/24/20 revealed: -Resident #1 returned to the facility from a rehabilitation facility on 08/20/20. -Resident #1 had increased confusion and respond appropriately to questions when asked. -She was currently using a wheelchair but was unable to propel herself in the wheelchair. -Staff propelled Resident #1 in her wheelchair. -Resident #1 required assistance from staff for transfers. Review of a physician communication report for Resident #1 dated 08/27/20 revealed Resident #1 had a fall (location not specified) and was sent to the ER on 08/27/20 for active bleeding from the nose. Review of facility's 15-minute check sheet for Resident #1 dated 08/27/20 revealed: -Staff provided supervision of Resident #1 every 15 minutes on 08/27/20. -Staff documented Resident #1 was in her bedroom from 7:45pm to 9:30pm when she was sent to the hospital. Review of Resident #1's ER summary notes dated 08/27/20 revealed: -Staff at the AL facility heard when Resident #1 fall and found the resident on the floor, bleeding from her nose (location not specified). -Resident #1 had swelling over her left eye and a history of falls. -Resident #1 was diagnosed with a fractured nose and a chronic fracture of her left eye socket. -Resident #1 was to follow-up with her PCP as	D 270		

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D 270	Continued From page 22 needed and follow-up with an ear-nose-throat specialist in two days for the multiple facial fractures. Review of a physician's order for Resident #1 dated 08/27/20 revealed a referral for PT to evaluate and treat Resident #1 due to generalized muscle weakness, unsteadiness on feet, and being a fall risk. Review of a facility's provider notification form for Resident #1 dated 08/28/20 revealed: -There was a request made by the SCC for a hospital bed, concave mattress, fall mat, and bed alarm due to Resident #1's increased falls for preventative measures. -The PCP electronically signed the order on 08/31/20. Observation of Resident #1 on 09/04/20 at 2:00pm revealed: -Resident #1 was sitting in her wheelchair at a table in the dining room of the SCU. -She had a large purplish bruise under her right eye and a yellow bruised area over her right eyebrow. -She had a raised area approximately half the size of a dime adjacent to her right eyebrow. Interview with a personal care aide (PCA) on 09/04/20 at 1:24pm revealed: -Resident #1 had returned to the facility from a rehabilitation facility about two weeks ago. -She was not sure why Resident #1 had been in the rehabilitation facility. -Resident #1 was a high risk for falls because she had problem with maintaining her balance if she tried to walk. -Resident #1 had a least one fall since she had returned to the facility, but she was not sure when	D 270		

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the fall occurred or if the resident was injured.
-Resident #1 had not been placed on increased supervision by the facility.
-She just "kept an eye on her" (Resident #1) and tried to keep Resident #1 close to her.
-She documented Resident #1's whereabouts every 15 minutes on the resident's monitoring sheets.

Telephone interview with the SCC 09/15/20 at 11:09am revealed:
-She was not sure of the number of falls Resident #1 had since she returned to the facility in August 2020.
-Resident #1 was placed on 15-minute checks once she returned from the hospital after her fall on 08/27/20.
-The staff were supposed to physically go and look at Resident #1 and then document her physical location accurately.
-She could not explain why the documentation of Resident #1's location of falls on 08/22/20 and 08/23/20 differed from what was documented on her the 15-minute checks sheets.
-The MAs were supposed to make sure the checks sheets were correct.
-She or Resident Care Coordinator (RCC) were supposed to monitor the residents' checks monthly for accuracy, but she had not yet had a chance to check behind the MAs.
-She had asked Resident #1's PCP for an order for a concave mattress, hospital bed, fall mat, and bed alarm on 08/28/20 to try to keep Resident #1 safe.

Telephone interview with Resident #1's family member on 09/17/20 at 9:25am revealed:
-He last saw Resident #1 on 09/08/20 during a visitation on the facility's porch.
-He did not visit with Resident #1 long because

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D 270	Continued From page 24 she was sleepy. -Resident #1 had a history of frequent falls. -He had noticed a decline in her walking ability for the last six months because her legs were "wobbly". -Resident #1 still believed she could walk without any problems and she fell when she tried to get up on her own. -He did not know how often staff supervised or checked on Resident #1. -Resident #1 did not have any falls when she was in the rehabilitation facility. -Resident #1 had to go to the rehabilitation facility in July 2020 for skilled PT after she fell at the AL facility and fractured her eye socket. -He was not sure how many falls Resident #1 had prior to July 2020. -Staff had reported to him Resident #1 had at least two falls since she returned to the AL facility in late August 2020. -Resident #1 had not been to the hospital or suffered any injuries from the falls that staff had reported to him in August 2020. Telephone interview with a second PCA on 09/18/20 at 11:03am revealed: -Resident #1 had not been stable walking independently since she returned to the facility from the rehabilitation facility. -Resident #1 was in a wheelchair because she was unsteady, and she required two-person assistance for transfers. -Resident #1 did not walk because her legs were too weak. -Resident #1 had one fall since her return to the facility (date unspecified), but the resident was not hurt. -Staff were not instructed to monitor Resident #1 any differently after the fall. -All residents in the SCU were subjected to	D 270		

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15-minute safety checks by staff.
-Resident #1 had been given a hospital bed, a bed alarm, and a fall mat for about three weeks.
-She did not think Resident #1 had a concave mattress on her bed.
-Staff had not been told to increase supervision to Resident #1 regarding her falls.
-Staff checked on Resident #1 every fifteen minutes and "tried to keep an eye on her" to keep her from falling.

Telephone interview with a third PCA on 09/18/20 at 1:48pm revealed:
-Resident #1 returned to the facility on 08/20/20 from a rehabilitation facility.
-Before Resident #1 went to the rehabilitation facility, she fell about once or twice a week.
-She did not know about Resident #1 having any falls since she had returned to the facility.
-She noticed that Resident #1 had some burgundy marks around her eyes a few weeks right after she returned to the facility.
-She did not know what caused the marks on Resident #1's face.
-Staff did 15-minute checks on Resident #1 for monitoring and Resident #1 was not on any type of increased supervision by staff.
-Resident #1 required a two person assist for transfers and used a wheelchair.
-Staff had to push Resident #1 in her wheelchair because she did not self-propel.

Telephone interview with a medication aide (MA) on 09/18/20 at 3:43pm revealed:
-Staff usually checked Resident #1 every 15 to 30 minutes to ensure safety.
-Resident #1 had several falls in the past (days unspecified), but not on the days when she worked.
-Resident #1 needed close supervision "now"

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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because her walking was unstable.
-No one had told her to check Resident #1 more frequently; she just did it because of the resident's recent falls.
-She first noticed Resident #1's ambulation was becoming unstable when the resident fell on 03/19/20, but Resident #1 did not need much supervision then.
-Resident #1 was currently using a wheelchair and required a two person assist for transfers.
-She noticed staff were supervising Resident #1 more closely when she worked on 09/14/20 by doing 15-minute checks and staff tried to stay close to Resident #1's bed at night in case she tried to get up at night.
-Resident #1 had a hospital bed and they were using a mattress as fall mat at night in case the resident got up.
-Resident #1 had a fall mat that had been ordered.

Telephone interview with a fourth PCA on 09/23/20 at 2:51pm revealed:
-Resident #1 went to a skilled rehabilitation facility in July 2020, but she was not sure why.
-Resident #1 returned to the facility toward the end of August 2020 and was identified to be at risks for falls.
-She could not specify who identified Resident #1 was a fall risk.
-Resident #1 required a two-person assist with bathing, dressing, toileting, and used a wheelchair for ambulation.
-Resident #1 was alert but disoriented.
-Staff performed 15-minute checks on Resident #1 for supervision and she did not know about Resident #1 having any falls since she had returned from the rehabilitation.
-Resident #1 had received a fall mat and bed alarm within the last two or three days to help

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D 270	Continued From page 27 ensure Resident #1's safety. Telephone interview with a second MA on 09/25/20 at 4:38pm revealed: -She was the MA working when Resident #1 fell on 08/27/20. -Resident #1 was in her bedroom and it looked like the resident tried to get up to go the bathroom alone. -Staff heard the noise when Resident #1 fell and found her on the floor of her bedroom. -Resident #1 did not appear hurt but her nose was bleeding. -"There was too much blood from the impact of her (Resident #1) hitting the floor" so she sent the resident to the ER. -All residents in the SCU were on 15-minute checks for supervision. -Resident #1's cognitive status was so unpredictable, so the staff assessed her need for supervision day by day. -The SCC/RCC had told the staff "to try to keep her (Resident #1) within eyesight" about 4 weeks ago. -Resident #1's ambulation was unsteady, and she used a wheelchair for ambulation. -Staff did 15-minute checks on Resident #1 to monitor for her safety. -Resident #1 had a history of frequent falls, but staff were only required to do 15-minute checks on Resident #1. Telephone interview with Resident #1's PCP on 09/23/20 at 5:15pm revealed: -Resident #1 was ambulatory on the beginning of 2020, but then Resident #1's dementia worsened, and her cognitive status declined, and she started falling frequently. -She told the SCC to call the family to see what the family wanted to do before Resident #1 went	D 270		

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to rehabilitation.
-Resident #1 needed frequent supervision to prevent falls but she did not specify how often staff should monitor Resident #1.
-She noticed that most of Resident #1's falls at the facility occurred in the afternoons.
-She had ordered for Resident #1 to have a wheelchair and she was currently receiving PT.
-She spoke directly to the SCC about Resident #1's return to the facility because she did not think the facility could meet the needs of Resident #1 because of her frequent falls.
-The SCC reported Resident #1's return to the facility was based on the request of Resident #1's family.

Telephone interview with the SCC on 09/28/20 at 10:28am revealed:
-Staff did not provide any increased supervision of Resident #1 other than 15-minute checks.
-The facility was adding additional staff in SCU to provide increased supervision for Resident #1 and the facility could meet the needs of the resident.

Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful.

Refer to telephone interview with a MA on 09/08/20 at 2:24pm.

Refer to telephone interview with a PCA on 09/08/20 at 3:25pm.

Refer to telephone interview with a second MA on 09/25/20 at 11:09am.

Refer to telephone interview with the SCC on 09/15/20 at 11:06am.

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D 270	Continued From page 29 Refer to telephone interview with the Administrator on 09/15/20 at 12:07pm. Refer to telephone interview with the previous Administrator on 09/16/20 at 3:02pm. Refer to telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm. Refer to telephone interview with the facility's Owner on 09/25/20 at 1:10pm. 2. Review of Resident #4's current FL-2 dated 08/31/20 revealed: -Diagnoses included dementia, depression, diverticulitis, hypertension, and acute. encephalopathy. -She was intermittently confused. -She had a history of wandering. -She required personal assistance with bathing and dressing. -She was ambulatory. -She was incontinent of bowel and bladder. There was no of documentation of a fall assessment for Resident #4. Observation of Resident #4 on 09/04/20 at 1:10pm revealed: -The resident was sitting in a recliner in her room. -The recliner's footrest was in the up position and the resident was leaning forward pulling at her socks. -The resident had a dark purple bruise approximately 2 x 3 inches on the front lower left leg and a second dark purple bruise approximately 2 x 2 inches on the inside of her lower left leg.	D 270		

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-The resident was rubbing and scratching her head with her fingers.

a. Review of Resident #4's physician communication dated 08/21/20 revealed:
-There was no time included on the document.
-The reason for report was a fall.
-She was sent to the emergency room (ER).
-First Aide was administered.
-Seventy-two-hour resident monitoring was started.
-The description of the incident that occurred outlined she returned from the emergency room with a prescription for a urinary tract infection (UTI).
-Her family member wanted her Seroquel discontinued.
-The PCP response was to discontinue Seroquel.
-There were no requests made for increased supervision or recommendations for fall prevention made for Resident #4.
-The document was electronically signed by the PCP on 08/24/20 at 11:54am.

There was no of documentation of an Accident/Injury report for 08/21/20.

Review of Resident #4's Emergency Provider Record dated 08/21/20 revealed:
-Resident #4 presented to the ER with a chief complaint of unwitnessed fall via Emergency Medical System (EMS).
-Staff had checked on her just 15 minutes previously and when they went to check on her again, they found her on the bed with blood on her head.
-It appeared she had fallen on the floor and climbed back into the bed.
-She had dementia at baseline and was unable to provide any history herself.

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D 270	Continued From page 31 -Her family requested a urinalysis, because she was started on Seroquel on 08/19/20 and she had been acting different and believed she may have a urinary tract infection (UTI). -The location of injury/pain was indicated as her head and her face. -There was dried blood all along her left scalp, no active bleeding, a small left frontal scalp raised area of bruising, and a small laceration to the forehead with no active bleeding. Review of Resident #4's ER wound repair dated 08/21/20 revealed the forehead laceration was closed with 2 staples. Observation of Resident #4 on 09/04/20 at 1:10pm revealed: -The resident was rubbing and scratching her head because it hurt but she did not know why it hurt. -The resident would not make eye contact when spoken to and she did not answer when she was asked about the bruises. -The resident did not answer any questions. Telephone interview with a Medication Aide (MA) on 09/25/20 at 11:23am revealed: -Resident #4 used to be able to care for herself till the end of July or beginning of August 2020. -She now required a two person assist with "everything." -She needed one-to-one care if there were "enough" scheduled staff. -Resident #4's current fall prevention intervention in place was 15-minute checks. -She was not aware of any other interventions in place to present Resident #4 from falling. -She was the MA who was working when Resident #4 fell on 08/21/20. -She could not recall where and what happened	D 270		

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related to Resident #4's fall on 08/21/20.
-She had completed an Accident/Injury report for her fall on 08/21/20 and had given it to the Administrator.

Interview with a second MA on 09/04/20 at 1:10pm revealed:
-The bruises on Resident #4's leg were caused by falls.
-Resident #4 fell frequently, she thought Resident #4's last fall was 08/21/20 or 08/28/20.
-She was not aware of the resident having any falls "this week."
-The resident walked independently without a walker.
-The resident usually fell when she was trying to get up because she would lose her balance.

Telephone interview with a third MA on 09/08/20 at 2:24pm revealed:
-Resident #4 was a Fall Risk.
-She was not working when Resident #4 fell on 08/21/20.
-Her last fall was 08/21/20 in her room and had two stitches close to her forehead, top of her head.
-She did not use a walker.
-She used a wheelchair.
-She began being unsteady on her feet about "3 weeks ago."
-She was not like she used to be months ago.
-She was hallucinating, she wanted to pick up objects that were not there.
-She wanted to leave the facility and go pick up her children.

Telephone interview with a Personal Care Aide (PCA) on 09/08/20 at 3:25pm revealed:
-Resident #4 required heavy care assistance with bathing, dressing, and walking.

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-She had a walker.
-Facility staff had to stay with Resident #4 because of falls.
-She would try to get up without assistance.
-The facility staff would try to get her to sit down.
-She could stand by herself, but her balance was "off."
-She was sometimes groggy and weak in the evening.
-She had fallen in the last month, she had staples in her head due to injuring herself during the fall.
-Her balance had been worse "now" that she had fallen.
-She thought she would see something in the air or ground.

Telephone interview with a second PCA on 09/18/20 at 11:03am revealed:
-The facility was short staffed some days, "we" have staff some days, and some days "we" do not have staff come back.
-There was a lot of staff turnover, "they" do the best "we" can.
-For first shift on the Special Care Unit (SCU), "we" had one MA and two PCAs.
-If a resident had a fall occur on her shift, she would call the MA immediately, implement the PCP's orders, complete the 15-minute checklist, and keep a "close eye" on the resident.
- "We" keep Resident #4 right there with "us."
-For example, she would be with us in the medication room or TV room.
-Resident #4 could not be left by herself.
-She had her last fall about two to three weeks ago.
-She would tilt over and would bump her head.
-On 8/22/20, Resident #4's fall did not occur on her shift.
-She had not fallen on any of her shifts.
-There was no other type of fall interventions in

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place other than 15-minute checks.
-She had never heard of 72-hour resident monitoring.

Telephone interview with a third PCA on 09/18/20 at 1:48pm revealed:
-If a resident had a fall occur on her shift, she would get the MA immediately, the MA would assess the resident because "we" cannot touch them.
-She kept Resident #4 beside her or close to her during her shift.
-As a team of 3 on the SCU, "we" supervise her to prevent falls.
-She helped Resident #4 to the bathroom.
-Resident #4 could not walk by herself, she was not "level."
-Fall intervention in place was 15-minute monitoring.
-She could not recall if Resident #4 had any recent falls.

Telephone interview with a fourth MA on 09/18/20 at 3:40pm revealed:
-If a resident had a fall occur on her shift, the MA would assess the resident immediately, send the resident to the Emergency Room, complete the Physician Communication, complete an A/I report and give it to the Administrator.
-Seventy-two-hour resident monitoring would be in place when the resident returned from the Emergency Room or had a fall.
-When the resident came back to the facility, "we" would monitor their general status and check the resident's vital signs every shift.
-She needed more assistance.
-She required help to the bathroom, assistance with dressing, and redirection to go back to her bed.
- "We" provided close supervision of her.

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D 270	Continued From page 35 -She was always by staff. -She would be in her wheelchair in the dayroom and there were staff outside of her room. - "We" completed the 15-minute check lists and provided one-to-one care for Resident #4. Telephone interview with a fourth PCA on 09/23/20 at 2:50pm revealed: -She worked mainly in the Special Care Unit (SCU). -She did not know which residents were identified as fall risks. When a resident had a fall, then they would be identified as a Fall Risk. -She was not aware if the facility had a falls policy. -PCAs did not document on the progress notes or in the progress notes. -She completed the 15-minute checklist on the SCU residents where she would document the location of the resident and the time of the check onto the checklist. -Resident #4 required assistance with bathing, ambulation, dressing, and toileting. -Staff would sit with Resident #4 more, making sure she did not fall. -If she had another personal care task to complete, another staff member would come and sit with Resident #4 until she came back. -She could not recall a specific date when the 24-hour supervision began only. -She knew the 24-hour supervision of Resident #4' began after her last fall but could not recall when her last fall had occurred. -She bumped her head, bending down to pick up something off the floor, came back up, hit her head, her head was bleeding, and she went to the Emergency Room. -A fall mat and a bed alarm were recently implemented for Resident #4.	D 270		

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D 270	Continued From page 36 Telephone interview with Resident #4's Primary Care Provider (PCP) on 09/23/20 at 4:22pm revealed: -After 07/15/20, Resident #4 was positive for COVID, started to become weak, unsteady, and following minimal instruction. -She had a poor appetite, increased confusion, and physical aggression. Telephone interview with a fifth PCA on 09/25/20 at 11:53am revealed: -If the facility was short of staff, she would work in the SCU. -When completing the 15/30-minute checklists, the PCA would check on the residents every 15-30 minutes, document the resident's location, and the time and initials of the PCA would be included on the checklist. -If the resident was in the hospital, on a leave of absence, or out of the facility, it should be documented on the 15/30-minute checklists. -Resident #4 required assistance with dressing and her shower. - "We" just keep our eyes on her. -For example, she was supervised while working on a word puzzle in her chair. Telephone interview with a sixth PCA on 09/25/20 at 12:16pm revealed: -A resident was identified as a Fall Risk if a "leaf" was outside on the wall of a resident's door. -Resident #4 required assistance with dressing and when transferring her to her wheelchair. -We keep an "eye" on her to make sure she does not fall. -Resident #4 was never alone. -Her current fall intervention in place was 15-minute checks. -To complete the care task assigned, each staff member took a turn when supervising her.	D 270		

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D 270	Continued From page 37 -Staff had to remind her to use her walker when ambulating. -Staff sat in the hallway and by her room within the Special Care Unit. -She did not recall when Resident #4's last fall occurred. Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful. Refer to telephone interview with a MA on 09/08/20 at 2:24pm. Refer to telephone interview with a PCA on 09/08/20 at 3:25pm. Refer to telephone interview with a second MA on 09/25/20 at 11:09am. Refer to telephone interview with the SCC on 09/15/20 at 11:06am. Refer to telephone interview with the Administrator on 09/15/20 at 12:07pm. Refer to telephone interview with the previous Administrator on 09/16/20 at 3:02pm. Refer to telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm. Refer to telephone interview with the facility's Owner on 09/25/20 at 1:10pm. b. Review of Resident #4's Physician Communication form dated 08/22/20 revealed: -There was no time included on the document. -There was no apparent injury.	D 270		

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D 270	Continued From page 38 -Seventy-two-hour resident monitoring was started. -The description of the incident that occurred outlined she slide to floor from her chair. -There were no requests made for increased supervision or recommendations for fall prevention made for Resident #4. -The primary care provider (PCP)'s response was "Aware, please monitor." -The document was electronically signed by the PCP on 08/24/20 at 11:55am. There was no of documentation of an Accident/Injury (A/I) report for 08/22/20. Observation of Resident #4 on 09/04/20 at 1:10pm revealed: -The resident was sitting in a recliner in her room. -The recliner's footrest was in the up position and the resident was leaning forward pulling at her socks. -The resident had a dark purple bruise approximately 2 x 3 inches on the front lower left leg and a second dark purple bruise approximately 2 x 2 inches on the inside of her lower left leg. -The resident was rubbing and scratching her head with her fingers. -The resident was rubbing and scratching her head because it hurt but she did not know why it hurt. -The resident would not make eye contact when spoken to and she did not answer when she was asked about the bruises. -The resident did not answer any further questions. Telephone interview with the Medication Aide (MA) on 09/24/20 at 11:58am revealed: -Resident #4 needed a walker and the assistance	D 270		

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of 2 people when ambulating.
-Resident #4 was incontinent and requested assistance to the bathroom.
-Fifteen-minute checks were the current supervision in place for Resident #4.
- "We" kept a "close eye" on her.
-If she got out of her wheelchair, she was "liable" to have a fall.
-Resident #4 did not have any balance; and she was "very" confused.
-She was disoriented to place, she thought she was at home.
-She hallucinated and tried to pick up "things" from the floor.
-She had recent falls with no additional details provided.
-Resident #4 had a fall and went to Emergency Room, she did not recall the date.
-She bumped her head when she fell and came back the same day.
-She was the MA who worked first shift when Resident #4 slid to the floor from chair on 08/22/20.
-An A/I Report was not completed because the SCC told her Resident #4 did not have a fall.
-She was not aware if Resident #4's fall assessments or fall tracking were completed.
-There was not recent training on supervision, or the facility falls policy.
-On a typically shift, there were 1 MA and 2 PCA.

Interview with a second MA on 09/04/20 at 1:10pm revealed:
-The bruises on Resident #4's leg were caused by falls.
-Resident #4 fell frequently, she thought Resident #4's last fall was 08/21/20 or 08/28/20.
-She was not aware of the resident having any falls "this week."
-The resident walked independently without a

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walker.
-The resident usually fell when she was trying to get up because she would lose her balance.

Telephone interview with a third MA on 09/08/20 at 2:24pm revealed:
-Resident #4 was a Fall Risk.
-She was not working when Resident #4 fell on 08/21/20.
-Her last fall was 08/21/20 in her room and had two stitches close to her forehead, top of her head.
-She did not use a walker.
-She used a wheelchair.
-She began being unsteady on her feet about "3 weeks ago."
-She was not like she used to be months ago.
-She was hallucinating, she wanted to pick up objects that were not there.
-She wanted to leave the facility and go pick up her children.

Telephone interview with a Personal Care Aide (PCA) on 09/08/20 at 3:25pm revealed:
-Resident #4 required heavy care assistance with bathing, dressing, and walking.
-She had a walker.
-Facility staff had to stay with Resident #4 because of falls.
-She would try to get up without assistance.
-The facility staff would try to get her to sit down.
-She could stand by herself, but her balance was "off."
-She was sometimes groggy and weak in the evening.
-She had fallen in the last month, she had staples in her head due to injuring herself during the fall.
-Her balance had been worse "now" that she had fallen.
-She thought she would see something in the air

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or ground.

Telephone interview with a second PCA on 09/18/20 at 11:03am revealed:
-The facility was short staffed some days, "we" have staff some days, and some days "we" do not have staff come back.
-There was a lot of staff turnover, "they" do the best "we" can.
-For first shift on the Special Care Unit (SCU), "we" had one MA and two PCAs.
-If a resident had a fall occur on her shift, she would call the MA immediately, implement the PCP's orders, complete the 15-minute checklist, and keep a "close eye" on the resident.
- "We" keep Resident #4 right there with "us."
-For example, she would be with us in the medication room or TV room.
-Resident #4 could not be left by herself.
-She had her last fall about two to three weeks ago.
-She would tilt over and would bump her head.
-On 8/22/20, Resident #4's fall did not occur on her shift.
-She had not fallen on any of her shifts.
-There was no other type of fall interventions in place other than 15-minute checks.
-She had never heard of 72-hour resident monitoring.

Telephone interview with a third PCA on 09/18/20 at 1:48pm revealed:
-If a resident had a fall occur on her shift, she would get the MA immediately, the MA would assess the resident because "we" cannot touch them.
-She kept Resident #4 beside her or close to her during her shift.
-As a team of 3 on the SCU, "we" supervise her to prevent falls.

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-She helped Resident #4 to the bathroom.
-Resident #4 could not walk by herself, she was not "level."
-Fall intervention in place was 15-minute monitoring.
-She could not recall if Resident #4 had any recent falls.

Telephone interview with a fourth MA on 09/18/20 at 3:40pm revealed:
-If a resident had a fall occur on her shift, the MA would assess the resident immediately, send the resident to the Emergency Room, complete the Physician Communication, complete an A/I report and give it to the Administrator.
-Seventy-two-hour resident monitoring would be in place when the resident returned from the Emergency Room or had a fall.
-When the resident came back to the facility, "we" would monitor their general status and check the resident's vital signs every shift.
-She needed more assistance.
-She required help to the bathroom, assistance with dressing, and redirection to go back to her bed.
- "We" provided close supervision of her.
-She was always by staff.
-She would be in her wheelchair in the dayroom and there were staff outside of her room.
- "We" completed the 15-minute check lists and provided one-to-one care for Resident #4.

Telephone interview with a fourth PCA on 09/23/20 at 2:50pm revealed:
-She worked mainly in the Special Care Unit (SCU).
-She did not know which residents were identified as fall risks. When a resident had a fall, then they would be identified as a Fall Risk.
-She was not aware if the facility had a falls

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policy.
-PCAs did not document on the progress notes or in the progress notes.
-She completed the 15-minute checklist on the SCU residents where she would document the location of the resident and the time of the check onto the checklist.
-Resident #4 required assistance with bathing, ambulation, dressing, and toileting.
-Staff would sit with Resident #4 more, making sure she did not fall.
-If she had another personal care task to complete, another staff member would come and sit with Resident #4 until she came back.
-She could not recall a specific date when the 24-hour supervision began only.
-She knew the 24-hour supervision of Resident #4' began after her last fall but could not recall when her last fall had occurred.
-She bumped her head, bending down to pick up something off the floor, came back up, hit her head, her head was bleeding, and she went to the Emergency Room.
-A fall mat and a bed alarm were recently implemented for Resident #4.

Telephone interview with a fifth PCA on 09/25/20 at 11:53am revealed:
-If the facility was short of staff, she would work in the SCU.
-When completing the 15/30-minute checklists, the PCA would check on the residents every 15-30 minutes, document the resident's location, and the time and initials of the PCA would be included on the checklist.
-If the resident was in the hospital, on a leave of absence, or out of the facility, it should be documented on the 15/30-minute checklists.
-Resident #4 required assistance with dressing and her shower.

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D 270	Continued From page 44 - "We" just keep our eyes on her. -For example, she was supervised while working on a word puzzle in her chair. Telephone interview with a sixth PCA on 09/25/20 at 12:16pm revealed: -A resident was identified as a Fall Risk if a "leaf" was outside on the wall of a resident's door. -Resident #4 required assistance with dressing and when transferring her to her wheelchair. -We keep an "eye" on her to make sure she does not fall. -Resident #4 was never alone. -Her current fall intervention in place was 15-minute checks. -To complete the care task assigned, each staff member took a turn when supervising her. -Staff had to remind her to use her walker when ambulating. -Staff sat in the hallway and by her room within the Special Care Unit. -She did not recall when Resident #4's last fall occurred. Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful. Refer to telephone interview with a MA on 09/08/20 at 2:24pm. Refer to telephone interview with a PCA on 09/08/20 at 3:25pm. Refer to telephone interview with a second MA on 09/25/20 at 11:09am. Refer to telephone interview with the SCC on 09/15/20 at 11:06am.	D 270		

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D 270	Continued From page 45 Refer to telephone interview with the Administrator on 09/15/20 at 12:07pm. Refer to telephone interview with the previous Administrator on 09/16/20 at 3:02pm. Refer to telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm. Refer to telephone interview with the facility's Owner on 09/25/20 at 1:10pm. c. Review of Resident #4's Accident/Injury (A/I) report completed on 08/22/20 at 5:00pm revealed: -She was trying to get up and fell face first onto the floor. -The resident was alone in her room. -There was an "opening" on her cheek area. -The type of injury was laceration and bruising. -Her vital signs were temperature of 99.6, blood pressure of 140/62, and pulse of 88. -She was alert and oriented. -She was taken to the emergency room. -She was admitted to the hospital for further treatment. -The Administrator contacted her family member on 08/24/20 to get an update. -Family member stated she was doing better and was on continuous antibiotics treatment as well. Review of Resident #4's physician communication dated 08/22/20 revealed: -There was no time included on the document. -The reason for the report was a fall. -There was an injury to the left side of her face. -She was sent to the emergency room. -The description of the incident that occurred outlined left side facial bruising with a laceration.	D 270		

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D 270	Continued From page 46 -There were no requests made for increased supervision or recommendations for fall prevention made for Resident #4. -The primary care provider response was "Aware." -The document was electronically signed by the PCP on 08/24/20 at 11:52am. Review of Resident #4's Emergency Room (ER) Provider Record dated 08/22/20 revealed: -Resident #4 presented by Emergency Medical Services status post fall with facial injury. -She was seen in the ER for the same. -A family member reported Resident #4 was able to carry on conversation with baseline dementia; however; was given Seroquel (A medication used to treat schizophrenia, bipolar disorder, and depression) first time two days ago due to agitation; was found to have a UTI on 08/21/20 on evaluation for falls; and reported she had been more confused and not herself for the past two days. -The location of injury was Resident #4's face. -Additional comments included resident with worsening confusion/altered mental status with UTI and increasing falls. Also, noted to have acute kidney injury. Review of the facility's 15-minute check sheet for Resident #4 dated 08/23/20 revealed: -The check sheets included the time, location, and the staff's initials. -There were three columns for all three shifts. -On 08/23/20, staff documented supervision of Resident #4 every 15-minutes. -Staff documented Resident #4 was in her bedroom the entire day. -The first, second, and third shift Medication Aides signed and dated the check sheet for 08/23/20.	D 270		

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-There was no documentation of Resident #4's hospitalization on 08/23/20.

Review of Resident #4's hospital discharge summary dated 08/25/20 revealed:
-Admitting diagnoses were acute metabolic encephalopathy, urinary tract infection (UTI), acute kidney injury, dementia with agitation, corona virus infection, recurrent falls.
-According to the family member, Resident #4 had been having episodes of agitation for last 2-3 days and was started on Ativan.
-She was also on Seroquel and Remeron (Remeron was a medication used for nausea, anxiety, post traumatic stress syndrome, and an appetite stimulant).
-She came to the hospital recently and was diagnosed with a UTI and was discharged on Bactrim (An antibiotic used to treat or prevent an infections).
Her medication was changed to Omnicef (An antibiotic used to treat or prevent an infections) due to the urine culture growing Escherichia coli.
-She returned with worsening confusion and altered mental status.
-According to the family member, she was able to carry on a conversation.
-She was usually awake and alert but had a history of dementia.
-She recently had falls because of agitation.
-Physical Therapy and Occupational Therapy were ordered.

Observation of Resident #4 on 09/04/20 at 1:10pm revealed:
-The resident was sitting in a recliner in her room.
-The recliner's footrest was in the up position and the resident was leaning forward pulling at her socks.
-The resident had a dark purple bruise

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approximately 2 x 3 inches on the front lower left leg and a second dark purple bruise approximately 2 x 2 inches on the inside of her lower left leg.
-The resident was rubbing and scratching her head with her fingers.
-The resident was rubbing and scratching her head because it hurt but she did not know why it hurt.
-The resident would not make eye contact when spoken to and she did not answer when she was asked about the bruises.
-The resident did not answer any further questions.

Telephone interview with the Medication Aide (MA) on 09/25/20 at 4:24pm revealed:
-Resident #4's mental status declined at the end of July 2020.
-It was a "complete 360" from her previous status.
-She did not talk or engage with facility staff.
-She required total care with her activities of daily living (ADLs).
-She was 1-2 person assist depending on the day.
-On a "good" day, she required the assistance of 1 staff member.
-On a "bad" day, she required the assistance of 2 staff members.
-She was not receiving one-to-one care, but staff would swap out with each other if they could not be with her.
-She was the MA who was working when Resident #4 fell on 08/22/20.
-On 08/22/20, her fall on evening shift occurred in her bedroom.
-A Personal Care Aide (PCA) was sitting in the hallway by her room.
-The MA was at the medication cart.

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D 270	Continued From page 49 -The PCA had just walked out of her room. -The PCA saw her stand up but could not get to her before she fell. -She stood up, fell and hit the "whole side of her face." -The MA bandaged her face up with gauze before sending her to the ER. -Her current fall intervention in place was the 15-minute checks. -Staff have her "close by;" staff would switch monitoring her if there was another personal care task with another resident. -She was too unpredictable; her falls would happen in an "instant." Interview with a second MA on 09/04/20 at 1:10pm revealed: -The bruises on Resident #4's leg were caused by falls. -Resident #4 fell frequently, she thought Resident #4's last fall was 08/21/20 or 08/28/20. -She was not aware of the resident having any falls "this week." -The resident walked independently without a walker. -The resident usually fell when she was trying to get up because she would lose her balance. Telephone interview with a third MA on 09/08/20 at 2:24pm revealed: -Resident #4 was a Fall Risk. -She was not working when Resident #4 fell on 08/21/20. -Her last fall was 08/21/20 in her room and had two stitches close to her forehead, top of her head. -She did not use a walker. -She used a wheelchair. -She began being unsteady on her feet about "3 weeks ago."	D 270		

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-She was not like she used to be months ago.
-She was hallucinating, she wanted to pick up objects that were not there.
-She wanted to leave the facility and go pick up her children.

Telephone interview with a Personal Care Aide (PCA) on 09/08/20 at 3:25pm revealed:
-Resident #4 required heavy care assistance with bathing, dressing, and walking.
-She had a walker.
-Facility staff had to stay with Resident #4 because of falls.
-She would try to get up without assistance.
-The facility staff would try to get her to sit down.
-She could stand by herself, but her balance was "off."
-She was sometimes groggy and weak in the evening.
-She had fallen in the last month, she had staples in her head due to injuring herself during the fall.
-Her balance had been worse "now" that she had fallen.
-She thought she would see something in the air or ground.

Telephone interview with a second PCA on 09/18/20 at 11:03am revealed:
-The facility was short staffed some days, "we" have staff some days, and some days "we" do not have staff come back.
-There was a lot of staff turnover, "they" do the best "we" can.
-For first shift on the Special Care Unit (SCU), "we" had one MA and two PCAs.
-If a resident had a fall occur on her shift, she would call the MA immediately, implement the PCP's orders, complete the 15-minute checklist, and keep a "close eye" on the resident.
- "We" keep Resident #4 right there with "us."

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D 270	Continued From page 51 -For example, she would be with us in the medication room or TV room. -Resident #4 could not be left by herself. -She had her last fall about two to three weeks ago. -She would tilt over and would bump her head. -On 8/22/20, Resident #4's fall did not occur on her shift. -She had not fallen on any of her shifts. -There was no other type of fall interventions in place other than 15-minute checks. -She had never heard of 72-hour resident monitoring. Telephone interview with a third PCA on 09/18/20 at 1:48pm revealed: -If a resident had a fall occur on her shift, she would get the MA immediately, the MA would assess the resident because "we" cannot touch them. -She kept Resident #4 beside her or close to her during her shift. -As a team of 3 on the SCU, "we" supervise her to prevent falls. -She helped Resident #4 to the bathroom. -Resident #4 could not walk by herself, she was not "level." -Fall intervention in place was 15-minute monitoring. -She could not recall if Resident #4 had any recent falls. Telephone interview with a fourth MA on 09/18/20 at 3:40pm revealed: -If a resident had a fall occur on her shift, the MA would assess the resident immediately, send the resident to the Emergency Room, complete the Physician Communication, complete an A/I report and give it to the Administrator. -Seventy-two-hour resident monitoring would be	D 270		

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in place when the resident returned from the Emergency Room or had a fall.
-When the resident came back to the facility, "we" would monitor their general status and check the resident's vital signs every shift.
-She needed more assistance.
-She required help to the bathroom, assistance with dressing, and redirection to go back to her bed.
- "We" provided close supervision of her.
-She was always by staff.
-She would be in her wheelchair in the dayroom and there were staff outside of her room.
- "We" completed the 15-minute check lists and provided one-to-one care for Resident #4.

Telephone interview with a fourth PCA on 09/23/20 at 2:50pm revealed:
-She worked mainly in the Special Care Unit (SCU).
-She did not know which residents were identified as fall risks. When a resident had a fall, then they would be identified as a Fall Risk.
-She was not aware if the facility had a falls policy.
-PCAs did not document on the progress notes or in the progress notes.
-She completed the 15-minute checklist on the SCU residents where she would document the location of the resident and the time of the check onto the checklist.
-Resident #4 required assistance with bathing, ambulation, dressing, and toileting.
-Staff would sit with Resident #4 more, making sure she did not fall.
-If she had another personal care task to complete, another staff member would come and sit with Resident #4 until she came back.
-She could not recall a specific date when the 24-hour supervision began only.

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-She knew the 24-hour supervision of Resident #4' began after her last fall but could not recall when her last fall had occurred.
-She bumped her head, bending down to pick up something off the floor, came back up, hit her head, her head was bleeding, and she went to the Emergency Room.
-A fall mat and a bed alarm were recently implemented for Resident #4.

Telephone interview with a fifth PCA on 09/25/20 at 11:53am revealed:
-If the facility was short of staff, she would work in the SCU.
-When completing the 15/30-minute checklists, the PCA would check on the residents every 15-30 minutes, document the resident's location, and the time and initials of the PCA would be included on the checklist.
-If the resident was in the hospital, on a leave of absence, or out of the facility, it should be documented on the 15/30-minute checklists.
-Resident #4 required assistance with dressing and her shower.
- "We" just keep our eyes on her.
-For example, she was supervised while working on a word puzzle in her chair.

Telephone interview with a sixth PCA on 09/25/20 at 12:16pm revealed:
-A resident was identified as a Fall Risk if a "leaf" was outside on the wall of a resident's door.
-Resident #4 required assistance with dressing and when transferring her to her wheelchair.
-We keep an "eye" on her to make sure she does not fall.
-Resident #4 was never alone.
-Her current fall intervention in place was 15-minute checks.
-To complete the care task assigned, each staff

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D 270	Continued From page 54 member took a turn when supervising her. -Staff had to remind her to use her walker when ambulating. -Staff sat in the hallway and by her room within the Special Care Unit. -She did not recall when Resident #4's last fall occurred. Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful. Refer to telephone interview with a MA on 09/08/20 at 2:24pm. Refer to telephone interview with a PCA on 09/08/20 at 3:25pm. Refer to telephone interview with a second MA on 09/25/20 at 11:09am. Refer to telephone interview with the SCC on 09/15/20 at 11:06am. Refer to telephone interview with the Administrator on 09/15/20 at 12:07pm. Refer to telephone interview with the previous Administrator on 09/16/20 at 3:02pm. Refer to telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm. Refer to telephone interview with the facility's Owner on 09/25/20 at 1:10pm. d. Review of Resident #4's physician communication dated 09/02/20 revealed: -There was no time included on the document.	D 270		

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-Reason for Report: Fall was marked "No."
-There was an injury marked "Yes."
-She was sent to the emergency room (ER).
-The description of the incident that occurred outlined she bent over to pick up something, came back up, and hit her head on the corner of dresser.
-The primary care provider (PCP)'s response was "Aware."
-The document was electronically signed by the PCP on 09/02/20 at 1:14pm.

Review of Resident #4's Accident/Injury report completed on 09/02/20 at 10:35am revealed:
-She was reaching down to pick up something, came back up and hit head on dresser.
-Resident was alone in her room.
-There was a laceration on the back of her head.
-The type injury was documented as a laceration.
-Resident #4 was alert and oriented.
-First aid was administered.
-She was taken to the ER.

Review of Resident #4's ER Report dated 09/02/20 revealed:
-The admission reason for visit was a fall.
-She was a high fall risk.
-The stated complaint details were Resident #4 was bending over in chair to pick up something off floor and fell out of her chair.
-There was an approximate 1-inch laceration to the back of her head.
-There was no active bleeding noted.
-It was a witnessed fall.
-There was no loss of consciousness.
-The injury was a laceration and a hematoma to her head.

Review of Resident #4's ER Provider Record dated 09/02/20 revealed:

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-The stated complaint was a head injury with scalp laceration.
-The chief complaint was a fall.
-The history of present illness was Resident #4 had complaints of falling out of her wheelchair and hitting her head with a scalp laceration. Per Emergency Medical Service, she was reaching down to pick up something while sitting down at a chair and fell off the chair. She was not able to walk.
-There was wound repair to her left posterior scalp 2 cm laceration.

Observation of Resident #4 on 09/04/20 at 1:10pm revealed:
-The resident was sitting in a recliner in her room.
-The recliner's footrest was in the up position and the resident was leaning forward pulling at her socks.
-The resident had a dark purple bruise approximately 2 x 3 inches on the front lower left leg and a second dark purple bruise approximately 2 x 2 inches on the inside of her lower left leg.
-The resident was rubbing and scratching her head with her fingers.
-The resident was rubbing and scratching her head because it hurt but she did not know why it hurt.
-The resident would not make eye contact when spoken to and she did not answer when she was asked about the bruises.
-The resident did not answer any further questions.

Telephone interview with a fourth PCA on 09/23/20 at 2:50pm revealed:
-She worked mainly in the Special Care Unit (SCU).
-She did not know which residents were identified

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as fall risks. When a resident had a fall, then they would be identified as a Fall Risk.
-She was not aware if the facility had a falls policy.
-PCAs did not document on the progress notes or in the progress notes.
-She completed the 15-minute checklist on the SCU residents where she would document the location of the resident and the time of the check onto the checklist.
-Resident #4 required assistance with bathing, ambulation, dressing, and toileting.
-Staff would sit with Resident #4 more, making sure she did not fall.
-If she had another personal care task to complete, another staff member would come and sit with Resident #4 until she came back.
-She could not recall a specific date when the 24-hour supervision began only.
-She knew the 24-hour supervision of Resident #4' began after her last fall but could not recall when her last fall had occurred.
-She bumped her head, bending down to pick up something off the floor, came back up, hit her head, her head was bleeding, and she went to the Emergency Room.

Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful.

Refer to telephone interview with a MA on 09/08/20 at 2:24pm.

Refer to telephone interview with a PCA on 09/08/20 at 3:25pm.

Refer to telephone interview with a second MA on 09/25/20 at 11:09am.

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D 270	Continued From page 58 Refer to telephone interview with the SCC on 09/15/20 at 11:06am. Refer to telephone interview with the Administrator on 09/15/20 at 12:07pm. Refer to telephone interview with the previous Administrator on 09/16/20 at 3:02pm. Refer to telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm. Refer to telephone interview with the facility's Owner on 09/25/20 at 1:10pm. 3. Review of Resident #3's current FL-2 dated 03/19/20 revealed: -Diagnoses included diabetes mellitus type 2, atrial fibrillation, hyperlipidemia, and cellulitis of left foot. -The resident was documented as intermittently disoriented. -The resident was documented as semi-ambulatory with a walker. -The resident was documented as incontinent of bladder and bowel. -The resident needed assistance with bathing and dressing. Review of Resident #3's current assessment and care plan dated 03/19/20 revealed: -The resident's diagnoses included primary mental retardation, hearing impairment, visual impairment, speech impairment, hypothyroidism, diabetes, chronic obstructive pulmonary disease, and anemia. -The resident was ambulatory with a walker and had limited strength in upper extremities. -The resident was occasionally incontinent of	D 270		

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bowel.
-The resident had an indwelling urinary catheter.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident's vision was limited (sees large objects) and he could hear loud sounds/voices.
-The resident's speech was slurred.
-The resident required supervision for ambulation and transferring.
-The resident required limited assistance with eating and toileting.
-The resident required extensive assistance with bathing and dressing.
-The resident required total assistance with grooming/personal hygiene.

Review of Resident #3's licensed health professional support (LHPS) review dated 09/07/20 revealed:
-The resident was ambulatory in hallway using rolling walker with one hand.
-The resident's gait was slow and steady and walker was rolling straight with one hand use.
-The resident had left arm sling, status post urinary tract infection with history of fall.

Review of Resident #3's primary care provider (PCP) encounter progress note dated 06/18/20 revealed:
-The resident ambulated with a rollator walker and continued to need assistance with activities of daily living.
-The resident had an irregular gait and had arthritic changes noted on elbows, hands, and knees.

Review of Resident #3's accident/injury reports, 72-hour monitoring reports, physician communication notes, and hospital records revealed:

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-The resident had 3 falls in 2 weeks from 08/12/20 - 08/27/20.
-The resident went to the emergency room (ER) for evaluation of injuries for one of the falls and required a separate visit for an x-ray and two visits to an orthopedic provider.
-The resident's injuries included abrasions, skin tears, and lacerations to the head and elbows and a fractured right clavicle (broken collarbone).

Review of a physician communication report for Resident #3 dated 08/12/20 revealed:
-The resident had a fall in his room while he was trying to sit in his chair.
-The resident lost his balance and fell.
-The resident had a skin tear on his left elbow and first aid was administered.
-The resident was not sent to the ER.
-Staff checked off that 72-hour resident monitoring started.
-The PCP electronically signed the form on 08/17/20 and noted "aware, please monitor".
-The area on the form for the Resident Care Coordinator (RCC) to follow up was left blank.
-The RCC did not note if the 72-hour resident monitoring report was started.
-The RCC did not note if an incident report was completed and given to the Administrator.
-The RCC did not sign and date the form.

Review of Resident #3's 72-hour report dated 08/12/20 revealed:
-The reason for the 72-hour report was documented as "fall".
-Documentation started on second shift on 08/12/20.
-No vital signs were recorded for second or third shift.
-Second shift staff documented the resident had a fall in his room and had a skin tear on his left

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D 270	Continued From page 61 elbow. -Third shift staff documented the resident showed no signs of distress. Review of Resident #3's 72-hour report dated 08/13/20 revealed: -The reason for the 72-hour report was documented as "fall". -No vital signs were recorded for first, second, or third shift. -First, second, and third shift staff documented the resident had no complaints. Review of Resident #3's 72-hour report dated 08/14/20 revealed: -The reason for the 72-hour report was documented as "fall". -No vital signs were recorded for first, second, or third shift. -First shift staff documented the resident was doing well. -Second and third shift staff documented the resident had no complaints or concerns. -There was one entry on the bottom of the page for first shift (08/15/20) with no vital signs documented and the resident had no complaints. Review of a physician communication report for Resident #3 dated 08/22/20 revealed: -The resident lost his balance on the way to the bathroom, fell and hit his head on the floor. -The resident was injured on the right side of his head and first aid was administered. -The resident was sent to the ER. -Staff checked off that 72-hour resident monitoring started. -The PCP electronically signed the form on 08/24/20 and noted "aware". -The PCP did not check the box indicating she wanted to see the resident.	D 270		

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-The area on the form for the RCC to follow up was left blank.
-The RCC did not note if reports from the ER visit were received or reviewed.
-The RCC did not note if the 72-hour resident monitoring report was started.
-The RCC did not note if an incident report was completed and given to the Administrator.
-The RCC did not sign and date the form.

Review of Resident #3's accident/injury report dated 08/22/20 at 9:15pm revealed:
-The resident lost his balance on the way to the bathroom and he fell and hit his head on the floor.
-Staff helped the resident with stopping the bleeding from his head and cleaning the blood on his head.
-Staff noted the resident had bruising on the right side of his head.
-The resident was taken to the ER by emergency medical services (EMS) at 9:30pm.

Review of Resident #3's ER summary report dated 08/22/20 - 08/23/20 revealed:
-The resident arrived to the ER on 08/22/20 at 9:54pm.
-The reason for visit was fall and right side of head laceration.
-When EMS arrived to the facility, the resident was lying on his back on the floor, bleeding was controlled and the laceration on the right side of his head was clotted upon their arrival.
-The resident also had some controlled bleeding to the right side of the bridge of his nose.
-The resident had minor abrasions and skin tears to both arms.
-The resident had a mental delay so he was not a good historian.
-The hospital provider noted facility staff did not have any concerns other than a fall that

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happened today in the bathroom; the resident slipped and fell and did not lose consciousness and was not on the floor long.
-The resident had a small superficial laceration on the right side of his head, mildly oozing blood with no tenderness.
-The resident had a superficial abrasion on his left elbow, no bony tenderness on all extremities, and non-tender full range of motion.
-The resident was to follow up with PCP in 1 to 2 days.
-The resident was discharged and departed the hospital ER on 08/23/20 at 3:26am.

Review of Resident #3's 72-hour report dated 08/22/20 revealed:
-The reason for the 72-hour report was "fall".
-Documentation started on second shift on 08/22/20.
-The resident's vital signs were documented for second shift but not for third shift.
-Second shift staff documented the resident had a fall in his bathroom and was sent to the ER.
-Third shift staff documented the resident was resting well.

Review of Resident #3's 72-hour report dated 08/23/20 revealed:
-The reason for the 72-hour report was "fall".
-No vital signs were recorded for first, second, or third shift.
-First shift staff documented the resident was resting with no complaints of pain and no concerns.
-Second shift staff documented the resident had a good evening with no issues.
-Third shift staff documented the resident had a good night.

Review of Resident #3's 72-hour report dated

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08/24/20 revealed:
-The reason for the 72-hour report was blank.
-No vital signs were recorded for first, second, or third shift.
-First shift staff documented the resident was doing well with no complaints of pain.
-Second shift staff documented the resident had a good evening with no issues.
-Third shift staff documented the resident had no complaints or concerns.
-There was one entry at the bottom of the page for first shift on 08/25/20 with no vital signs documented and the resident had no complaints.

Review of Resident #3's physician's order dated 08/24/20 revealed an order for an x-ray of the right shoulder due to shoulder pain.

Review of Resident #3's 72-hour report dated 08/27/20 revealed:
-The reason for the 72-hour report was return from ER, intravenous (IV) antibiotics.
-No vital signs were recorded for first, second, or third shift.
-First shift staff documented the resident had no complaints or issues.
-Second shift staff documented the resident had been out of his room this evening and had no complaints.
-Third shift staff documented the resident yelled out after getting medications. He had slipped down on the floor beside the recliner. The resident had no bruises, skin tears, or redness. The resident stated he was fine and refused to go to the hospital. Staff would monitor and they reminded the resident to ask for help when needed.

Review of a physician communication report for Resident #3 dated 08/27/20 revealed:

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NAME OF PROVIDER OR SUPPLIER: WILSON ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 3501 SENIOR VILLAGE LANE, WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 65 -The resident had a fall but there were no injuries documented. -The resident stated he slipped on the floor. -The PCP electronically signed the form on 08/28/20 with no comments. -The area on the form for the RCC to follow up was left blank. -The RCC did not note if the 72-hour resident monitoring report was started. -The RCC did not note if an incident report was completed and given to the Administrator. -The RCC did not sign and date the form. Review of Resident #3's 72-hour report dated 08/28/20 revealed: -The reason for the 72-hour report was return from ER / IV antibiotics. -There was no documentation the monitoring was related to the resident falling on third shift on 08/27/20. -No vital signs were recorded for first, second, or third shift. -First shift staff documented the resident was up walking around and had no complaints. -Second shift staff documented the resident had a good evening, ate 100% of his supper, and took all his night medications. -Third shift staff documented the resident was good and had no concerns. -There was an entry at the bottom of the page for first shift on 08/29/20 with no vitals signs documented and staff noted the resident was okay. Review of Resident #3's physician's order dated 08/31/20 revealed the PCP wrote an orthopedic referral order for subluxation (dislocation) of right shoulder joint. Review of Resident #3's orthopedic visit note	D 270		

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dated 09/03/20 revealed:
-The reason for visit was right shoulder.
-Right shoulder x-ray results were non-displaced distal clavicle fracture (broken collarbone).
-The physician orders section included an order to work with physical therapy (PT) on gentle range of motion of shoulder.
-There was an order for simple sling with activity and for comfort.
-There was an order to encourage gentle range of motion with elbow, wrist, and hand.
-There was an order to encourage gentle pendulum exercises with right shoulder.
-The resident was to follow up in 2 weeks.

Review of Resident #3's 30-minute check sheets for August 2020 revealed:
-The check sheet had a column for first shift (7:00am - 2:30pm), second shift (3:00pm - 10:30pm), and third shift (11:00pm - 6:30am).
-There were columns for staff to document the location and their initials for each 30-minute increment of time.
-Staff initialed and documented the resident's location in the facility every 30 minutes on each shift from 08/01/20 - 08/30/20.
-There was no 30-minute check sheet for 08/31/20 and therefore no documentation of any 30-minute checks for Resident #3 on that day.
-Staff initialed and documented the resident was in his bedroom on 08/22/20 from 10:00pm - 3:30am but the resident had fallen and was at the ER during this time period. (Per ER records, the resident was admitted to the ER on 08/22/20 at 9:54pm and departed from the ER on 08/23/20 at 3:26am.)
-There was no documentation on the 30-minute check sheet dated 08/22/20 indicating the resident was not in the facility; staff continued to initial and note the resident was in his bedroom.

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D 270	Continued From page 67	D 270		

-Staff initialed and documented the resident was in his bedroom on 08/26/20 from 7:30pm - 10:00pm but the resident was at the ER to get IV antibiotics during this time period. (Per ER records, the resident was admitted to the ER on 08/26/20 at 7:31pm and departed from the ER on 08/26/20 at 10:03pm.)
-There was no documentation on the 30-minute check sheet dated 08/26/20 indicating the resident was not in the facility; staff continued to initial and note the resident was in his bedroom.

Review of Resident #3's 30-minute check sheets for September 2020 revealed:
-The check sheet had a column for first shift (7:00am - 2:30pm), second shift (3:00pm - 10:30pm), and third shift (11:00pm - 6:30am).
-There were columns for staff to document the location and their initials for each 30-minute increment of time.
-There were no 30-minute check sheets for 09/01/20 - 09/09/20, and therefore no documentation of any 30-minute checks for Resident #3 during this time period.
-On 09/10/20, there was no documentation of 30-minute checks from 1:00pm - 2:30pm.
-On 09/11/20, there was no documentation of 30-minute checks on third shift from 3:30am - 6:30am.
-On 09/18/20, there was no documentation of 30-minute checks from 12:00pm - 2:30pm.
-There was no 30-minute check sheet for 09/20/20 and therefore no documentation of any 30-minute checks for Resident #3 on that day.

Telephone interview with a medication aide (MA) on 09/08/20 at 2:25pm revealed:
-Resident #3 had a fall recently and fractured his shoulder but she could not recall the date.
-The resident used a rolling walker and usually

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had a steady gait.
-Staff usually did routine 2-hour checks on all residents.
-Residents on the assisted living (AL) side who were fall risks were usually checked every 30 minutes.
-She could not recall if any residents on the AL side, including Resident #3, were on 30-minute checks.

Telephone interview with a personal care aide (PCA) on 09/18/20 at 11:04am revealed:
-Resident #3 currently needed help with "everything" because his arm was in a sling.
-The resident used a walker for ambulation.
-The resident had a fall in August 2020 and hurt his shoulder, so his arm was in a sling.
-It was unusual for Resident #3 to fall and he had refused physical therapy (PT) "a while back" (did not know date).
-She thought Resident #3 had been on 15-minute checks for about 1 to 2 months.
-She did not know why Resident #3 was on 15-minute checks.
-The resident had previously been on 30-minute checks and 2-hour checks but she did not know when.

Telephone interview with a second MA on 09/18/20 at 3:44pm revealed:
-Resident #3 used a rollator walker but had some falls.
-The resident fell "a month ago or more" while trying to pull his pants down and got tangled in the leg bag of his catheter.
-She also heard staff mention the resident fell again but she could not recall when.
-The resident was currently wearing an arm sling because he hurt his collarbone.
-Resident #3 was on 30-minute checks but she

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D 270	Continued From page 69 did not know why. -Either a PCA or MA was supposed to "put eyes on" the resident, document the resident's location, and make sure the resident did not need help every 30 minutes. -Staff were supposed to document the date, time, location, and their initials. -When a resident fell, the MAs looked at the resident, sent the resident out if needed, sent a notification to the PCP, and filled out an accident/injury report. -Staff reminded a resident after a fall if they needed to get up to let staff know. -For any fall, staff would do 72-hour monitoring including checking vital signs each shift and checking to see if the resident was in pain. Telephone interview with a third MA on 09/25/20 at 11:09am revealed: -She sometimes provided care to Resident #3 when she worked on the AL side on third shift. -She could not recall if she was at the facility when the hospital called when the resident went to the ER for a fall on 08/22/20. -Resident #3 was on 30-minute checks but she did not know why or when the checks started. -When staff did the checks, they were supposed to document the location of the resident. -When Resident #3 was in the hospital, staff should have documented the resident was in the hospital instead of in his bedroom. -She did not know why staff would document the resident was in the facility when the resident was at the hospital except staff did not actually do their checks. Telephone interview with a second PCA on 09/25/20 at 11:45am revealed: -Resident #3 needed assistance with bathing, dressing, and reminders of when to eat.	D 270		

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D 270	Continued From page 70 -Resident #3 sometimes needed assistance with emptying his catheter bag. -She thought Resident #3 was on 30-minute checks but she did not know why. -For 30-minute checks, staff would document the location of the resident for each check. -If the resident was in the hospital, staff should document an "H" on the check sheet to show the resident was in the hospital. -She thought the resident was currently wearing an arm sling because of a fall. Telephone interview with the Special Care Coordinator (SCC) on 09/15/20 at 11:06am revealed: -On 08/22/20, Resident #3 fell and was sent to the ER. -Resident #3 kept complaining of shoulder pain so the PCP sent a referral for an x-ray. -She did not know how long or when the resident started complaining of shoulder pain. -Resident #3 was seen by an orthopedist and was diagnosed with a broken collarbone. -Resident #3 used a walker for ambulation but had difficulty seeing because of cataracts but he refused to have cataract surgery. Telephone interview with the Administrator on 09/15/20 at 3:39pm revealed he had not yet completed a falls assessment for Resident #3. Review of Resident #3's fall risk assessment form dated 09/17/20 revealed: -The form was completed by the Administrator. -The Administrator rated the resident with a total score of 3. -A total score of 10 or above represented high risk for falls. -In the section for level of consciousness/mental status, the Administrator gave 0 points for alert	D 270		

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D 270	Continued From page 71 and oriented x 3 but the resident's FL-2 noted the resident was intermittently disoriented and the care plan noted the resident was sometimes disoriented, forgetful, and needed reminders. -Intermittent confusion on the form would require 4 points being added to the score instead of 0. -For history of falls in the past 3 months, the Administrator assigned a score of 2 for 1 to 2 falls but this would have required a score of 4 because the resident had 3 falls in August 2020. -For vision status, the Administrator gave 0 points for adequate vision with glasses but according to the resident's ophthalmology provider, the resident had poor vision due to cataracts in both eyes. -Poor vision, with or without glasses would required 2 points being added to the score instead of 0. -For gait and balance, the Administrator only gave 1 point for the resident having a walker but the resident also had balance issues as indicated by accident/injuring reports noting the resident lost his balance when falling. -Balance problems required at least 1 additional point being added to the score in the gait/balance section. -For predisposing diseases, this section was left blank but would have required a score of 2 due the resident having a current fractured collarbone and a history of hip fracture. -If assessed according to the criteria on the form, the resident would have scored at least 14 points which would have required the second page for interventions to be initiated to be completed. -The second page for interventions was blank with no interventions noted for Resident #3. Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful.	D 270		

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Observations of Resident #3 on 09/04/20 at 11:16am and 11:39am revealed the resident was walking down the hall using a rollator walker on each occasion.

Telephone interview with Resident #3's PCP on 09/23/20 at 4:22pm revealed:
-She was aware the resident had some falls in August 2020.
-On 08/24/20, the SCC called her and reported the resident had some shoulder pain so she ordered an x-ray.
-She expected staff to check on the resident for any problems when doing the 72-hour falls monitoring.
-She expected the facility to follow their falls policy for supervising residents after falls.

Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful.

Refer to telephone interview with a MA on 09/08/20 at 2:24pm.

Refer to telephone interview with a PCA on 09/08/20 at 3:25pm.

Refer to telephone interview with a second MA on 09/25/20 at 11:09am.

Refer to telephone interview with the SCC on 09/15/20 at 11:06am.

Refer to telephone interview with the Administrator on 09/15/20 at 12:07pm.

Refer to telephone interview with the previous Administrator on 09/16/20 at 3:02pm.

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Refer to telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm.

Refer to telephone interview with the facility's Owner on 09/25/20 at 1:10pm.

______

Telephone interview with a MA on 09/08/20 at 2:24pm revealed:
-All residents in the SCU were on 15-minute checks for monitoring.
-The frequency of monitoring was still every 15-minute checks for residents with increased falls.

Telephone interview with a PCA on 09/08/20 at 3:25pm revealed when she worked with a resident who was at risk for falls, she sat by their bedroom door so that she could catch them before they got up and fell.

Telephone interview with a second MA on 09/25/20 at 11:09am revealed:
-It was hard trying to supervise the residents in the SCU for falls because they did not have enough staff.
-Most shifts were only staffed with two PCAs and MA and they had at least two residents in the SCU who needed one-on-on supervision.
-The facility did not have enough staff in the SCU to provide one-on-one supervision.
-If the MAs were passing medications, the PCAs were feeding or changing residents on the hall.

Telephone interview with the SCC on 09/15/20 at 11:06am revealed:
-She had never done any fall assessments, fall intervention plans, or fall tracking logs.
-She did not know the facility had a falls policy

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until it was requested by the surveyors for this survey.
-She had not been able to locate any fall assessments for any residents.
-She was not sure who was responsible for completing fall assessments at the facility.
-She thought it may be the responsibility of the Administrator to complete the fall assessments.
-When a resident fell, the MA would assess the resident, fill out an accident/injury report, fill out a physician communication form, and fax that information to the resident's PCP.
-She and the RCC would get the original copy of the physician communication form and the Administrator got the original copy of the accident/injury report.
-If a resident hit their head, the resident would "automatically" be sent to the ER unless they lived on the AL side of the facility and they refused.
-When a resident came back from the ER, a 72-hour monitoring report was started to check on the resident for the next 72 hours.
-The resident's vital signs would be checked each shift for 72 hours.
-The MAs and the PCAs would work together each shift to keep a "closer eye" on the resident for 72 hours.
-A "closer eye" meant the MAs and PCAs would work together to prevent further falls.
-If a resident was on 30-minute checks prior to a fall, they would be on 15-minute checks for 72 hours after the fall.
-If a resident was on 15-minute checks prior to a fall, they would stay on 15-minute checks because the facility staff did not monitor more frequently than 15-minute checks.
-They did not do one-on-one monitoring because they did not have enough staff.
-For the 15-minute and 30-minute checks, staff

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D 270	Continued From page 75 were supposed to "lay eyes on the resident" and document their location. -The MAs were supposed to check the 15-minute and 30-minute monitoring sheets. -She was supposed to check the 15-minute and 30-minute monitoring sheets the first week of the month but she had not had time to monitor the sheets. -The 72-hour monitoring reports were only done if a resident went to the hospital for a fall. -If a resident fell and did not go to the hospital, they did not do 72-hour monitoring but they would document on the physician communication form and fax it to the PCP. -They would also document the fall on an accident/injury report. -She assumed the Administrator was responsible for completing fall assessment forms for residents. -She did not know if the former Administrator completed any fall assessment forms for the residents and she could not find any fall assessments for any residents. -Interventions for falls depended on the resident and what issue was causing the resident to fall. -They usually faxed all physician communication forms to the PCP and the PCP usually responded within 24 to 48 hours. -If a resident had more than two falls, they tried to get orders for a PT/OT referral. -She, the Administrator, RCC, and MAs would get together to discuss what other steps to take such as getting a wheel chair or walker. -They did not document their meetings, it was all verbal and the PCP would have the final say on interventions. Telephone interview with the Administrator on 09/15/20 at 12:07pm revealed: -When a resident had a fall, his expectations	D 270		

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D 270	Continued From page 76 were for the MA to assess the resident immediately. -The MA would complete an accident/injury (A/I) report and a physician communication form. -The MA would fax the physician communication form to the PCP. -The SCC and and the RCC would receive a copy of the physician communication form and the Administrator would receive the A/I report. -The therapy team was not able to come to the facility since March 2020 because of COVID-19. -The therapy team began seeing residents again in the middle of August 2020. -If a resident was COVID-19 positive, therapy would not work with the resident. -For the 15/30-minute checks, he was monitoring them to verify if they were completed, but he did not monitor for accuracy regarding staff's documentation. -He was not aware if there were errors on the 15/30-minute checklists. -Residents with falls were supposed be on 15-minute checks by staff and the staff documented on the residents' checks sheets. -He did not know about the facility's fall policy. -He had not completed any fall assessments for any residents since he started working at the facility about a month ago. -He had inquired about fall assessments for the residents and he thought fall assessments were done by the MA and the RCC or SCC followed up with the assessments. -He did not know he was supposed to be doing the fall assessments for the residents. -He asked the previous Administrator about residents fall assessments and the previous Administrator reported that residents were referred to PT for fall assessments. -He had a meeting with the PT provider on 09/13/20 regarding residents with falls in the	D 270		

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D 270	Continued From page 77 facility. -He started tracking residents' falls on a board in his office a few weeks ago. -He did not know about increased supervision for the residents with falls. Telephone interview with the previous Administrator on 09/16/20 at 3:02pm revealed: -She had been the Administrator at the facility for the past two and half years. -Her last day at the facility was 07/31/20. -For any A/I report, the Administrator would have been called by the facility staff. -She maintained a fall tracking record, she would write every incident down. -She and the facility's onsite therapist would have a monthly fall meeting and documentation of the meetings was kept in the Administrator's office. -Fall assessments were completed by the facility's onsite therapy team. -A fall meeting did not take place in June and July 2020. -If a resident was not assigned to the therapy's caseload, she would request an assessment be completed. -15-minute checks were implemented for residents who were at risk for a fall or were an elopement risk. -The fall interventions in place for high fall risk residents were concave mattresses, the resident's bed in a low position, slip grips for the chairs, a falling leaf placed outside a resident's door, and any suggestions from the PCP. -Other fall interventions in place were having the resident out in the hall and more staff. -It depended on what was going on in the building. -The falls tracking log ended in April 2020 because everything went "crazy."	D 270		

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Telephone interview with the facility's contracted occupational therapists on 09/23/20 at 2:01pm revealed:
-They received information for the falls screening through discussion with the staff.
-There was meetings every two weeks to a month with the previous Administrator to discuss residents' falls.
- "We" were struggling to get staff observations of a resident's decline in health status."
-There was limited staff and they were having to keep their eyes on all the residents who were identified as fall risks.
-She thought the facility staff needed to keep fall risk residents in common areas.
-The facility needed more staff in the SCU because of resident falls.

Telephone interview with the facility's Owner on 09/25/20 at 1:10pm revealed:
-The facility staff should follow the facility's policy for falls.
-The Administrator usually handled falls and interventions for falls.
-She was not usually involved with the facility's falls policy.
-For supervision checks, staff should document a resident was out of the facility if the resident was not in the facility during the check.
-Falls were always a concern and the facility had 15-minute and 30-minute checks in place.
-If a resident needed one-on-one supervision, they would have to look t see if they could provide that.
-She expected staff to follow the facility's falls policy.

____

The facility failed to provide supervision for 3 residents who had multiple falls with injuries including Resident #1 who had a known history of

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D 270	Continued From page 79 repeated falls, sustaining multiple contusions, head hematoma, and multiple facial fractures; Resident #4 who had multiple falls with injuries including facial lacerations and staples to the head; and Resident #3 who had three falls in two weeks including one fall that resulted in a fractured collarbone. The failure of the facility to provide supervision resulted in serious injury and serious neglect of the residents and constitutes a Type A1 Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 28, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure provider notification and obtaining care for 3 of 5 sampled residents (#1, #3, #4) related to failing to send a resident with a urinary catheter to the emergency room as instructed by the home health nurse for symptoms of urinary tract infection (#3); failing to obtain diabetic shoes and physical therapy as ordered for a resident with 3 falls in two weeks	D 273		

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D 273	Continued From page 80 who suffered a broken collarbone (#3); failing to follow up with the primary care provider to obtain a second order for a urinalysis for a resident with symptoms of urinary tract infection (#1); and failing to obtain a urinalysis without delay for a resident with symptoms of a urinary tract infection including altered mental status changes with falls (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 03/19/20 revealed: -Diagnoses included diabetes mellitus type 2, atrial fibrillation, hyperlipidemia, and cellulitis of left foot. -The resident was documented as intermittently disoriented. -The resident was documented as semi-ambulatory with a walker. -The resident was documented as incontinent of bladder and bowel. -The resident needed assistance with bathing and dressing. Review of Resident #3's current assessment and care plan dated 03/19/20 revealed: -The resident's diagnoses included primary mental retardation, hearing impairment, visual impairment, speech impairment, hypothyroidism, diabetes, chronic obstructive pulmonary disease, and anemia. -The resident was ambulatory with a walker and had limited strength in upper extremities. -The resident had an indwelling urinary catheter. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident's vision was limited (sees large objects) and he could hear loud sounds/voices. -The resident required total assistance with	D 273	The policy at Wilson Assisted Living for healthcare referral and follow-up is to assure that the routine and acute care needs of our residents are met. All healthcare and referral orders will be given to the RCC/SCC immediately and followed through timely as ordered by physician. RCC/SCC will report health care concerns to Administrator daily/weekly. Med Staff will monitor fax throughout shift for new orders and fax to pharmacy as well as give copy to RCC/SCC for review.	10/28/20

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D 273	Continued From page 81 grooming/personal hygiene. -Other personal care tasks listed for the resident included urinary catheter care. a. Review of Resident #3's home health nurse (HHN) skilled visit form dated 08/21/20 revealed: -The HHN arrived due to facility staff calling the HHN to assess the resident's Foley catheter. -The resident had urine in the catheter bag and the urine was cloudy. -The HHN informed the medication aide (MA) that the resident appeared to have a urinary tract infection. -The primary care provider's (PCP) office was closed at this time so facility staff would have to send the resident out to the emergency room (ER). -The MA stated she would check the resident's catheter to see what the urine looked like in the bag when the resident's bag got some urine and the MA would send the resident out if the urine was dark and cloudy with the catheter bag change. Review of Resident #3's 24-hour report notes and provider visit notes revealed no documentation the MA checked the resident's urine or sent the resident to the ER for symptoms of a urinary tract infection on 08/21/20 as instructed by the HHN. Telephone interview with the Special Care Coordinator (SCC) on 09/28/20 at 10:27am revealed: -She was not aware the HHN instructed staff to send Resident #3 to the ER during the visit on 08/21/20. -Staff should have called her when the HHN instructed them to send the resident out and staff should have sent the resident to the ER. -The MAs were supposed to empty, clean, and	D 273 D273	Addendum per telephone with Ms. Beth Burrell on 11/25/20: The RCC/SCC are auditing resident records at least weekly to assure health care needs and referral orders are being met and implemented. RCC/SCC will forward UA orders to MAs. The MAs are responsible for processing the orders and implementing. The RCC/SCC will monitor at least weekly or more often as needed to assure compliance. W. Williams 11/25/20	

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switch Resident #3's urinary catheter bags.
-If the resident's urine was dark or cloudy, staff should have reported it to the SCC and the PCP.
-If the HHN instructed the resident should be sent to the ER for a possible urinary tract infection, she expected staff to send the resident to the ER as instructed.

Review of Resident #3's ER summary report dated 08/22/20 - 08/23/20 revealed:
-The resident arrived at the ER on 08/22/20 at 9:54pm.
-The reason for visit was fall and right side of head laceration.
-When emergency medical services (EMS) arrived to the facility, the resident was lying on his back on the floor, bleeding was controlled and the laceration on the right side of his head was clotted upon their arrival.
-Hospital staff went to prep the resident for discharge and noted an odor believed to be a bowel movement.
-The hospital nurse went to assist with cleaning and changing the resident but the resident did not have a bowel movement.
-The resident had an indwelling catheter and upon exam, the leg bag had dark brown urine and odor was noted from the urine.
-The catheter bag was emptied and dark brown sludge was noted to be coming from the urine as well.
-The facility was notified that a urinalysis was going to be done before discharging the resident.
-The nurse confirmed with staff at the facility that the resident had "brown color urine for a while" but no fever.
-The urinalysis results were abnormal and indicated the resident had blood, bacteria, and mucus in his urine.
-The resident was given an antibiotic by

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D 273	Continued From page 83 intramuscular injection and a prescription for an oral antibiotic. -The resident was to follow up with PCP in 1 to 2 days. -The resident was discharged and departed the hospital ER on 08/23/20 at 3:26am. Telephone interview with a MA on 09/25/20 at 4:24pm revealed: -She was working on another hall on third shift on 08/22/20 when Resident #3 fell. -The other MA reported the resident slipped on his urine in the bathroom. -She did not know if his catheter bag was leaking. -The hospital staff called her that night and reported the resident had a very severe urinary tract infection. -She told the nurse at the hospital that the resident's urine had been cloudy with a brown tint for "a good week". -Before the resident went to the hospital on 08/22/20, the resident's urine was cloudy with a brown tint and it was that way a week before that. -She thought the HHN came to the facility and checked the catheter but she did not know when. Review of Resident #3's HHN skilled visit form dated 08/24/20 revealed: -The resident was in need of HHN visits for monthly Foley catheter changes. -When HHN arrived, facility staff stated the resident had a fall on Friday and was sent to the ER. -The resident was diagnosed with a urinary tract infection while at the ER and was sent a prescription for antibiotics. -The resident was lying in bed and staff stated the resident had been lying in bed all day. -The HHN reminded staff to watch for pain/burning/dark/cloudy urine and change bags	D 273		

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D 273	Continued From page 84 daily. -Staff should change bags with clean, washed hands and gloves on to prevent infection. -The HHN informed staff that the resident allowed the HHN to help and staff should at least go in and try to help the resident daily to prevent future infections. Telephone interviews with Resident #3's HHN on 09/25/20 at 9:20am and 09/28/20 at 1:17pm revealed: -She went to the facility on 08/24/20 and changed the resident's catheter. -The resident's urine had never been brown to her knowledge. -The resident's urine was normally straw-colored or amber. -No one had ever reported the resident's urine being brown or having brown sludge in it. -Facility staff should call the HHN if the resident's urine was brown. -She sometimes had problems with the facility staff regarding Resident #3's catheter. -Staff would call and say something was wrong with the catheter but once she got to the facility, the staff on duty could not tell her what was wrong with the resident or the catheter. -She took 30 leg bags to the facility each month so staff could use a new leg bag each day but facility staff were putting the same leg bag back on the resident's catheter without changing to a new one. -Not changing to a new bag each day could contribute to the resident's urinary tract infections because the used bags could have bacteria where it was reconnected. -The resident always let the HHN nurse help him and change his catheter with no problems. -She told facility staff "all the time" to make sure they helped the resident with his catheter care	D 273		

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D 273	Continued From page 85 and checked it every day. -She was concerned the resident was not washing his hands when providing his own catheter care and that could also contribute to urinary tract infections. -She was not aware the resident's urine was brown or that he had brown sludge in his catheter when he went to the hospital on 08/22/20. -Facility staff told the HHN the resident had been to the hospital on 08/22/20 and had a urinary tract infection but she was not aware the resident went back to the hospital on 08/26/20 for intravenous (IV) antibiotics. -She went to the facility on 08/21/20 because facility staff called her to assess the resident's catheter because he was not urinating. -When she changed the resident's catheter, there was a little urine in the bag and it was cloudy. -It was after 5:00pm on a Friday afternoon (08/21/20), so she would not be able to get an order for a urinalysis. -She told the MA (could not recall her name) to check the resident within the next hour and if the resident's urine was cloudy or dark to send the resident to the ER. -She did not hear anything else from the facility that day, 08/21/20, or over the weekend. -She called the facility on Monday, 08/24/20, to follow up to see the resident but the RCC told the HHN the resident had been to the ER over the weekend for a fall and was diagnosed with a urinary tract infection. Telephone interview with the SCC on 09/24/20 at 2:54pm revealed: -She had informed Resident #3's home health provider a couple of times when the catheter was bothering the resident and the HHN came to the facility to check the catheter. -Facility staff had not reported any issues with	D 273		

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D 273	Continued From page 86 unusual colored urine for Resident #3 but staff had reported a strong smell from his urine. -She alerted the HHN and the PCP of the strong odor but she could not recall when but it had been less than 6 months ago. -She was not aware Resident #3 had brown urine with brown sludge when the resident went to the ER for a fall on 08/22/20. -She expected staff to notify the MA, the SCC, the PCP, and the HHN of any concerns with the resident's urine or catheter. -No one had reported Resident #3 had brown urine or sludge in his catheter bag. Telephone interview with Resident #3's PCP on 09/23/20 at 4:22pm revealed: -Facility staff should be monitoring the resident's catheter and making sure there were no problems on a daily basis. -Facility staff should at least check the catheter to make sure it was intact and there was no blood in his urine. -She was not aware the resident had brown urine with brown sludge when he went to the hospital after a fall on 08/22/20. -Dark urine could be caused by dehydration, decreased kidney function, and resident had a history of urinary tract infections. -If the resident had brown urine with sludge or sediment, it should have been reported to her or to his home health provider. b. Review of Resident #3's accident/injury reports, 72-hour monitoring reports, physician communication notes, and hospital records revealed: -The resident had 3 falls in 2 weeks from 08/12/20 - 08/27/20. -The resident went to the emergency room (ER) for evaluation of injuries for one of the falls and	D 273		

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required a separate visit for an x-ray and two visits to an orthopedic provider.
-The resident's injuries included abrasions, skin tears, and lacerations to the head and elbows and a fractured right clavicle (broken collarbone).

Review of a physician communication report for Resident #3 dated 08/12/20 revealed:
-The resident had a fall in his room while he was trying to sit in his chair.
-The resident lost his balance and fell.
-The resident had a skin tear on his left elbow and first aid was administered.
-The resident was not sent to the ER.

Review of a physician communication report for Resident #3 dated 08/22/20 revealed:
-The resident lost his balance on the way to the bathroom, fell and hurt his head on the floor.
-The resident was injured on the right side of his head and first aid was administered.
-The resident was sent to the ER.

Review of Resident #3's accident/injury report dated 08/22/20 at 9:15pm revealed:
-The resident lost his balance on the way to the bathroom and he fell and hurt his head on the floor.
-Staff helped the resident with stopping the bleeding from his head and cleaning the blood on his head.
-Staff noted the resident had bruising on the right side of his head.
-The resident was taken to the ER by emergency medical services (EMS) at 9:30pm.

Review of Resident #3's ER summary report dated 08/22/20 - 08/23/20 revealed:
-The resident arrived at the ER on 08/22/20 at 9:54pm.

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D 273	Continued From page 88 -The reason for visit was fall and right side of head laceration. -When EMS arrived to the facility, the resident was lying on his back on the floor, bleeding was controlled and the laceration on the right side of his head was clotted upon their arrival. -The resident also had some controlled bleeding to the right side of the bridge of his nose. -The resident had minor abrasions and skin tears to both arms. -The resident had a mental delay so he was not a good historian. -The hospital provider noted speaking to staff at the facility who did not have any other concerns other than a fall that happened today in the bathroom; the resident slipped and fell and did not lose consciousness and was not on the floor long. -The resident had a small superficial laceration on the right side of his head, mildly oozing blood with no tenderness. -The resident had a superficial abrasion on his left elbow, no bony tenderness on all extremities, and non-tender full range of motion. -The resident was to follow up with primary care provider (PCP) in 1 to 2 days. -The resident was discharged and departed the hospital ER on 08/23/20 at 3:26am. Telephone interview with the Special Care Coordinator (SCC) on 09/15/20 at 11:06am revealed: -On 08/22/20, Resident #3 fell and was sent to the ER. -Resident #3 kept complaining of shoulder pain so the PCP sent a referral for an x-ray. -She did not know how long or when the resident started complaining of shoulder pain. -Resident #3 was seen by an orthopedist and was diagnosed with a broken collarbone.	D 273		

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D 273	Continued From page 89 -Resident #3 used a walker for ambulation but had difficulty seeing because of cataracts but he refused to have cataract surgery. Review of a physician communication report for Resident #3 dated 08/27/20 revealed: -The resident had a fall but there were no injuries documented. -The resident stated he slipped on the floor. Review of Resident #3's orthopedic visit note dated 09/03/20 revealed: -The reason for visit was right shoulder. -Right should x-ray results were non-displaced distal clavicle fracture (broken collarbone). -The physician orders section included an order to work with physical therapy (PT) on gentle range of motion of shoulder. -There was an order for simple sling with activity and for comfort. -There was an order to encourage gentle range of motion with elbow, wrist, and hand. -There was an order to encourage gentle pendulum exercises with right shoulder. -The resident was to follow up in 2 weeks. Review of Resident #3's provider visit notes revealed no documentation the resident had received PT as ordered on 09/03/20 by the orthopedic provider. Telephone interview with a therapist from the facility's contracted in-house therapy provider on 09/14/20 at 1:01pm revealed there was no record of their agency providing any PT services for Resident #3. Review of Resident #3's orthopedic visit note dated 09/18/20 revealed: -The reason for visit was follow up to right clavicle	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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fracture.
-There was an order to continue sling with activity and as needed for comfort.
-There was an order to remove sling to perform gentle pendulum exercises of elbow, wrist, hand, and fingers.
-There was an order for range of motion exercises to prevent stiffness.

Telephone interview with a medication aide (MA) on 09/18/20 at 3:44pm revealed:
-Resident #3 used a rollator walker but had some falls.
-The resident fell "a month ago or more" while trying to pull his pants down and got tangled in the leg bag of his catheter.
-She also heard staff mention the resident fell again but she could not recall when.
-The resident was currently wearing an arm sling because he hurt his collarbone.

Telephone interview with Resident #3's PCP on 09/23/20 at 4:22pm revealed:
-She was aware the resident had some falls in August 2020.
-On 08/24/20, the SCC called the PCP and reported the resident had some shoulder pain.
-She ordered an x-ray for his shoulder.
-She did not know if the resident had received PT.
-When there was a referral for PT, she expected the facility to follow through with the referral.

Telephone interview with the SCC on 09/28/20 at 10:27am revealed:
-She did not recall seeing the PT referral order from the orthopedic provider note dated 09/03/20.
-A PT referral order was sent to the facility's in-house therapy provider on 09/18/20.
-The facility's in-house therapy provider could not

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D 273	Continued From page 91 do PT services for Resident #3 due to insurance because the resident was receiving catheter care services from another home health provider. -The resident's home health provider was supposed to be coming to do PT with the resident but she did not know when. Telephone interviews with Resident #3's home health nurse (HHN) on 09/25/20 at 9:20am and 09/28/20 at 1:17pm revealed: -She called the facility on Monday, 08/24/20, to follow up to see the resident but the SCC told the HHN the resident had been to the ER over the weekend for a fall and was diagnosed with a urinary tract infection. -The SCC sent an order to the HHN for a PT referral on 09/08/20. -She thought the SCC was coordinating the PT to be done by the in-house therapy provider at the facility because that's what the SCC told her when they verbally discussed the PT order. -She thought the SCC sent her a copy of the PT order for informational purposes to let her know the resident was getting PT since the SCC told her the facility had their own therapy provider. -She called the SCC about 2 weeks after she received the order to check on the status and found out the resident was not receiving PT. -The SCC told her the facility's in-house therapy could not provide PT for the resident since the resident was already on the caseload for the HHN's agency. -No one at the facility had contacted the HHN to let her know the resident was not receiving PT via the in-house therapy provider. Telephone interview with a patient support specialist at Resident #3's orthopedic office on 09/25/20 at 12:50pm revealed: -The orthopedic office had their own PT	D 273		

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department.
-Their PT department contacted the facility (not sure of date) regarding a PT order.
-The orthopedic office saw the resident again on 09/18/20 and the provider still wanted the resident to have PT so they sent an order to the resident's home health provider on 09/22/20.
-She was unsure about a PT order on 09/03/20.

Telephone interview with a receptionist at Resident #3's orthopedic PT department on 09/28/20 at 1:37pm revealed:
-She was not sure about the PT order from the visit on 09/03/20.
-The orthopedic provider put another order in for PT for the resident on 09/18/20.
-She called the facility on 09/21/20 and spoke with a female staff person (did not know staff's name).
-The facility staff person told the receptionist there was a conflict in the resident having PT at the facility and at the orthopedic PT office.
-The facility staff person said the resident's PT would have to be provided by the home health agency that already provides other services for the resident.
-They sent another order to the resident's home health provider on 09/22/20.
-The sooner the resident started PT the less chance the joint would freeze up.

c. Review of Resident #3's podiatry visit form dated 06/05/20 revealed:
-The resident was seen for diabetic foot care.
-The resident was ambulatory with a walker.
-The resident had an altered mental status, making history and some exam findings difficult or unable to be performed.
-Toenails were debrided in length and thickness to prevent pain and other symptoms.

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D 273	Continued From page 93 -The resident's pre-ulcerative callus was debrided/pared to prevent further breakdown and pain. -The resident was noted to have hammertoes (abnormal bend in the middle joint of the toe) on the left foot. -The podiatrist recommended extra depth diabetic shoes to further manage hammertoes and bunions (a bony bump that forms on the joint at the base of the big toe) due to cavus foot (the foot has an arch that is much higher than normal and can cause pain and instability). -The resident was to follow up in 2 to 3 months. -There was a computer printed note indicating upon the primary care provider's (PCP) review of the most current consult note and plan of care, should the PCP not agree with the medical necessity of both the care delivered and the proposed plan of care, the podiatry provider was to be notified immediately. Telephone interview with a medication aide (MA) on 09/25/20 at 3:52pm revealed Resident #3 wore regular tennis shoes and he did not have diabetic shoes to her knowledge. Telephone interview with a personal care aide (PCA) on 09/25/20 at 12:04pm revealed: -The resident had regular shoes and she had not seen any diabetic shoes for the resident. -She saw a piece of paper on the desk today, 09/25/20) with information indicating the resident was supposed to get diabetic shoes. Telephone interviews with the Special Care Coordinator (SCC) on 09/24/20 at 2:54pm and 09/28/20 at 10:27am revealed: -She overlooked the podiatrist's recommendation for diabetic shoes in the notes for the visit in June 2020.	D 273		

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-She did not think the resident was diabetic and she did not notice the podiatrist's documentation related to his diabetic foot care.
-The resident did not currently have diabetic shoes.
-She was going to try to get the resident some diabetic shoes or check with the podiatrist to see if she wanted to discontinue the order.

Review of Resident #3's podiatry visit form dated 09/18/20 revealed:
-The resident was seen for diabetic foot care.
-The resident was ambulatory with a walker.
-Toenails were debrided in length and thickness to prevent pain and other symptoms.
-The resident's pre-ulcerative callus was debrided/pared to prevent further breakdown and pain.
-There was no documentation indicating if the resident had diabetic shoes.
-The resident was to follow up in 2 to 3 months.

Telephone interview with the scheduler at Resident #3's podiatry office on 09/28/20 at 1:46pm revealed the facility was supposed to notify the resident's PCP of the podiatrist's recommendation and the PCP would write an order for the diabetic shoes.

Telephone interview with Resident #3's podiatrist on 09/28/20 at 3:45pm revealed:
-She always shared her recommendations to the facility staff during her on-site visits with residents.
-It would be up to the facility to get diabetic shoes from a vendor for the resident.
-Without the diabetic shoes, the resident's condition could worsen with lack of arch support that could cause stress to the feet and it could contribute to instability if the resident was in pain

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or had skin breakdown on his feet.
-She saw the resident on 09/18/20 and no one made her aware the resident did not have diabetic shoes.

2. Review of Resident #4's current FL-2 dated 08/31/20 revealed:
-Diagnoses included dementia, depression, diverticulitis, hypertension, and acute encephalopathy.
-She was intermittently confused.
-She was indicated as a wanderer.
-She required personal assistance with bathing and dressing.
-She was ambulatory.
-She was incontinent of bowel and bladder.

Review of Resident #4's Emergency Provider Record dated 08/21/20 revealed:
-Resident #4 presented to the emergency room (ER) with a chief complaint of unwitnessed fall via Emergency Medical Services (EMS).
-Staff had checked on her just 15 minutes previously and when they went to check on her again, they found her on the bed with blood on her head.
-It appeared she had fallen on the floor and climbed back into the bed.
-She had dementia at baseline and was unable to provide any history herself.
-Her family also requested a urinalysis, because she was started on Seroquel 2 days ago, she had been acting different and believed she may have a urinary tract infection (UTI).
-The location of injury/pain was indicated as her head and her face.
-There was dried blood all along left scalp, no active bleeding, left frontal scalp hematoma about 2 cm palpable. Midline frontal scalp with 1 cm laceration no active bleeding.

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-Her severity of symptoms was moderate.
-She was a High Fall Risk.
-The primary impression was a scalp laceration.
-The secondary impression was a UTI.

Review of Emergency Room urinalysis macroscopic results dated 08/21/20 revealed Resident #4 had a UTI.

Review of lab order dated 08/17/20 revealed an order for urinalysis, reflex culture (This is a lab test used to detect cells and substances in the urine to help screen and diagnose urinary tract infections or kidney diseases).

Review of lab diagnostic final report dated 08/21/20 revealed:.
-The report results were for a culture, urine routine.
-The specimen was collected on 08/18/20 at 3:08pm.
-The specimen was received on 08/20/20 at 3:21pm.
-The specimen was reported on 08/21/20 at 1:10pm.
-The urine culture's result revealed a urinary tract infection.

Telephone interview with a customer representative at the facility's contracted clinical laboratory on 09/24/20 revealed Resident #4's urine specimen result was reported via fax to the facility 08/21/20 at 1:19pm.

Telephone interview with the Special Care Coordinator (SCC) on 09/24/20 at 2:55pm:
-The Medication Aide (MA) would collect the resident's specimen, label the tube, and place in the refrigerator.
-It was the responsibility of the Resident Care

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Coordinator (RCC), the SCC, and the MAs to contact the facility's contracted clinical laboratory to schedule specimen pickup as lab work was ordered.
-Resident's specimen collection was dependent on the facility's contracted clinical laboratory.
-She was not aware of the two-day delay from the documented collection date and specimen date.
-She was not sure why the delay occurred.

Second telephone interview the Special Care Coordinator (SCC) on 09/28/20 at 10:50am:
-She expected the MA on duty to complete the collection of the resident's specimen, place in the proper packaging, contact the facility's contracted clinical laboratory to schedule specimen pickup, and to have the ordered lab work pickup on the same day.
-The MA should inform the RCC, SCC, and the Administrator of any delays in specimen pickup.

Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful.

3. Review of Resident #1's current FL-2 dated 08/25/20 revealed:
-Diagnoses included dementia, muscle weakness, traumatic subdural hemorrhage with loss of consciousness, repeated falls, and history of other specified skull and facial bone fractures.
-Resident #1 was constantly disoriented and semi-ambulatory with a walker.
-Resident #1's recommended level of care was the Special Care Unit (SCU).

Review of a provider order request/notification form for Resident #1 revealed:
-The Resident Care Coordinator (RCC) documented notification to Resident #1's primary

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D 273	Continued From page 98 care provider (PCP) on 06/11/20 that Resident #1 exhibited unusual behavior, was agitated, fidgeting, and staff were unable to redirect. -The PCP wrote an order dated 06/11/20 for Resident #1 to have a urinalysis with culture and sensitivity. Review of the Resident #1's urinalysis results revealed: -Resident #1's urine specimen was received by the laboratory on 06/12/20 at 2:05pm with no date of collection documented by the facility. -The laboratory used the date Resident #1's urine was received for her collection date. -Resident #1's preliminary urinalysis results were reported on 06/13/20 at 4:02am with evidence of staphylococcus bacterial infection and the preliminary report was faxed to the facility from the laboratory at 5:02am. -Resident #1's final urinalysis results were reported on 06/13/20 at 7:38pm with evidence of staphylococcus bacterial infection that was susceptible to nitrofurantoin (Nitrofurantoin is an antibiotic used to treat bacterial infections in the body including urinary tract infections). -The final urinalysis results were faxed to the facility on 06/13/20 at 7:45pm. Review of a medication order for Resident #1 dated 06/17/20 revealed an order for nitrofurantoin 100mg - 1 capsule every 12 hours for seven days. Telephone interview with Resident #1's PCP on 09/23/20 revealed: -She did not know of any problem or delay with getting lab results from the facility regarding Resident #1's urinalysis results from 06/13/20. -It usually took the laboratory three or four days to process the specimen and send it back to the	D 273		

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D 273	Continued From page 99 facility. -She expected Resident #1's urinalysis was processed within a week and then she wrote a prescription if needed based off the results. Telephone interview with the Speical Care Coordinator (SCC) on 09/24/20 at 4:00pm revealed: -She and the medication aides were responsible to check the fax and to notify the PCP of residents' lab results. -She was not sure why there was delay in Resident #1's urinalysis results and the prescribing of her antibiotics. -She saw the preliminary urinalysis results for Resident #1 for 06/13/20; she took a picture on her cellular phone and texted to the PCP on the morning of 06/13/20. -The PCP responded by text later on 06/13/20 that urinalysis specimen collection was wrong and needed to be repeated; staff need to ensure urine specimen was collected in the right container. -The text did specify the recollection of urine was for Resident #1, but she assumed the PCP meant for Resident #1's urinalysis to be repeated. -She would have to find the PCP's order for the recollection of urinalysis and the results of recollections. -She kept up with PCP's order and notifications through texts on her cell phone. Telephone interview with Administrator on 09/25/20 at 11:00am revealed: -He was not the Administrator during the time of Resident #1's urinalysis orders in June 2020. -He would be clarifying with the medication aides and the SCC in a staff meeting on 09/25/20 his expectation to following the PCP for changes in residents' condition or the need to repeat labs.	D 273		

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Telephone interview with the SCC on 09/28/20 at 4:25pm revealed:
-She was not able to find the order for recollection of the urinalysis on 06/13/20 or the results of the urinalysis.
-The second order for the urinalysis was not followed up with the PCP and was not collected.

____

The facility failed to follow the instructions of a home health nurse to send Resident #3 to the emergency room (ER) for symptoms of a urinary tract infection (UTI) resulting in the resident falling and being sent to the ER the next day and noted to have brown urine with brown sludge in his catheter bag at the ER; failure to obtain physical therapy services for Resident #3 after having 3 falls in 2 weeks with one fall resulting in a broken collarbone; a delay in obtaining a urinalysis leading to a delay in treatment for Resident #4 who was experiencing symptoms of UTI including altered mental status and falls requiring staples for a head wound; and a delay in obtain a second urinalysis order for Resident #1 who was experience symptoms of UTI. The facility's failure resulted in serious harm and serious neglect and constitutes a Type A1 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/20 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 28, 2020.

D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of

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D 338	Continued From page 101 all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure the recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (DHHS) were implemented and maintained when caring for residents during the global Coronavirus (COVID-19) pandemic as related to screening of staff and temperature screenings for residents. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed: -Personnel should always wear a face mask in the facility. -Face masks should not be worn under the nose or mouth. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Personnel should be screened for fever and symptoms of COVID-19 before starting each shift. -Screen residents daily for fever and symptoms of COVID-19. -All personnel should practice social distancing (remain at least six feet apart) when in common areas. -Implement social distancing among residents. -If COVID-19 is identified in the facility, restrict	D 338	It is the policy of Wilson Assisted Living to assure that the rights of our residents are maintained and are exercised properly. The Med Aides of Wilson Assisted Living are tasked in making sure that all residents have their temperature taken daily on each shift. Med Aides will notify residents primary care provider with any temperatures that are out of noted parameters. Wilson Assisted Living staff are screened daily upon entering the facility and upon returning from outside breaks. There is an assigned staff member in place at the front entrance to screen all staff and vendors entering the facility. Administrator and RCC will review these attestation sheets weekly.	11/12/20

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D 338	Continued From page 102 residents to their rooms. -Residents with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N-95 mask is not available. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed: -All facility staff should wear a mask while in the facility. -Residents and staff should be screened daily for signs and symptoms of COVID-19. -All essential visitors should be screened for signs and symptoms of COVID-19 before entering the building. -Social distancing should be implemented among the residents. Review of the facility's Policies and Procedures for COVID-19 Beginning 03/13/20 revealed: -No visitors permitted until further notice. Staff and healthcare personnel only. -All staff must answer questionnaire and have temperatures taken upon arrival before beginning shift. -All residents to have temperatures taken daily. -All staff to wear masks when providing personal care to residents and/or within 6 feet of residents. -No beauty shop or barber permitted until further notice. -All group activities stopped until further notice. -Social distancing for residents at meal time. Meals will be served in shifts and no more than 1 resident per table in the assisted living (AL) dining room. -Special care unit (SCU) residents who need	D 338 D338	Addendum per telephone with Ms. Beth Burrell on 11/25/20: The RCC/SCC will monitor resident temperature logs at least weekly to assure compliance. W. Williams 11/25/20	

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NAME OF PROVIDER OR SUPPLIER: WILSON ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 3501 SENIOR VILLAGE LANE, WILSON, NC 27896

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D 338	Continued From page 103 feeding assistance to be seated 1 per table in the dining room with 2 to 3 aides to assist. -All other SCU residents to eat in their rooms with 2 aides on the hall to assist. Review of the facility's Policies and Procedures for COVID-19 Addendum effective 07/09/20 and ongoing revealed: -07/09/20: All residents confined to their rooms. If they leave their room, they must wear a mask. No exceptions. All meal service on shifts for the AL dining, canceled. All residents must be served in their rooms. Thermometers and blood pressure cuffs are divided for COVID-19 and well residents. -07/10/20: Shifting of residents/resident rooms. Begin to move COVID-19 positive residents to far end of hallway. AL defined rooms for quarantined residents and ready on 03/13/20 continues. Additional 2 barrels purchased for SCU and additional 2 barrels for the 300 hall to dispose of contaminated clothing and trash from COVID-19 residents. Any linen/clothing you remove from resident room must be taken out of room in a bag and placed in barrel specifically for COVID-19 linen/laundry. Any trash removed from resident room must be bagged in room and placed in barrel specifically for COVID-19 trash. These barrels cannot be emptied on the hall. Trash barrel is to be wheeled outside before bag removal, and linen barrel to laundry before bag removal. -07/18/20: New log in place for who is entering each COVID-19 and COVID-19 presumptive room. This log will be in effect beginning 07/18/20 on 1st shift and continue until resident is confirmed negative. These logs will be kept in a binder on the hall. -Personal Protective Equipment: REMINDER - ALL staff must wear masks inside the building.	D 338		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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When caring for residents, care for your "well" residents first, then COVID-19 residents second. When caring for COVID-19 residents, make sure you are wearing mask, gloves, gowns, face shields, and shoe covers.

Interviews with the facility's Owner on 09/04/20 at 10:45am and 2:11pm revealed:
-The facility had an outbreak of COVID-19 in July 2020.
-Multiple staff and residents tested positive including all residents except for one in the special care unit (SCU).
-Several residents passed away and some residents were moved to facilities with a higher level of care.
-She could not recall the number of residents and staff who were positive or the number of residents who passed away but she would locate documentation with that information.
-There was a second mass testing for residents in the middle of August 2020 and 3 residents tested positive, 2 in the AL side and 1 in the SCU.
-The 3 residents who were positive in August 2020 were past the 14-day quarantine but were still isolating in their rooms, awaiting follow-up testing.

Review of documentation of COVID-19 test results for the facility revealed:
-There were 35 residents who were tested for COVID-19 on 07/15/20 and were positive.
-There were 13 staff who were tested for COVID-19 on 07/15/20 and were positive.

Review of a list of deceased residents provided by the facility revealed:
-There were 12 residents documented as expired in July 2020.
-There were 2 residents documented as expired

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D 338	Continued From page 105 in August 2020. 1. Review of the facility's COVID Policies and Policies beginning 03/13/20 revealed: -There were no visitors permitted until further notice. Staff and healthcare personnel only. -All staff must answer questionnaire and have temperature taken upon arrival before beginning shift. Review of the facility's staff schedule, time cards, and Daily Symptom Attestation Form COVID-19 for 08/17/20 to 08/31/20 revealed: -There were columns for the date/time, name, recent travel to CDC Designated Level 3 Affected Countries/Areas (Y/N), Close Contact with Person Diagnosed with Coronavirus Disease (Y/N), Fever Greater than 100.4 (Y/N), Sneezing (Y/N), Cough (Y/N), Sore Throat (Y/N), Shortness of Breath (Y/N). -On 08/17/20, there were 7 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/18/20, there were 10 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/19/20, there were 8 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/20/20, there were 12 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/21/20, there were 6 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift.	D 338		

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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D 338	Continued From page 106 -On 08/22/20, there were 13 out of 17 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/23/20, there were 10 out of 17 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/24/20, there were 10 out of 18 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/25/20, there were 8 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/26/20, there were 10 out of 21 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/27/20, there were 11 out of 21 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/28/20, there were 9 out of 19 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/29/20, there were 14 out of 17 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/30/20, there were 10 out of 17 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 08/31/20, there were 12 out of 21 total staff members who did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift.	D 338		

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D 338	Continued From page 107 -This was all staff including management, medication aides, personal care aides, dietary, housekeeping, laundry, and maintenance. -Multiple staff did not sign in consistently each shift they worked including the Owner, Administrator, and Special Care Coordinator (SCC). Review of the facility's staff schedule, time cards, and Daily Symptom Attestation Form COVID-19 for staff/visitors for 09/01/20 - 09/19/20 revealed: -There were columns for the date/time, name, recent travel to CDC Designated Level 3 Affected Countries/Areas (Y/N), Close Contact with Person Diagnosed with Coronavirus Disease (Y/N), Fever Greater than 100.4 (Y/N), Sneezing (Y/N), Cough (Y/N), Sore Throat (Y/N), Shortness of Breath (Y/N). -On 09/01/20, 16 out of 20 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/02/20, 20 out of 23 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/03/20, 20 out of 21 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/04/20, 10 out of 20 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/05/20, 11 out of 15 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/06/20, 10 out of 16 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/07/20, 15 out of 27 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/08/20, 14 out of 29 staff members did not	D 338		

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D 338	Continued From page 108 sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/09/20, 13 out of 32 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/10/20, 10 out of 26 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/11/20, 17 out of 25 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/12/20, 8 out of 20 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/13/20, 8 out of 20 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/14/20, 13 out of 25 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/15/20, 15 out of 27 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/16/20, 10 out of 27 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/17/20, 9 out of 26 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/18/20, 5 out of 25 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -On 09/19/20, 11 out of 18 staff members did not sign the Daily Symptom Attestation Form COVID-19 at the beginning of shift. -This was all staff including management, medication aides, personal care aides, dietary, housekeeping, laundry, and maintenance. -Multiple staff did not sign in consistently each shift they worked including the Owner,	D 338		

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D 338	Continued From page 109 Administrator, and SCC. Telephone interview with the SCC on 09/17/20 at 12:06pm revealed: -All staff used the same log for screening for COVID-19. -Staff were supposed to screen before clocking in for their shift. -She was not sure if staff were supposed to screen again for COVID-19 if they left the facility for lunch and then came back to the facility. . Telephone interview with the Administrator on 09/17/20 at 12:06pm revealed: -If staff left the facility during their shift and came back, they should re-screen (temperature and questionnaire) for COVID-19. -He did not think staff, like the transporter, had been re-screening when they left and returned to the facility on the same day. -If staff, including himself, had left and re-screened, it would be documented on the same screening log. -He was unable to locate a written policy for staff screening for COVID-19 but staff had been told verbally to complete the screening when they came to work. -He did not think staff had been screening but once a day when they clocked in. Telephone interview with a personal care aide (PCA) on 09/18/20 at 11:04am revealed: -When she came into work, she had to check her temperature and answer a questionnaire. -All staff documented their temperatures and questionnaires on the same form. -She usually stayed inside the facility during her breaks but if staff left the facility, they were supposed to check their temperatures again.	D 338		

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D 338	Continued From page 110 Telephone interview with the facility's transporter on 09/18/20 at 1:18pm revealed: -She had to take her temperature when she came into the facility each day for work. -They used a handheld temporal thermometer that did not have to touch the skin to get a reading. -There was a book at the front desk staff used to document their name, temperature, and answer a questionnaire. -She usually only screened for COVID-19 once a day when she first got to the facility. -The Administrator told her today, 09/18/20, that she needed to screen for COVID-19 each time she came back to the facility during her shift each day. Telephone interview with a second PCA on 09/18/20 at 1:47pm revealed: -As soon as staff walked into the doors of the facility, they had to take their temperatures and write in down in a book. -They also had to answer a couple of questions and document that in the book. -If their temperature was greater than 100 degrees Fahrenheit (F), they had to leave the facility. -Staff were required to check their temperatures and answer the questions every day when they came to work. -Last week, they started re-screening for COVID-19 if they left the facility and came back from a break. Telephone interview with a medication aide (MA) on 09/23/20 at 3:55pm revealed: -When staff came to work, they could either take their own temperature or someone at the front desk would take it. -They documented their temperature and	D 338		

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answered some questions on the form.
-She had forgotten at times to take her temperature and answer the questions when she came into work.
-She would usually remember and go back and do it about 10 or 15 minutes later.
-She kept forgetting to take her temperature and answer the questions for about 1 ½ weeks around the end of July 2020.

Telephone interview with the SCC on 09/22/20 at 3:30pm revealed she was not aware of any system in place to monitor the facility's Daily Symptom Attestation Form COVID-19.

Telephone interview with the Administrator on 09/22/20 at 3:15pm revealed:
-He was responsible to review the facility's Daily Symptom Attestation Form COVID-19 every day.
-He was not aware of any monitoring of the facility's Daily Symptom Attestation Form COVID-19 prior to 09/01/20.
-He started reviewing the facility's Daily Symptom Attestation Form COVID-19 about three weeks ago or the beginning of September 2020.
-He was observing errors with the facility's Daily Symptom Attestation Form COVID-19 "here and there."
-Staff would tell him they forgot to sign in and do the screening when he asked them about it.
-He would call the third shift staff if he did not see their sign in or he would remind the staff along with staff's supervisor to complete the facility's Daily Symptom Attestation Form COVID-19.
-If he did not see their name on the facility's Daily Symptom Attestation Form COVID-19 and he knew the staff was onsite, he would discuss with the staff immediately and have them come to front of the facility to complete the facility's Daily Symptom Attestation Form COVID-19.

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D 338	Continued From page 112 -For example, the morning of 09/22/20, the laundry staff person did not do the COVID-19 screening so he called the laundry staff person from her post and had her to do the screening. -If he did not see a staff person's documentation who had worked and they had already left the facility, he would remind the supervisor on duty that staff were not doing the screenings. -His expectation was for all staff which included transportation, dietary, housekeeping, maintenance, PCAs, MAs, SCC, Administrator, the facility's Owner, vendors, and healthcare personnel to complete the facility's Daily Symptom Attestation Form COVID-19 upon entering the facility. -He also put up a sign on Monday, 09/21/20, reminding staff about handwashing and signing the Daily Symptom Attestation Form COVID-19. Telephone interview with the facility's Owner on 09/25/20 at 1:12pm revealed: -She was usually at the facility an average of 2 to 3 days per week. -She was checking her temperature at home before coming to the facility. -She did not sign the facility's Daily Symptom Attestation Form COVID-19. -Her expectation for the facility's Daily Symptom Attestation Form COVID-19 was staff should check their temperatures and complete the questionnaire document on the staff log each time they came in for their shift. -She was not aware why staff was not completing when starting their shift, they should have completed the facility's Daily Symptom Attestation Form COVID-19. -Completing the Daily Symptom Attestation Form COVID-19 was for the staff and residents' "protection". -She could "guess" there was a monitoring	D 338		

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system for the facility's Daily Symptom Attestation Form COVID-19 in place but did not know that for a fact.

2. Review of resident temperature logs dated August 2020 received on 09/10/20 at 4:53pm revealed:
-If temperature was below 96.0 degrees Fahrenheit (F) or above 99.0 degrees F, notify the primary care provider (PCP).
-Residents' temperatures recorded for 08/01/20 through 08/31/20 ranged from 90.7 degrees F to 99.6 degrees F.
-Residents' temperatures were outside the specified parameters for 43 times of 90 opportunities.
-There was no documentation the PCP had been notified of temperatures outside the parameters via physician communication forms.

Review of resident temperature logs dated September 2020 received on 09/10/20 at 4:53pm revealed:
-If temperature is below 96.0 degrees F or above 99.0 degrees F, notify the PCP.
-Residents' temperatures recorded for 09/01/20 through 09/30/20 ranged from 86.2 degrees F to 101.3 degrees F.
-Residents' temperatures were outside the specified parameters on 9 times of 30 opportunities.
-Two residents were not listed on the temperature log for 09/01/20.
-There was no documentation the PCP had been notified for temperatures outside the parameters via the physician communication form.

Telephone interview with a medication aide (MA) on 09/08/20 at 2:24pm revealed:
-Residents' temperatures were screened 3 times

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per day and documented on the temperature log.
-The PCP was notified of temperatures outside the parameters via the physician communication sheet.

Telephone interview with the Special Care Coordinator (SCC) on 09/15/20 at 11:06am revealed:
-The MAs were responsible for auditing temperature logs for completeness and accuracy weekly.
-The SCC and Resident Care Coordinator (RCC) were responsible for conducting monthly audits on the temperature logs for completeness and accuracy.
-The audits were not conducted due to the absence of the RCC.
-The SCC did not know about the missing temperatures, signatures, or the 86.2 degrees F temperature reading because she had not audited the temperature logs.

Telephone interview with the Administrator on 09/22/20 at 3:41pm revealed:
-The expectation was to check each resident's temperature daily for all 3 shifts.
-Taking the residents' temperatures was a joint effort between the personal care aides (PCAs) and the MAs.
-If residents had temperatures less than 96.0 degrees F and greater than 99.0 degrees F, they were to contact the PCP and complete a physician's communication sheet.
-It was the responsibility of the PCAs to report the temperatures outside of parameters to the MAs.
-The MAs were expected to review resident temperature logs daily and report to the PCP any temperatures outside of parameters.
-The SCC should be notified of any temperatures outside of parameters.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 338	Continued From page 115	D 338		

-He was not aware of any temperatures outside of parameters.

Telephone interview with a MA on 09/23/20 at 3:55pm revealed:
-Temperatures outside the parameters were reported to the PCP via the physician communication sheet.
-The MA would fax the physician communication sheet to the PCP for confirmation.
-The PCP would advise them to give the resident Tylenol if the fever was high.
-Extremely low temperatures should be rechecked for accuracy but she did not know why they had not been rechecked.
-There should be no missing temperatures on the temperature logs and she could not explain how this occurred on two shifts.

Telephone interview with a MA on 09/25/20 at 3:53pm revealed:
-The PCP should be notified for temperatures outside the parameters.
-The physician communication sheet should be completed for each temperature outside the parameters.
-The residents on the back hall should be listed on a separate temperature log.
-The MA was responsible for completing the temperature logs.
-She did not know why the temperature logs had missing temperatures.
-The RCC reviewed the logs sometimes.

Telephone interview with the facility's Owner on 09/25/20 at 1:12pm revealed:
-The expectation was for staff to notify the PCP when temperatures were outside the parameters.
-Extremely low temperatures should have been retaken and the thermometer should have been

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D 338	Continued From page 116 checked for accuracy. -The temperature of 86.2 degrees F was considered troubling to her because it was inaccurate. ______ The facility failed to adhere to the guidelines and recommendations established by the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic in which multiple residents and staff residing in the facility tested positive for COVID-19. The facility failed to ensure all staff were screened for symptoms and exposure to COVID-19 and failed to ensure the residents' temperatures were checked and the provider was notified of readings outside of the established parameters. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/22/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 12, 2020.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	D 358		

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D 358	Continued From page 117 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents sampled (#3, #4) including delays in starting ordered antibiotics for urinary tract infections (#3, #4) and a two-day delay in implementing a physician order to reduce an anti-anxiety medication (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 08/31/20 revealed: -Diagnoses included dementia, depression, diverticulitis, hypertension, and acute encephalopathy. -She was intermittently confused. -She had wandering behaviors. -She required personal assistance with bathing and dressing. -She was ambulatory. -She was incontinent of bowel and bladder. a. Review of Resident #4's Visit Report dated 08/24/20 revealed a new prescription for Cefdinir 300mg by mouth every day for 7 days. (Cefdinir is an antibiotic used to treat bacterial infections). Review of Resident #4's August 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Cefdinir 300mg take 1 capsule by every day x 7 days. -Cefdinir was scheduled to be administered at 8:00am.	D 358	It is the policy of Wilson Assisted Living, that medication orders are received and started timely as ordered. The Med Aides are responsible for checking the fax throughout the shift to assure that any new health care referral or medication order is followed up on and started promptly. The Med Aide will fax all med orders to the pharmacy and place copy for RCC/SCC to review. The policy for antibiotics is to start all antibiotics ASAP. The Med Aide will fax to pharmacy and assure that the back up pharmacy Is notified, so that we may start the new antibiotic the day its ordered.	

Division of Health Service Regulation

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D 358	Continued From page 118 -The first dose of Cefdinir was documented as administered on 08/27/20 at 8:00am. -Cefdinir was documented as administered on 08/28/20, 08/28/20, 08/29/20, 08/30/20, and 08/31/20 at 8:00am. Review of Resident #4's September 2020 eMAR revealed: -There was an entry for Cefdinir 300mg take 1 capsule by every day x 7 days. -Cefdinir was scheduled to be administered at 8:00am. -Cefdinir was documented as administered on 09/01/20 at 8:00am. -On 09/02/20, "Exp" was documented. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/24/20 at 10:57am revealed: -They received an order for Resident #4 for Cefdinir 300mg take 1 capsule by every day x 7 days on 08/25/20. -Cefdinir was dispensed and delivered to the facility on 08/25/20. -The packing slip for Cefdinir did not state the time it was delivered to the facility. Telephone interview with the Special Care Coordinator (SCC) on 09/24/20 at 2:55pm revealed: -When the facility received a new medication order for a resident, the medication aide (MA) would fax the medication order to the facility's contracted pharmacy. -The facility's contracted pharmacy would add the new medication to the resident's eMAR. -The Resident Care Coordinator (RCC), the SCC, the Administrator, and the lead MA could approve medication orders entered on the eMAR by the facility's contracted pharmacy.	D 358 D358	The RCC/SCC will review all new med orders and check for compliance As well as notify Administrator with any concerns. Addendum per telephone with Ms. Beth Burrell on 11/25/20: The RCC/SCC will conduct resident record audits at least weekly to check medication orders, MARs, and meds on hand to assure compliance and meds are being administered as ordered. The RCC/SCC will review all new med orders and check for compliance at least weekly. W. Williams 11/25/20	11/13/20

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D 358	Continued From page 119 -Once a designated facility staff (the RCC, the SCC, the Administrator, or the lead MA) approved the medication, it would go "live" on the facility's eMAR. -She was not sure why Resident #4 did not start her antibiotic until 08/27/20. -She believed there was a delay in approving the medication but would investigate the situation. Second telephone interview with the SCC on 09/28/20 at 10:50am revealed she was not sure why Resident #4 did not start her antibiotic until 08/27/20, the only thing she could think of was she did not approve Resident #4's medication order for Cefdinir until 08/27/20. Telephone interview with the facility's Owner on 09/25/20 at 2:07pm revealed: -The resident's antibiotics were important and should start as soon as possible. -She did not know why there were any delays in starting the antibiotics. -Her expectation was physician orders should always be followed and given per the eMAR instructions. Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful. Refer to the telephone interview with the medication aide (MA) on 09/25/20 at 11:23am. Refer to the second telephone interview with the MA on 09/25/20 at 3:51pm. b. Review of Resident #4's primary care provider (PCP)'s order dated 08/19/20 revealed Lorazepam 0.5mg tab take 1 tablet once a day as needed (prn) for anxiety and agitation	D 358		

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D 358	Continued From page 120 (Lorazepam is a medication used to anxiety). Review of PCP's Visit Note dated 09/03/20 revealed: -An order to stop Lorazepam 0.5mg twice a day prn. -An order to start Lorazepam 0.5mg tab: take ½ tab (0.25mg) twice a day prn with the rationale noted as reduce per Power of Attorney request due to falls. Review of Resident #4's August 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam tab 0.5mg take 1 tablet by mouth once a day prn for anxiety and agitation (control). -Lorazepam was documented as administered on 08/19/20 at 4:41pm, on 08/20/20 at 1:23pm, on 08/21/20 at 12:36pm, on 08/22/20 at 12:18pm, on 08/26/20 at 11:29am, on 08/27/20 at 12:00pm, on 08/28/20 at 3:34am, and 08/31/20 at 4:18pm. Review of Resident #4's September 2020 eMAR revealed: -There was an entry for Lorazepam tab 0.5mg take 1 tablet by mouth once a day prn for anxiety and agitation (control). -Lorazepam was documented as administered on 09/01/20 at 8:47am, on 09/02/20 at 8:20am, and on 09/03/20 at 11:00am. Review of Resident #4's September 2020 eMAR revealed: -There was an entry for Lorazepam tab 0.5mg take ½ tab (0.25mg) by mouth twice a day prn (control). -Lorazepam was documented as administered on 09/05/20 at 11:03am, on 09/07/20 at 8:24pm, on 09/08/20 at 8:25am, on 09/09/20 at 8:29am, and	D 358		

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D 358	Continued From page 121	D 358		

on 09/09/20 at 7:18pm.

Third telephone interview with the MA on 09/25/20 at 4:24pm revealed:
-From the review of the eMAR system, the PCP's order dated 08/19/20 to start Lorazepam 0.5mg tab: take 1 tab by mouth once a day prn for anxiety and agitation was discontinued on 09/05/20.
-From the review of the eMAR system, the PCP's order dated 09/03/20 to start Lorazepam 0.5mg tab: take ½ tab (0.25mg) twice a day prn noted as reduce per Power of Attorney request due to falls was "approved" on 09/05/20.
-She was not sure why the delay occurred.

Attempted telephone interview with the Administrator on 09/28/20 at 9:11am was unsuccessful.

Refer to the telephone interview with the medication aide (MA) on 09/25/20 at 11:23am.

Refer to the second telephone interview with the MA on 09/25/20 at 3:51pm.

2. Review of Resident #3's current FL-2 dated 03/19/20 revealed:
-Diagnoses included diabetes mellitus type 2, atrial fibrillation, hyperlipidemia, and cellulitis of left foot.
-The resident was documented as intermittently disoriented.

Review of Resident #3's emergency room (ER) summary report dated 08/26/20 revealed:
-The resident arrived to the ER on 08/26/20 at 7:31pm.
-The reason for visit was intravenous (IV) antibiotics.

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-The resident was seen at the ER "a few days ago" after a fall, urine was taken that day, and he was discharged on an oral antibiotic for a urinary tract infection.
-The urine culture came back today (08/26/20) and it was resistant to the antibiotic so he was sent back to the ER today.
-No IV antibiotics were administered at the ER; the resident was administered one Cefdinir 300mg capsule at 8:10pm. (Cefdinir is an oral antibiotic used to treat infections.)
-The resident was given a prescription for Cefdinir 300mg twice a day for 10 days.
-The resident was discharged and departed from the ER on 08/26/20 at 10:03pm.

Review of Resident #3's August 2020 electronic medication administration record (e-MAR) revealed:
-There was an entry dated 08/27/20 for Cefdinir 300mg 1 capsule twice a day for 10 days.
-Cefdinir was scheduled to be administered at 8:00am and 8:00pm.
-The blocks for 08/26/20 and 08/27/20 were marked with an "X" for both times and there was no reason documented of why Cefdinir was not administered on those days.
-The first dose of Cefdinir was documented as administered at 8:00am on 08/28/20, 2 days after it was ordered.
-Cefdinir was documented as administered twice daily from 08/28/20 at 8:00am through 08/31/20 at 8:00pm, for a total of 8 doses.

Review of Resident #3's September 2020 e-MAR revealed:
-There was an entry for Cefdinir 300mg 1 capsule twice a day for 10 days with scheduled administration times of 8:00am and 8:00pm.
-Cefdinir was documented as administered twice

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D 358	Continued From page 123	D 358		

daily from 09/01/20 at 8:00am through 09/06/20 at 8:00pm, for a total of 12 doses.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/24/20 at 1:49pm revealed:
-The pharmacy received the order for Resident #3's Cefdinir 300mg 1 capsule twice a day for 10 days on 08/26/20 at 10:40pm.
-The pharmacy processed and filled the prescription on 08/27/20 and it was sent out with the regular delivery that night.
-Their delivery driver did not leave the pharmacy to deliver medications until 7:00pm at night.
-If the facility needed the medication sooner, they could have called the pharmacy on the morning of 08/27/20 and the pharmacy could have contacted the back-up pharmacy.
-If called into the back up pharmacy on the morning of 08/27/20, the facility could have picked up the antibiotic that morning on 08/27/20 as soon as the back-up pharmacy could get it ready that morning.

Telephone interview with a medication aide (MA) on 09/25/20 at 3:52pm revealed:
-When they received medication orders, the MAs faxed them to the pharmacy and the pharmacy entered the order into the e-MAR system.
-Only the Resident Care Coordinator (RCC) or Special Care Coordinator (SCC) could approve medication orders in the e-MAR system.
-The residents were supposed to start antibiotics a soon as possible.
-If the MAs received an order for an antibiotic after hours, they were supposed to call the back-up pharmacy to get the medication.

Telephone interview with the SCC on 09/24/20 at 2:54pm revealed:

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D 358	Continued From page 124 -Resident #3's prescription for Cefdinir was faxed to the pharmacy on 08/26/20 after the resident returned from the hospital. -The order was entered into the e-MAR system by the pharmacy on the morning of 08/27/20. -She approved the order for Cefdinir in the e-MAR system on 08/28/20 and administration was started at 8:00am on 08/28/20. -Medication orders were not active in the e-MAR system until the orders were approved by facility management. -The SCC, RCC, lead MA, and the Administrator were the only ones at the facility with access to approve medication orders in the e-MAR system. -The facility's medications were not delivered by the contracted pharmacy until 11:00pm at night. -The facility used a local pharmacy as a back-up pharmacy. -Antibiotics should be started the same day the order was received or the next day. -She did not call the back-up pharmacy to obtain Resident #3's Cefdinir on 08/26/20 or 08/27/20. -She had no explanation for not contacting the back-up pharmacy, causing a delay in Resident #3 receiving the antibiotic for his urinary tract infection. Telephone interview with the facility's Owner on 09/25/20 at 1:10pm revealed: -To her knowledge, the facility staff should use the back-up pharmacy to get medications like antibiotics and pain medications started as soon as possible. -It sounded like there was a procedural problem with getting Resident #3's antibiotic. -Antibiotics should be started right away. Refer to the telephone interview with the medication aide (MA) on 09/25/20 at 11:23am.	D 358		

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D 358	Continued From page 125 Refer to the second telephone interview with the MA on 09/25/20 at 3:51pm. Telephone interview with the medication aide (MA) on 09/25/20 at 11:23am revealed: -The Resident Care Coordinator (RCC), the Special Care Coordinator (SCC), and the Administrator were the only staff at the facility who could approve a medication to appear on the eMAR for staff to administer after the facility's contracted pharmacy entered a new medication order. -There had been "pending" medication orders especially over the weekends. -She has called the SCC previously on the weekend and she had to come onsite or would give the staff her "password" to approve the pending the medication for staff to administer. Second telephone interview with the MA on 09/25/20 at 3:51pm revealed: -When the facility received a new medication order for a resident, the MA would fax the medication order to the facility's contracted pharmacy. -The facility's contracted pharmacy would add the new medication to the eMAR, but it would not appear on the eMAR until approved by designated facility staff (RCC and SCC). -If the facility staff was supposed to start a new medication and it was not approved by the designated staff members, the facility staff would use paper MARs. -A resident's antibiotic should be started as soon as possible. -If the facility's contracted pharmacy was closed, the facility's backup pharmacy should be contacted.	D 358		

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D914	Continued From page 126	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect as related to personal care and supervision and resident rights pertaining to COVID-19 infection control. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #3, #4) with histories of multiple falls with injuries including multiple facial fractures, hematomas, and bruising (#1); bruising, multiple head injuries and lacerations requiring staples on two occasions (#4); and three falls in two weeks with one fall resulting in a broken collarbone (#3). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure provider notification and obtaining care for 3 of 5 sampled residents (#1, #3, #4) related to failing to send a resident with a urinary catheter to the emergency room as instructed by the home health nurse for symptoms of urinary tract infection (#3); failing to obtain diabetic shoes and physical therapy as ordered for a resident with 3 falls in two weeks who suffered a broken collarbone (#3); failing to follow up with the primary care provider to obtain	D914	It is the policy of Wilson Assisted Living to provide and promote all of NC Declaration of Residents Rights and ensure all residents are free of neglect. All staff are in-serviced on these rights at hire and yearly thereafter.	11/13/20

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D914	Continued From page 127 a second order for a urinalysis for a resident with symptoms of urinary tract infection (#1); and failing to obtain a urinalysis without delay for a resident with symptoms of a urinary tract infection including altered mental status changes with falls (#4). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).] 3. Based on interviews and record reviews, the facility failed to ensure the recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (DHHS) were implemented and maintained when caring for residents during the global Coronavirus (COVID-19) pandemic as related to screening of staff and temperature screenings for residents. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation).]	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: ______ B. WING ______	09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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D934	Continued From page 128 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 6 staff sampled (Staff E) who was a medication aide completed the state approved annual infection control training. The findings are: Review of Staff E's, a medication aide (MA), personnel record revealed: -Staff E was rehired on 05/21/19 as a medication aide. -There was documentation Staff E completed the state infection control training course on 05/27/19. -There was no additional documentation of state infection control training for Staff E. Interview with Staff E on 09/28/20 at 1:33pm revealed: -She worked as a medication aide (MA). -She remembered completing an infection control training upon hire and one additional training but did not remember when the training was completed. -The facility should have documentation of any additional infection control trainings. -She was scheduled to take state infection control training today at 2:00pm. Interview with LHPS (Licensed Health Professional Support) nurse on 09/25/20 at 4:33pm revealed: -She visited the facility every week on Mondays. -She conducted the state infection control trainings. -It was the facility's responsibility to make her aware of any needed state infection control trainings.	D934	It is the policy of Wilson Assisted Living to make available all necessary training for staff and maintain records for compliance. Staff receive infection control training during new hire orientation and then yearly thereafter. Spread sheets have been created to monitor and maintain records of completion of training. Administrator will monitor monthly for compliance.	11/13/20

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D934	Continued From page 129 -Staff should not be without an updated state infection control training. -The Administrator called her on 09/24/20 and requested a new state infection control training date which is scheduled on 09/28/20. Interview with Owner on 09/28/20 at 10:27am revealed: -Staff E was hired May 2019. -There was no additional documentation for state infection control completed after May 2019.	D934		