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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and follow-up survey from 01/12/22 through 01/14/22 and 01/18/22 with an exit via telephone on 01/19/22. The complaint was initiated on 01/06/22 by Randolph County Department of Social Services.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed ensure a heat/air conditioning unit was operable and in good repair resulting in a resident (Resident #12) being cold at night. The findings are: Observation of Resident #12's room on 01/12/22 at 11:45am revealed: -There was a heat/air unit in the wall directly underneath the window. -The heat/air unit had slats in the front of the unit. -There was a square wood frame around the unit mounted to the wall. -The wood frame did not cover the openings of the unit which were viewable to the outside. -The heat/air unit had slats in front for ventilation. -There were several slats missing from the front of the unit. -Facing the unit, the square wood frame on the left side of the unit was missing and there was a	D 105		

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two inch opening between the wall and the unit.
-Through the opening you could see to the outside.
-There was a mixture of dirt and other debris on the floor directly to left of the unit.
-The unit was inoperable when turned on.

Interview with Resident #12 on 01/14/22 at 5:30pm revealed:
-The heat/air conditioning unit had been broken for about two weeks.
-A few days ago, he told a medication aide (MA) about the heat/air conditioning unit in his room not working.
-He was unable to recall which MA he told the unit was not working.
-He used extra blankets at night to keep warm.

Interview with a MA on 01/18/22 at 4:52pm revealed:
-The heat/air conditioning unit in Resident #12's room had been broken several times in the past and replaced.
-The resident had a motorized wheelchair and each time he got into the bed the wheelchair hit the unit.
-The resident did not tell her the unit was not working.
-When she worked, she administered medications to Resident #12 in his room.
-She had not noticed the wood frame around the heat/air unit was broken and she was not aware how long it had been broken.

Interview with a MA on 01/19/22 at 12:17pm revealed:
-Resident #12 had broken the heat/air conditioning unit in his room several times.
-The resident continually destroyed the unit with his wheelchair.

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-The resident had not told her the unit was not working.
-The resident did not like staff coming in his room, so unless she was administering medications she did not enter the resident's room.
-She did not realize the unit was broken and missing the frame to see to the outside.

Interview with a personal care aide (PCA) on 01/19/22 at 12:42pm revealed:
-Resident #12's heat/air unit had always looked like it did on 01/12/22 with the frame missing and pieces broken off.
-She did not report the unit to anyone for repair.

Interview with the housekeeper on 01/19/22 at 10:07am revealed:
-She tried to clean Resident #12's room at least 2 to 3 days per week.
-She thought the last time she was in the resident's room was Thursday, 01/06/22, but she was not sure.
-The resident did not like staff in his room and when she cleaned the room she tried to quickly leave.
-If the heat/air conditioning unit was broken and missing the wood frame she did not notice it.

Interview with the Executive Director (ED) on 01/19/22 at 1:52pm revealed:
-She was aware that Resident #12 did not like for staff to enter his room.
-She was not aware the heat/air conditioning unit in Resident #12's room was broken.
-The cord to the unit had been replaced sometime between November 2021 and December 2021.
-Someone entering the room should have made her aware the wood frame around the unit

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D 105	Continued From page 3 needed to be replaced.	D 105		
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 observations, interviews and record reviews, the facility failed to provide toileting assistance/incontinence care and nail care according to the resident's needs and care plan for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 04/09/21 revealed: -Diagnoses included mental retardation, hypertension, non-insulin dependent diabetes mellitus, corneal implant, psychiatric disorder, renal failure, hypothyroid, hyperlipidemia, and mood disorder. -The resident was ambulatory with a walker. -She required personal care assistance with bathing and dressing and was incontinent of bladder and bowel. Review of Resident #1's Care Plan dated 10/09/20 revealed: -She required limited assistance with eating.	D 269		

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-She required extensive assistance with toileting, bathing, dressing and grooming.
-She required supervision with ambulation and transfers.

Observation on 01/12/21 at 9:40am of Resident #1's color photos taken by the hospital staff, the resident's Power of Attorney (POA) and adult protective services (APS) social worker dated 12/02/21 revealed the resident's toenails on her feet were over grown past the end of her toes and the toenails were long and curved.

Interview with the APS social worker on 01/12/22 at 9:50am revealed:
-During an interview with Resident #1, the resident told her that her toenails were so long when she wore shoes her feet hurt.
-Facility staff were supposed to trim the resident's toenails.
-The resident was unable to say when the last time her toenails were trimmed by facility staff.

Telephone interview with Resident #1's POA on 01/12/21 at 9:00am revealed:
-She thought the facility was providing podiatry care for Resident #1.
-She was not aware the resident's toenails were not trimmed.
-Resident #1 had declined recently and had become more incontinent requiring staff to assist with toileting.
-On 10/22/21, she arrived to the facility around 12:00pm or 1:00pm and Resident #1 was still in the bed.
-The resident had the same clothes on that she had put on the resident on 10/21/21.
-She was upset because facility staff did not put on the resident's bedtime sleeping clothes, but let her sleep in the clothes that she had on all day on

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10/21/21.
-The resident was wet with urine from her neck to her feet.
-No staff had checked on the resident all day or night because Resident #1 was soaked in urine.
-She also found out Resident #1 had not eaten all day.
-When she told the Executive Director (ED) that she found Resident #1 wet and in the same clothes that she was wearing on 10/21/21, her only response was that she was "short staff."

Interview with a resident on 01/14/22 at 5:19pm revealed:
-The resident knew Resident #1, she used to reside next door to Resident #1, they shared a bathroom.
-Once she had heard Resident #1 screaming for staff to come and help her off the toilet, and no staff came.
- Resident #1 was left on the toilet for 20-30 minutes, and no one came to help her.
-She began to scream for help for Resident #1.
-It was a long time before staff stopped to check on her and Resident #1.

Telephone interview with a Medication Aide (MA) on 01/18/22 at 4:58pm revealed:
-The personal care aide (PCA) who gave the resident showers should have identified Resident #1's toenails.
-If the PCA was unable to trim the resident's toenails, then the supervisor should have been notified.

Telephone interview with the ED on 01/19/22 at 1:52pm revealed:
-Personal care should be provided on shower days.
-If a resident was not a diabetic then nail care

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D 269	Continued From page 6 should be provided, which including trimming toenails. -The Resident Care Coordinator (RCC) was supposed to do random checks to ensure nail care was being provided. -She did not know why Resident #1's toenails were not trimmed. -The PCAs provided incontinence care every two hours. -If the resident needed incontinence care sooner than every two hours then that should be taken care of. Telephone interview with the Administrator on 01/19/22 at 2:37pm revealed: -He expected when staff did showers they were to provide nail care unless the resident was a diabetic -The RCC should have done random checks to ensure nail care was done. Based on observation, record review and attempted interview on 01/14/22 at 2:40pm, it was determined Resident #1 was not interviewable.	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	D 270		

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Based on observation, interviews and record reviews the facility failed to provide supervision for 2 of 7 sampled residents (Residents #1 and #13) with current symptoms of multiples falls that resulted in a resident who had a brain bleed, unexplained bruising to the neck, hip, right side, arms, right breast, head and continually scratched herself (#1) and a resident who had multiple falls causing injuries to the head, lacerations, scrapes and bruises to the hip, ankle, and face (#13).

The findings are:

Review of the facility's fall policy revealed:
-The policy aimed to provide guidance to residents and staff on fall prevention and education, steps to take when a fall occurred and actions for proper reporting.
-When a fall occurred an incident report would be completed.
-Procedures for what to do after a fall occurred would be on a case by case basis.

1. Review of Resident #13's current FL2 dated 11/06/21 revealed:
-Diagnoses included legally blind, history of right hip fracture, seizure disorder, atrial fibrillation, major depressive disorder, mood disorder, hypertension and anemia.
-He was non-ambulatory using a wheelchair.
-His verbal communication was "slurred speech."
-He was incontinent of bladder and bowel.
-He needed assistance with bathing and dressing.

Review Resident #13's Care Plan dated 03/11/21 revealed:
-He required limited assistance with eating, toileting, ambulation, bathing, grooming and

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transferring.
-He required extensive assistance with dressing.

a. Review of Resident #13's care note dated 07/13/21 at 4:30pm revealed Resident #13 fell out of his wheelchair in the dining room and hit his head.

Review of the emergency service call report dated 07/13/21 at 4:32pm revealed Resident #13 had a fall in the dining room striking his head.

Review of Resident #13's hospital discharge summary report dated 07/13/21 revealed the reason for being at the emergency room (ER) was fall.

Telephone interview with the medication aide (MA) on 01/18/22 at 7:03pm who discovered the incident on 07/13/21 revealed:
-She found Resident #13 on the floor a lot.
-Another resident found Resident #13 on the floor and told her.
-She did not recall if the resident had any injuries.
-The resident required assistance with incontinence care, which was provided every two hours.
-Due to his mental status, providing care for the resident was difficult because he was unable to comprehend what was being said.
-She also thought the resident was unable to remember to ask for staff assistance with transferring.
-When a resident had a fall, the resident was put on safety checks for 24 to 48 hours.
-The Executive Director (ED) decided the frequency time to check on the resident (i.e., 15 to 30 minutes or 1 hour).
-Resident #13 previously had been placed on safety checks for monitoring the resident more

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frequently, but she was unable to recall exactly when or how long the safety checks lasted.
-She was unable to remember if the resident was put on safety checks after the fall on 07/13/21.
-Resident #13 had not been placed on safety checks since mid-November 2021.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

b. Review of Resident #13's care note dated 09/03/21 at 1:15am revealed:
-Resident #13 was found on the patio by another resident.
-Resident #13 had a large knot and cut above his left eye.
-The resident was sent to the hospital.

Review of Resident #13's hospital discharge summary report dated 09/03/21 revealed:
-The resident was in the hospital because he fell out of his wheelchair and hit his head.
-The resident was found on the ground unresponsive.
-The resident was well known at the ER for multiple visits for falls and head trauma.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

Attempted interview on 01/18/22 with the MA who discovered the resident on 09/03/21 was unsuccessful.

c. Review of Resident #13's hospital discharge summary report dated 09/05/21 revealed

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Resident #13 was at the ER for a scalp contusion.

Review of Resident #1's care notes and incident/accident reports revealed:
-There was no documentation of this fall and the resident was sent to the hospital.
-There was no documentation of increased supervision or safety checks put in place after the resident returned from the hospital.

Telephone interview with a MA on 01/19/22 at 12:06pm revealed:
-Resident #13 was unable to see well and he transferred himself from the wheelchair to the bed or from the bed to the wheelchair.
-Because the resident could not see well during the transfer he fell to the floor.
-Safety checks for Resident #13 would be more time than her workday consisted of and she would not get anything else done.
-She had previously told the resident to use the call light and ask for help before getting up but that did not work because he did not remember.
-Resident #13 had previously been placed on safety checks, (she was unable to recall when but thought it had been longer than three months ago).

Telephone interview with a Personal Care Aide (PCA) on 01/19/22 at 12:32pm revealed:
-Resident #13 was fragile and she did not think the resident could see very well.
-The resident wheeled himself into doors, walls and other people.
-She tried to communicate with the resident to ask staff for assistance, but the resident mentally did not understand.
-Safety checks were supposed to be implemented for 24 hours after a resident had a

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fall.
-The resident was not placed on safety checks after each fall.
-Each time the resident ended up on the floor it was not a fall.
-The resident slid out of his wheelchair to the floor.
-She tried to continually keep an eye on Resident #13 because he wandered into other residents' rooms.
-She was unable to state how frequently she checked on the resident.

d. Review of Resident #13's care note dated 09/20/21 at 4:00pm revealed:
-Resident #13 was unresponsive and was sent to the hospital.
-There was no further documentation.

Review of Resident #13's emergency service call report dated 09/20/21 at 3:54pm revealed Resident #13 was unresponsive when emergency medical services responded to the call.

Review of Resident #13's hospital discharge summary report dated 09/20/21 revealed the resident had a fall and received a forehead contusion.

Telephone interview with the MA on 01/18/22 at 7:03pm who discovered the incident on 09/20/21 revealed:
-Resident #13 was on the floor a lot.
-On 09/20/21, the resident had a fall and needed incontinence care.
-When trying to get the resident to the shower, he kept passing out.
-The resident was sent to the hospital.
-Due to Resident #13's mental status, providing care for the resident was difficult because he was

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unable to comprehend what was being said.
-She was not sure the resident was able to remember to ask for assistance if needed.
-The resident had previously been placed on safety checks for monitoring more frequently, but she was unable to recall exactly when or for how long.
-The resident had not been placed on safety checks since mid-November 2021.
-She was not sure why the safety checks stopped because it was the facility's protocol if a resident had a fall, the resident was placed on safety checks for 24 to 48 hours.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

e. Review of Resident #13's incident/accident report dated 10/02/21 revealed at 5:45pm Resident #13 was found on the floor in his room. The resident had a cut above his right eye, and it was bleeding.

Review of Resident #13's emergency service call detail report dated 10/02/21 at 5:34pm revealed Resident #13 had a fall and was bleeding from his head.

Review of Resident #13's hospital discharge summary report dated 10/02/21 revealed:
-Resident #13 was seen in the ER due to a fall causing a right eye laceration.
-The resident received stitches.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

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D 270	Continued From page 13 Attempted interview on 01/18/22 with the staff who discovered the incident was unsuccessful. f. Review of Resident #13's care note dated 11/03/21 (no time documented) revealed Resident #13 fell out of his wheelchair and the resident's pulse was 49. Review of Resident #13's incident/accident report dated 11/03/21 revealed: -At 9:00pm, Resident #13 had a fall in the hallway and hit his head. -The resident received stitches over his right eye. -The resident's pulse rate was low, and he was sent out to the hospital. Review of Resident #13's physician's visit progress note dated 11/03/21 revealed: -The facility called the physician because Resident #13 was found on the floor in his room. -The resident appeared to be in and out of lethargy. -The resident had suffered a fall and hit his head. -The resident's pulse rated was checked and found to be in the upper 40's. -The facility was instructed to send the resident to the hospital for evaluation of bradycardia and fall in which the resident struck his head. Review of Resident #13's hospital discharge summary report dated 11/03/21 revealed: -Resident #13 was disoriented at baseline. -The resident's verbal responses were confusing. -The resident diagnosis was contusion to his forehead. -Facility staff reported the resident fell out of his wheelchair hitting his head. -Resident #13 had impaired mobility, altered mental status and was a high fall risk.	D 270		

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D 270	Continued From page 14 Telephone interview with the MA on 01/18/22 at 3:58pm who discovered the incident on 11/03/21 revealed: -Resident #13 had a lot of unwitnessed falls. -After a fall, the resident was usually sent to the hospital because he was on a blood thinner (aspirin). -Resident #13 had trouble seeing and he bumped into things and other people with his wheelchair. -If the resident stood up and tried to transfer himself, he would fall because he was unable to stand. -On 11/03/21, Resident #13 fell in the hallway and hit his head. -When the resident's vital signs were checked, his pulse rate was low. -She thought the resident's low pulse rate caused some of his falls. -She thought at one point Resident #13 had been placed on safety checks for increased supervision and to observe the resident more frequently. -She was unable to recall how long ago the safety checks were started. -She thought maybe the PCAs were doing safety checks. -She was not sure if the safety checks were documented or how frequently the resident was checked. Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall. g. Review of Resident #13's care note dated 11/04/21 at 2:00pm revealed Resident #13 complained of pain and swelling in the right hip. The resident was unable to say what happened.	D 270		

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D 270	Continued From page 15 Review of Resident #13's incident/accident report dated 11/04/21 revealed at 2:00pm Resident #13 complained of pain and a hematoma on his right hip. Review of Resident #13's emergency services call detail report dated 11/04/21 at 2:59pm revealed Resident #13 complained of a broken or dislocated hip. Review of Resident #13's hospital discharge summary report dated 11/04/21 revealed Resident #13's diagnosis was fall resulting in right gluteus intramuscular hematoma. Telephone interview with the MA on 01/18/22 at 4:39pm who discovered the incident on 11/04/21 revealed: -On 11/04/21 and on multiple occasions she found Resident #13 on the floor. -There were a few times the resident was hurt as a result of the fall. -Resident #13 had a difficult time seeing; she thought the resident only saw shadows. -When approaching the resident, she had to be careful and announce herself. -Resident #13's falls were because the resident tried to transfer himself without staff assistance and he could not see. -The resident did not ask for staff assistance with transferring. -The resident sometimes slept in his wheelchair and slid out of the chair when sleeping and was not falling. -The resident's falls had gotten worse and were happening more frequently in the past year. -Due to Resident #13's limited mental ability to understand and remember directions, it was getting difficult to provide adequate supervision to	D 270		

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keep the resident from falling.
-She thought the ED had instructed the PCAs to "keep an eye" on Resident #13; meaning when they were walking in the hallway, they should try to view the resident.
-The facility had a falls protocol which consisted of implementing safety checks for 24 to 48 hours after a resident had a fall.
-Safety checks required staff to check and view the resident during scheduled increments (i.e., 15 or 30 minutes or every hour).
-She was unable to recall if safety checks had been implemented each time Resident #13 had a fall.
-The ED would be the one who set the increments for the safety checks.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

h. Review of Resident #13's incident/accident report dated 11/10/21 revealed:
-At 5:00pm, Resident #13 was found on the floor in the dining room.
-The resident had a cut on his right ankle.
-The resident was helped back into his wheelchair and the ankle was bandaged.
-There was a note to monitor the resident but there was no documented frequency as to how often to monitor the resident.

Telephone interview with the MA on 01/18/22 at 5:22pm who discovered the incident on 11/10/21 revealed:
-It was not uncommon to find Resident #13 on the floor.
-Resident #13 had a lot of falls, usually in the hallway.

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-Some falls resulted in injuries, but not every fall.
-The resident had received cuts and bruises, once he hurt his shoulder but no fractures that she was able to recall.
-On 11/10/21, she found the resident in the dining room on the floor.
-She noticed the resident cut his right ankle.
-She bandaged the ankle and she and another staff helped to get the resident back into his wheelchair.
-If a resident had a fall, the resident was placed on safety checks.
-The instructions for the safety checks came from the ED.
-Resident #13 was not placed on safety checks after the fall on 11/10/21.

i. Review of Resident #13's care note dated 11/13/21 at 10:00am revealed:
-Resident #13 was found on the floor in his room.
-The resident appeared to be in severe pain but could not tell where he was injured.
-The resident was sent to the hospital.

Review of Resident #13's incident/accident report dated 11/13/21 at 12:40pm revealed Resident #13 was found on the floor in his room. No injuries were noted on the report.

Review of Resident #13's emergency services call detail report dated 11/13/21 at 12:17pm revealed Resident #13 had a history of falls and was having pain all over.

A request was made on 01/18/22 for the hospital report dated 11/13/21, and was not provided prior to exit on 01/19/22.

Telephone interview with the MA on 01/18/22 at 7:03pm who discovered the incident on 11/13/21

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revealed:
-She found Resident #13 on the floor a lot.
-On 11/13/21, she found the resident on the floor in his room.
-The resident complained of pain and was sent to the hospital.
-Being on the floor was a daily thing for Resident #13.
-Today (01/18/22), she found the resident on the floor three times.
-Due to his mental status, Resident #13 was unable to follow directions well.
-Providing care and keeping the resident safe was difficult because he was unable to comprehend what was being said.
-She was not sure the resident was able to remember to ask for staff assistance if needed.
-She thought the resident had previously been placed on safety checks for monitoring more frequently, but she was unable to recall exactly when or for how long.
-The resident had not been on safety checks since mid-November 2021.
-She was not sure why the safety checks stopped because it was the facility's protocol if a resident had a fall, the resident was placed on safety checks for 24 to 48 hours.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

Review of Resident #13's primary care provider (PCP) physician's visit progress note dated 11/17/21 revealed:
-The resident was non-ambulatory with a history of frequent falls.
-The resident had a large contusion on his left buttock.

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-Would discuss with the ED, possibly transfer to skilled care.
-The resident's care needs were discussed with staff.
-The resident overall had declined, had falls, and weakness with increased confusion.

Interview with a MA on 01/13/22 at 11:13am revealed:
-Resident #13 fell a lot.
-She was not sure why Resident #13 was falling so much.
-Sometimes the resident got weak and fell out of his wheelchair face forward.
-Resident #13 fell on an average of 8 to 10 times per week.
-Resident #13 previously was put on 15 minute safety checks (unable to recall when).
-She was not sure if the resident was still on safety checks.
-The safety checks were not documented.
-When Resident #13 was up moving around she tried to keep an eye on him. She was unable to say how frequently she viewed Resident #13 but more frequently than the required every two hours for incontinence care.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

j. Review of Resident #13's care note dated 12/09/21 revealed:
-At 3:33am, Resident #13 rolled off his bed.
-He had a "big goose egg" over his left eye and was sent to the hospital.

Review of Resident #13's incident/accident report dated 12/09/21 at 3:55am revealed:

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-Resident #13 was found on the floor in his room.
-The resident hit his face and had a cut on his left eye.

Review of Resident #13's emergency services call detail report dated 12/09/21 at 4:13am revealed Resident #13 fell and hit his head.

Review of Resident #13's hospital discharge summary report dated 12/09/21 revealed:
-The primary reason the resident was at the ER was for a fall, acute pain of left shoulder, hematoma to left eye, and altered mental status.
-The discharge diagnosis was major neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance.
-The resident had a left frontal scalp hematoma and chronic nasal bone fractures.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

Attempted interview on 01/18/22 with the staff who discovered the incident on 12/09/21 was unsuccessful.

k. Review of Resident #13's care note dated 12/21/21 at 7:00pm revealed:
-Resident #13 was found in the floor.
-There was an injury to the resident's face (eye) and he was sent to the hospital.

Review of Resident #13's incident/accident report dated 12/21/21 revealed:
-At 8:00pm, Resident #13 was found on the floor in the hallway.
-The resident had cut open his right eyebrow and had scrapes and bruises on his face.

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D 270	Continued From page 21 Review of Resident #13's emergency services call detail report dated 12/21/21 at 7:14pm revealed Resident #13 had a fall in the front hallway. A request was made on 01/18/22 for the hospital report dated 12/21/21 and was not provided prior to exit on 01/19/22. Telephone interview with the MA on 01/18/22 at 5:22pm who discovered this incident on 12/21/21 revealed: -Resident #13 was sent out to the hospital "a bunch of times" for health issues and for falls. -She usually found Resident #13 on the floor in the hallway. -Resident #13 went through phases, some days the resident had no falls, then some days he fell 3 to 4 times in a day. -The resident was unable to stand, but he was able to transfer himself from his bed to his wheelchair or from wheelchair to the bed. -On 12/21/21, she found Resident #13 on the floor in the hallway. -The resident hit his face and cut open his right eyebrow. -She sent the resident to the hospital because he hit his head. -Resident #13 used to be on 15 minute safety checks and staff had to document that the resident was checked. -About one and one-half months ago, the ED told staff they no longer had to do 15 minute checks on the resident. -She was not sure why the ED stopped the 15 minute safety checks. Review of Resident #13's care notes and incident/accident reports revealed there was no	D 270		

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documentation Resident #13 was put on safety checks or increased supervision after this fall.

I. Review of Resident #13's care note dated 01/02/22 revealed:
-At 7:16pm, Resident #13 was on the floor yelling for help.
-When the resident was gotten up off the floor and into this wheelchair, he passed out and kept blacking out.

Review of Resident #13's emergency service call detail report dated 01/02/22 at 7:28pm revealed Resident #13 was not breathing normal and Cardio-Pulmonary Resuscitation (CPR) was in progress.

Review of Resident #13's hospital discharge summary report dated 01/02/22 revealed:
-The resident was in the ER for altered mental status, seizure and recurrent falls.
-The resident had a Stage 2 pressure ulcer to the left hip and a Stage 1 to 2 pressure ulcer to the right hip.
-The resident had abrasions to the right foot with multiple abrasions also to the left foot.

Telephone interview with the MA on 01/18/22 at 5:08pm who discovered the incident on 01/02/22 revealed:
-On 01/02/22, Resident #13 was yelling for help.
-After she and two other staff got the resident off the floor he passed out.
-The resident was sent out to the hospital.
-Resident #13 was not placed on safety checks on the days that she worked.
-The safety checks were assigned to a resident by the ED.
-The ED decided how frequently to monitor a resident on safety checks.

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-After a fall, a resident was supposed to be on safety checks, but there was no system to document or show the checks were completed.
-She did not do safety checks on Resident #13 because she had not been told to do them.

Review of Resident #13's care notes and incident/accident reports revealed there was no documentation Resident #13 was put on safety checks or increased supervision after this fall.

Review of the Resident #13's additional care notes and incident reports from May 2021 to December 2021 revealed:
-On 05/01/21 (no time documented), Resident #13 was found on the floor in his room. The resident had a knot and laceration to his right eye.
-On 06/29/21 (no time documented), Resident #13 had a bruise on his right side from elbow to the rib cage. The resident said that he fell but was unable to tell when or how he fell.
-On 07/18/21 (no time documented), Resident #13 was found on the floor by another resident. No injuries were noted.
-On 08/08/21 at 12:30pm, Resident #13 had a long unopened scrape to the top right arm. The resident was unable to tell staff what happened. The scrape was not present at the beginning of the shift.
-On 11/11/21 at 6:45am, Resident #13 was found on the floor in his room. No injuries were noted.
-On 11/11/21 at 7:40am, Resident #13 was found on the floor on Hall A hallway. No injuries were noted.
-On 11/11/21 at 8:30am, Resident #13 was found on the floor in his room. No injuries were noted.
-On 11/11/21 at 1:00pm, Resident #13 was found on the floor in his room. No injuries were noted.
-On 11/11/21 at 9:07pm, Resident #13 was found on the floor in the doorway of his room with his

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wheelchair on top of him. No injuries were noted.
-On 11/12/21 at 3:00pm, Resident #13 was found on the floor in his room. No injuries were noted.
-On 11/12/21 at 7:00pm, Resident #13 was found on the floor by the doorway to his room. No injuries were noted.
-On 11/26/21 at 8:00pm, Resident #13 was found on the floor in his bedroom.
-On 11/28/21 at 2:00am, Resident #13 was found in the dining room on the floor. No injuries were noted.
-On 11/28/21 at 4:39am, Resident #13 was in his bedroom on the floor. No injuries were noted.
-On 12/03/21 at 4:00am, Resident #13 was found in the dining room on the floor.
-On 12/19/21 (no time documented), Resident #13 was found on the floor. Slid out of his wheelchair.
-On 12/21/21 at 1:00am, Resident #13 was found on the floor in the hallway. No injuries were noted.

Review of additional emergency service call detailed reports from July 2021 through January 2022 revealed:
-On 09/03/21 at 4:27am, Resident #13 was found incoherent and with left foot pain.
-On 10/10/21 at 3:24pm, Resident #13 fell in the smoking area near the kitchen and was not alert.

Telephone interview with Resident #13's family member on 01/19/22 at 1:08pm revealed:
-She was aware Resident #13 had several falls since October 2021.
-Resident #13 had a short attention span and was unable to follow instructions.
-Resident #13 also had "bad eyesight."
-A staff told her Resident #13's eyesight had gotten worse.
-She was unable to recall if the facility had talked with her regarding systems to put in place to

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prevent Resident #13's falls.
-Resident #13's room was at the end of the hallway, and she thought maybe the resident should be moved so he was not so far away, and staff could check on him more frequently.
-She had not discussed this with the ED or any staff at the facility.
-At the last hospital visit, the physician thought Resident #13's falls were happening because the resident was needing to go to the bathroom.
-The physician suggested staff check for incontinence more frequently.

Telephone interview with Resident #13's primary care provider (PCP) on 01/19/22 at 10:59am revealed:
-Resident #13 was legally blind and falls may be due to the resident's inability to see.
-Resident #13's mental status may also be a contributing factor to why the resident was not asking for staff assistance.
-Supervision was the best intervention to help Resident #13 and try to eliminate as many falls as possible.
-She could not put a time on how frequently to check on the resident.

Telephone interview with Resident #13's mental health provider on 01/19/22 at 10:21am revealed:
-She visited Resident #13 in August, September, October and November 2021.
-Resident #13 was diagnosed with dementia with behavior disturbance, bipolar effective disorder and anxiety.
-Resident #13 was a "very disheveled" man on the best of days.
-The resident would not be able to tell you where he fell or how he fell.
-The resident "probably" needed more supervision.

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-Over the past several months as the resident had more falls, more confusion, and questionable health status the need for more supervision had evolved.

Telephone interview with the ED on 01/19/22 at 1:52pm revealed:
-During Resident #13's last hospital visit it was discussed putting the resident on hospice, but the resident's health started to improve back to his baseline.
-She had discussed with Resident #13's family member systems to put in place to keep the resident at the facility and off the floor.
-In the past, two years ago, they had tried things like bed/chair alarms, but the resident destroyed them.
-Resident #13 should still be on increased supervision.
-She had not instructed staff to stop safety checks for the resident.
-Staff should view the resident each time they went down the hallway.
-She did not put a time on how frequent the resident was supposed to be checked.
-She stopped documenting safety checks because documentation does not mean staff actually viewed the resident and could not be truthful.
-Staff were supposed to check on the resident in between incontinence care, which was provided every two hours.

Telephone interview with the Administrator on 01/19/22 at 2:47pm revealed:
-He was not aware staff had not increased supervision for Resident #13.
-Increased supervision should be provided for residents that had falls.
-There should be documentation of the increased

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supervision.

Based on observations, record reviews and interviews, it was determined Resident #13 was not interviewable.

2. Review of Resident #1's current FL2 dated 04/09/21 revealed:
-Diagnoses included mental retardation, hypertension, non-insulin dependent diabetes mellitus, corneal implant, psychiatric disorder, renal failure, hypothyroid, hyperlipidemia, and mood disorder.
-The resident was ambulatory with a walker.
-She required personal care assistance with bathing and dressing and was incontinent of bladder and bowel.

Review of Resident #1's Care Plan dated 10/09/20 revealed:
-She required limited assistance with eating.
-She required extensive assistance with toileting, bathing, dressing and grooming.
-She required supervision with ambulation and transfers.

a. Review of Resident #1's incident/accident report dated 10/02/21 at 5:30am revealed:
-Resident #1 was found on the floor in her bathroom. The resident injured her face and had a cut.
-The resident was sent to the hospital.
-There was no documentation Resident #1 was put on safety checks or supervised more frequently than every two hours for incontinent care.

Review of Resident #1's emergency service report dated 10/02/21 revealed Resident #1 had a fall and her eye was bleeding.

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D 270	Continued From page 28 Review of Resident #1's hospital admission/discharge summary report dated 10/02/21 revealed: -Resident #1's problem identified for the visit included a fall hitting her left eye which caused a ruptured globe and left lower lid laceration. Telephone interview with Resident #1's Power of Attorney (POA) on 01/12/21 at 9:00am revealed: -Resident #1 had a fall on 10/02/21 and ended up having surgery to repair her left eye. -On 10/02/21, the ophthalmologist who performed Resident #1's eye surgery on 10/03/21, told her because of the fall, Resident #1 would absolutely lose her sight in the left eye. -This was the first time she had been notified about Resident #1 having a fall. -No one had discussed with her increased supervision for Resident #1. -On 10/21/21, she asked the Executive Director (ED) if she should consider getting a sitter for Resident #1 because she found the resident soaked with urine from her neck to her feet. -The ED said the facility was shorted staff, but getting a sitter was not necessary. Telephone interview with a medication aide (MA) on 01/18/22 at 4:58pm revealed: -Resident #1 had an unwitnessed fall on 10/02/21, in her bathroom. -The resident had an eye injury and was sent to the hospital. -It was the facility's protocol after a fall a resident was put on safety checks for 24 to 48 hours. -The safety checks required staff to check on a resident more frequently than the required every two hours for incontinent care. -The ED set the frequency for the safety checks (i.e., 15 to 30 minutes or one hour).	D 270		

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-To her knowledge, Resident #1 was never put on safety checks.

Telephone interview with a first shift personal care aide (PCA) on 01/19/22 at 12:23pm revealed:
-On 10/02/21, Resident #1 fell off the toilet and hit her eye.
-The damage was significant, and the resident had eye surgery as a result of the fall.
-She did not observe the resident have any falls on her shift.
-Resident #1 was checked every two hours for incontinent care.
-There had been no instructions for increased supervision for Resident #1.

Based on record review and interviews there was no documentation the resident was put on safety checks per the facility's protocol for a resident that had a fall. There was no documentation that showed Resident #1 was checked more frequently than every two hours that was required for incontinent care.

According to the National Center for Biotechnology Information (NCBI) an injury resulting in a ruptured globe "will likely cause vision loss, the amount of vision loss will depend on how soon the rupture globe was repaired."

b. Review of Resident #1's incident/accident report dated 11/14/21 at 11:00pm revealed:
-Resident #1 was found on the floor in her room.
-The resident had injuries to her throat.

Interview with a PCA on 01/13/22 at 3:34pm revealed:
-On 11/14/21, she found Resident #1 on the floor.
-She told the MA the resident was on the floor.
-She did not recall seeing any bruises that day.

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-Later, she saw bruises on Resident #1's legs but did not tell anyone.
-Resident #1 was not put on safety checks, which was the facility's protocol after a resident had a fall.
-The ED informed when to put a resident on safety checks.

Based on record review and interviews there was no documentation the resident was put on safety checks or checked more frequently than every two hours that was required for incontinent care.

c. Review of Resident #1's care note dated 11/16/21 revealed:
-Resident #1 was walking in the hallway.
-Staff observed the resident's legs gave out in the hallway.
-Staff tried to assist the resident; she fell to the floor on her knees and then to her bottom.
-The resident said she could not bend her legs and could not get up.
-The resident was unable to assist staff with help getting her off the floor and emergency medical services (EMS) was called.
-The resident told EMS that she wanted to go to the hospital.

Review of Resident #1's emergency service detail report dated 11/16/21 revealed Resident #1 fell in the hallway and complained of knee and chest pain.

Review of Resident #1's hospital admission/discharge summary report dated 11/16/21 revealed:
-The resident was admitted to the hospital due to an "accidental fall" (reported by facility staff).
-The resident had a posttraumatic hematoma of the right breast, swollen of the left knee, swelling

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of the right upper extremity, traumatic ecchymosis of the neck, and a shoulder contusion.
-The resident reported to EMS that she was walking alone in the hallway using her walker and fell.

Telephone interview with Resident #1's POA on 01/12/21 at 9:00am revealed:
-She received a call on 11/16/21, around mid-day from staff at the facility that Resident #1 was walking from the dining room and the resident's legs gave out.
-The facility staff said they lowered Resident #1 easily down to the floor.
-Facility staff never reported to her that Resident #1 had injuries resulting from the fall as reported by the hospital nurse.
-If there were falls after 11/16/21 or Resident #1 was found on the floor no one at the facility told her.
-No one had ever discussed with her implementing increased supervision for Resident #1.
-No one at the facility told her Resident #1 had unexplained bruises on her body.

Telephone interview with a second shift MA on 01/18/22 at 3:39pm revealed:
-On 11/16/21, staff told her Resident #1 was on the floor.
-The resident was walking in the hallway using her walker.
-The resident's legs gave out and she started falling.
-The staff tried to assist the resident with falling and the resident ended up on the floor.
-The staff were unable to get her up off the floor and EMS was called.
-When EMS arrived Resident #1 said she wanted

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to go to the hospital.
-To her understanding the PCAs checked Resident #1 every two hours for incontinent care.
-She was not aware if Resident #1 was checked more frequently.
-It was the facility's policy that after a fall, a resident was put on safety checks for 24 to 48 hours.
-She did not think Resident #1 was put safety checks.
-Safety checks were determined by the ED.

Based on record review and interviews there was no documentation Resident #1 was put on safety checks or checked more frequently than every two hours that was required for incontinent care.

d. Review of Resident #1's care note dated 11/20/21 at 9:00am revealed:
-The supervisor pulled the cover back to help Resident #1 sit up.
-The supervisor noticed bruising on the resident.
-The supervisor asked the resident if she fell, and the resident said no.

Review of Resident #1's hospital admission/discharge summary report dated 11/21/21 revealed:
-Resident #1 was sent to the hospital for difficulty urinating.
-While at the hospital the hospital staff observed bruises on the resident.
-The physician at the hospital noted on the report that Resident #1 was "diffusely bruised and swollen."
-The resident told hospital staff that she had a fall yesterday (11/20/21).
-The physician that examined the resident on 11/16/21 was present and visualized the resident.
-The physician explained that there was new

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bruising and swelling that was not present when he saw the resident on 11/16/21.
-The EMS reported to the hospital staff they were concerned because the call to pick-up the resident was for difficulty urinating, but the resident appeared to have fallen and had extensive bruising.
-The resident told EMS and hospital staff the bruises resulted from falls.
-The physician noted the resident's "hemoglobin had likely dropped due to the amount of bruising" on the resident.

Interview with the adult protective services (APS) social worker on 01/12/22 at 9:50am revealed:
-When she visited Resident #1 on 11/22/21, the resident told her that she had some falls recently and had been sent to the hospital the day before (11/21/21), for a fall.
-The resident stated she fell a lot.
-The resident stated most times when she fell, she was alone.
-The resident stated when she fell, she laid in the floor 15 to 20 minutes.
-The resident stated she knew there were bruises on her legs and arms that she could not see which resulted from the falls.
-She observed dark purple bruises on the resident's upper and lower left and right arms, and dark purple bruising on the resident's upper and lower legs.
-There was slight bruising with a yellowish tent on the resident's chest and neck.
-The resident stated sometimes when she fell, she was using her walker to walk.
-The ED informed APS social worker that Resident #1 fell often at the facility.

Telephone interview with a MA on 01/18/22 at 4:58pm revealed:

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-After the fall on 10/02/21, Resident #1 started to decline fast and did not want to get out of bed.
-In November 2021, Resident #1 started requiring the use of a wheelchair because she was too weak to use her walker.
-The resident went from stand by assistance to needing two people to assist her.
-There was a report Resident #1 had a fall in November 2021 (not sure of exact date).
-The resident told her that she had a fall.
-She did not see the resident fall, but she had observed bruises on the resident that the resident said came from a fall.

Telephone interview with a first shift PCA on 01/19/22 at 12:23pm revealed:
-One day (unable to recall exact date), in November 2021, she noticed bruises on the resident's right side, arm and right breast.
-The bruises were not on the resident the day before.
-She did not know how the resident got the bruises and she could not say the bruises did not come from a fall.
-She did not observe the resident have any falls on her shift.
-Resident #1 was checked every two hours for incontinent care.
-There had been no instructions for increased supervision for Resident #1.

Based on record review and interviews there was no documentation of the resident's fall on 11/20/21. There was no documentation Resident #1 was put on safety checks or supervised more frequently.

e. Review of Resident #1's hospital admission/discharge summary report dated 11/29/21 revealed:

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D 270	Continued From page 35 -Resident #1 was at the hospital due to being lethargic and the hospital staff noticed the resident had bruising and swelling to the right breast. -There was bruising to the left breast. -There was bruising to the anterior neck that were in different stages of healing. -There was bruising to both shoulders. -The resident had bruising that was seen on her neck, both shoulders, breast and hips. -The resident had been seen in the emergency room twice in the past few weeks and bruising was extensive. Telephone interview with a second shift MA on 01/18/22 at 3:39pm revealed: -On 11/20/21, 11/24/21, and 11/26/21 she noticed bruises on Resident #1. -She noticed the resident had bruising on her hip, breast, chest and right arm. -She asked the resident what happened and the resident stated she fell. -She took pictures of the bruises and notified the ED. -One day (unable to recall the exact date), a third shift staff told her that Resident #1 was found on the floor. -When she worked, she had not witnessed Resident #1 have falls or was found on the floor. -She was unable to explain how Resident #1's bruises occurred and was unable to say the bruises did not result from falls. -No increased or additional supervision was put in place for Resident #1. -Resident #1 was never put on safety checks, which was the facility's protocol for a resident after a fall. -The ED determined when a resident was put on increased supervision (safety checks) and for how long.	D 270		

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D 270	Continued From page 36 Based on record review and interviews there was no documentation Resident #1 was put on safety checks. There was no documentation Resident #1 was supervised more frequently. f. Review of Resident #1's emergency services detail report dated 12/02/21 revealed EMS was called because Resident #1 was weak. Review of Resident #1's hospital admission/discharge summary report dated 12/02/21 revealed: -Resident #1 was at the hospital for weakness and hospital staff noticed the resident had new bruises from previous hospital visits. -The physician's clinical impression included chest wall erythema (redness), pain of right breast, and hematoma of breast. -The physician documented there was discoloration and bruising to the upper chest inferior to the sternal notch and bilateral clavicle areas and contusion to the left hip. -The physician documented there was ecchymosis (discoloration of the skin caused by bleeding under the skin) and skin blistering on the anterior chest associated with a pectoral hematoma (trauma caused to the chest), along with significant redness and edema of the right breast as well as various other sores concerning for pressure wounds. -The physician documented the right hip had a deep tissue pressure injury wound that measured 5 centimeters (cm) x 6 cm, and non-blanching erythema (intact thin blister over maroon tissue). -The physician documented the right ankle had a deep tissue pressure wound that measured .05 cm x 0.5 cm that was maroon in color. -The physician documented there was a concern for subarachnoid hemorrhage (common cause	D 270		

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was head trauma).
-The computed tomography scan (CT scan) showed the resident had scattered chronic subarachnoid blood products from prior subarachnoid hemorrhage.
-This was not noted on the CT scan performed on 10/02/21.

Observation on 01/12/21 at 9:40am of Resident #1's colored photos taken upon admission to the hospital on 12/02/21 by the hospital staff and the resident's POA and photos taken on 12/03/21 by the APS social worker revealed:
-The photos showed that Resident #1 had multiple bruises and scabbed over wounds on the upper chest area below the neck that extended from the right shoulder to the left shoulder.
-The photos showed one wound was scabbed over.
-According to the photo the scab was very dark purple in color (almost black).
-There were multiple dark colored wounds all over the resident's body.
-Based on the photo most wounds had very dark purplish scabs.
-Some of the wounds were a deep reddish color.
-There was a circular wound on the resident's upper left chest that was covered with a transparent bandage.
-The wound was very dark purple and was visible through the bandage.
-Looking at the photos you could see there were bruises that extended up the resident's neck that were a deep reddish color.
-There was a bruise on the resident's right elbow.
-There were multiple bruises on the sides of the resident's right and left legs.
-There were deep reddish color bruises on the resident's forehead, temple of the head and center of the head near the back of the head.

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D 270	Continued From page 38 Telephone interview with Resident #1's POA on 01/12/21 at 9:00am revealed: -On 12/02/21, the family visited Resident #1 and observed the resident was very lethargic, "almost comatose." -She observed the resident had bruises on her arms and side. -The bruises were "strange looking." -The facility staff told her that Resident #1's medications caused the bruises. -The nurse and physician at the hospital told her that Resident #1's medications would not have caused that type of bruising. -The resident was currently in a skilled nursing facility on the same medications that she was on at the facility and did not have bruises. -The resident's medications did not changed after the fall on 10/02/21 and she did not have bruises prior to that fall. -When the family visited the resident on 12/02/21, the resident was lethargic and weak. -The family insisted the resident be sent to the hospital. -On 12/02/21, the physician at the hospital told her Resident #1's CT scan showed the resident had a "brain bleed." -The brain was not currently bleeding but from the scan, brain bleed could be seen. -The physician told her the brain bleed was not present on the CT scan done on 10/02/21. -The physician said sometime between 10/02/21 and 12/02/21 (today's visit) something caused the resident's brain bleed. -On 11/30/21, Resident #1 told a police detective that she fell out of bed. Interview with APS social worker on 01/12/22 at 9:50am revealed: -When she visited Resident #1 on 12/06/21 at the	D 270		

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hospital the physician at the hospital informed Resident #1's family that the resident had a brain bleed.
-The brain bleed had stopped on its own.

Review of Resident #1's primary care provider (PCP) physician's visit progress note dated 12/01/21 revealed:
-The physician documented Resident #1 had multiple falls and sustained multiple contusions to the neck, left hip, arms, right breast, and the right breast had moderate swelling.
-The resident had generalized weakness.
-The resident was a 2 person assist with lying and sitting.

Telephone interview with Resident #1's PCP on 01/14/22 at 11:53am revealed:
-She had seen Resident #1 several times since the resident's fall on 10/02/21.
-Resident #1 had started to decline quickly.
-She was told during several visits to the facility by the resident and facility staff that Resident #1 had multiple falls.
-She had seen Resident #1 on 10/13/21 for a wrist injury that she was told resulted from a fall.
-A week prior to that, Resident #1 went out to the hospital for a head injury that resulted in the resident needing eye surgery.
-She checked her records and she had seen the resident for multiple falls but had no documented dates specific to when the falls occurred.
-On 12/01/21, she saw Resident #1 and assessed the resident's body.
-She noted in her records that Resident #1 had obvious contusions on her hips, thighs, arms, right breast and head.
-She had observed the resident's extensive bruising.
-She noted the bruises came from falls; that

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information came from either the resident or facility staff.

Interview with a therapist from the contracted physical therapy agency on 01/12/22 at 11:50am revealed:
-Resident #1 had "a lot of falls."
-Resident #1 was barely maintaining and eventually got to a point where she had to be hospitalized.
-He got Resident #1 a bedside commode because the ED said the resident kept falling.
-He did not witness any of Resident #1's falls.
-Facility staff and the resident told him about the falls.
-He did not document when he was told the resident had a fall.

Interview with a resident on 01/14/22 at 4:32pm revealed:
-Resident #1 had a lot of falls.
-Resident #1 had asked staff for a wheelchair on multiple occasions, because it hurt to walk on her own, and staff told Resident #1 "no".

Interview with a second resident on 01/14/22 at 5:19pm revealed:
-Staff would leave Resident #1 on the toilet for 20 to 30 minutes.
-The resident would hear Resident #1 yelling for staff to come and get her off the toilet, but it still took them a long time to come.
-The resident would help Resident #1 yell for staff to come and help get her off the toilet.
-The resident had observed Resident #1 on the floor on multiple occasions.
-Resident #1 had "some really bad looking bruises on her neck."
-When the resident asked Resident #1 how she got the bruises, Resident #1 told the resident that

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D 270	Continued From page 41 she fell. Based on record review and interviews there was no documentation Resident #1 was put on safety checks per the facility's protocol for a resident that had a fall. There was no documentation that showed Resident #1 was checked more frequently than every two hours that was required for incontinent care. Interview with the ED on 01/14/22 at 6:28pm revealed: -She was aware Resident #1 had falls. -The falls should be documented. -Safety checks was something that would be discussed with everyone (management and corporate) to get input. -Resident #1 was not put on safety checks. -She had told staff to "keep an eye" on the resident. -She did not tell staff to document when they checked on the resident. -She was unable to recall exactly when she gave staff the instructions. Based observation, record review and attempted interview on 01/14/22 at 2:40pm, it was determined Resident #1 was not interviewable. Attempted interviews with hospital staff on 01/14/22 at 11:40am and 01/18/21 at 2:10pm was unsuccessful. _____ The facility failed to provided supervision for 2 of 7 sampled residents related to a resident who was legally blind, non-ambulatory and had greater than 30 falls from May 2021 through January 2022 resulting in head injuries with lacerations requiring stitches, severe pain, scrapes and bruises which could have caused the resident to	D 270		

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D 270	Continued From page 42 be permanently disabled (Resident #13); a resident with falls and unexplained bruises (Resident #1) resulting in a brain bleed, lost eye sight and multiple bruises. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection on 01/14/22 in accordance with G.S.131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2022	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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 7 sampled residents (Residents #1 and #3) related to not notifying the primary care provider and mental health provider that a resident scratched, picked and picking skin "tags" causing extensive bleeding (#1) and following through with orders for physical/occupational therapy (#3). The findings are: 1. Review of Resident #1's current FL2 dated 04/09/21 revealed:	D 273		

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D 273	Continued From page 43 -Diagnoses included mental retardation, hypertension, non-insulin dependent diabetes mellitus, corneal implant, psychiatric disorder, renal failure, hypothyroid, hyperlipidemia, and mood disorder. -The resident was ambulatory with a walker. -She required personal care assistance with bathing and dressing and incontinent of bladder and bowel. Review of Resident #1's Care Plan dated 10/09/20 revealed: -She required limited assistance with eating. -She required extensive assistance with toileting, bathing, dressing and grooming. -She resident required supervision with ambulation and transfers. Observation on 01/12/21 at 9:40am of Resident #1's color photos taken by the hospital staff and the resident's Power of Attorney (POA) on 12/02/21, and adult protective services (APS) social worker dated 12/03/21 revealed: -Based on the photos Resident #1 had multiple bruises that were scabbed over wounds on her upper chest area below the neck that extended from the right shoulder to the left shoulder. -According to the photos the resident had one vertical wound almost center the resident's chest that was scabbed over. -The scab was very dark purple in color (almost black). -The photo showed the resident had multiple wounds that had very dark purplish scabs. -Some of the wounds had a deep reddish color. -There was a circular wound on the upper left side of the resident's chest that was covered with a transparent bandage. -The wound was very dark purple and was visible through the bandage.	D 273		

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-Based on the photo the resident had bruises that extended up the resident's neck that were a deep reddish color
-There was a bruise on the resident's right elbow.
-There were multiple bruises on the sides of the resident's right and left legs.
-There were deep reddish colored bruises on the resident's forehead, temple of the head and center of the head near the back of her head.

Review of Resident #1's care note dated 11/24/21 (no time documented), revealed:
-Resident #1 had a skin "tag" on the right side of her chest collar bone area.
-Resident pulled off the skin "tag" and scratched the area which caused a skin tear.

Review of Resident #1's care notes and incident/accident reports revealed there was no more documentation, entries or reports regarding the resident scratching to the point of bleeding, picking skin "tags," or explanation of bruises.

Telephone interview with Resident #1's POA on 01/12/21 at 9:00am revealed:
-On 12/02/21, family visited Resident #1 and observed the resident was "very lethargic, almost comatose."
-She observed the resident had bruises on her arms and on the sides of her body.
-The bruises were "strange looking."
-The facility staff told her the resident's medications caused bruises.
-The nurse and physician at the hospital told her that Resident #1's medications administered at the facility would not have caused that type of bruising.
-The resident was currently at a skilled nursing facility and was on the same medications that she was on at the facility and she did not have

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bruises.
-She was never notified that Resident #1 continually scratched her skin and caused herself to bleed or that the resident had unexplained bruising.

Interview with a medication aide (MA) on 01/12/22 at 3:15pm revealed:
-Resident #1 had unexplained bruises.
-The resident had a skin tag like a "little mole."
-The resident told her that she "got the skin tag off."
-She observed blood running down the resident's chest and there was blood all over the resident's shirt.
-There were bruises on the resident's chest from the resident continually scratching herself.
-She did not reported the resident pulled the skin tag off or that the resident scratched herself to the point of bleeding all over her shirt.
-As far as she knew, Resident #1 had always scratched herself around her collar bone.
-She did not put anything on the wound or the scratches.
-Resident #1's primary care provider (PCP) was in the facility every Thursday, and she was able to contact the PCP by telephone 24 hours a day, seven days per week.
-She did not tell the resident's PCP that the resident pulled off the skin tag.
-She did not tell the resident's PCP that the resident continually scratched herself to the point of causing blood and bruising.
-She did not think to notify the resident's mental health provider regarding the resident continually scratching herself.

Interview with another MA on 01/13/21 at 11:13pm revealed:
-In November 2021 (unable to recall exact date),

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she had observed Resident #1 had scratched the skin on her chest and had blood on her hands and skin under her finger nails.
-She did not document the incident and did not put any cream on the scratches because she did not think it was significant.
-She did not recall Resident #1 having any skin "tags."
-The only scratches she noticed on the resident was what she called a skin tear; meaning the resident had broken, like a paper cut.
-The skin tear was about one-half inch long in length and not that significant.
-She did not report the scratches or the skin tear to any one nor did she treat them with anything.

Interview with a personal care aide (PCA) on 01/13/22 at 3:34pm revealed:
-Resident #1 had bruises because she scratched herself causing wounds.
-When Resident #1 scratched herself the MA would give her a cream to put on the scratches.
-She was not sure what type of cream was used, but she thought the cream was to help with itching and infection.
-Resident #1 had been scratching herself since October 2021.
-When she saw the scratches, she reported it to the supervisor.
-The supervisor was responsible for notifying the Resident Care Coordinator (RCC) and the Executive Director (ED).
-The RCC and ED contacted the resident's PCP.
-The MA told her Resident #1's medication made her itch and caused the bruises.

Telephone interview with a second shift MA on 01/18/22 at 3:39pm revealed:
-One day (unable to recall the exact date), a staff told her that Resident #1 picked off a skin "tag."

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-She did not witness the resident scratching and she did not see the resident picking off the skin tag.
-She saw the wound where the skin tag had been, and it was the size of a dime.
-She did not see Resident #1 scratch and pick skin tags.
-She did not know the resident had skin tags.
-Resident #1's PCP was at the facility every Thursday.
-She did not tell the resident's PCP that the resident scratched herself and picked off the skin tag.

Telephone interview with another second shift MA on 01/18/21 at 6:57pm revealed:
-Third shift had reported Resident #1 had been scratching and made a skin tear.
-The skin tear she observed was not that big, but it seemed "a little much for a scratch."
-She observed scratches on the resident's neck, nothing major.
-She thought the resident had severely dry skin.
-She did not tell anyone because the third shift MA told her about the skin tear so the third shift MA should have documented the incident and reported it.

Telephone interview with a PCA on 01/19/22 at 11:55am revealed:
-Resident #1 continually scratched her chest and made her chest "raw."
-She told the MA and the MA put a cream on the resident's chest.
-The scratching had gotten so bad the wounds were bleeding because the resident scratched so hard.
-One day when she worked first shift (unable to recall the exact date), she noticed Resident #1 was scratching herself continually.

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-On the same day, she worked the second shift and the resident was still scratching her chest.
-The resident's scratching had gotten so bad the wounds were bleeding.
-She observed the resident scratching sometime after or before November 2021 (unable to recall exactly when).
-She told the MA about the resident's scratching so much that she was bleeding.
-She did not know what the MA did about the scratching.
-She cleaned skin and blood from the resident's finger nails.
-She did not document the scratching and she did not tell anyone else but the MA.
-She did not tell the resident's PCP or mental health provider when they were at the facility.

Telephone interview with Resident #1's mental health provider on 01/14/22 at 10:49am revealed:
-She provided mental health services to Resident #1 since March 2021.
-The protocol was to see Resident #1 every 1 to 3 months but she tried to see the resident every month.
-She saw Resident #1 on 10/12/21 and 11/09/21, and no staff at the facility told her the resident scratched herself to the point of causing bruises, wounds and bleeding.
-If the resident was scratching to the point of causing bruising and bleeding, then she would wanted to know that.
-She would have checked the resident's medications to see if the medications caused the itching and then possibly changed the medications.
-There could have been issues where the resident was having increased anxiety, which also could cause intense itching.
-She ordered three medications for Resident #1's

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mood and behaviors, one of which was klonopin, an as needed medication to treat anxiety.
-The klonopin could possibly have been administered to help with the itching.
-Either way, she would have wanted to be notified about a change in the resident's mental status and behaviors.
-When she visited a resident at the facility, she usually looked at the resident's record.
-There was no documentation in Resident #1's record that showed the resident was scratching herself to the point of bleeding and bruises.
-The facility staff were able to contact her office twenty-four hours a day, seven days a week.
-Her records did not show the facility contacted her with any issues related to Resident #1.

Telephone interview with Resident #1's PCP on 01/14/22 at 11:53am revealed:
-On 12/01/21, she saw Resident #1 and conducted a physical assessment of the resident's body.
-She had observed the resident's extensive bruising but no one at the facility made her aware that some of the bruises came from the resident itching and scratching so hard that she caused open wounds with blood coming from them.
-She was not aware the resident continually scratched herself to the point of bleeding and scarring.
-She was in the facility every Thursday and she was accessible by telephone.
-She wanted to be notified if the resident constantly scratched herself so deep that she had blood and skin under her fingernails causing wounds and bruises.
-Staff at the facility never told her Resident #1 was itching.

Interview with the ED on 01/14/22 at 6:22pm

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revealed:
-If a resident had marks or bruises, they were to be reported to the supervisor.
-The supervisor reported to the RCC.
-Wounds should be reported to the resident's PCP and documented.
-Resident #1's PCP should have been notified the resident was itching enough to scratch her skin and cause bleeding.
-It should also be reported to her.
-She was told the resident had marks and scratches but not that the resident continually itched, scratched her skin and caused bleeding.

Telephone interview with the Administrator on 01/19/21 at 2:53pm revealed staff should have followed-up with Resident #1's PCP and attempted to do something about the itching and scratching as well.

2. Review of Resident #3's current FL2 dated 11/03/21 revealed:
-Diagnoses included vertigo, adult failure to thrive, paranoid schizophrenia and type 2 diabetes.
-Ambulatory status was listed as ambulatory with the use of a walker.

Review of Resident #3's physician order dated 10/27/21 revealed a new order for outpatient physical therapy (PT)/occupational therapy (OT) evaluation and treatment.

Review of Resident #3's current Licensed Health Professional Support (LHPS) evaluation dated 10/28/21 revealed Resident #3 required the use of a walker or wheelchair for mobility.

Interview with the Resident Care Coordinator (RCC) on 01/14/22 at 3:05pm revealed:

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-The PT would let her know by word of mouth if he was unable to treat a resident due to insurance.
-She had not been employed at the facility when Resident #3's PT referral had been written on 10/27/21 so she was not sure if Resident #3 received PT services at that time or not.

Telephone interview with the physical therapist from the outpatient PT agency on 01/14/22 at 3:28pm revealed:
-He had not done a PT evaluation for Resident #3.
-He likely could not treat Resident #3 due to her insurance, and if her insurance would not cover therapy through him, the other option would be to do PT/OT through home health.
-If he got a referral to treat a resident who was not eligible for his services due to their insurance, he would tell the RCC to cancel the referral. He did this by word of mouth while at the facility, he did not document this type of notification.

Telephone interview with Resident #3's previous home health (HH) agency on 01/14/22 at 4:05pm revealed:
-They had been providing Resident #3 with home health PT/OT services, but she had been discharged from their services on 10/26/21.
-They had not received a new referral for PT/OT since discharging Resident #3 on 10/26/21.

Telephone interview with Resident #3's primary care provider (PCP) on 01/14/22 at 4:25pm revealed:
-Typically, if she wrote an order for PT/OT that a resident was not able to carry out due to their insurance, both the physical therapist and the facility would notify her.
-She did not remember if the physical therapist

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had notified her that he was unable to complete the PT/OT evaluation and treatment for Resident #3 as ordered.
-She did not remember if the facility had notified her either.
-She had ordered PT/OT for Resident #3 to help with her gait and strengthening after having an acute illness.
-It was her expectation that she be notified if her written orders were not able to be completed.

Interview with Resident #3 on 01/14/22 at 6:00pm revealed:
-She last received home health PT/OT three to four months prior.
-Therapy helped her with ambulating with her walker, and with getting in and out of bed.
-If she was able to continue receiving PT/OT services she would like to; therapy felt helpful to her.

Interview with the Executive Director (ED) on 01/14/22 at 6:30pm revealed:
-It was their protocol to notify the PCP if she wrote an order that the facility was unable to carry out.
-She could not remember if the PCP had been notified that PT/OT would not be seeing Resident #3.
-The physical therapist did not provide them with a written statement that Resident #3 was not eligible for PT/OT services due to her insurance.

_____

The facility failed to ensure referral and follow up for 2 of 5 sampled residents by not notifying the PCP and mental health provider when a resident continually picked and scratched her skin causing severe bleeding and extensive bruising which could lead to extensive tissue damage and skin infections (Resident #1); and failed to follow-up

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D 273	Continued From page 53 with orders for PT/OT for a resident who needed help with gait training and strengthening after an acute illness (Resident #3) This failure was detrimental to health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection on 01/14/22 in accordance with G.S.131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 6, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure physician orders were implemented for 2 of 5 sampled residents (#4 and #2) who had orders for thromboembolic deterrent (TED) hose (#4), and a urinalysis (#2). The findings are: 1. Review of Resident #4's current FL2 dated 09/09/21 revealed: -Diagnoses included major depressive disorder,	D 276		

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post traumatic stress disorder and chronic obstructive pulmonary disease (COPD).
-The resident was documented as being able to verbally make her needs known.

Review of Resident #4's previous FL2 dated 02/03/21 revealed diagnoses included congestive heart failure (CHF) and poor short-term memory.

Review of physician's order for Resident #4 dated 11/17/21 revealed there was a new order for thigh-high thromboembolic deterrent (TED) hose to be applied in the morning and removed at bedtime.

Review of signed Physician's Orders sheet for Resident #4 dated 01/06/22 revealed there was an order for thigh-high TED hose apply every morning and remove at bedtime.

Review of Resident #4's December 2021 TED Hose Documentation Form revealed:
-There was a check mark documented as applied in the "Ted Hose On" column on 12/03/21, 12/07/21, and 12/08/21.
-There was a check mark documented as removed in the "Ted Hose Off" column on 12/03/21.
-There was an X documented as not removed in the "Ted Hose Off" column on 12/01/21, 12/02/21, 12/04-12/13/21, 12/16-12/21/21, 12/23-12/26/21, 12/28-12/31/21.

Review of Resident #4's January 2022 TED Hose Documentation Form revealed:
-There was an X documented as not applied in the "Ted Hose On" column daily from 01/01/22 through 01/13/22.
-There was an X documented as not removed in the "Ted Hose Off" column daily from 01/01/22

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D 276	Continued From page 55 through 01/12/22. Interview with a medication aide (MA) on 01/13/22 at 2:50pm revealed: -The MA staff were supposed to document on the TED Hose Documentation Form daily. -The X's indicated that the TED hose were not applied or removed, and the check marks indicated that the TED hose were applied or removed. -Resident #4 previously had a pair of TED hose but she had wanted to wash them herself and staff had not seen the TED hose since. -She did not know when Resident #4 had initially obtained her pair of TED hose or when she had last seen her TED hose. -She assumed the TED hose were somewhere in Resident #4's room. -The primary care provider (PCP) had just been made aware of the missing TED hose that day on 01/13/22. Observation of Resident #4 on 01/13/22 at 11:50am revealed: -She was sitting in a chair in her room with her feet down on the floor. -There was a small amount of swelling to both of her ankles as evidenced by an imprinted ring where the top of her socks had been on both legs after she pushed the socks down. Interview with Resident #4 on 01/13/22 at 11:55am revealed: -She did not have a pair of TED hose on. -She denied ever having been measured for or provided with a pair of thigh-high TED hose. -She would like the TED hose to help with swelling in her feet and ankles. -She had not asked staff about her TED hose or requested a new pair.	D 276		

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D 276	Continued From page 56 Interview with Resident #4's primary care provider (PCP) on 01/13/22 at 12:50pm revealed: -She had ordered TED hose for Resident #4 due to swelling in her legs. -She had not been notified prior to that day that Resident #4 had not been wearing the thigh-high TED hose as ordered. -Without the TED hose being applied as ordered, the only adverse effect to Resident #4 was that her swelling could have gotten worse. -It was her expectation that staff implement orders as she wrote them, or to notify her if they were unable to implement the order. Telephone interview with a representative from the facility's contracted pharmacy on 01/13/22 at 4:45pm revealed: -They had received measurements for thigh-high TED hose for Resident #4 that day to correspond with the order for TED hose dated 11/17/21. -They had last dispensed thigh-high TED hose for Resident #4 on 01/21/21, then the order had been discontinued on 02/02/21. -They had received the signed physician order sheet dated 01/06/22 but they had not dispensed a pair of TED hose because they were awaiting the required measurements first. Interview with another MA on 01/14/22 at 10:00am revealed: -Resident #4 had TED hose at one point, but she had told staff that she did not trust them to wash her TED hose for her, so she kept them in her room to wash and they had not seen them since. -She was not sure when she had last seen Resident #4's TED hose. -She had been measured for a new pair of thigh-high TED hose the day prior (01/13/22), they had been delivered from the pharmacy the	D 276		

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previous evening and was now wearing them that day.

Observation of Resident #4 on 01/14/22 at 10:07am revealed she was laying down in bed wearing thigh-high TED hose, no swelling was noted to either ankle or foot.

Interview with the Resident Care Coordinator (RCC) on 01/14/22 at 3:05pm revealed:
-She had started working at the facility in November 2021 and had never seen Resident #4 with TED hose on prior to that day.
-She was not able to find Resident #4's November 2021 TED Hose Documentation Form.
-It was her responsibility to fax physician orders to the pharmacy and follow up on those orders.
-The MA staff should be applying, removing and documenting on the Ted Hose Documentation Form daily.

Interview with the Executive Director (ED) on 01/14/22 at 6:30pm revealed:
-When the PCP wrote orders for TED hose, the facility would fax that order to the pharmacy. The pharmacy would then fax the facility a measurement sheet, and once completed they would dispense a pair of TED hose as ordered.
-The RCC was responsible for following up on orders written by the PCP.
-She did not know why, but they did not fax Resident #4's TED hose order dated 11/17/21 to the pharmacy.

Telephone interview with a third MA on 01/18/22 at 3:06pm revealed:
-She typically worked the second shift which was from 2:00pm to 10:00pm.
-She had documented under the "Ted Hose Off" column on Resident #4's TED Hose

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Documentation Form on 12/04/21, 12/07/21, 12/10/21, 12/13/21, 12/20/21, 12/24/21, 12/31/21, 01/01/22, 01/02/22, 01/03/22, 01/07/22 and 01/12/22.
-The second shift MA was responsible for documenting that Resident #4's TED hose were not on at bedtime, and removing them if they were.
-She could not remember ever seeing Resident #4 wearing TED hose, but Resident #4 was independent with many of her activities of daily living so she had thought she had removed her own TED hose at night.

2. Review of Resident #2's current FL2 dated 12/10/21 revealed diagnoses included type 2 diabetes, dementia and chronic kidney disease stage 2.

Review of Resident #2's subsequent primary care provider's (PCP) orders revealed there was an order dated 11/24/21 for a urinalysis and culture and sensitivity lab work.

Interview with Resident #2 on 01/14/22 at 5:40pm revealed:
-She remembered having to urinate in a container around Thanksgiving (11/25/21), about two months ago.
-She could not remember which staff assisted her when the urine was collected.
-She did not have any pain, burning or difficulty urinating and was not sure why the test was ordered.

Interview with a medication aide (MA) on 01/14/22 at 5:50pm revealed:
-The MAs were responsible for collecting urine samples from residents for ordered labs.
-The MAs labeled the urine specimen containers

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and filled out the lab order request sheet and put the form with the sample in the specimen refrigerator.
-She was not sure when the contracted laboratory staff picked up the samples or if the facility staff had to call to request the samples to be picked up.
-She and another MA collected urine samples from multiple residents, she thought on Sunday second shift on 11/28/21 but was not sure.
-She thought Resident #2's sample was collected by the second MA, she could not remember which MA it was.
-She did not remember her having any fever, burning with urination or increased confusion.

Interview with the Resident Care Coordinator (RCC) on 01/14/22 at 12:00pm revealed:
-She reviewed orders from the PCP and let the MAs know who needs urine samples collected and what test is ordered.
-When resident specimens were collected, they were labeled and stored in the specimen refrigerator until one of them delivered them to the contracted laboratory.
-Many urine samples had been sent and she could not remember if Resident #2's was collected and sent to the contracted laboratory.
-She could have just missed the order.
-She did not remember that Resident #2 had any confusion or other symptoms of a urinary tract infection during the time of the order.

Interview with the PCP on 01/14/22 at 4:25pm revealed:
-She ordered a urinalysis culture and sensitivity for Resident #2 in November 2021 due to her slight confusion to rule out a urinary tract infection.
-She did not have fever, burning or problems

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urinating at the time of the urinalysis order.
-She did not recall seeing the results of the urinalysis culture and sensitivities and had not inquired as to the results from the staff or the contracted laboratory.
-If Resident #2 had an untreated urinary tract infection, she could become increasingly confused and could have developed sepsis.
-She expected her orders for residents to be completed by facility staff.

Telephone interview with a representative at the facility's contracted laboratory on 01/18/22 at 10:08am revealed:
-Staff from the facility brought collected samples to the contracted laboratory window.
-Samples must be labeled with the resident's name, date of birth, date and time it was collected, and the lab order sheet must be with the sample.
-Samples greater than 24 hours old would be out of date and could not be processed.
-Samples that were not labeled correctly and/or did not have a lab order sheet with them would not be processed.
-If laboratory staff could tell where the sample came from, they would have called the facility to inform the staff a resident's sample could not be processed and it would be documented.
-Resident #2 had not had any documented laboratory sample delivered to the contracted laboratory since 05/28/20.
-A sample may have been delivered to the contracted laboratory and was not labeled properly and did not have an order sheet with it for laboratory staff to tell who it belonged to.

Interview with the Executive Director (ED) on 01/14/22 at 10:00am revealed:
-The RCC processed orders from the PCP.

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D 276	Continued From page 61 -MAs collected urine for ordered labs and stored them in the refrigerator. -Staff delivered resident samples to the contracted laboratory. -She could not find any results for Resident #2's urinalysis culture and sensitivity ordered on 11/24/21. -She expected the PCP orders to be processed and carried out as ordered by staff.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve the therapeutic diet ordered by the physician for 3 of 3 sampled residents who had an order for no concentrated sweets diets (NCS) (#1, #2, #3). The findings are: Observation of the kitchen on 01/13/21 at 11:25am revealed there was a therapeutic diet list posted. Review of the seven day week-at-glance menu for 01/13/22 lunch meal revealed meal was to	D 310		

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consist of: beef tips with mushroom gravy, duchess potatoes, southern style greens, wheat dinner roll or bread, forest pears and beverage of choice.

Review of the therapeutic diet menu for the lunch meal on 01/13/21 revealed residents ordered an NCS diet was to be served: beef tips with mushroom gravy, duchess potatoes, southern style greens, wheat dinner roll or bread, 2 halves diet forest pears and diet beverage.

1. Review of Resident #2's current FL2 dated 12/10/21 revealed:
-Diagnoses included diabetes mellitus type 2, dementia, schizophrenia, vitamin D deficiency and chronic kidney disease.
-There was an order for NCS diet with ground meats.

Review of Resident #2's diet order sheet dated 12/13/21 revealed the resident was ordered an NCS diet with ground meats.

Observation of Resident #2's meal on 01/13/21 at 11:45am revealed the resident's meal consisted of:
-Unsweetened tea, greens, mashed potatoes, canned apples with orange gelatin, ground beef tips.
-The resident consumed 100% of the meal.
-Resident #2's blood sugar ranged between 91 to 195 for November 2021, 76 to 195 for December 2021 and 77 to 135 January 2022.

Review of the nutrition facts on the container of orange gelatin revealed:
-There was 17 grams of sugar in one serving ½ cup of gelatin.
-The first ingredient was sugar.

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D 310	Continued From page 63 Review of the can apples revealed a serving of apples ½ cup had 8 grams of sugar. Observation of the facility's food storage on 01/13/21 at 12:30pm revealed there was no diet forest pears to serve for the meal. Interview with Resident #2 on 01/14/22 at 4:50pm revealed: -No one had never told her that she was a diabetic. -She had always been served the same meal as other residents at the facility. Refer to interview with the food service manager on 01/13/21 at 12:53pm. Refer to interview with the Executive Director (ED) on 01/13/21 at 4:06pm. 2. Review of Resident #5's current FL2 dated 03/03/21 revealed: -Diagnoses included diabetes mellitus type 2, chronic kidney disease. -There was an NCS diet with ground meats and honey thickened liquids. Review of Resident #5's diet order sheet revealed there was an order an NCS, mechanical soft, ground meat, honey thickened liquids and double portions. Observation of Resident #5's meal on 01/13/21 at 11:45am revealed the resident's meal consisted of: -Honey thickened orange beverage in a 16 ounce glass, greens, mashed potatoes, canned apples with orange gelatin, ground beef tips. -The resident consumed 100% of the meal and ¾	D 310		

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of the beverage.

Review of the nutrition fact on the container of orange gelatin revealed:
-There was 17 grams of sugar in one serving ½ cup of gelatin.
-The first ingredient on was sugar.

Review of the can apples revealed a serving of apples ½ cup had 8 grams of sugar.

Review of the of the nutrition facts on the orange drink mix revealed:
-A serving, 12 ounces had 31 grams of sugar.
-The first ingredient was sugar.

Observation of the facility's food storage on 01/13/21 at 12:30pm revealed there was no diet forest pears to serve for the meal.

Interview with Resident #5 on 01/14/22 at 4:42pm revealed:
-He a diabetic but was unable to tell when his blood sugar was up.
-He thought his beverages were sugar free but was not sure.
-He was not aware the gelatin with apples that was served yesterday had sugar.
-Resident #5's blood sugars ranged from 83 to 326 in November 2021, 101 to 457 in December 2021 and 64 to 347 in January 2022

Interview with the dietary aide on 01/13/21 at 12:43pm revealed:
-She prepared Resident #5's beverage for the lunch meal.
-She used the orange drink mix that was in the kitchen.
-She knew the drink had sugar but served it to the resident because in the past he refused sugar

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free drinks.
-The only sugar free drink the facility had was tea sweetened with an artificial sweetener or water.

Refer to interview with the food service manager on 01/13/21 at 12:53pm.

Refer to interview with the Executive Director (ED) on 01/13/21 at 4:06pm.

3. Review of Resident #6's current FL2 dated 12/01/21 revealed:
-Diagnoses included peripheral neuropathy, schizophrenia and renal insufficiency.
-There was an order for low fat low cholesterol diet.

Review of Resident #6's diet order dated 12/07/21 revealed the resident diet changed to NCS low fat low cholesterol diet.

Observation of Resident #6's meal on 01/13/21 at 11:45am revealed the resident's meal consisted of:
-Unsweetened tea, greens, mashed potatoes, canned apples with orange gelatin, ground beef tips.
-The resident consumed 100% of the meal.

Review of the nutrition fact on the container of orange gelatin revealed:
-There was 17 grams of sugar in one serving ½ cup of jello.
-The first ingredient on was sugar.

Review of the can apples revealed a serving of apples ½ cup had 8 grams of sugar.

Observation of the facility's food storage on 01/13/21 at 12:30pm revealed there was no diet

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D 310	Continued From page 66 forest pears to serve for the meal. Interview with Resident #6 on 01/14/22 at 4:58pm revealed: -No one told him that he was ordered a diabetic diet. -He tried to eat sweets because in the past he had blood tests that showed his blood sugar levels were high. -He stopped eating sweets and thought he no longer had diabetes. Refer to interview with the food service manager on 01/13/21 at 12:53pm. Refer to interview with the Executive Director (ED) on 01/13/21 at 4:06pm. _____ Interview with the food service manager on 01/13/21 at 12:53pm revealed: -She prepared the dessert for the lunch meal today. -She did not realize the jello and apples had sugar. -She was not sure what sugar free item could have been substituted to comply with the menu. Interview with the Executive Director (ED) on 01/13/21 at 4:06pm revealed: -No one had ever brought this issue up before. -She ordered the food and she was as much to blame for the diabetes getting sugar dessert today as the food service manager.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	D 338		

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Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observation, record review, and interviews the facility failed to ensure residents were free of verbal and physical abuse and treated with respect related to a staff yelling, cursing, physically treating residents rough (Staff A, personal care aide (PCA), and a staff making residents to go bed and calling the residents names (Staff B, medication aide/supervisor (MA/S).

The findings are:

1. Review of Resident #1's current FL2 dated 04/09/21 revealed:
-Diagnoses included mental retardation, hypertension, non-insulin dependent diabetes mellitus, corneal implant, psychiatric disorder, renal failure, hypothyroid, hyperlipidemia, and mood disorder.
-She was ambulatory with a walker.
-She required personal care assistance with bathing and dressing and incontinent of bladder and bowel.

Review of Resident #1's Care Plan dated 10/09/20 revealed:
-She required limited assistance with eating.
-She required extensive assistance with toileting, bathing, dressing and grooming.
-She required supervision with ambulation and transfers.

a. Telephone interview with Resident #1's Power of Attorney (POA) on 01/12/21 at 9:00am

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revealed:
-She was never notified about the scratching or having unexplained bruising.
-On 12/02/21, family visited Resident #1 and observed the resident was "very lethargic, almost comatose."
-She observed the resident had bruises on her arms and side.
-The bruises were "strange looking."
-The physical and occupational therapist at the hospital told her that Resident #1 specifically stated Staff A, personal care aide, threw her on the bed and was rough with her.
-The resident stated she was afraid of Staff A.
-Resident #1 told her that she did not want to ever go back to the facility because staff were not nice to her at the facility.

Interview with a Detective from the local police department on 01/14/22 at 10:15am revealed:
-He received a report from the hospital on 11/22/21 regarding Resident #1's unexplained bruising.
-Hospital staff reported to him that Resident #1 told them Staff A had thrown her on the bed and was mean to her.
-Staff A told him that Resident #1 did not get out of bed without assistance and the bruises were from scratch marks.
-Staff A denied being mean or rough with Resident #1.

Interview with adult protective services (APS) social worker on 01/12/22 at 9:50am revealed:
-When she visited Resident #1 on 12/10/21, the resident was alert and able to give clear responses.
-The resident told her that she (Resident #1) did not want to go back to the facility.
-The resident stated Staff A was an aide at the

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facility.
-Staff A "can be stressed, and if you cross the line with her, you better watch out."
-The resident stated she would not feel safe if she went back to the facility and did not want to go back to the facility.

Interview with a resident on 01/14/22 at 5:19pm revealed:
-The resident knew Resident #1.
-The resident had heard Resident #1 say to a staff they were hurting her.
-Whenever Staff A went into Resident #1's room, the resident heard Resident #1 scream "stop it you're hurting me."
-The resident had witnessed Staff A causing Resident #1 to cry out in pain on multiple occasions.
-The resident had observed Resident #1 in the floor on multiple occasions.
-Once, the resident heard Resident #1 screaming for help, and no staff came.
-Resident #1 was left on the toilet for 20-30 minutes, and no staff came to help.
-It was a long time before staff came to check on Resident #1.
-Resident #1 had "some really bad looking bruises on her neck."
-Resident #1 told the resident the bruising came from falls, but she did not think the bruising was from falls.
-The resident thought that Staff A caused the bruising because every time Staff A went in Resident #1's room, Resident #1 cried out in pain.
-On multiple occasions, Staff A removed the rocking chair out of Resident #1's room because Resident #1 used the chair to help get out of bed.
-Staff A would leave Resident #1 in the bed for "2 or 3 days" before checking on her again.

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-The resident had informed the Executive Director (ED) what was going on and how Staff A treated residents, but it kept happening.
-The "ED never does anything to help us any way."
-When Staff A helped the resident with applying an incontinent brief, Staff A would put it on too tight, which would cause her pain in her legs.
-The night prior (night of 01/13/22) the resident asked another staff to provide incontinence care, and Staff A said "kiss my [expletive]" and would not help the resident.
-Staff A cursed at residents "a lot."

Interview with a second resident on 01/14/22 at 4:32pm revealed:
-There were a couple of staff who did not check residents frequently for incontinence care.
-The staff moved too quickly, and hurt residents when providing incontinence care.
-Staff A was the main staff that was rough when providing incontinence care.
-The resident observed Staff A being very rough with Resident #1.
-Resident #1 told the resident that Staff A and another staff "yanked" Resident #1's legs around when getting her out of bed.
-The resident heard Resident #1 cry out in pain and Resident #1 told staff to "stop it, you're hurting me."
-The resident had witnessed staff being rough with Resident #1 while dressing her.
-Staff A was heard to say to Resident #1 "you can get out of bed yourself, just do it."
-The resident witnessed Staff A "yank" Resident #1 by the collar of the clothes, causing bruising in the past.
-The resident noticed extensive bruising on Resident #1, that "probably came from them yanking her around by the neck of her clothes, I

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have seen them do that a lot with her."
-The resident had not said anything to the ED because "it wouldn't have done no good."
-The ED was not told when there was a problem with staff because the ED "puts her staff above us and was always snippy when you ask for help."
-The residents "got no respect" at the facility.

Interview with a MA on 01/13/21 at 11:13pm revealed:
-She had seen multiples bruises on Resident #1.
-She thought the bruises on Resident #1 resulted from the PCAs rough handling the resident.
-She had not reported the bruises or her suspicion the bruises were from staff handling the resident roughly, to anyone.

Interview with Staff A on 01/13/22 at 3:34pm revealed:
-Once Resident #1 told her "they" were mean to me.
-She asked but Resident #1 would not say what staff was mean to her.
-She had never been mean or rough with Resident #1.
-She had worked at the facility four 4 years and she loved the residents.
-She believed in treating the residents the way she wanted to be treated.

b. Interview with a resident on 01/12/22 at 12:19pm revealed:
-Staff A "was not nice at all."
-Staff A would get in the resident's face and yelled calling the resident [expletive].
-When she was asleep Staff A would slap the resident in the face to wake the resident up.
-Sometimes Staff A pulled and shoved the resident.

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-Yesterday (01/11/22), at 8:00pm Staff A got in the resident's face called the resident a [expletive] and then said, "try me."
-If Staff A was mad, she sometimes did not provide snacks.
-When passing out snacks, Staff A would say to the residents "you get a snack, you get a snack, but you (meaning the resident) don't get a snack".

Interview with a second resident on 01/14/22 at 5:38pm revealed:
-Staff A was mean to the residents.
-When Staff A was asked to do things she would not help.
-Staff A was asked for help for another resident and Staff A would say "I am busy."

Interview with a third resident on 01/14/22 at 5:17pm revealed:
-The resident's one issue was with Staff A.
-Staff A was "rough as [expletive]," and caused bruises on the resident when she assisted with incontinence care.
-The resident pointed out three obvious visible bruises; two on the right arm and one on the left arm.
-The resident stated Staff A caused the bruises when providing incontinence care.

Interview with the Executive Director (ED) on 01/14/22 at 6:05pm revealed:
-A detective from the local police department came to the facility on 11/29/21, and told her Staff A was suspected of abusing Resident #1.
-She reported the information provided by the detective to the community liaison on 11/30/21.
-She did not do her own investigation regarding Staff A's abuse.

Telephone interview with the Administrator on

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D 338	Continued From page 73 01/19/21 at 2:58pm revealed: -He expected residents to be treated appropriately with respect. -Abuse of residents was not allowed. -Staff A was suspended after he was made aware on 01/14/22. 2. Interview with a resident on 01/14/22 at 4:56pm revealed: -The resident was afraid of Staff B (medication aide/supervisor (MA/S). -When Staff B worked, she made the residents go to bed at 11:00pm. -If the resident did not do what Staff B said, then she called the resident names like "stupid." -Staff B yelled at residents and call them all names. -When Staff B called the resident stupid, it made the resident angry at the way Staff B treated the resident, but did not say anything and went to bed. Interview with a second resident on 01/14/22 at 5:00pm revealed: -Staff B made the residents go to bed at 11:00pm each night. -The resident was not ready to go to bed at 11:00pm, but Staff B said that was the facility's rules. -If the resident did not do what Staff B said, then Staff B called the resident "stupid." -When Staff B called the resident stupid, it sometimes made the resident cry because the resident did not want to be treated that way. -The resident was a person just like everyone else and just because the resident lived in the facility did not make someone stupid. -The resident had not told the Executive Director (ED) because of being afraid.	D 338		

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D 338	Continued From page 74 Interview with a third resident on 01/14/22 at 5:02pm revealed: -Staff B made residents go to bed at 11:00pm each night. -The resident did not want to go to bed at 11:00pm, but did what Staff B said to do. -Staff B yelled and told the resident to get out of the other resident's room and to go to the resident's room. -The resident was afraid of Staff B and did what Staff B told the resident to do. Attempted telephone interview with Staff B on 01/18/22 was unsuccessful. Interview with the ED on 01/14/22 at 6:05pm revealed: -She did not tell staff, residents had to be in their rooms and in bed at a certain time. -She asked that residents keep the noise down after 11:00pm because other residents were trying to sleep. -She was not aware Staff B made residents go to their rooms and go to bed at a certain time. Telephone interview with the Administrator on 01/19/21 at 2:58pm revealed: -He expected residents to be treated appropriately with respect. -The residents were not children and there were no rules that residents had to be at a certain place at a certain time. _____ The facility failed to ensure the residents were free of verbal and physical abuse related to a staff (Staff A) yelling, and cursing at residents and physically rough with residents resulting in obvious bruises being left on residents, especially Resident #1; and a staff (Staff B) making residents go to their rooms and go to bed at a	D 338		

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D 338	Continued From page 75 specific time and calling the residents names resulting in the residents feeling hurt, crying, angry and afraid. This failure resulted in residents being physically and verbally abused and placed the residents at substantial risk for harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/14/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2022	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 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to administer medications and treatments as ordered for 1 of 5 sampled residents (#3) who had orders for foot soaks and lotion. The findings are: Review of Resident #3's current FL2 dated 11/03/21 revealed:	D 358		

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-Diagnoses included adult failure to thrive, paranoid schizophrenia, and type 2 diabetes.
-There was documentation that Resident #3 was able to verbally make her needs known.

Review of Resident #3's Care Plan dated 01/19/21 revealed she required extensive assistance with bathing and grooming.

Review of Resident #3's physician order dated 07/21/21 revealed there was an order to soak feet in soapy warm water for 10 minutes once a week.

Review of Resident #3's podiatry physician consultation report dated 07/30/21 revealed there was an order for diabetic lotion daily.

Review of Resident #3's November 2021 medication administration record (MAR) revealed:
-There was an entry to soak feet in soapy warm water for 10 minutes weekly on Thursdays at 8:00pm.
-There was documentation the foot soaks were completed on 11/05/21, 11/11/21, 11/18/21, and 11/25/21.
-There was an entry to apply a diabetic skin lotion to feet once daily at 8:00am.
-There was documentation the diabetic skin lotion had been applied daily at 8:00am from 11/01/21 through 11/30/21.

Review of Resident #3's December 2021 MAR revealed:
-There was an entry to soak feet in soapy warm water for 10 minutes weekly on Thursdays at 8:00pm.
-There was documentation that the foot soaks were completed on 12/03/21, 12/10/21, 12/17/21, 12/24/21 and 12/31/21.
-There was an entry to apply a diabetic skin lotion

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to feet once daily at 8:00am.
-There was documentation the diabetic skin lotion had been applied daily at 8:00am from 12/01/21 through 12/31/21.

Review of Resident #3's January 2022 MAR revealed:
-There was an entry to soak feet in soapy warm water for 10 minutes weekly on Thursdays at 8:00pm.
-There was documentation that the foot soak was completed on 01/06/22.
-There was an entry to apply a diabetic skin lotion to feet once daily at 8:00pm.
-There was documentation the diabetic skin lotion had been applied daily at 8:00pm from 01/01/22 through 01/12/22.

Review of Resident #3's podiatry note dated 12/21/21 revealed:
-The reason for the visit was problematic toenails with thickness and pain.
-The podiatrist noted poor pedal hygiene with no signs of an infection, and dirt and debris were noted to the plantar foot.
-All ten toenails were debrided and hyperkeratotic lesions (callouses) x2 were pared down.

Observation of medications on hand on 01/14/22 at 12:30pm revealed there was a pump-top container of over-the-counter diabetic skin lotion for Resident #3 with a dispensed date on 07/30/21.

Telephone interview with a representative from the facility's contracted pharmacy on 01/19/22 at 1:40pm revealed:
-The pharmacy last dispensed the diabetic skin lotion for Resident #3 on 07/30/21 and one container should have lasted around 30 days.

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BROOKSTONE HAVEN	501 POINTE SOUTH DRIVE RANDLEMAN, NC 27317

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-They had not received a refill request for the diabetic skin lotion since it was last dispensed on 07/30/21.

Observation of Resident #3 on 01/14/22 at 6:00pm revealed:
-Her toenails were thick but trimmed and did not appear overgrown or discolored.
-She had a large callous on the outer edge of her right great toe, and a smaller callous on the outer edge of her left great toe.
-There was no open skin or discoloration to her feet.

Interview with Resident #3 on 01/14/22 at 6:05pm revealed:
-Staff used to soak her feet more often but it had been a couple of months since her last foot soak.
-The medication aide (MA) provided nail care for her and appled lotion to her feet, but not as often as she would have liked; she could not remember when it was last done or how often it was done.
-She did not ask staff to do her foot soaks or apply lotion to her feet because she thought the staff were too busy.
-Staff had never told her that they were too busy to provide foot care to her.

Telephone interview with Resident #3's primary care provider (PCP) on 01/18/22 at 11:40am revealed:
-Resident #3 was able to ask for things she wanted or needed.
-She had ordered the weekly foot soaks and daily lotion for Resident #3 due to her having a large callous on her foot in April 2021.
-She had seen Resident #3 five days prior, but it was for an acute issue, so she did not look at her feet during that visit.
-Resident #3 had never reported to her that the

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foot soaks were not being done every week.
-Staff had never reported to her that they were not doing or unable to complete the ordered foot soaks and daily application of lotion.
-A possible implication for Resident #3's foot care not being done was that the callusing could worsen and require treatment from a podiatrist.

Telephone interview with an MA on 01/18/22 at 3:06pm revealed:
-She was familiar with Resident #3 and her foot care routine which was to soak her feet every week and apply lotion to them every day.
-She could not remember the exact date of the last time she had completed a foot soak for Resident #3 but thought it had been recent.

Telephone interview with another MA on 01/18/22 at 3:20pm revealed:
-She typically worked the second shift which was from 2:00pm to 10:00pm.
-She knew Resident #3 had orders to apply lotion to her feet every day and to soak her feet every Thursday night.
-If she was working with Resident #3 she never skipped doing her foot care.

Telephone interview with the Executive Director on 01/19/22 at 11:02am revealed:
-She was aware that Resident #3 had a foot care routine which included applying lotion to her feet daily.
-Resident #3 did not like to wear shoes and previously had a large callous to the bottom of her foot because of it.
-The facility had purchased and provided several different types of shoes and house slippers for Resident #3 to try to keep her feet covered.
-Resident #3 had been seen by the restorative foot care team to measure her for diabetic shoes,

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D 358	Continued From page 80 but she did not like to wear those shoes either. -Resident #3's feet had improved a lot compared to how they looked last year before the foot soaks and lotions were implemented. -Resident #3 was able to make her needs known and had never mentioned to her that her foot care was not being completed.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to submit a report of allegations of verbal and physical abuse by Staff A and Staff B and a resident with bruises of unknown origin to the Health Care Personnel Registry (HCPR) within 24 hours and complete a 5 day report after becoming aware of allegations that Staff A was physically abusive to a resident. The findings are: Review of Resident #1's current FL2 dated 04/09/21 revealed diagnoses included mental retardation, hypertension, non-insulin dependent diabetes mellitus, corneal implant, psychiatric disorder, renal failure, hypothyroid, hyperlipidemia, and mood disorder.	D 438		

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D 438	Continued From page 81 Observation on 01/12/21 at 9:40am of Resident #1's colored photos taken by the hospital staff and the resident's Power of Attorney (POA) on 12/02/21, and adult protective services (APS) social worker dated 12/03/21 revealed: -Based on the photos Resident #1 had multiple bruises that appeared to be scabbed over wounds on her upper chest area below the neck that extended from the right shoulder to the left shoulder. -According to the photos the resident had one vertical wound almost center the resident's chest that was scabbed over. -The the scab was very dark purple in color (almost black). -The photo showed the resident had multiple wounds that had very dark purplish scabs. -Some of the wounds were a deep reddish color. -There was a circular wound on the resident's upper left chest that was covered with a transparent bandage. -The wound was very dark purple and was visible through the bandage. -The resident had bruises that extended up the resident's neck that were a deep reddish color -There was a bruise on the resident's right elbow. -There were multiple bruises on the sides of the resident's right and left legs. -There were deep reddish colored bruises on the resident's forehead, temple of the head and center of the head near the back of her head. Telephone interview with Resident #1's POA on 01/12/21 at 9:00am revealed: -She was never notified about the scratching or having unexplained bruising. -On 12/02/21, family visited Resident #1 and observed the resident was "very lethargic, almost comatose." -She observed the resident had bruises on her	D 438		

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arms and on both sides of her body.
-The bruises were "strange looking."
-Resident #1 was hospitalized on 12/02/21, during the hospital visit the resident told the physical and occupational therapists at the hospital that Staff A, personal care aide (PCA) threw her on the bed and was physically rough with her.
-The resident stated she was afraid of Staff A.
-Resident #1 told her that she did not want to ever go back to the facility because staff were not nice to her at the facility.

Interview with a Detective from the local police department on
01/14/22 at 10:15am revealed:
-Hospital staff reported to him that Resident #1 told them Staff A had thrown her on the bed and was mean to her.
-During an interview with Staff A, she denied being mean or rough with Resident #1.

Interview with Staff A on 01/13/22 at 3:34pm revealed:
-She had never abused Resident #1 or any residents at the facility.
-She "loved the residents" and treated them the way she wanted to be treated.

Interview with the Executive Director (ED) on 01/14/22 at 6:17pm revealed:
-The detective from the local police department told her about the allegations against Staff A in November 2021.
-She did not contact the Health Care Personnel Registry (HCPR) and did not do an investigation.
-She was unable to tell why she did not report the allegations to the HCPR.
-She reported the allegations to the corporate community liaison on 11/30/21.

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D 438	Continued From page 83 Telephone interview with the Administrator on 01/19/21 at 2:58pm revealed: -Staff A and Staff B with allegations had been suspended from work. -The facility would report the staff to HCPR. -He expected residents to be treated appropriately with respect. -Staff A and Staff were suspended on 01/15/21 pending the facility's internal investigation. Based on observation, record review and attempted interview on 01/14/22 at 2:40pm, it was determined Resident #1 was not interviewable. [Refer To Tag 0338 10A NCAC 13F .0909 Residents Rights (TYPE A2 VIOLATION)] _____ The facility failed to investigate and report to HCPR an allegation of physical abuse related to Staff A who yelled and cursed at residents, treated residents mean and was physically abusive to residents when providing incontinence care and Staff B yelled at residents and called the residents names. This failure to report allegations of abuse to HCPR resulted in Staff A and Staff B continuing to work in the facility which placed the residents at substantial risk for harm and constitutes a Type A2 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 01/24/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2022.	D 438		

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D912	Continued From page 84	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 7 sampled residents (Residents #1 and #3) related to not notifying the primary care provider and mental health provider that a resident scratched, picked and picking skin "tags" causing extensive bleeding (#1) and following through with orders for physical/occupational therapy (#3). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912		
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.	D914		

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D914	Continued From page 85	D914		

This Rule is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, residents rights and health care personnel registry.

The findings are:

1. Based on observation, interviews and record reviews the facility failed to provide supervision for 2 of 7 sampled residents (Residents #1 and #13) with current symptoms of multiples falls that resulted in a resident who had a brain bleed, unexplained bruising to the neck, hip, right side, arms, right breast, head and continually scratched herself (#1) and a resident who had multiple falls causing injuries to the head, lacerations, scrapes and bruises to the hip, ankle, and face (#13). [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]

2. Based on observation, record review, and interviews the facility failed to ensure residents were free of verbal and physical abuse and treated with respect related to a staff yelling, cursing, physically treating residents rough (Staff A, personal care aide (PCA), and a staff making residents to go bed and calling the residents names (Staff B, medication aide/supervisor (MA/S). [Refer to Tag 0338 10A NCAC 13F .0909 Residents Rights (Type A2 Violation).]

3. Based on interviews and record reviews, the

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D914	Continued From page 86 facility failed to submit a report of allegations of verbal and physical abuse by Staff A and Staff B and a resident with bruises of unknown origin to the Health Care Personnel Registry (HCPR) within 24 hours and complete a 5 day report after becoming aware of allegations that Staff A was physically abusive to a resident. [Refer to Tag 0438 Health Care Personnel Registry (Type A2 Violation).]	D914		