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	HAL092142	A. BUILDING: _____ B. WING _____	04/14/2022

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FALLS RIVER VILLAGE ASSISTED LIVING COMMUNI	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 13 - 14, 2022.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1of 3 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -There was a position offer letter for the employee dated 08/19/21 -Staff A was hired on 08/19/21 as a Personal Care Aide. -There was no consent for a criminal background check. -The was no documentation for a criminal background check performed. Interview with Staff A on 04/14/22 at 11:51am revealed: -Staff A was rehired in September 2021 as a medication aide/personal care aide. -She assisted residents with meal service, bathing, grooming, dressing, and transferring. -She administered medications to residents. Interview with the Administrator on 04/14/22 at 4:35pm revealed:	D 139		

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D 139	Continued From page 1 -Staff A had been employed at the facility since 2021 but she did not remember the exact date. -The Business Office Manager (BOM) was responsible for new hire personnel records. Interview with the Business Office Manager (BOM) on 04/14/22 at 5:00pm revealed: -She was responsible for requesting a criminal background check for employees. -She had recently been hired as the BOM. -She started reviewing employee records at the end of March 2022. -She thought Staff A had a criminal background check completed upon hire. -There was a document in Staff A's personnel record from the company that performed criminal background checks for the facility staff. Interview with the BOM on 04/14/22 at 5:45pm revealed: -She checked Staff A's electronic record again on 04/14/12. -There was no criminal background check requested upon hire. -She requested the criminal background check be performed on 04/14/22.	D 139		
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:	D 270		

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D 270	Continued From page 2 TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 5 residents (#3) sampled with a recent history of a fall resulting in a fractured hip and subsequent falls with one resulting in a head injury with a scalp laceration. The findings are: Review of Resident #3's current FL-2 dated 03/07/22 revealed: -Diagnoses included a fractured part of the neck of the right femur, heart failure, coronary obstructive pulmonary disease and malignant neoplasm. -The resident was semi-ambulatory. Review of Resident #3's assessment and care plan dated 09/06/21 revealed: -The resident was sometimes disoriented and forgetful and needed reminders. -The resident had limited mobility and required an assistive device. -The resident required extensive staff assistance with toileting, bathing, dressing and limited staff assistance with grooming and transferring. Interview with Resident #3 on 04/13/22 at 9:57am revealed: -She had lived at the facility for approximately one year. -She had a lot of falls. -She had a fall last year and broke her hip. -She had 2 falls in the last week (week of 04/03/22) however, she did not get hurt except a cut on her head. -She had attempted to get up and use her walker independently without calling staff for assistance	D 270		

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when she had the two falls last week (week of 04/03/22).
-Staff at the facility had been instructing and encouraging her not to attempt to get up without assistance and to call for help prior to attempting to ambulate or transfer.
-During her last 2 falls she was using her walker and did not call for staff assistance because she thought she could make it a few feet in her room without falling.
-During both recent falls she was able to alert staff that she had fell by pressing her call button on a pendant she wore around her neck.
-After the last two falls, staff were placing her wheelchair and walker out of her sight and reach so that she would not attempt to ambulate without assistance.
-She thought not having the ambulatory devices near her would remind her to call for staff assistance.

Observation in Resident #3's room on 04/13/22 at 9:57am revealed the resident was lying in bed; the resident's wheelchair and walker were positioned near the room entrance door and not in reach of the resident.

Interview with the Administrator on 04/13/22 at 4:00pm revealed staff would not have been instructed to move the resident's mobility devices out of the residents' reach.

Telephone interview with Resident #3's hospice nurse on 04/14/22 at 4:22pm revealed:
-The resident was placed on hospice on 06/17/21.
-There was no documentation the resident had any falls prior to 11/13/21.

a. Review of an incident and accident report for

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Resident #3 dated 11/13/21 at 7:40pm revealed:
-The resident stated that she stepped on the oxygen code [sic] (cord).
-The description of the resident's injury was documented as "none for now".
-The resident was sent to the hospital.
-In the follow-up section there was an entry, the resident's family called and reported the resident broke her hip (no date and time documented).

Review of Resident #3's admission notes from a local hospital dated 11/13/21 revealed:
-The resident was brought into the emergency room (ER) for evaluation after a mechanical fall.
-The resident had complaints of severe right hip pain.
-The resident reported that she was using her rolling walker and when she tried to turn, she lost her balance and fell to the right side.
-The resident denied any symptoms prior to the fall.
-An x-ray of the right hip was suspicious for a fracture and an orthopedic surgeon had been notified.

Review of Resident #3's inpatient rehabilitation progress notes revealed the resident was admitted to rehabilitation on 11/19/21 after being hospitalized for a right hip fracture and hip surgery.

Review of Resident #3's progress note dated 12/15/21 at 1:00pm revealed the resident returned to the facility from rehabilitation today (12/15/21) and there were no complaints to note at that time.

Review of Resident #3's record revealed there was no documentation of fall interventions put in place when the resident returned to the facility on

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D 270	Continued From page 5 12/15/21. b. Review of Resident #3's progress note dated 12/18/21 at 2:30pm revealed: -The resident was found sitting on the floor. -The resident reported that she slid from her recliner, there were no injuries and hospice was notified. -There was no documentation of fall interventions put in place after the fall. Review of Resident #3's progress note dated 01/25/22 with a time documented as "7-3" revealed the resident left the facility today to have hip surgery. Interview with Resident #3's family member on 04/14/22 at 12:25pm revealed: -The resident had surgery in November 2021 due to a hip fracture from a fall and the fracture was repaired using a plate and screw at the fractured site, however the resident was having pain after the surgery and was not able to stand. -On a follow up appointment in January 2022 with the orthopedic provider, tests were completed that showed the resident's fractured area of her hip did not heal and was unstable; the resident underwent a total hip replacement in January 2022. Review of Resident #3's recertification for hospice signed by the hospice medical provider on 03/10/22 revealed: -The resident revoked hospice services in January 2022 after developing severe right hip pain, which was found to be related to nonunion of her previously fixed femoral neck. -A total hip replacement was offered, and the resident agreed to the procedure given the significant pain.	D 270		

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-The resident was found to have a new right foot drop on exam prior to the procedure.
-The resident was discharged to rehabilitation where she had several falls.
-Currently, the resident was mobilizing using a wheelchair, but was able to stand/pivot and walk a few steps.
-The resident was impulsive and would try to get up by herself.

c. Review of Resident #3's progress note dated 03/24/22 with a time documented as "3-11" revealed:
-The resident stated that she slid off the commode trying to place water down for the cat. The nurse was notified.
-There was no documentation of fall interventions put in place after the resident slid off the commode.

Telephone interview with Resident #3's hospice nurse on 04/14/22 at 4:22pm revealed there was no documentation hospice was notified when the resident fell on 03/24/22.

Interview with a Medication Aide/Personal Care Aide (MA/PCA) on 04/14/22 at 3:58pm revealed she wrote a note in Resident #3's record on 03/24/22 when she found the resident sitting on the bathroom floor beside the commode. She informed the Health and Wellness Director (HWD) and was instructed to perform a full body assessment and ask the resident if she had hit her head.

Interview with the Administrator on 04/14/22 at 4:59pm revealed:
-She was not aware Resident #3 had slid off the commode attempting to water the cat, if she had known she would have put interventions in place

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for the resident.
-There was no documentation of fall interventions for Resident #3 after the fall on 03/24/22.

d. Review of Resident #3's progress note dated 04/04/22 with a time documented as "3-11" revealed:
-The resident was still trying to go to the bathroom by herself without calling, the resident was doing fine and there were no complaints due to the fall today, (04/04/22) on day shift.
-There was no documentation of fall interventions put in place after the fall.

Telephone interview with Resident #3's hospice nurse on 04/14/22 at 4:22pm revealed:
-On 04/04/22, hospice was notified the resident had an unwitnessed fall and the resident had no injuries but was seen by the facility's primary care provider (PCP).
-She visited the resident on 04/04/22 and obtained information regarding the resident's unwitnessed fall.
-The resident got out of her recliner without asking for staff help, was ambulating using her walker and fell on her buttocks, then fell back and hit her head.
-The resident had a "goose egg" on her right posterior head but did not have any other injuries or bruising.

Review of the facility's 24-hour communication binder on 04/14/22 at 4:35pm revealed:
-On 04/04/22 day shift, there was documentation Resident #3 had a fall, her PCP and hospice provider was notified, and she was given PRN morphine for pain.
-On 04/04/22 evening shift, there was documentation Resident #3's "A1C" was checked due to a fall.

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-On 04/04/22 third shift, there was documentation Resident #3 was post fall.
-There was no documentation of fall interventions put in place after the resident's fall.

e. Review of Resident #3's progress note dated 04/08/22 with a time documented as "3-11p" revealed:
-The resident was found on the floor in her bedroom bleeding from the head area; emergency medical services (EMS) was called, and the resident was transferred to a local hospital.
-There was no documentation of fall interventions put in place after the fall.

Review of an incident and accident report for Resident #3 dated 04/08/22 at 9:50am revealed:
-The resident was observed on the floor in her bedroom, bleeding from her head area.
-EMS assessed the resident and the resident was sent to the emergency room (ER).
-In the follow-up section there was an entry the resident returned from the ER and was seen by hospice on 04/11/22; no new orders.
-The form was signed by a medication aide (MA) and the Administrator.

Review of an ER discharge visit note for Resident #3 dated 04/08/22 revealed:
-The resident was seen for a fall.
-There were instructions the resident was seen for a fall and head laceration and declined imaging that could rule out any neck fractures or bleeding from the brain.
-The resident's diagnoses included a closed head injury, fall from standing and a laceration of the occipital region of the scalp without complication.

Review of a 72-hour observation form for

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Resident #3 dated 04/09/22 revealed:
-There were instructions for staff to document their observation of the resident for 72 hours after the event/change of condition occurred.
-Documentation should include observations of the resident, all actions taken and the resident's actual statements of how they feel; include times if appropriate.
-There were no supervision instructions for the resident.
-There was no documentation of fall interventions put in place after the resident's fall.

Review of the facility's 24-hour communication binder on 04/14/22 at 4:35pm revealed:
-On 04/09/22 evening shift, there was documentation Resident #3 was post fall.
-There was no documentation of fall interventions put in place after the resident's fall.

Interview with Resident #3 on 04/14/22 at 3:59pm revealed:
-When she was in her room, staff checked on her first thing in the mornings but did not check on her unless she pressed her call button.
-She thought staff checked on her more often for a while after she had a fall but was not sure how often.
-If she needed staff assistance, she pressed her button on her pendant.

Interview with Resident #3's family member on 04/14/22 at 12:25pm revealed:
-She was not sure how often facility staff checked on the resident.
-The resident had a "ton of falls" at the facility.
-She knew staff instructed the resident not to get up without staff assistance.
-If the resident had her assistive devices in sight, the resident would attempt to get up.

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D 270	Continued From page 10 -The resident was very independent and determined. Interview with a Medication Aide/Personal Care Aide (MA/PCA) on 04/14/22 at 3:58pm revealed: -She assisted Resident #3 with toileting and dressing. -She considered Resident #3 as total care except feeding. -Resident #3 was a fall risk and staff had to "continually" check on Resident #3. -She found Resident #3 on the floor beside a chair in the resident's living room earlier this year. -When a resident had a fall, staff checked on the resident every 30 minutes for 72 hours. -Every 30-minute checks should be documented in the resident progress notes. -She had "not really" been given any other instructions on care to provide to Resident #3 after the resident had fallen except, she would tell Resident #3 to pull her pendant for assistance and not to go to the bathroom alone. -She checked on Resident #3 six to eight times during the shift when she worked. -She had never been told by her supervisor to check on a resident other than every 30 minutes for 72 hours after a fall. -It was the duty of everybody to check on the residents that need more assistance. Interview with a second MA on 04/14/22 at 5:58pm revealed: -She was aware Resident #3 had a history of falls and had fallen recently. -Residents were placed on 30-minute checks for 72-hours after there was an incident such as a fall. -She thought Resident #3 was placed on increased 30-minute checks for 72 hours after the resident fell.	D 270		

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-Residents were routinely checked on by staff every two hours.
-The resident's every 2-hour checks were not documented.
-When residents were on every 30-minute checks, staff documented the 30-minute checks on a monitoring form which was placed in the resident's record.

Interview with the Administrator on 04/14/22 at 4:59pm revealed:
-The facility had temporary service plans/72-hour reports that should have been implemented for Resident #3 after each fall.
-The 72-hour reports and temporary service plans were available so there were immediate fall interventions after a fall occurred; interventions should have been implemented for Resident #3.
-Resident #3's monitoring checks should have increased to every 30-minutes after the resident's falls and the 30-minute checks should have been documented by staff.
-She was unable to locate any additional information regarding interventions implemented for Resident #3's falls.
-Stand-up meetings were completed daily with staff Monday - Friday at 9:30am.
-The Health and Wellness Director (HWD) was responsible to bring the 24-hour report communication binder to each stand up meeting so that all resident incidences and concerns including falls were reviewed and discussed with staff during the meetings.
-She also asked staff about resident falls during the meetings.
-The HWD was responsible for initiating the temporary service plans/72-hour reports after a resident fell.
-Interventions should have been implemented after Resident #3 had falls in order to increase

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the resident's safety and to possibly prevent further falls.
-She would provide a copy of the 30-minute check monitoring forms used after a resident falls.

Telephone interview with Resident #3's hospice nurse on 04/14/22 at 4:22pm revealed:
-Resident #3 was at risk for falls.
-She expected increased frequency of monitoring by staff after the resident had sustained the falls; staff should check on the resident more often.
-The resident was at risk of serious injury from falls,
-It was important for the facility to put interventions in place after a fall to keep the resident safe.

Attempted interview with the HWD was unsuccessful prior to exit on 04/14/22 at 7:15pm.

At the time of exit on 04/14/22 at 7:15pm, the 30-minute monitoring forms were not provided for review.

_____

The facility failed to provide supervision for one resident with a recent history of a fall which resulted in a hip fracture and had 4 subsequent falls, one of which required an emergency room evaluation and resulted in a closed head injury and laceration of the scalp (#3). This failure resulted in substantial risk of serious injury from further falls and constitutes a Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/14/22 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14,

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D 270	Continued From page 13 2022.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of physician's orders for 1 of 5 residents (#4) regarding an order to check on the resident every thirty minutes for a 24-hour period. The findings are: Review of Resident #4's current FL-2 dated 02/24/22 revealed: -Diagnoses included dementia, cognitive impairment, and hearing impairment. -There was documentation the resident had intermittent disorientation. Review of Resident #4's mental health provider's note dated 04/12/22 revealed: -The resident had a history of passive suicidal ideations without prior attempts or plans. -There was an order to increase supervision for 30 minutes checks for 24 hours from 04/12/22 to 04/13/22. -It was faxed to the facility on 04/12/22 at 12:30pm.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092142	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE ASSISTED LIVING COMMUNI	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 276	Continued From page 14 Interview with Resident #4 on 04/13/22 at 9:49am revealed: -She did not know why she was moved from her home to the facility. -She did not want to stay at the facility. -She "did not want to live, period", and she "just wanted to die" because she could not go home. Interview with the Administrator on 04/13/22 at 12:05pm revealed: -Resident #4 frequently expressed suicidal thoughts to the staff and the mental health provider. -Resident #4 had not expressed a specific plan or made any attempts in the past. A second interview with the Administrator on 04/13/22 at 4:40pm revealed: -She was waiting for Resident #4's mental health provider to return her call regarding the resident statement of wanting to die. -Residents were routinely checked on every 2 hours unless there was an order or a concern to do otherwise. Interview with the Administrator on 04/14/22 at 1:47pm revealed: -She was not aware Resident #4 had orders for 30 minutes checks for a 24-hour period from 04/12/22 to 04/13/22 written and faxed to the facility on 04/12/22. Interview with Resident #4 on 04/14/22 at 10:00am revealed: -She did not need the staff to assist her with anything. -She did not know how often the staff came to her room to check on her. -The staff came to her room when it was time to	D 276		

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D 276	Continued From page 15	D 276		

go to the dining hall for meals and to give her medications.
-The staff did not come check on her if she did not go to the dining hall.

Interview with the Administrator on 04/14/22 at 1:47pm revealed:
-Faxed provider notes and orders were received at the medication room fax machine.
-The MAs were expected to make a copy of the notes or orders and give them to the HWD or place the orders in her box in the absence of the HWD.
-She did not know why a copy of the provider's order dated 04/12/22 was not placed in the HWD box to be reviewed.
-She expected the visiting provider to also notify her or the HWD of any changes in the resident's supervision needs before leaving the facility.
-The mental health provider did not notify her of the recommendation to increase Resident #4's checks to every 30 minutes for 24 hours on 04/12/22.

Interview with a MA on 04/14/22 at 1:33pm revealed:
-Visit notes and orders faxed to the facility from the mental health provider should be filed in the resident's record after they were reviewed by the HWD.
-In the absence of the HWD, the notes and orders should be given to the Administrator.
-She had no knowledge of the 04/12/22 orders to increase Resident #4's checks to every 30 minutes for a 24-hour period.
-There was no documentation in Resident #4's record that resident checks had been done every 30 minutes between 04/12/22 and 04/13/22.

Telephone interview with Resident #4's family

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	HAL092142	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE ASSISTED LIVING COMMUNI	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 276	Continued From page 16	D 276		

member on 04/14/22 at 2:46pm revealed:
-She was Resident #4's power of attorney.
-The resident frequently expressed she wanted to die or would commit suicide over the past 20-25 years.
-The resident had never expressed an actual plan to harm herself.
-She believed the resident's reports of suicidal ideations were a way of seeking attention.
-She was not aware of the mental health provider's visit and orders on 04/12/22.
-She did not know why the provider would have increased the resident's checks to every 30 minutes.

Interview with a second MA on 04/14/22 at 4:45 pm revealed:
-She worked second shift but was not working on 04/12/22.
-She had no knowledge of the 04/12/22 orders to increased Resident #4's checks to every 30 minutes for a 24-hour period.
-All new orders were documented in the facility's 24-hour communication binder for each shift.
-Faxed orders and physician notes were received via the fax machine in the medication room.
-The MAs were expected to provide a copy of received orders to the HWD or Administrator prior to filing them in the resident's record.

Review of the facility's 24-hour communication binder on 04/14/22 at 4:35pm revealed there was no documentation of increased checks every 30 minutes for a 24-hour period for Resident #4 from 04/12/22 through 04/14/22.

Review of Resident #4's mental health provider's note dated 04/14/22 revealed:
-She was informed by the facility that Resident #4's order for resident checks to be done every

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D 276	Continued From page 17 30 minutes for 24 hours from 04/12/22 was not seen by staff and was not implemented. Attempted telephone interview with Resident #4's mental health provider on 04/14/22 at 2:44pm was unsuccessful.	D 276		
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 personal care and supervision. The findings are: Based on interviews and record reviews, the facility failed to provide supervision for 1 of 5 residents (#3) sampled with a recent history of a fall resulting in a fractured hip and subsequent falls with one resulting in a head injury with a scalp laceration. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D912		