STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092217	A. BUILDING: _____ B. WING _____	R 06/10/2022

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MORNINGSIDE OF RALEIGH	801 DIXIE TRAIL RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted and annual and follow-up survey and complaint investigation on 06/07/22 - 06/10/22.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 4 exit doors that were accessible to a resident with known cognitive impairment and a recent history of elopement activated the sounding device that sounded when the exit doors were opened to alert staff for 1 of 6 sampled residents (#6) on the Assisted Living (AL) unit. The findings are: Observations of the exit doors on AL unit on	D 067		

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06/07/22 from 9:15am - 10:30am revealed:
-There were 4 exit doors located on the AL unit that each led into the stairway.
-There was 1 exit door that led from the AL unit, down 4 flights of stairs and to the outside of the facility.
-There were 2 of 4 exit doors on the AL unit that did not have the sounding device activated.

Review of Resident #6's current FI-2 dated 07/19/21 revealed:
-Diagnoses included left femur fracture, muscle weakness, hypertension (HTN), depressive disorder, hyperlipidemia, dementia, difficulty walking and allergic rhinitis.
-She was intermittently disoriented and was ambulatory.

Review of an incident report for Resident #6 dated 06/04/22 revealed:
-On 06/04/22 at 7:00pm, the medication aide (MA) responded to the alarming door on 200 hall and noted Resident #6 had walked down the stairs.
-The MA followed Resident #6 outside where she leaned against the building.
-Resident #6 voiced complaints of pain to her right knee with swelling noted.

Review of Resident #6's progress notes dated 06/04/22 revealed:
-Resident #6 was put to bed at approximately 7:30pm.
-Resident #6 changed out of her night clothes to a different set of clothes and went downstairs.
-The staff found Resident #6 standing outside against the wall.
-Resident #6 was brought back inside the facility and noted to have swelling to her right knee.
-Resident #6's primary care provider (PCP) and

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responsible party were notified.

Interview with the Executive Director (ED) on 06/07/22 at 10:25am revealed:
-The alarming devices were probably turned off by the Maintenance Department because their office was downstairs, and they walked between the floors throughout the day.
-There was one resident the facility was working on transferring to the Special Care Unit (SCU) due to confusion.
-The alarming devices on the exit doors of the AL unit should be activated at all times.

Second interview with the ED on 06/07/22 at 10:40am revealed that all alarming devices for the exit doors on the AL unit were activated.

Interview with the Maintenance Director on 06/07/22 at 11:05am revealed:
-The AL unit was not a secured unit and the exit doors were not locked.
-He disarmed the alarming devices on the AL unit when he arrived at the facility at approximately 7:30am and reactivated the alarming devices when he left the facility at approximately 5:00pm.
-His office was downstairs, below the AL unit, and he constantly walked between the floors and would disarm the sounding devices while he was working.
-The stairwell went into the Special Care Unit (SCU) downstairs and a code was needed to enter into the SCU.
-The stairwell did not lead to an outside entrance.

Interview with a medication aide (MA) on 06/08/22 at 7:46am revealed:
-Resident #6 had episodes of confusion and would forget where she was at times.
-Resident #6 had a history of frequent urinary

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tract infections (UTIs) that caused an increase in wandering behaviors and increased confusion.
-The exit doors on the AL unit were usually armed with the sounding devices for safety.
-It was the responsibility of the MAs to check the exit doors on the AL unit to ensure alarming devices were activated.

Interview with a second MA on 06/08/22 at 2:15pm revealed:
-Resident #6 had chronic UTIs that caused her to have wandering behaviors.
-Resident #6 did not normally go outside of the building but had hallucinations and would look for family members that were not there.
-There were at least 2 residents on the AL unit that exhibited exit seeking behaviors.

Interview with a third MA on 06/09/22 at 4:49pm revealed:
-Resident #6 was assisted from the dining to bed on 06/04/22 at approximately 7:00pm - 7:30pm.
-The personal care aide (PCA) completed a care round at approximately 8:00pm and noted Resident #6 not to be in her room.
-The PCA alerted the MA and they searched the AL unit for Resident #6.
-She went to one of the exit doors on the AL unit, walked down the 4 flights of stairs, and observed Resident #6 standing on the outside of the building next to the exit door.
-She assessed Resident #6 for injuries, with none noted, and assisted Resident #6 up the stairs back to the AL unit.
-She notified Resident #6's responsible party, the ED, the Resident Care Director (RCD), and Resident #6's primary care provider (PCP.)
-She did not hear the alarming device sound on the exit door on the AL unit and did not get an alert to her pager that the exit door was opened.

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D 067	Continued From page 4 Interview with a PCA on 06/10/22 at 6:20pm revealed: -On 06/04/22, she assisted Resident #6 with putting on her night clothes and getting into bed at approximately 7:00pm - 7:30pm. -She completed a care round at approximately 8:30pm and noted that Resident #6 was not in her room and that her night clothes were on the bed. -She alerted the MA on duty and they searched the AL unit for Resident #6. -She noted that Resident #6's wheelchair was located next to the exit door at the stairwell. -The PCA and MA went down the stairwell and located Resident #6 standing outside of the building beside of the door. -The PCA and MA assisted Resident #6 back inside of the building. -She did not hear the alarming device for the exit door sounding and did not get an alert to her pager that the door was opened. -The pagers alerted the staff when there was an opened exit door and when a resident used their call lights for assistance. -She did not check the exit doors prior to the shift on 06/04/22 because she did not have time. -It was the responsibility of the PCA and the MA to wear the pagers throughout their shifts to monitor call lights and exit doors. -It was the responsibility of the MA and PCA to check the exit doors door alarms at the beginning and end of their scheduled shifts. -She was not aware of any other residents on the AL unit with wandering behaviors. A second interview with the Maintenance Director on 06/10/22 at 9:55am revealed: -He was not at work when Resident #6 eloped from the facility on 06/04/22.	D 067		

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-On 06/04/22, he was contacted by another staff member that Resident #6 eloped and he provided them with instructions, via telephone, related to alarming sounding devices on the doors.
-He checked the alarming devices for exit doors on the AL unit daily.
-He was not aware that the alarming devices for the exit doors on the AL unit needed to be activated.
-He would deactivate the alarming devices during the day due to vendors having to frequently walk the stairwells.
-He would reactive the alarming devices at the end of his shift.

Interview with Resident #6's PCP on 06/09/22 at 12:05pm revealed:
-Resident #6 had symptomatic bradycardia (heart rate less than 60 beats per minute) that contributed to falls.
-It was hard to predict when Resident #6 would have a bradycardia episode and needed increased supervision by staff to ensure the resident's safety.

Based on observations, interviews and record review, it was determined Resident #6 was not interviewable.

Attempted telephone interview with Resident #6's responsible party on 06/10/22 at 10:30am was unsuccessful.

_____

The facility failed to ensure 2 of 4 exit doors on the Assisted Living (AL) Unit had alarming sounding devices activated with a resident who resided on the AL known to be disoriented, with a recent history of elopement from the facility without staff knowledge on 06/04/22 (Resident #6.) This failure resulted in substantial risk of

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D 067	Continued From page 6 serious neglect to Resident #6 and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/22. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 10, 2022.	D 067		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Review of Staff E's medication aide (MA) personnel record revealed: -Staff E was hired on 10/25/21. -There was no documentation a HCPR was completed prior to hire. Review of Staff E's HCPR check dated 06/10/22 revealed there were no substantiated findings.	D 137		

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D 137	Continued From page 7 Interview with the Business Office Manager (BOM) on 06/10/22 revealed: -It was her responsibility to ensure the HCPR was completed and there were no substantiated findings prior to hire. -She was not aware that Staff E's HCPR was not completed prior to this date. -She had audited employee's files approximately 2 - 3 months ago. Interview with the Executive Director (ED) on 06/10/22 at 12:13pm revealed: -It was the responsibility of the BOM to ensure that the HCPR was completed and there were no substantiated findings prior to hire. -It was the responsibility of the BOM to audit employee personnel records monthly to ensure all information was present and up to date. -It was the responsibility of the BOM to notify the ED if employee personnel records were out of compliance.	D 137		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the care plan assessor had signed the care plan upon completion for 5 of 6 sampled residents (#1, #2, #4, #5, #6). The findings are: 1. Review of Resident #6's current FL-2 dated 07/19/21 revealed:	D 262		

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-Diagnoses included left femur fracture, muscle weakness, hypertension (HTN), depressive disorder, hyperlipidemia, dementia, difficulty walking and allergic rhinitis.
-Resident #6 was documented as ambulatory with no assistive device needed.

Review of Resident #6's care plan revealed:
-The care plan was initiated on 08/13/20.
-On 04/26/22 there was documentation that Resident #6 used a walker to maximize independence with ambulation.
-There was no signature or date by the Assessor or the primary care provider (PCP.)

Refer to interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm.

Refer to telephone interview with the RCD on 06/10/22 at 6:07pm.

2. Review of Resident #1's current FL-2 dated 11/08/21 revealed:
-Diagnoses included dementia, history of a heart attack, urinary tract infections, and acute kidney failure.
-Resident #1 was documented as continent of bowel and bladder

Review of Resident #1's Resident Register revealed:
-He was admitted into the facility on 11/08/21.
-He sometimes required assistance with dressing, bathing, shaving, ambulation, toileting, feeding, and positioning.

Review of Resident #1's Care Plan revealed:
-The care plan was initiated on 11/09/21.
-There was no signature or date by the assessor or the PCP.

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D 262	Continued From page 9 Refer to interview with the Assistant RCD on 06/10/22 At 5:35pm. Refer to telephone interview with the RCD on 06/10/22 on 6:07pm. 3. Review of Resident #5's current FL-2 dated 01/04/22 revealed: -Diagnoses included acute delirium, hypothyroidism, essential hypertension, dementia, and acute hip pain. -She was not oriented to time or place, required limited assistance with bathing, and required supervision with dressing. -There was no documentation of her ambulation status. Review of Resident #5's Resident Register revealed: -She was admitted into the facility on 10/01/21. -She was forgetful and needed reminders. Review of Resident #5's Care Plan revealed: -The care plan was initiated on 10/01/21. -There was no signature or date by the assessor or the PCP. Refer to interview with the Assistant RCD on 06/10/22 At 5:35pm. Refer to telephone interview with the RCD on 06/10/22 on 6:07pm. 4. Review of Resident #2's current FL-2 dated 03/22/22 revealed diagnoses included dementia, gait dysfunction, chronic obstructive pulmonary disease, constipation, anemia and iron deficiency. Review of Resident #2's Care Plan revealed:	D 262		

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D 262	Continued From page 10 -As of 03/31/22, the resident was a moderate fall risk and required physical assistance with toileting, bathing, transfers and ambulation and continuous supervision during toileting. -As of 05/08/22, staff were to ensure the side rail was up when the resident was in bed. -As of 06/07/22, the resident had demonstrated safe use of the side rail for transfer out of bed or for bed mobility. -The service plan was not signed by the assessor and there was no date of the assessment. -The service plan was not signed by primary care provider (PCP). Refer to interview with the Assistant RCD on 06/10/22 at 5:35pm. Refer to telephone interview with the RCD on 06/10/22 at 6:07pm. 5. Review of Resident #4's current FL-2 dated 03/31/22 revealed diagnoses included dementia and acute psychosis. Review of Resident #4's Care Plan revealed: -As of 03/03/22, the resident had wandering and elopement behaviors. -As of 03/03/22, he was independent with toileting, bathing, transfers, ambulation and eating. -The service plan was not signed by the assessor and there was no date of the assessment. -The service plan was not signed by primary care provider (PCP). Refer to interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm. Refer to telephone interview with the RCD on 06/10/22 at 6:07pm.	D 262		

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D 262	Continued From page 11 Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm revealed the RCD was responsible for completing resident assessments and care plans. Telephone interview with the RCD on 06/10/22 at 6:07pm revealed: -She was responsible for completing resident assessments and care plans every 3 to 6 months. -She was new to the position and had not completed care plans on all residents as yet. -Care plans were signed by the primary care provider (PCP) and scanned into the electronic record. -She was certain there were completed and signed care plans for the sampled residents. -The care plans might have been completed by the previous RCD and not scanned into the residents' electronic record. Upon request on 06/07/22 and 06/08/22, signed care plans for Resident #1, #2, #4, #5 and #6 were not available for review.	D 262		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the	D 263		

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care plan.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure the resident's care plans were signed by their primary care provider (PCP) for 5 of 6 sampled residents (#1, #2, #4, #5, #6).

The findings are:

1. Review of Resident #6's current FL-2 dated 07/19/21 revealed:
-Diagnoses included left femur fracture, muscle weakness, hypertension (HTN), depressive disorder, hyperlipidemia, dementia, difficulty walking and allergic rhinitis.
-Resident #6 was documented as ambulatory with no assistive device needed.

Review of Resident #6's care plan revealed the care plan was initiated on 08/13/20 and not signed or dated by Resident #6's primary care provider (PCP.)

2. Review of Resident #1's current FL-2 dated 11/08/21 revealed:
-Diagnoses included Parkinson's disease, (A brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination.), dementia, history of a heart attack, urinary tract infections, and acute kidney failure.

Review of Resident #1's Resident Register revealed:
-He was admitted into the facility on 11/08/21.
-He sometimes required assistance with dressing, bathing, shaving, ambulation, toileting, feeding, and positioning.

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Review of Resident #1's Care Plan revealed:
-The care plan was initiated on 11/09/21 and was not signed by the resident's PCP.
-Diagnoses included Parkinson's disease, and unspecified dementia with behavioral disturbances.
-On 11/09/21, there was documentation the resident was a risk to wander or elope and required visual checks, hourly checks, and night checks, and required daily staff monitoring for fall risks.
-The resident used a wheelchair to maximize independence with ambulation, required stand-by assist and supervision for transferring on a regular basis, required assistance with bathing and toileting, and needed staff escort to meals.

Refer to interview with the Assistant RCD on 06/10/22 At 5:35pm.

Refer to telephone interview with the RCD on 06/10/22 on 6:07pm.

3. Review of Resident #5's current FL-2 dated 01/04/22 revealed:
-Diagnoses included acute delirium, hypothyroidism, essential hypertension, dementia, and acute hip pain.
-She was not oriented to time or place, required limited assistance with bathing, and required supervision with dressing.
-There was no documentation of her ambulation status.

Review of Resident #5's Resident Register revealed:
-She was admitted into the facility on 10/01/21.
-She was forgetful and needed reminders.

Review of Resident #5's Care Plan revealed:

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D 263	Continued From page 14 -The care plan was initiated on 10/01/21 and was not signed by the resident's PCP. -Diagnoses included unspecified dementia with behavioral disturbances, delirium due to an unknown physiological condition, hypothyroidism, and anemia. -On 10/01/21, there was documentation the resident was a risk to wander within the facility and required supervision and redirection. -On 12/28/21, there was documentation the resident was at a moderate or high risk for falls. -The resident was independent with transfers, and needed assistance with bathing, dressing, and grooming, and continuous supervision during toileting. Refer to interview with the Assistant RCD on 06/10/22 At 5:35pm. Refer to telephone interview with the RCD on 06/10/22 on 6:07pm. 4. Review of Resident #2's current FL-2 dated 03/22/22 revealed diagnoses included dementia, gait dysfunction, chronic obstructive pulmonary disease, constipation, anemia and iron deficiency. Review of Resident #2's Care Plan revealed: -As of 03/31/22, the resident was a moderate fall risk. -As of 05/08/22, staff were to ensure the side rail was up when the resident was in bed. -As of 06/07/22, the resident had demonstrated safe use of the side rail for transfer out of bed or for bed mobility. -As of 03/31/22, she required physical assistance with toileting, bathing, transfers and ambulation and continuous supervision during toileting. -The service plan was not signed by primary care provider (PCP).	D 263		

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D 263	Continued From page 15 Refer to interview with the Assistant RCD on 06/10/22 at 5:35pm. Refer to telephone interview with the RCD on 06/10/22 at 6:07pm. 5. Review of Resident #4's current FL-2 dated 03/31/22 revealed diagnoses included dementia and acute psychosis. Review of Resident #4's Care Plan revealed: -As of 03/03/22, the resident had wandering and elopement behaviors. -As of 03/03/22, he was independent with toileting, bathing, transfers, ambulation and eating. -The service plan was not signed by the primary care provider (PCP). Refer to interview with the Assistant RCD on 06/10/22 at 5:35pm. Refer to telephone interview with the RCD on 06/10/22 at 6:07pm. _____ Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm revealed the RCD was responsible for completing resident assessments and care plans. Telephone interview with the RCD on 06/10/22 at 6:07pm revealed: -She was responsible for completing resident assessments and care plans every 3 to 6 months. -She was new to the position and had not completed care plans on all residents as yet. -Care plans were signed by the primary care provider (PCP) and scanned into the electronic record.	D 263		

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D 263	Continued From page 16 -She was certain there were completed and signed care plans for the sampled residents. -The care plans might have been completed by the previous RCD and not scanned into the residents' electronic record. Upon request on 06/07/22 and 06/08/22, signed care plans for Resident #1, #2, #4, #5 and #6 were not available for review.	D 263		
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 eating assistance for 1 of 5 sampled residents (#4) with dementia who required prompting and cueing to be present for and eat meals. The findings are: Review of Resident #4's current FL-2 dated 03/31/22 revealed diagnoses included dementia and acute psychosis. Review of Resident #4's Care Plan revealed: -As of 03/03/22, the resident was independent with eating and only needed assistance with	D 269		

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setting up the meal.
-The care plan was not signed by the primary care provider (PCP).

Review of Resident #4's June 2022 Personal Care Record revealed:
-There was an entry for staff to escort the resident to all meals and to call the daughter with any care and/or meal refusals.
-There were no staff initials documenting the care was provided for first shift from 06/02/22 through 06/07/22 and 06/09/22.
-There were no staff initials documenting the care was provided for second shift on 06/04/22, 06/05/22 and 06/07/22.
-There were no staff initials documenting the care was provided for third shift from 06/01/22 through 06/09/22.

Review of Resident #4's progress notes revealed there were no entries dated after 04/02/22.

Observations of the breakfast meal on 06/08/22 from 7:36am until 8:31am revealed Resident #4 was not in the dining room for breakfast.

Observation of Resident #4 on 06/08/22 at 8:39am revealed the resident was asleep across his bed.

Interview with a personal care aide (PCA) on 06/08/22 at 8:39am revealed:
-Resident #4 was not at the breakfast meal that morning because he did not want to get up.
-Resident #4 was "hit or miss" for breakfast.
-Sometimes he slept all day and other times he went to the dining room late and the kitchen would fix him something to eat.

Observations on 06/10/22 from 8:55am until

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D 269	Continued From page 18 9:59am revealed: -Resident #4 was not in the dining room from 8:55am through 9:25am. -At 9:25am, Resident #4 was seen standing in the closet of his room. -At 9:42am, Resident #4 had gone into the hallway, looked around and went back into his room several times. -A female resident announced she saw Resident #4 all the time looking as if he was lost in the hallway. -The resident said Resident #4 never made it to breakfast that morning (06/10/22). -At 9:59am, the Assistant Resident Care Director (RCD) walked Resident #4 to the dining room because he was hungry and asked for ice cream. Telephone interview with Resident #4's family member on 06/09/22 at 12:45pm revealed: -She was concerned about the resident not eating. -She had spoken with the Executive Director (ED) and Resident Care Director (RCD) one month ago. -The ED and RCD said they would make sure the resident was up for and encouraged to eat meals. -She was not called when the resident did not get up for breakfast and/or lunch. -There was no plan to have food available for the resident at night when he was awake. -She often found uneaten meal trays in his room when she visited him at the facility. -She asked to have weekly weight monitoring but had not heard back from the ED or RCD. -Staff did not engage him in any activities including meals. -He spent most of his time in his room. Interview with a personal care aide (PCA) on 06/10/22 at 12:20pm revealed:	D 269		

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D 269	Continued From page 19 -Resident #4 needed staff to supervise meals and prompt him to stay focused on eating. -When Resident #4 did not get up for breakfast and lunch she was instructed to save his plate for him. Interview with the Executive Director (ED) on 06/09/22 at 4:03pm revealed: -Interventions had been put into place for Resident #4's eating. -If he refused to eat a meal staff were instructed to call his family member whose number was posted in his room. -Anytime Resident #4 did not get up to eat, staff called his family member. -Staff always had access to food for the resident. -She monitored staff compliance with providing personal care assistance for residents through documentation on activities of daily living (ADL) sheets and care plans. -She also did rounds throughout the building. -She was not able to say how often she observed staff providing assistance to residents. -Staff knew each resident's needs through report at shift change. Attempted interview with Resident #4's Primary Care Provider on 06/10/22 at 10:45am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 270		

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D 270	Continued From page 20 (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 6 sampled residents (#1, #2, #5) with a history of a falls resulting in unresponsiveness, facial fractures, hospitalization for 10 days and discharge to a skilled nursing facility (#5), 15 reported falls within 3 months related to increased behaviors and/or tremors (#1), and 4 falls within 3 months with no documentation of increased supervision(#2). The findings are: Review of the facility's fall assessment policy dated 12/01/02 revealed: -An episode where a resident lost his/her balance and would have fallen without staff intervention was considered a fall. -A fall without injury was still a fall. -When a resident was found on the floor, a fall was considered to have occurred. -Residents identified as a high risk for falls remained a fall risk for the duration of their stay in the facility unless their risk assessment score decreased, and they no longer met high risk criteria. 1. Review of Resident #5's current FL-2 dated 01/04/22 revealed: -Diagnoses included acute delirium, hypothyroidism, essential hypertension,	D 270		

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dementia, and acute hip pain.
-She was not oriented to time or place, required limited assistance with bathing, and required supervision with dressing.
-There was no documentation of her ambulation status.

Review of Resident #5's Resident Register revealed:
-She was admitted into the facility on 10/01/21.
-She was forgetful and needed reminders.

Review of Resident #5's Care Plan revealed:
-The care plan was not dated and was not signed by a licensed healthcare provider.
-Diagnoses included unspecified dementia with behavioral disturbances, delirium due to an unknown physiological condition, hypothyroidism, and anemia.
-As of 10/01/21, the resident was a fall risk.
-As of 12/28/21, the resident was at a moderate or high risk for falls.
-As of 02/07/22, the staff was reminded to keep the resident's room clutter-free and check resident for appropriate footwear and a fall mat at bedside when in bed.
-As of 04/04/22, the resident had wandering behaviors inside the community, may enter other resident's rooms, and required supervision and redirection.
- As of 04/04/22, the resident used a cane, walker or wheelchair without assistance, but needed occasional verbal cues or reminders
- As of 04/04/22, the resident required physical assistance with bathing, grooming, and dressing with frequent clothing changes and resident required continuous supervision with toileting.
-As of 04/04/22 and 04/26/22, the resident was moderately confused with unpredictable behaviors such as hitting, kicking, biting, and care

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refusals.
-As of 04/06/22, the resident used a cane, walker or wheelchair without assistance, but needed occasional verbal cues or reminders, required verbal cues/reminders to use the bathroom but was independent in toileting activities.

Review of Resident #5's Incident/Accident report dated 02/06/22 revealed:
-The resident was found on the floor in her room at 8:45am.
-The medication aide (MA) found the resident lying on her right side, and crying.
-The resident reported she fell and hit her head and it hurt.
-A visible knot was noted on the right side of her head and was bruised.
-The resident was assisted off the floor, dressed and transported to the hospital by emergency medical services (EMS).
-The resident's primary care provider (PCP) was notified at 10:05am on 02/06/22 and no new interventions or orders were documented.
-The resident's family member was notified on 02/06/22 at 9:05am.

Review of Resident #5's facility fax report form dated 03/09/22 revealed the resident was found on the floor in the day room and complained of right shoulder pain.

Review of Resident #5's Incident/Accident report dated 03/09/22 revealed:
-There was an unwitnessed fall and the resident was found in the hallway with a "goose egg" on her forehead at 3:10pm by the special care unit (SCU) Resident Care Director (RCD).
-The resident was transported to the hospital by EMS at 3:30pm.
-The resident's PCP was notified on 03/09/22.

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-The resident's family member was notified on 03/09/22 at 3:30pm.
-The resident was evaluated by her PCP on 03/10/22 with no new interventions or orders were documented.

Review of Resident #5's Incident/Accident report dated 03/15/22 revealed:
-There was a witnessed fall when the resident was about to stand up from the dinner table and fell on her bottom onto the floor at 4:30pm.
-The was no injury documented and resident was not taken to the hospital by EMS.
-The resident's PCP was notified on 03/15/22 at 6:00pm with no new interventions or orders were documented.

Review of Resident #5's Incident/Accident report dated 05/16/22 revealed:
-There was an unwitnessed fall and the resident was found face down on the floor in her room at 11:00pm by a personal care aide (PCA).
-The resident was bleeding from her face and head.
-The resident was transported to the hospital by EMS at 11:10pm.
-The resident's PCP was notified on 05/16/22 at 11:30pm.
-There was documentation the county adult home specialist (AHS) was notified on 05/17/22 at 11:19am.
-The resident's family member was notified on 05/16/22 at 11:19pm.
-There was no signature or title information for the staff that completed the report.

Review of an EMS patient care record dated 05/16/22 revealed:
-A call was received from the facility on 05/16/22 at 10:59pm requesting EMS services for a

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resident with a fall.
-EMS was dispatched to the facility at 11:00pm and arrived at the facility at 11:05pm and arrived at the resident's room at 11:08pm.
-The resident was found face down on the floor with a significant amount of blood on her face and the floor.
-She was unresponsive, clammy and pale, and in obvious stress.
-The staff reported the resident was normally alert, but disoriented due to her dementia.
-The staff reported they were not sure how long the resident may have been on the ground.
-The resident had a deformity to her nose, contusion to her forehead, left cheek, and mouth.
-There was significant bleeding from the nose.
-The resident's blood oxygen saturation was 80% at 11:19pm when the resident was placed into the ambulance. (A normal level of blood oxygen saturation is 95% or higher.)
-The resident's airway was suctioned and she required ventilation with oxygen via a bag valve mask due to shallow respirations. (A bag valve mask is used to deliver positive pressure ventilation to persons with insufficient or ineffective breaths.)
-The resident's lung sounds were clear and equal bilaterally in all fields.
-The resident's blood oxygen saturation improved to 95-98% in route to the hospital.

Interview with an EMS team member on 06/09/22 at 12:54pm revealed:
-She was dispatched to the facility on 05/16/22 at approximately 11:00pm as an advanced practice provider to assess if the resident required hospital care.
-The initial dispatch call did not specify the severity of the resident's injury.
-The other EMS members upgraded the

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resident's injuries to a higher level after they entered the resident's room.
-She did not go into the facility but prepared to drive the ambulance to the hospital.
-When the resident was placed in the back of the ambulance, she observed the resident was pale, and had shallow respirations.
-There was blood covering a large portion of the resident's face around her nose and mouth and a visible nose injury.
-The resident required two EMS members for care and oxygen with bag valve mask ventilation.

Interview with a second EMS team member on 06/10/22 at 10:04pm revealed:
-She was dispatched to the facility on 05/16/22 at approximately 11:00pm for a resident fall.
-The resident's room was on the bottom floor of the facility and required the EMS team to take an elevator down one floor.
-The resident's room was located toward the end of one of the hallways.
-There were 3 staff members standing down the hallway near the resident's room.
-There was a gurgling sound coming from the resident's room that could be heard about halfway down the hallway to the room.
-There was a double-sided dresser with a mirror and shelves between the door of the room and the resident's bed.
-The resident's bed was located on the far side of the room near the window.
-The resident was on the floor between her bed and the dresser.
-The resident was lying face down in a huge amount of blood and was making a gurgling sound while trying to breathe in the puddle of blood.
-The blood puddle size was approximately 2-3 inches from the outside diameter of the resident's

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head and facial area.
-The blood around the resident's nose and mouth was clotted with a paste like consistency.
-There were no staff members in the room with resident when EMS entered her room.
-The staff members in the hallway reported they did not know how long the resident had been on the floor.

Review of Resident #5's hospital record for 05/16/22 through 05/26/22 revealed:
-The resident was admitted through the emergency department on 05/16/22 for a fall with nasal bone and septal fractures, and other facial injuries, and altered mental status.
-The resident was admitted to the intensive care unit on 05/16/22 and required ventilation for respiratory support until 05/19/22.
-The resident required cardiology, neurology, urology, and trauma surgery consultations during her hospital stay from 05/16/22 to 05/26/22.
-The resident was transferred to an intermediate cardiovascular care unit on 05/19/22.
-The resident was discharged to a skilled nursing facility on 05/26/22.

Telephone interview with an intensive care unit nurse on 6/09/22 at 6:19pm was unsuccessful.

Interview with a medication (MA) on 06/09/22 at 9:25am revealed:
-Every time the resident was found on the floor it was treated as an unwitnessed fall.
-Each resident on the special care unit were supposed to be checked on at least every 2 hours.

Telephone interview with a PCA on 06/09/22 at 1:11pm revealed:
-He worked the third shift, 11:00pm to 7:00am, on

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D 270	Continued From page 27 05/16/22. -The second shift PCA reported to him that she had last checked on Resident #5 at approximately 10:30pm and she was in her bed. -He found the resident on the floor in her room between 10:50pm and 10:55pm at the beginning of his shift. -The resident's bed was located on the other side of the room from the entrance door. -There was a large piece of furniture between her bed and the door, it had a dresser and mirror on both sides to divide the room and be used by two separate residents if needed. -The resident's bed could not be fully seen from the door and he had to go in almost to the foot of her bed to check on her when she was in bed. -The resident was face down on her floor with a lot of blood around her head and upper body. -There was no fall mat on the floor beside the resident's bed. -The resident was wearing her incontinent brief, no other bottom covering, and no top covering. -The resident's bed sheet was tangled up around her lower legs. -The was dried blood on the resident's abdomen down to her brief waistline. -The outer edge of the blood puddle had a jelly consistency. -Checks of residents every two hours were not documented. Interview with a MA on 06/10/22 at 4:37pm revealed: -Resident #5 was checked on every 2 hours during second shift on 05/16/22. -She was called to the resident's room at around 10:45pm to 10:55pm by the third shift PCA. -The resident was face down on the floor and a small pool of blood was around here face and smeared on her abdominal area.	D 270		

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D 270	Continued From page 28 -EMS arrived and then took the resident to the hospital. -She notified the resident's PCP and POA shortly after EMS transported the resident to the hospital. -Resident #5 required assistance with transferring, changing briefs and toileting, and feeding. -All residents were supposed to be checked on every 2 hours by staff. -The 2-hour checks were not documented in the resident's chart. -She knew Resident #5 had multiple falls in the past. -The second shift PCA reported she checked on the residents at 10:30pm on 05/16/22. Interview the special care unit (SCU) Resident Care Director (RCD) on 06/10/22 at 12:43 revealed: -Resident #5 had previous falls and was considered a high fall risk. -The MA notified her at approximately 11:15pm on 05/16/22 about Resident #5's fall. -A PCA reported the resident was last check on between 10:30pm to 10:50pm by a second shift PCA. -The PCA reported the resident was found face down in a lot of blood. -Resident falls mostly happen on second shift but she did not know why. -Residents on the SCU were supposed to be checked on at least every 2 hours. -Resident checks were not always documented in the resident records. -There was no process in place to ensure staff were checking on residents every 2 hours or more often. -Residents were encouraged to stay in common areas, like the television room/day room for more supervision by staff.	D 270		

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D 270	Continued From page 29 Interview with Resident #5's PCP on 06/09/22 at 12:06pm revealed: -He assessed the resident only once before she was discharged from the facility. -Resident #5 had progressive dementia and an unsteady gait. -Staff routinely checked on residents every 2 hours. -Resident #5 required increased supervision. Telephone interview with Resident #5's family member on 06/09/22 at 6:13pm was unsuccessful. Based on record reviews and interviews, Resident #5 was not interviewable. 2. Review of Resident #1's current FL-2 dated 11/08/212 revealed: -Diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia, history of a heart attack, urinary tract infections, and acute kidney failure. -There was no documentation of his orientation status. -There was no documentation of his ambulation status. Review of Resident #1's Resident Register revealed: -He was admitted into the facility on 11/08/21. -He sometimes required assistance with dressing, bathing, shaving, ambulation, toileting, feeding, and positioning during Parkinson's episodes. Review of Resident #1's current licensed health	D 270		

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professional support (LHPS) evaluation dated 11/08/21 revealed:
-The resident required supervision with transfers and ambulation for safety.
-There was a recommendation for a sitter or discharge to a higher level of care.

Review of Resident #1's care plan revealed:
-The care plan was not dated and was not signed by licensed healthcare provider.
-Diagnoses included Parkinson's disease, and unspecified dementia with behavioral disturbances.
-As of 11/09/21, the resident was a fall risk, required staff to monitor for falls daily, and was a wander risk with a potential for unintended exit.
-As of 11/09/21, was the staff was reminded to keep the resident's room clutter-free and check resident for appropriate footwear and a fall mat at bedside when in bed.
-As of 12/08/21, the resident required continuous supervision during toileting.
-As of 12/28/21, the resident required visual checks, hourly checks, night checks, and additional safety monitoring.
-As of 02/22/22, the resident required physical assistance with bathing, dressing, grooming, and ambulation on a regular basis.
-As of 02/22/22, the resident was confused and had unpredictable behaviors.
-As of 04/12/22, the resident used had a fall mat in place at bedtime.
-As of 04/27/22, the resident was noted to put himself on the floor on the floor deliberately from both bed and chair and could stay on the fall mat if he resisted moving.

Review of Resident #1's progress note dated 03/09/22 at 2:03pm revealed:
-The resident was found on the floor on his right

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side in the day room.
-He complained of right should pain.

Review of Resident #1's progress note dated 03/10/22 at 2:55pm revealed:
-The resident was found on the floor no injuries noted.
-The resident reported he was trying to get something to eat.

Review of Resident #1's service note dated 03/21/22 at 1:04pm revealed the resident was found on the floor in his room with no injuries at 7:40am.

Review of Resident #1's service note dated 03/22/22 revealed:
-The resident was found on the floor in his room with no injuries.
-There was no time documented for this incident.

Review of Resident #1's record revealed there were no Incident/Accident reports for the falls documented on 03/09/22, 03/10/22, 03/21/22, and 03/22/22.

Review of Resident #1's Incident/Accident report dated 04/05/22 revealed:
-The resident had an unwitnessed fall and was found on the floor bedside his bed at 11:00pm.
-The resident had no injuries and was lifted off the floor and put back in bed.
-The resident's primary care provider (PCP) was notified, but no time was documented, and no new interventions or orders were documented.
-The resident's family member was notified at 11:45am on 04/05/22.

Review of Resident #1's Incident/Accident report dated 04/13/22 revealed:

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-The resident had an unwitnessed fall and was found on the floor, on his back near the foot of his bed, with his wheelchair turned over at 8:15am.
-The resident had no injuries and was assisted off the floor.
-The resident's PCP was notified at 11:10am on 04/13/22 and no new interventions or orders were documented.
-The resident's family member was notified at 11:13am on 04/13/22.

Review of Resident #1's Incident/Accident report dated 04/15/22 revealed:
-The resident was "ambulating with his feet" while sitting in his wheelchair and fell out of the wheelchair in the hallway at 12:15pm.
-The resident had no injuries and was assisted off the floor.
-The resident's PCP was notified at 12:40pm on 04/15/22 and no new interventions or orders were documented.
-The resident's family member was not notified at 12:30pm on 04/15/22.

Review of Resident #1's Incident/Accident report dated 04/24/22 revealed:
-The resident was found on the floor in his room at 10:00pm.
-The incident was described as the "resident slid from an armchair to the floor".
-The resident's PCP was notified at 10:00pm on 04/24/22 and no new interventions or orders were documented.
-The resident's family member was notified at 10:00pm on 04/24/22.

Review of Resident #1's Incident Report dated 05/04/22 revealed:
-The resident had an unwitnessed fall and was found sitting on the floor in his room at 8:00pm.

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-The resident had no injuries and was assisted off the floor and put in his wheelchair.
-The resident's PCP was notified at 10:00pm on 05/04/22 and no new interventions or orders were documented.
-The resident's family member was notified at 9:43pm on 05/04/22.

Review of Resident #1's Incident/Accident report dated 05/10/22 revealed:
-The resident was found on the floor, related to behaviors with three falls in his room and one fall in the day room, at 11:35am.
-The incident was described as the "resident placed himself on the floor x3. He walked to his room, [a] few minutes later he was found on the floor. He stated that he fell."
-The resident had redness on his right cheek area.
-The resident was assisted off the floor four times.
-The resident's family member was notified at 12:50pm on 05/10/22.
-The resident's PCP was notified at 1:00pm on 05/10/22 and no new interventions or orders were documented.

Review of Resident #1's Incident/Accident report dated 05/10/22 revealed:
-The resident was found on the floor at 1:15pm.
-The incident was described as the "resident placed himself on the floor and [was] stating he fell."
-The resident had redness on his right cheek area
-The resident was assisted off the floor four times.
-The resident's family member and PCP were notified on 05/10/22, the times were not documented, and no new interventions or orders

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were documented.

Review of Resident #1's Incident/Accident report dated 05/13/22 revealed:
-The resident had an unwitnessed fall in the dining room at 6:00pm.
-The incident was described as the "resident slid out of his wheelchair onto the floor."
-The resident had no injuries and was lifted off the floor and put back in his wheelchair.
-The resident's PCP and his family member were notified at 9:15pm on 05/13/22 and no new interventions or orders were documented.

Review of Resident #1's Incident/Accident report dated 05/26/22 revealed:
-The resident walked out of his room and fell in the hallway at 11:25pm.
-The resident had no injuries but was shaking excessively.
-The resident was given a medication for agitation, dressed and sat in the television room with the staff until he calmed down.
-The resident's family member was notified at 7:00am on 05/27/22.
-The resident's PCP was notified on 05/27/22, no time was documented, and no new interventions or orders were documented.

Review of Resident #1's Incident/Accident report dated 05/30/22 revealed:
-The resident was found on the floor in the day room on his right side at 1:50pm.
-The resident had an area of redness on the right side of his forehead.
-The resident was not taken to the hospital.
-The resident's family member was notified at 2:05pm on 05/30/22.
-The resident's PCP was notified, no date or time was documented, and no new interventions or

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orders were documented.

Review of Resident #1's Incident/Accident report dated 05/30/22 revealed:
-The resident had an unwitnessed fall and was found on the fall mat in his room at 10:25pm.
-The resident had no injuries.
-The resident's PCP was notified at 10:35pm on 05/30/22 and no new interventions or orders were documented.
-The resident's family member was notified at 10:39pm on 05/30/22.

Review of Resident #1's Incident/Accident report dated 06/02/22 revealed:
-The resident slid out of his chair in the day room at 10:25pm.
-The resident had no injuries.
-The resident's PCP was notified on 06/02/22, no time was documented, and no new interventions or orders were documented.
-The resident's family member was notified at 9:20am on 06/02/22.

Review of Resident #1's PCP progress note dated 01/06/22 revealed he had gait impairment, recurrent falling, and poor safety awareness.

Review of Resident #1's PCP progress note dated 03/10/22 revealed he had gait impairment, was quite debilitated, wheelchair bound, and had "another fall".

Review of Resident #1's activities of daily living (ADL) log implemented in June 2022 revealed:
-There was an entry for safety checks every hour for fall risk.
-There were no one hour checks documented as completed during 1st shift on 06/01/22, and 06/04/22 - 06/08/22.

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-There were no one hour checks documented as completed during 2nd shift on 06/02/22, and 06/09/22 - 06/10/22.
-There were no one hour checks documented as completed during 3rd shift on 06/01/22, 06/03/22 - 06/06/22, and 06/08/22 - 06/10/22.

Interview with Resident #1's family member on 06/09/22 at 4:48pm revealed:
-He had multiple falls at home due to his Parkinson's disease.
-The facility had reported he had falls, "real and staged" by the resident.
-The resident required with adequate supervision to prevent injuring himself with all falls, including "staged" falls.
-She was not sure how often the staff checked on the resident during each shift.
-The resident had a history of wandering from his home prior to moving into the facility.

Interview with a medication (MA) on 06/09/22 at 9:25am revealed:
-Resident #1 was frequently found on the floor with unwitnessed falls.
-The resident had behavioral episodes and would slide himself into the floor from his wheelchair or chair but would not have any injuries.
-The resident would have real falls when he had tremors.
-Every time the resident was found on the floor it was treated as an unwitnessed fall.
-Each resident on the special care unit was supposed to be checked on at least every 2 hours.

Interview the special care unit (SCU) Resident Care Director (RCD) on 06/10/22 at 12:43pm revealed:
-Resident #1 had previous falls and was

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considered a high fall risk.
-Residents on the SCU were supposed to be checked on at least every 2 hours.
-Resident checks were not always documented in the resident records.

Interview with Resident #1's PCP on 06/09/22 on 12:06pm revealed:
-The resident's falls were related to his progressive Parkinson's disease process and dementia.
-The resident had attention seeking behaviors and initially put himself on the floor.
-The resident required increased supervision with staff checking on him more often than every 2 hours.

Based on record reviews and interviews, Resident #1 was not interviewable.

3. Review of Resident #2's current FL-2 dated 03/22/22 revealed diagnoses included dementia, gait dysfunction, chronic obstructive pulmonary disease, constipation, anemia and iron deficiency.

Review of Resident #2's Care Plan revealed:
-As of 03/31/22, the resident was a moderate fall risk and required special services including safety checks, night checks and additional safety monitoring.
-As of 05/08/22, staff were to ensure the side rail was up when the resident was in bed.
-As of 06/07/22, the resident had demonstrated safe use of the side rail for transfer out of bed or for bed mobility.
-As of 03/31/22, she required physical assistance with toileting, bathing, transfers and ambulation and continuous supervision during toileting.
-There was no documentation of a fall mat.
-The service plan was not signed by the assessor

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and there was no date of the assessment.
-The service plan was not signed by primary care provider (PCP).

Review of Resident #2's June 2022 Care Record revealed:
-There were entries for every one hour checks, transfer assistance and ensure the side rail was up when the resident was in bed.
-There were no staff initials for first shift from 06/02/22 through 06/07/22 and 06/09/22.
-There were no staff initials for second shift on 06/04/22, 06/05/22 and 06/07/22.
-There were no staff initials for third shift from 06/01/22 through 06/09/22.
-There was no documentation of a fall mat.

Observation of Resident #2 on 6/07/22 at 10:10am revealed:
-Resident #2 was laying in the bed removing her shirt and adult brief while attempting to get out of the bed.
-Resident #2 stated that she had been trying to get out of bed for hours but no one would help her.
-There was a bed rail on the left side of the bed and the right side of the bed was pushed against the wall.

Observation of Resident #2 on 06/08/22 at 8:40am revealed:
-The resident was lying in bed on top of the body pillow with the side rail up.
-Her left leg was over the side of the bed and the lower end of the side rail.
-There was no fall mat on the floor next to the bed.

Interview with a personal care aide (PCA) on 06/09/22 at 12:22pm revealed:

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-Resident #2 was supposed to have a fall mat on the floor next to the bed when the resident was in the bed, but she had not seen it lately.
-She did not see Resident #2 lying in the bed with the side rail up and the floor mat under the bed yesterday morning (06/08/22).

Observation of Resident #2's room on 06/08/22 at 9:51am revealed:
-There was a fall mat on the floor underneath the resident's bed.
-Resident #2 was sitting in her wheelchair eating breakfast alone in her room.

Interview with a family member on 06/08/22 at 1:30pm revealed:
-Resident #2 had nightmares and frequently rolled out of the bed.
-The side rail, weighted body length pillows and floor mat were used for her safety.
-The resident also fell from her wheelchair when she tried to get up on her own alone in her room.
-The resident needed two people for assistance to transfer to and from her wheelchair to the toilet and her bed.
-Staff tried to keep the resident in the TV room in the front area but sometimes she did not want to be there.

Review of Resident #2's progress note dated 04/20/22 at 7:30am revealed:
-The resident had a non-injury fall.
-She was going to be seen by the PCP on the next facility visit.
-There was no documentation of interventions put in place to prevent falls.

Review of Resident #2's Accident/Incident report dated 04/20/22 at 7:30am revealed:
-The resident was found sitting on the floor in

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front her bed and did not have any injury.
-The resident's family member and PCP were notified.
-Every two hour checks were included as action taken by staff.

Review of Resident #2's Accident/Incident report dated 05/08/22 at 10:00am revealed:
-The resident was found on the floor in front of her bed holding her body pillow.
-She did not have any injury and the family member and PCP were notified.
-Every two hour checks were included as action taken by staff.

Review of Resident #2's progress note dated 05/28/22 at 9:30pm revealed:
-The resident was found sitting on the floor by her bed.
-She had no injury and the PCP was notified.
-There was no documentation of interventions put in place to prevent falls.

Review of Resident #2's Accident/Incident report dated 05/28/22 at 9:30pm revealed:
-The resident was found sitting on the floor by her bed without injury.
-The resident's family member and PCP were notified.
-There was no documentation of interventions put in place to prevent falls.

Review of Resident #2's Accident/Incident report dated 05/29/22 at 4:40pm revealed:
-The resident was found on the floor away from her bed with no clothes on.
-She did not have any injury and the family member and PCP were notified.
-There was no documentation of interventions put in place to prevent falls.

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D 270	Continued From page 41 Review of Resident #2's progress note dated 06/02/22 at 7:00am to 11:00pm revealed staff documented "extra, extra" rounds were made on Resident #2. Review of Resident #2's Accident/Incident report dated 06/04/22 at 9:30pm revealed: -The resident was found on the floor in her room. -She was lying on the floor of her room with her upper body in the hallway area and her lower body extending into the bathroom. -She did not have any injury and the family member and PCP were notified. -There was no documentation of interventions put in place to prevent falls. Interview with a medication aide (MA) on 06/10/22 at 11:27am revealed: -She was not sure what measures were put in place for Resident #2 after each fall in April and May 2022. -The resident had pillows on each side of her to keep her from coming out of the bed. Interview with a MA on 06/10/22 at 1:20pm revealed: -She wrote the resident service note dated 06/02/22 for Resident #2. -The resident "got herself on the floor a lot"; staff found the resident on the floor frequently. -"Extra, extra checks" meant staff rounded on the resident every one hour to one and a half hours when she was in her room. -Staff did not document rounds. -Staff tried to keep Resident #2 out in the common area as much as possible because of her falls. Interview with a PCA on 06/10/22 at 12:20pm	D 270		

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revealed staff rounded on residents every 2 hours; there were two residents on the AL side that needed hourly checks because they had increased urinary incontinence (Resident #2 was not one of the two named).

Interview with Resident #2's PCP on 06/09/22 at 12:06pm revealed:
-He or the physician's office staff were notified of each of Resident #2's falls.
-The staff usually faxed a notification to his office.
-Usually follow up for falls included a medication review and referral for physical and occupational therapy.
-He also evaluated the resident's injuries, hydration status, gait stability and cognitive status.
-He was new in his role as the facility's PCP and was still working with facility staff on the healthcare needs of residents.

Interview with the Assistant RCD on 06/10/22 at 5:35pm revealed:
-The side rail and fall mat were implemented when Resident #2 was in the special care unit (SCU) in March 2022.
-There were no additional interventions such as increased supervision checks implemented following the falls in April and May 2022.

Interview with the Executive Director (ED) on 06/09/22 at 4:03pm revealed:
-She monitored staff compliance in providing supervision for residents through documentation on activities of daily living (ADL) sheets and care plans.
-She also did rounds throughout the building.
-She was not able to say how often she observed staff supervising residents.
-Staff knew each resident's needs through report

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D 270	Continued From page 43 at shift change. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. _____ The facility failed to provide supervision for 3 residents with a history of a falls which resulted in one resident who sustained nasal bone and septal fractures, intensive care unit hospitalization and subsequent discharge to a skilled nursing facility for a higher level of care after a fall (#5), and multiple falls related to behaviors and tremors and bruising (#1, #2).This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/09/22. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 10, 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: Based on observations, interviews and record reviews, the facility failed to notify the primary care provider (PCP) on weight discrepancies within one month for 2 of 5 sampled residents (#2 and #4); decreased nutritional intake at breakfast and lunch meals and continued right arm pain for	D 273		

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Resident #2.

The findings are:

1. Review of Resident #4's current FL-2 dated 03/31/22 revealed diagnoses included dementia and acute psychosis.

Review of Resident #4's visit note by the facility's contracted provider dated 03/07/22 revealed:
-The resident had an outside primary care provider (PCP) according to the resident's family member.
-The family member wished to keep the facility's contracted provider for urgent matters.

Telephone interview with Resident #4's family member on 06/09/22 at 12:45pm revealed:
-The resident saw an outside provider for his primary care and the facility's contracted provider was for urgent healthcare needs.
-She took him to his PCP appointments.

Interview with the facility's contracted PCP on 06/09/22 at 12:06pm revealed:
-He had not seen Resident #4.
-He was not aware that his physician's service provided urgent healthcare needs for the resident.

a. Interview with Resident #4 on 06/07/22 at 9:30am revealed he was having right arm and shoulder pain for a week and had not told anyone about it.

Interview with a medication aide (MA) on 06/07/22 at 9:30am revealed:
-She was aware of Resident #4 having right arm and shoulder pain and already given him Tylenol.
-The resident had been having the pain off and

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on for a while; she could not remember how long.
-He saw a provider on 06/06/22 about the continued right arm and shoulder pain.

Telephone interview with Resident #4's family member on 06/09/22 at 12:45pm revealed:
-She did not know he was having continued right arm pain.
-She would have wanted to know so she could have told his PCP or made an appointment for him.

Review of Resident #4's facility contracted PCP visit notes revealed there was no documentation of a visit on 06/06/22.

Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm revealed:
-She first heard about Resident #4's continued right arm pain on 06/09/22.
-The RCD normally contacted the facility's contracted provider with resident concerns via an electronic system which the MAs did not have access to.
-The RCD may document contact with the provider through electronic notes which the MAs did not have access to.

Telephone interview with the RCD on 06/10/22 at 6:07pm revealed:
-She was sure Resident #4's PCP had been notified about the resident's continued right arm pain.
-There should have been a note documented in the resident's notes or a fax notification in the record.

Review of Resident #4's progress notes revealed there were no entries dated after 04/02/22.

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Review of Resident #4's record revealed there was no physician notification regarding the resident's continued right arm and shoulder pain.

Upon request on 06/07/22 and 06/08/22, Resident #4's electronic progress notes were not available for review.

b. Telephone interview with Resident #4's family member on 06/09/22 at 12:45pm revealed:
-She was concerned about the resident not eating.
-She had spoken with the Executive Director (ED) and RCD one month ago.
-She asked to have weekly weight monitoring but had not heard back from the ED or RCD.

Review of Resident #4's New Resident Admit Note dated 03/02/22 revealed the resident weighed 148.6 pounds.

Review of Resident #4's licensed health professional support (LHPS) evaluation dated 03/02/22 the resident's weight was 167.0 pounds.

Review of Resident #4's LHPS evaluation dated 06/02/22 the resident's weight was 136.1 pounds and there were no recommendations.

Review of Resident #4's weight and vital signs summary dated 06/10/22 revealed the following weights: on 05/10/22 141 pounds, on 05/17/22 140.8 pounds, on 05/23/22 138 pounds, on 05/30/22 136.1 pounds and on 06/09/22 140.8 pounds.

Observation of Resident #4's weight on 06/09/22 at 1:11pm revealed he weighed 141.8 pounds on the electronic chair scale.

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D 273	Continued From page 47 Interview with a MA on 06/10/22 at 1:20pm revealed: -She was able to see the resident's previous weight and if there were changes in his weight, she reported it to the facility's contracted provider when they were in the facility on Mondays and Thursdays. -She weighed Resident #4 in May 2022 and he weighed 143 pounds. -She did not know why the weight was not documented on the resident medication administration record (MAR) or the sheet at the front of the book. -She did not think Resident #4 had not a significant weight change to report to the PCP. Interview with the Assistant RCD on 06/10/22 at 5:35pm revealed: -She was not aware of the 18 pound discrepancy between the admission note and LHPS evaluation both completed on 03/02/22 for Resident #4; and the recorded weight of 136.1 pounds documented on the LHPS evaluation dated 06/02/22 (a 19% weight loss). -There was no process for MAs to report weights; resident weights were documented on the MAR and that was it. -Prior to 06/07/22, resident weights had not been reviewed. -If she had been aware of Resident #4's weights, she would have checked the chair scale for accuracy and reweighed the resident. Interview with the Assistant RCD on 06/10/22 at 5:35pm revealed: -Staff reported resident concerns to her or the RCD and they contacted the facility's contracted provider. -She did not know Resident #4's PCP was an outside provider.	D 273		

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-Normally the family member let her know if the resident's PCP was other than the facility's contracted provider and she placed a note in the front of the chart and a sheet in front of the MAR.

Telephone interview with the RCD on 06/10/22 at 6:07pm revealed:
-She did not know if residents' weights were reviewed prior to June 2022.
-She did not know if the weight discrepancies for Resident #4 had been reported to the PCP.
-She was sure Resident #4's PCP had been notified about the resident's not being awake for breakfast and lunch meals frequently due to not sleeping at night.
-There should have been a note documented in the resident's notes or a fax notification in the record.

Review of Resident #4's progress notes revealed there were no entries dated after 04/02/22.

Review of Resident #4's record revealed there was no physician notification regarding the resident not being awake for breakfast and lunch meals frequently due to not sleeping at night.

Upon request on 06/07/22 and 06/08/22, Resident #4's electronic progress notes were not available for review.

Attempted interview with Resident #4's Primary Care Provider on 06/10/22 at 10:45am was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview with a personal care aide

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(PCA) on 06/09/22 at 1:08pm.

Refer to interview with a medication aide (MA) on 06/10/22 at 12:15pm.

Refer to interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm.

Refer to telephone interview with the RCD on 06/10/22 at 6:07pm.

2. Review of Resident #2's current FL-2 dated 03/22/22 revealed diagnoses included dementia, gait dysfunction, chronic obstructive pulmonary disease, constipation, anemia and iron deficiency.

Review of Resident #2's weights and vital signs summary dated 06/07/22 revealed:
-Weight result of 108.2 pounds on 04/15/22 and 143 pounds on 05/15/22.
-There were no further results documented.

Review of Resident #2's resident progress dated 04/02/22 through 06/02/22 revealed there was no documentation the resident's primary care provider (PCP) was notified the resident had a 35 pound weight change in one month (a 25% weight gain).

Interview with a medication aide (MA) on 06/10/22 at 1:20pm revealed Resident #2 was weighed by second shift staff because the resident was uncooperative.

Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm revealed she was not aware of the 35 pound weight discrepancy from 04/15/22 to 05/15/22 for Resident #2.

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D 273	Continued From page 50 Interview with the RCD on 06/10/22 at 10:59am revealed: -In response to request for an observation of Resident #2's weight, she had asked the staff to obtain a weight for the resident on 06/10/22. -There were 3 scales in the facility; a standard chair scale, an electronic chair scale and a wheelchair accessible scale. Interview with the RCD on 06/10/22 at 1:02pm revealed she weighed Resident #2 after lunch, and her weight was 110.6 pounds in the electronic chair scale. Attempted interview with Resident #2's PCP on 06/10/22 at 5:19pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to interview with a personal care aide (PCA) on 06/09/22 at 1:08pm. Refer to interview with a medication aide (MA) on 06/10/22 at 12:15pm. Refer to interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm. Refer to telephone interview with the RCD on 06/10/22 at 6:07pm. _____ Interview with a personal care aide (PCA) on 06/09/22 at 1:08pm revealed: -PCAs weighed residents the first of every month. -PCAs documented resident weights on a weight and vital signs sheet that was given to the medication aide (MA) on duty. -The MA kept the documented weights in the	D 273		

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D 273	Continued From page 51 front of the binder on the medication cart. Interview with a medication aide (MA) on 06/10/22 at 12:15pm revealed: -MAs were able to see a previous weight done on a resident. -MAs gave recorded weights to the Resident Care Director (RCD) or the Assistant RCD. -The RCD or Assistant RCD reviewed any weight changes and followed up with the resident's PCP. Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm revealed: -Residents were first re-weighed for any weight changes or weight discrepancies. -If a true weight change was identified, then she contacted the PCP. -There was no current system of staff reporting weights and either her or the RCD monitoring for changes. Telephone interview with the RCD on 06/10/22 at 6:07pm revealed: -Either she, the Assistant RCD or SCU RCD notified the PCP and documented the contact in progress notes or by copy of faxed notifications. -Weights and vital signs were documented in the book by PCAs and MAs. -The book was not reviewed until last month and she did not know if the PCP was aware of any weight discrepancies.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas	D 282		

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D 282	Continued From page 52 shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the ice machine, kitchen counter surfaces, beverage dispensers, food carts and cup trays were clean and free of contamination. The findings are: Observations of the kitchen on 06/08/22 at 7:30am revealed: -There was a white and brown substance build up on both sides of the inner rear groove for the lid slide on the ice machine. -There were drip marks of various colors of white, tan and brown on the front and side exterior of the ice machine. -There was a heavy buildup of dust on the vent cover and between a piece of loose plastic trim on the front of the ice machine. -There were spots of white, tan and brown on the sides of the food and beverage cart. -There was heavy dust build up on the grill of the drink dispenser tray. -There were numerous brownish splash and drip marks around the inside of the condiment dispenser. -There was a large brown stain on the counter between the beverage dispenser and the condiment dispenser. -There was dried brown stains on the clean cup tray. Interview with a dietary aide (DA) on 06/09/22 at 11:44am revealed:	D 282		

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D 282	Continued From page 53 -All kitchen staff were responsible for cleaning the kitchen daily after serving each meal. -Cleaning included wiping down surfaces, trays, carts and cleaning the floor. -The beverage and condiment dispensers were cleaned daily. -There was no cleaning schedule. Observations of the kitchen on 06/09/22 at 11:57am revealed: -There was a white and brown substance build up on both sides of the inner rear groove for the lid slide on the ice machine. -There were drip marks of various colors of white, tan and brown on the front and side exterior of the ice machine. -There was a heavy buildup of dust on the vent cover and between a piece of loose plastic trim on the front of the ice machine. -There were spots of white, tan and brown on the sides of the food and beverage cart. -There was heavy dust build up on the grill of the drink dispenser tray. -There were numerous brownish splash and drip marks around the inside of the condiment dispenser. -There was a large brown stain on the counter between the beverage dispenser and the condiment dispenser. Observation of the ice machine cleaning log on 06/09/22 at 1:24pm revealed: -The log was posted on the side of the ice machine and had columns for date, staff initials and comments. -There was documentation the ice machine was cleaned on 11/03/21, 12/03/21, 12/09/21, 02/15/22 and 05/02/22. Interview with the Food Service Director (FSD) on	D 282		

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D 282	Continued From page 54 06/09/22 at 11:57am revealed: -He cleaned the exterior areas of the ice machine monthly. -The ice machine was due to be cleaned according to the log on the side of the machine. -There was a contracted vendor that drained and cleaned the inside of the ice machine. -DAs cleaned the beverage dispenser, counter tops and condiment dispenser every week. -The buildup of stains on the drink and condiment dispenser may look like a build of weeks or months but there was a lot of splash back when they were used. -There was no regular or deep cleaning schedule for the kitchen. Interview with the Executive Director (ED) on 06/09/22 at 1:30pm revealed: -The FSD was responsible for the cleaning schedule in the kitchen. -She did random walk throughs of the kitchen to ensure cleanliness and compliance with proper preparation and storage of food. -She recently completed a walk through to specifically to check food containers were labeled and dated in the refrigerator. -She did not remember when she did the last walk through of the kitchen.	D 282		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA	D 307		

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diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure there were signed primary care provider (PCP) orders for therapeutic diets and nectar thickened liquids for 2 of 2 sampled residents (#9 and #10) receiving therapeutic diets.

The findings are:

1. Review of Resident #9's current FL-2 dated 02/17/22 revealed:
-Diagnoses included dementia.
-There was no diet order.

Review of Resident #9's Order Summary Report dated 06/08/22 revealed:
-There was an order for a mechanical soft texture diet and nectar consistency liquids.
-There was no primary care provider (PCP) signature on the report.

Observation of the breakfast meal on 06/08/22 from 8:25am until 8:55am revealed:
-Resident #9 was served finely chopped sausage patty, scrambled eggs, grits and toast at 8:25am.
-She had premixed nectar thickened lemon water and apple juice.
-She ate and drank 100% and finished her meal independently at 8:55am.

Upon request on 06/07/22 and 06/08/22, a signed PCP order for nectar thickened liquids for Resident #9 was not available for review.

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D 307	Continued From page 56 Attempted interview with Resident #9's Primary Care Provider on 06/10/22 at 5:19pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #9 was not interviewable. Refer to interview with the Food Service Director (FSD) on 06/09/22 at 1:20pm. Refer to interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm. Refer to Telephone interview with the RCD on 06/10/22 at 6:07pm. 2. Review of Resident #10's current FL-2 dated 02/22/21 revealed: -Diagnoses included atrial fibrillation, dementia, muscle weakness and pneumonia. -There was an order for a regular diet. Review of Resident #10's Order Summary Report dated 06/08/22 revealed: -There was an order for a pureed texture diet and nectar consistency liquids. -There was no primary care provider (PCP) signature on the report. Observation of the breakfast meal on 06/08/22 from 8:25am until 8:55am revealed: -Resident #10 was served a pureed plate of sausage patty, scrambled eggs and grits at 8:25am. -She had premixed nectar thickened lemon water and apple juice. -She ate 96% of her food, drank half the water and all the apple juice finishing her meal at	D 307		

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D 307	Continued From page 57 9:00am. Upon request on 06/07/22 and 06/08/22, a signed PCP order for a pureed diet and nectar thickened liquids for Resident #10 was not available for review. Attempted interview with Resident #10's Primary Care Provider on 06/10/22 at 5:19pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #10 was not interviewable. Refer to interview with the Food Service Director (FSD) on 06/09/22 at 1:20pm. Refer to interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm. Refer to Telephone interview with the RCD on 06/10/22 at 6:07pm. _____ Interview with the Food Service Director (FSD) on 06/09/22 at 1:20pm revealed: -The official diet list was kept in a binder in his office. -The list was provided by the Resident Care Director (RCD) and updated when there were changes and new residents. -There was a cheat sheet of therapeutic diets posted at the warming table which included how many finger food, mechanical soft and pureed plates and thickened liquid beverages were needed for the assisted living (AL) side and special care unit (SCU). Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 5:35pm revealed:	D 307		

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D 307	Continued From page 58 -The RCD was responsible for diet orders. -Diet orders were entered into the electronic record system, printed and then signed by the PCP. Telephone interview with the RCD on 06/10/22 at 6:07pm revealed: -The original signed dietary orders for Resident #9 and Resident #10 were before she started working at the facility in March 2022 and she was not able to locate them. -She added new and changed diet orders to the electronic record and printed the diet order on the Order Summary Report for the PCP to sign. -The signed dietary order was then scanned into the electronic record. -She had not done new or changed diet orders for Resident #9 or Resident #10.	D 307		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure residents received appropriate care and services and reasonable responses to requests for personal care assistance and supervision needs by staff that were present and able to provide care. The findings are:	D 338		

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D 338	Continued From page 59 Review of the facility's census report dated 06/07/22 revealed: -There were 26 residents on the special care unit (SCU). -There were 43 residents on the assisted living (AL) side. a. Observation of SCU on 06/10/22 at 9:57am to 11:57am revealed: -At 10:16am, a male resident, a new admission within the prior 24 hours, exited the dining room and day room area, and walked toward the resident rooms hallway. -He walked with a slow shuffling gait and hand tremors. -He turned to his right from the hallway dining/day room hallway. -At 10:20am, the resident walked up to the laundry staff outside of another resident's room, the second door on the right after the double fire door hallway threshold. -The resident did not know where his room was located. -The laundry staff asked the resident to have a seat on a bench located approximately 30 feet behind him and adjacent to the end of the hallway leading to the dining/day room. -The resident turned and walked back toward the bench on the resident's right side of the hallway. -At 10:22am and approximately 14 feet from the laundry staff, the resident lost his balance, attempted to catch himself on the arm rail with his right hand but was unsuccessful. -The resident fell forward onto the arm rail, hitting the right side of his forehead on the railing, then falling onto the floor with a slight roll onto his left side, and rested on his back. -There were no personal care assistants (PCAs) or medication aide (MA) in the hallway at the time of the resident's fall.	D 338		

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-This surveyor left the area to find a staff member to assist the resident while the laundry staff stayed at the resident's side.
-A PCA was in the dining room adjusting her hair in the mirror over the fireplace and was notified of the resident's fall.
-The PCA went to the resident, instructed him to not move and requested the laundry staff to retrieve the MA from the nurses' station.
-The MA arrived at the resident, checked his vital signs and then requested emergency medical services (EMS) to be called.
-The facility phones were down at the time staff attempted to call EMS and the special care unit (SCU) Resident Care Director's (RCD) cell phone was used to call EMS at 10:38am.
-EMS arrived at the facility to assume care of the resident at 10:48am and was transported to the hospital.

Interview with SCU RCD on 06/10/22 at 12:43pm revealed:
-Sometime the layout of the facility interferes with staff observation of the residents.
-Staff frequently leave the floor or were not where they were expected to be when they were on the floor.
-Staff location and supervision concerns were reported to the Administrator in the past 1-2 months but has not followed up since that time.

b. Interview with a resident on 06/07/22 at 9:36am revealed:
-She thought the facility did not have enough staff and the staff that worked at the facility worked 16 hour days for 6-8 days in a row.
-She thought staffing was the worst on the weekends when there was sometimes one personal care aide (PCA) for the assisted living

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(AL) unit.
-There were 12 new residents admitted to the AL unit in the last one to two months and most of the new residents were physically and/or cognitively impaired and needed more assistance from staff.
-The medication aides (MAs) and PCAs were tired and not responding to residents needs and requests for assistance because they were tired.
-Some staff were grumpy, tired and did not speak respectfully to residents.
-Staff were frazzled, overworked and spoke of quitting their jobs at the facility in the presence of residents.
-She did not want to name any of the staff.
-Staff frequently did not respond to bathroom call lights for more than 20 minutes.
-Staff would say the call light was not working and the staff did not receive the call light signal on their pager.
-Staff would also say they were busy helping other residents and could not respond sooner.
-She was concerned the delayed response especially to bathroom call lights, delayed assistance to residents that could have fallen in the bathroom.

Observation of a bathroom call light signal on 06/07/22 from 9:47am until 10:05am revealed:
-At 9:47am the bathroom call light was activated and showed a red light.
-At 10:05am, a PCA stood at the door not entering the room and asked the resident if they needed help.
-The resident had to ask the PCA to de-activate the call light in the bathroom before she left the room.

Telephone interview with an outside provider on 06/08/22 at 1:03pm revealed:
-She thought the facility was short of staff on all

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shifts "all the time".
-There were times when there was one MA and one PCA for the entire facility.
-She could not remember specific dates.
-A resident fell in the special care unit (SCU) within the last month and laid on the floor for hours before staff found her.
-She did not know the name of the resident.
-Residents were frequently saturated with urine and soiled with feces at the start of the first shift (7:00am).
-Third shift staff were seen sleeping at 6:30am.
-First shift housekeepers were frequently pulled from housekeeping duties to perform PCA duties when there were not enough PCAs and MAs.
-Residents were not assisted with showering and/or bathing; they were wiped down and dressed in the morning.

Interview with a family member on 06/08/22 at 1:30pm revealed:
-She was at the facility at least every other day and saw that staffing levels were low.
-Low staff was evident by not being able to find staff for assistance with transfers and toileting and waiting more than 20 minutes for response to assist her family member to the bathroom.

Interview with a MA on 06/08/22 at 2:15pm revealed:
-There were times that the facility was short staffed on first shift on the AL unit and she administered medications and provided personal care assistance for about 20 residents.
-There were times when she administered medications late due to performing PCA duties and MA duties when there was not enough staff to meet the needs of the residents.
-The Assistant Resident Care Director (RCD) was responsible for completing the staff schedule.

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D 338	Continued From page 63 -It had been reported to the Assistant RCD and the Executive Director (ED) that they didn't have enough staff to meet the needs of the residents. Interview with a PCA on 06/10/22 at 12:20pm revealed: -She worked regularly on the AL unit and the SCU. -There were normally two PCAs each assigned to a whole hall on the AL unit for first and second shifts. -There were normally two MAs on the AL unit for first and second shifts. -Normally on Monday, Wednesday and Friday there were 3-5 residents needing assistance with showering on first shift and the same number on second shift. -On Tuesday, Thursday and Saturday there were 4-7 residents needing assistance with showering on first and the same number on second shift. -There were two residents on the AL unit who ate meals in their rooms and needed assistance with eating. -A third resident needed staff to supervise meals and prompt to stay focused on eating. -Four additional residents usually ate meals in their rooms. -A fourth resident needed staff supervision to make sure she did not get on the elevator to the SCU or visit a male resident on the AL unit who was "very touchy". -The male resident liked to hug and rub the arms and legs of female residents. -Staff rounded on residents every 2 hours; there were two residents on the AL unit that needed hourly checks because they had increased urinary incontinence. -There was a third resident who needed to be checked every hour because she had behavioral changes.	D 338		

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-Not all staff worked to the same standard at the facility; some staff did less, and some did more.
-When a resident did not get up for breakfast and lunch she was instructed to save the plate.
-Any concerns about a resident or a staff were reported to the SCU RCD, RCD and the Executive Director (ED) for the SCU; and the Assistant RCD, RCD and ED for the AL side.
-She had reported concerns about a staff to the management that were not addressed.

Interview with a MA on 06/10/22 at 1:20pm revealed:
-There were three residents on the AL unit staff had to "keep an eye on" due to falls, behaviors and wandering.
-There were 4 residents who needed two staff for assistance with transfers, ambulation, showering and toileting.

Interview with the SCU RCD on 06/10/22 at 12:43pm revealed:
-There were widespread staffing issues including call outs and lack of supervision of residents especially on the SCU.
-Staff did not check on residents like they were supposed to.
-Staff stayed in the common area on the SCU and were not on the hall checking on residents who were not in the common area.
-Two staff left the SCU at the same time taking multiple unscheduled breaks on 1st shift.
-She had multiple conversations with the RCD, Assistant RCD and ED about the two staff taking multiple breaks and one of the two who also had a high call out rate.
-The ED spoke with the PCAs about staying in their designated areas one month ago, but the behavior did not change.
-There was also a tardiness issue on all shifts

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and a problem with 3rd shift leaving at 7:00am with only one 1st shift staff present on the SCU.
-The RCD was on the SCU one to two times a day but did not observe staff behaviors and performance.
-The ED was not usually on the SCU unless there was tour happening for a potential new resident.
-There was no process of routine monitoring of the care and supervision of residents on the SCU by the RCD and ED.

Interview with another PCA on 06/10/22 at 6:20pm revealed:
-There had been times where there was not enough staff to care for the residents' needs on second shift on the AL unit.
-There were 5 residents on the AL unit that required x2 assistance completing personal care that could take up to an hour to complete per resident.
-She had informed the Assistant RSD and the ED about her staffing concerns and nothing was done.

Telephone interview with the RCD on 06/10/22 at 6:07pm revealed:
-She had put together a break schedule for staff to follow and minimize the number of staff on break at one time.
-She did not directly monitor staff compliance with the break schedule; the SCU RCD was diligent about checking up on staff.

Interview with the ED on 06/10/22 at 4:15pm revealed:
-Staff breaks were assigned on sheets daily and staff followed the planned breaks to the best of her knowledge.
-Staff told her there was not enough staff.
-Staffing hours were audited monthly and the

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facility had 180 staff hours daily verses the 103 staff hours required according to the census for May 2022.

c. Observation of the breakfast meal on 06/08/22 from 7:36am until 8:31am revealed:
-A female resident seated with 3 other residents announced she was having a difficult time hearing staff.
-A dietary aide (DA) repeated what she said and asked if the resident heard her.
-The resident replied in loud angry voice that the DA did not have to be sarcastic because she was hard of hearing.
-The female resident then began yelling at a resident seated at the table with her.
-The female resident yelled at the other resident to just be quiet, she did not know what it was like to be deaf, not to look at her and mind your own business in loud angry tones.
-A second female resident upon finishing her meal attempted to stand from sitting and was having difficulty.
-She was unable to reach her walker which was approximately 3 feet from her chair against the wall.
-As the resident made a second attempt a DA entered the dining room from the kitchen and helped the resident get and use her walker to stand and leave the dining room.
-There was no direct care staff in the dining room except to bring residents to the dining room.

Observation of the dining room on 06/09/22 at 8:15am revealed there were no staff in dining room with residents eating the breakfast meal.

Interview with a DA on 06/09/22 at 11:44am revealed:
-The personal care aides (PCAs) were

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D 338	Continued From page 67	D 338		

responsible for supervising and helping residents in the dining room.
-DAs helped residents in wheelchairs to and from the dining room sometimes.

Interview with a second DA on 06/09/22 at 11:52am revealed:
-There were usually two PCAs in the dining room but not today (06/09/22).
-Sometimes there were no staff available to supervise and assist residents in the dining room because the staff was busy helping residents to the dining room.
-Once all the residents were in the dining room, the PCAs stayed in the dining room.

Interview with a PCA on 06/09/22 at 12:22pm revealed:
-PCAs were not normally in the dining room to supervise and assist residents for breakfast.
-PCAs were normally in and out of the dining room because they were getting residents up and into the dining room.
-PCAs were normally in the dining room to assist and supervise residents during the lunch and dinner meals.

Observation of the dining room on 06/10/22 at 8:55am revealed:
-There were 10 residents in the dining room eating the breakfast meal.
-There was a second female resident sleeping in a wheelchair at the table.

Interview with the Assistant Resident Care Director (RCD) on 06/10/22 at 9:04am revealed:
-There was no staff in the dining room because staff had called in that morning (06/10/22).
-She was not made aware of the call in(s) until 9:00am.

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D 338	Continued From page 68 -She was going to have to help administer medications to residents because staff had to be shifted around. -She had to pull activity staff and a housekeeper to assist with PCA tasks. Interview with a housekeeper on 06/10/22 at 12:07pm revealed: -She helped assist residents to the dining room, getting seated and with getting beverages. -Everything she could do to help residents was part of her job. Interview with the Assistant RCD on 06/10/22 at 5:35pm revealed: -She was aware of residents having verbal altercations in the dining room. -She had reported the issue to the Executive Director (ED) a month ago and again last week. -The resident was transferred from the special care unit (SCU) to the assisted living (AL) unit. -The resident's behaviors and schedule were still "all over the place" and a solution had not been identified yet. _____ The facility failed to provide appropriate care and services and a reasonable response to requests for personal care assistance and supervision which resulted in lack of supervision, delayed responses to call lights, behavior disruption during meals and delayed assistance in the dining room during meals. The facility's failure was detrimental to the health, safety and well-being of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/22 for this violation. THE CORRECTION DATE FOR THE TYPE B	D 338		

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D 338	Continued From page 69 VIOLATION SHALL NOT EXCEED JULY 10, 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 observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#7, #8) observed during the medication pass including errors with a thyroid medication, an acid reducer and an anticoagulant (#7). The findings are: 1. The medication error rate was 13% as evidenced by the observation of 4 errors out of 29 opportunities during the 8:00am/9:00am medication pass on 06/08/22. a. Review of Resident #7's current FL-2 dated 07/19/21 revealed: -Diagnoses included Paramedian Pontine Infarct, atrial fibrillation, Type II Diabetes, hypertension, hypothyroidism, gait impairment and osteoarthritis. -There was an order for Levothyroxine 25mcg	D 358		

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D 358	Continued From page 70 once a day. (Levothyroxine was used to treat hypothyroidism.) Review of a signed physician's order for Resident #7 dated 05/26/22 revealed there was an order for Levothyroxine 25mcg once a day at 7:00am with instructions for the medication to be taken on an empty stomach. Observation of the 8:00am/9:00am medication pass on 06/08/22 revealed: -The medication aide (MA) administered Resident #7's Levothyroxine at 8:38am. -Resident #7 had already consumed breakfast. Review of Resident #7's June 2022 medication administration record (MAR) revealed: -There was an entry for Levothyroxine 25mcg once a day to be taken on an empty stomach with scheduled administration time at 7:00am. -Levothyroxine was documented as administered on 06/08/22 for the 7:00am administration time. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/08/22 at 4:25pm revealed: -Taking Levothyroxine with a meal can affect the absorption of Levothyroxine. -Levothyroxine was best absorbed on an empty stomach. Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable. Refer to interview with a medication aide (MA) on 06/08/22 at 2:15pm. Refer to interview with the Resident Service Director (RSD) on 06/08/22 at 4:40pm.	D 358		

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D 358	Continued From page 71 Refer to interview with the Executive Director on 06/09/22 at 1:15pm. b. Review of Resident #7's current FL-2 dated 07/19/21 revealed there was an order for Omeprazole 20mg once a day. (Omeprazole was used to treat acid reflux.) Observation of the 8:00am/9:00am medication pass on 06/08/22 revealed: -The medication aide (MA) administered Resident #7's Omeprazole at 8:38am. -Resident #7 had already consumed breakfast. Review of Resident #7's June 2022 medication administration record (MAR) revealed: -There was an entry for Omeprazole 20mg once a day with scheduled administration time of 7:00am. -Omeprazole was documented as administered on 06/08/22. Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/08/22 at 4:25pm revealed: -Omeprazole should be taken before a meal to decrease heartburn. -Taking Omeprazole after a meal could take the medication longer to work or could potentially not work at all. Refer to interview with a medication aide (MA) on 06/08/22 at 2:15pm. Refer to interview with the Resident Service	D 358		

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D 358	Continued From page 72 Director (RSD) on 06/08/22 at 4:40pm. Refer to interview with the Executive Director on 06/09/22 at 1:15pm. c. Review of Resident #8's current FL-2 dated 07/19/21 revealed there was an order for Omeprazole 40mg once daily with directions to take medication thirty minutes prior to morning meal. (Omeprazole was used to treat acid reflux.) Observation of the 8:00am/9:00am medication pass on 06/08/22 revealed: -The medication aide (MA) administered Resident #8's Omeprazole at 8:34am. -Resident #8 had already consumed breakfast Review of Resident #8's June 2022 medication administration record (MAR) revealed: -There was an entry for Omeprazole 40mg once a day, with scheduled administration time of 7:00am and instructions to administer thirty minutes prior to meal. -Omeprazole was documented as administered on 06/08/22 for the 7:00am administration time. Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/08/22 at 4:25pm revealed: -Omeprazole should be taken before a meal to decrease heartburn. -Taking Omeprazole after a meal could take the medication longer to work or could potentially not work at all.	D 358		

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D 358	Continued From page 73 Refer to interview with a medication aide (MA) on 06/08/22 at 2:15pm. Refer to interview with the Resident Service Director (RSD) on 06/08/22 at 4:40pm. Refer to interview with the Executive Director on 06/09/22 at 1:15pm. Interview with a medication aide (MA) on 06/08/22 at 2:15pm revealed some medications were administered late during the 8:00am/9:00am medication pass because she was assisting residents personal care needs. Interview with the Resident Service Director (RSD) on 06/08/22 at 4:40pm revealed it was the responsibility of the medication aide (MA) to administer medications within 1hr before or 1hr after the scheduled administration times. Interview with the Executive Director (ED) on 06/09/22 at 1:15pm revealed it was the responsibility of the medication aide (MA) to administer medications within 1hr before or 1hr after the scheduled times.	D 358		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:	D 484		

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D 484	Continued From page 74 (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by:	D 484		

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Based on observations, interviews and record reviews, the facility failed to ensure the care planning process was complete prior to implementing the use of side rails to prevent one resident from rolling out of the bed (#2).

The findings are:

1. Review of Resident #2's current FL-2 dated 03/22/22 revealed diagnoses included dementia, gait dysfunction, chronic obstructive pulmonary disease, constipation, anemia and iron deficiency and the level of care was for assisted living.

Upon request on 06/09/22 and 06/10/22, the order for the side rail for Resident #2 was not available for review.

Review of Resident #2's Care Plan revealed:
-As of 03/31/22, the resident was a moderate fall risk.
-As of 05/08/22, staff were to ensure the side rail was up when the resident was in bed.
-As of 06/07/22, the resident had demonstrated safe use of the side rail for transfer out of bed or for bed mobility.
-There was no documentation of the alternatives to restraints.
-There was no documentation of a completed assessment of Resident #2's need for the use of side rails.
-There was no documentation for care of the resident while side rails were in use.
-The service plan was not signed by primary care provider (PCP).

Review of Resident #2's licensed health professional support (LHPS) evaluation dated 03/31/22 revealed there was no documentation of the use of side rails for the resident.

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D 484	Continued From page 76 Observation of Resident #2 on 6/07/22 at 10:10am revealed: -Resident #2 was laying in the bed removing her shirt and adult brief while attempting to get out of the bed. -Resident #2 stated that she had been trying to get out of bed for hours, but no one would help her. -There was a bed rail on the left side of the bed and the right side of the bed was pushed against the wall. Observation of Resident #2 on 06/08/22 at 8:40am revealed: -The resident was lying in bed on top of the body pillow with the side rail up. -Her left leg was over the side of the bed and the lower end of the side rail. Observation of Resident #2 on 06/10/22 at 9:24am revealed: -The resident was sleeping in her bed with the side rail up. -There was a body length pillow between her and the side rail. Interview with a family member on 06/08/22 at 1:30pm revealed: -Resident #2 had nightmares and frequently rolled out of the bed. -The side rail, weighted body length pillows and floor mat were used for her safety. Interview with a medication aide (MA) on 06/09/22 at 12:20pm revealed: -Resident #2 came from the special care unit (SCU) with the side rails and the floor mat. -She did not know if there was an order for the side rails.	D 484		

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D 484	Continued From page 77 Interview with Resident #2's PCP on 06/09/22 at 12:06pm revealed: -He was not sure about the use of side rails for the resident. -He was new in his role as the facility's PCP and was still working with facility staff on the healthcare needs of residents. Interview with the Assistant RCD on 06/10/22 at 5:35pm revealed: -The side rail was used for transfer assistance and to keep Resident #2 from falling out of the bed. -The side rail was implemented when the resident was in the special care unit (SCU). Telephone interview with the Resident Care Director (RCD) on 06/10/22 at 6:07pm revealed: -There was an order dated 05/22/22 for Resident #2's side rail. -The bed came with a side rail and a pillow was used to keep the resident from rolling out of the bed. -She received all new orders from the PCP and scanned them into the electronic record. -Resident assessments and care plans were completed every 3 to 6 months by the facility nurse. Interview with the Executive Director (ED) on 06/09/22 at 4:03pm revealed: -The side rail was used for mobility assistance for Resident #2. -She would look into documentation of the order and inclusion in the care plan for the use of the side rail. Based on observations, interviews and record reviews, it was determined Resident #2 was not	D 484		

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D 484	Continued From page 78 interviewable.	D 484		
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 observations, 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 and residents' rights. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 6 sampled residents (#1, #2, #5) with a history of a falls resulting in unresponsiveness, facial fractures, hospitalization for 10 days and discharge to a skilled nursing facility (#5), 15 reported falls within 3 months related to increased behaviors and/or tremors (#1), and 4 falls within 3 months with no documentation of increased supervision(#2) [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure residents received appropriate care and services and	D912		

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D912	Continued From page 79 reasonable responses to requests for personal care assistance and supervision needs by staff that were present and able to provide care [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].	D912		