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	HAL063016	A. BUILDING: ______ B. WING ______	R-C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVENTRY	105 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

(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 an annual survey and complaint investigation on August 30 -31, 2022 and September 1, 2022 with a telephone exit on September 1, 2022.. The Moore County Department of Social Services initiated the complaint investigation on August 15, 2022.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the Special Care Unit was free of hazards related to razors, scissors, hair spray, lotions, powder, shaving cream, perfume and other personal care items being stored in resident rooms; hand sanitizer and disinfectant wipes were stored unsecured on top of the medication carts. The findings are: Review of the SCU census dated 08/30/22 revealed there were 12 residents who resided in the SCU. Observation of Resident Room #162 on 08/30/22	D 079		

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at 9:37am revealed:
-There was a disposable razor, four pair of scissors, and one Tylenol tablet in the resident's bathroom drawer.
-There were two containers of hair spray, a bottle of anti-aging serum, two bottles of hand sanitizer, one bottle of antimicrobial skin cleanser, two containers of body powder, two containers of bath wash, two containers of body lotion, and one tube of toothpaste on the bathroom counter.

Observation of Resident Room #160 on 08/30/22 at 10:00am revealed there were two bottles of dry eraser cleanser and two dry erase markers on the residents table.

Observation of Resident Room #159 on 08/30/22 at 10:03am revealed:
-There was a disposable razor and an electric razor in the resident's bathroom vanity drawer.
-There was a container of shaving cream on top of the bathroom vanity.

Observation of Resident Room #156 on 08/30/22 at 10:10am revealed:
-There were three pairs of scissors, one pair of nail cutters, and two tweezers, and a bottle of perfume on the resident's dresser.
-There was an unopened sample packet of triple antibiotic ointment

Observation of Resident Room #152 on 08/30/22 at 10:19am revealed there were two disposable razors, two bottles of vision lens cleaner, one electric razor, a container of pre shave cream/lotion, and a container of mouthwash on the bathroom counter.

Observation of the SCU kitchenette on 08/30/22 at 10:36am revealed:

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-The kitchenette was located between the dining room and common living area.
-The kitchenette was enclosed with lower walls and a bottom half swing door.
-There was a slide lock on the inside of the swing door which was easily accessible and unlocked and opened without difficulty with one hand.
-There were drawers and cabinets with keyhole locks inside the kitchenette.
-The keyhole locks were not locked, and the drawers and cabinets opened freely.
-There was one long blade knife, a manual can opener with a corkscrew, and a pair of long blade scissors in one drawer that was unlocked and opened freely.
-In a lower cabinet were six containers of cleaning chemicals, two bottles of dish detergent, and one spray bottle of surface disinfectant.

Observation of the common area of the SCU on 08/30/22 at 10:05am revealed:
-There were no staff present.
-There were three residents in the common area of the SCU.
-There was a medication cart in the cross of the T hallway of the SCU by the common living room.
-There was a bottle of hand sanitizer in a basket on top of the medication cart.
-There was one resident sitting beside the medication cart.
-There was a second medication cart to the left of the common living room located by the medication room.
-On top of the second medication cart was a bottle of hand sanitizer and a container of disinfectant wipes.

Review of the disinfectant wipes' manufacturers label on 08/30/22 revealed:
-Hazardous to humans.

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-Causes substantial but temporary eye damage; do not get in eyes or on clothing.
-Avoid contact with skin.
-Call a poison control center or doctor for treatment advice.

Interview with a medication aide (MA) on 08/30/22 at 10:06am revealed:
-She was attending to a resident in the resident's room.
-The disinfectant wipes were to be stored and locked on the medication cart.
-It was the responsibility of the MA who was assigned to the cart to ensure the disinfecting wipes were stored and locked on the medication cart.
-The hand sanitizers were not to be locked on the medication carts because staff needed easy access to the hand sanitizer instead of reaching in their pockets or using the keys to unlock the cart.
-Any resident could access the hand sanitizers or disposable wipes when not secured/locked in the medication cart.
-Staff could not monitor the carts or the residents when staff were assisting residents in their rooms.

Based on observations and interviews, it was determined the resident's for rooms number 152, 156, 159, 160, and 162 were not interviewable.

1. Review of Resident #5's current FL-2 dated 03/14/22 revealed:
-Diagnoses included vascular dementia, anxiety, and falls.
-She was constantly disoriented.
-There was no documentation completed for the inappropriate behavior information.

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D 079	Continued From page 4 Review of Resident #5's current care plan dated 07/14/22 revealed: -The resident's mental/social health history included resisting care and disruptive behaviors. -She had difficulty adjusting to the Special Care Unit (SCU). -She was sometimes disoriented and forgetful, needed reminders. -She was alert to self only, and required reorientation to time, place, and situation. Review of Resident #5's monthly nursing summary dated 08/03/22 revealed: -She was confused and anxious, had poor memory, and was easily upset and hostile. -She had difficulty resting and required medication at night to help her sleep. Observation of Resident #5's room on 08/30/22 at 9:54am revealed: -The resident was sitting in a chair. -There was a private personal care aide (PCA) removing clothing from the resident's dresser. -There were four plug-in air fresheners in an open package on the bathroom counter. -There was one plug-in air freshener in the outlet beside the bathroom counter. -There was one can of hairspray, two tubes of skin protectant ointment, two under arm deodorants, one container of shampoo, and one container of lotion on the bathroom counter. -There were two pairs of scissors and one nail trimmer in the bathroom drawer. Review of the plug-in air fresheners manufactures label on 08/30/22 revealed: -Caution: eye irritant contains fragrance oils. Avoid contact with eyes -If swallowed, do not induce vomiting, call a poison control center or physician immediately.	D 079		

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Review of the skin protectant manufactures label on 08/30/22 revealed for external use only, avoid contact with eyes, if swallowed get medical attention or contact a poison control center immediately.

Review of the hair sprays manufacturer's label on 08/30/22 revealed:
-Warning, contents under pressure, do not puncture.
-Avoid spraying in the eyes.
-Inhaling the contents could be harmful or fatal.

Interview with Resident #5's private duty PCA on 08/30/22 at 9:56am revealed:
-She was a private sitter whose duties were to assist Resident #5 with personal care.
-She did not know anything about the scissors, plug-in air fresheners, or toiletry items.
-Resident #5 was confused at times.

Interview with Resident #5 on 08/30/22 at 9:58am revealed:
-She used the scissors to cut her hair.
-She did not remember the last time she cut her hair.
-She had the scissors for a long time; she did not remember how she obtained them.
-Her family member gave her the plug-in air fresheners, hairspray, skin protectant ointment, and deodorants.

Interview with a second MA on 08/30/22 at 10:06am revealed:
-Resident #5's family member gave the resident scissors.
-Resident #5 has had her own personal scissors in her room for years.
-Resident #5 cut her own hair with the scissors.

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-Resident #5 refused to give staff the scissors when asked for them.
-She last asked Resident #5 for the scissors two weeks ago and the resident refused.
-She did not know if she had told anyone in management Resident #5 had the scissors in her room and refused to give them to her.
-Facility management knew Resident #5 had scissors in her room and cut her own hair.
-She did not remember who told her management knew of the scissors in Resident #5's room.

Telephone interview with the facility's contracted mental health provider on 08/31/22 at 4:13pm revealed:
-Resident #5 had a diagnosis of dementia and her cognitive function could change on a daily basis.
-She was in the SCU because of her cognitive impairment.
-There was no reason the resident should have access to scissors.

2. Review of Resident #3's current FL-2 dated 03/15/22 revealed:
-The resident's current and recommend level of care was a rest home.
-The resident's current facility was documented as the Special Care Unit.
-Diagnoses included dementia and anxiety.
-The resident was constantly disoriented, wandered, and was ambulatory with a walker.

Observation of Resident #3's room on 08/30/22 at 10:13am revealed:
-Resident #3 was sitting on the bed, there was an elevated walker with arm rests at his bedside.
-There was a razor, two pair of scissors, and a pair of nail cutters on the bathroom counter.

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Interview with Resident #3 on 08/30/22 at 10:15am revealed:
-He used the razor to shave himself every night.
-He last shaved last night, 08/29/22.
-He was unsupervised when he shaved.
-He never used the scissors.
-He did not know where the scissors came from.
-He had never cut himself shaving.

Interview with a medication aide (MA) on 08/30/22 at 10:29am revealed:
-A resident wandered in Resident #3's room on 08/28/22 looking through the resident's belongings.
-The resident was easily directed from Resident #3's room.

____

Interviews with a MA on 08/30/22 at 9:40am and 10:29am revealed:
-Razors and scissors were to be stored and locked in the bottom drawer of the medication cart or in the medication room.
-She checked resident rooms to be sure there were no hazards in their rooms.
-She did not know how often she checked or remembered the last time she checked resident rooms for hazards.
-She had not had time today, 08/30/22, to check resident rooms for hazards.
-There was a resident in the SCU who wandered in other resident rooms and looked through their belongings.
-The resident would pick up anything in sight but had never picked up razors or scissors that she knew of.

Interview with a second medication aide (MA) on 08/30/22 at 9:48am revealed:
-There were no specific resident room checks for

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hazards.
-If she saw hazards in a resident room while performing resident care, she would remove the hazard.
-She had never performed resident room checks specifically for hazards.
-It was SCU policy that no hazards were allowed in resident rooms because the residents had diagnoses of dementia.
-She had never been informed to remove items such as body wash, hair spray, perfumes or other items from rooms of SCU residents.
-Facility management had not performed SCU resident room checks for hazards.
-There were two residents' in the SCU who wandered.
-One of the two residents wandered in other resident rooms at times.

Interview with the Administrator on 08/30/22 at 10:30am revealed:
-She did not know if the facility had a hazards policy related to storage of items in the SCU.
-She did not know residents in the SCU had razors, scissors, hair spray, deodorant, shaving cream, perfumes, nail clippers, lotions, plug in air fresheners, or shampoos in their rooms.
-Residents in the SCU were there because of cognitive impairments.
-Residents in the SCU were not allowed to have razors, scissors, or hair spray, deodorant, shaving cream, perfumes, nail clippers, lotions, plug in air fresheners, or shampoos in their rooms because they were considered hazards.
-The residents could cut themselves with the razors and scissors.
-All toiletries were to be locked and secured because they were hazardous to the residents in the SCU.
-Residents could easily access the hazards by

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walking into other resident rooms.
-The MA was responsible to ensure there were no hazards in resident rooms by performing a walk through in each room every day searching for hazards.
-The MA was responsible to ensure all hazards were secured and locked away from residents to keep the residents safe.
-The MAs did active room checks for hazards daily.
-The MA was responsible to take any hazards found out of the residents' rooms, document the hazard found on a log, secure and lock the hazard away from residents, and let her know.
-There should be no unsecured knives, scissors, can openers, or cleaning and disinfecting chemicals stored in the kitchenette.
-The drawers and cabinets in the kitchenette were always to be locked when unsupervised by staff.
-She had not performed any SCU observations since her employment of about one month because she had not had time.
-There was no Special Care Coordinator (SCC) to perform observations in her absence.
-She assigned a designated MA to review the logs weekly once completed by the MAs.
-The designated MA was responsible to review for hazards documented on the logs then inform her.
-Staff had not told her there were unsecured hazards in the SCU.

Interview with a third MA on 08/30/22 at 10:35am revealed:
-She was the designated MA assigned to review staff documented logs for the SCU.
-She did not review the logs for hazards documented.

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Review of the SCU medication cart #4 report dated 08/30/22 6:00am to 6:00pm revealed there were no hazards documented on the report to include Resident #3's room, and resident rooms #152 and #156.

Review of the SCU medication cart #5 report dated 08/30/22 revealed:
-The shift was not specified.
-There were no hazards documented on the report to include Resident #5's room, and resident rooms #159, #160, and #162.

Second interview with the second MA on 08/30/22 at 10:32am revealed she did not document hazards discovered in resident rooms on the medication cart reports because she did not know she was supposed to.

Telephone interview with the facility's contracted mental health provider on 08/31/22 at 4:13pm revealed:
-There were residents in the SCU who wandered, had severe cognitive decline, and could not follow simple commands.
-Residents in the SCU should not have access to scissors or razors because they were safety hazards and were at risk for cutting themselves.
-Residents in the SCU should not have access to hair sprays, shampoos, lotions, perfumes, or fragrance air fresheners or chemicals due to the residents could inhale or ingest the products placing them at risk for harm.

____

The facility failed to ensure residents with dementia and who wandered were protected from hazards in the SCU regarding razors, scissors, hair sprays, an antibiotic ointment, deodorant, shaving cream, perfumes, nail clippers, lotions, plug in air fresheners, or shampoos stored in

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D 079	Continued From page 11 resident rooms; hand sanitizer and disinfectant wipes stored unsecured on the medication cart unsupervised by staff, and a long bladed knife and a pair of scissors stored in an unlocked drawer of the kitchenette. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/30/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Non-compliance continues with increased severityresulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision	D 270		

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to 2 of 5 (#1, #2) residents sampled related to a resident with 2 falls within two weeks (#1) and a resident who wandered (#2).

The findings are:

1. Review of Resident #2's current FL-2 dated 07/13/22 revealed:
-A diagnosis of dementia.
-There was no information provided regarding orientation or behaviors.

Review of Resident #2's Resident Register dated 07/22/21 revealed:
-The resident was admitted to the facility from home on 07/22/21.
-The resident was forgetful, needed reminders, had significant memory loss, and must be directed.

Review of Resident #2's New Resident Checklist dated 07/22/21 revealed the resident required companion for offsite visits.

Review of Resident #2's Clinical Notes dated 08/19/22 revealed a wanderguard alarm bracelet was placed on the resident "around 3:00pm" and the resident would need to be monitored for 24 hours with 15-minute checks for the first hour and then hourly checks.

Review of Resident #2's Clinical Notes dated 08/23/22 revealed the staff "kept eyes on resident as she did a lot of walking today up especially around the lobby where the front doors are" until the resident went to bed at 7:00pm.

Review of Resident #2's Clinical Notes dated 08/27/22 revealed
-The resident wandered to another resident's

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apartment in a neighboring building.
-The resident was escorted back to the facility.
-The facility manager was called and notified of the resident wandering.
-The resident was placed on hourly checks for 24 hours.

Review of a report form (unnamed) completed for Resident #2 dated 08/27/22 revealed:
-On 08/27/22 at 1:30pm a security officer responded to an incident involving Resident #2.
-Resident #2 was reported as "being lost and confused" in a neighboring building.
-Resident #2 was escorted to a clubhouse by a resident in the neighboring building.
-A clubhouse employee escorted Resident #2 back to the facility.

Interview with a medication aide (MA) on 08/30/22 at 9:39am revealed:
-A wanderguard alarm bracelet was placed on Resident #2 last month.
-If a resident with a wanderguard alarm bracelet approached an exit door, an alarm would sound and staff were supposed to go check the door.
-The wanderguard alarm sound was a different sound than the sound heard when a door was opened and no wanderguard was close to the door.
-She thought Resident #2 was the only resident in Assisted Living with a wanderguard alarm bracelet.

Interview with another MA on 08/30/22 at 2:30pm revealed:
-Resident #2 wandered.
-Resident #2 got confused on how to return to the facility about 3 weeks ago when the resident went to a neighboring building for a church service.
-When there was a big crowd of people, Resident

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#2 would go with the crowd.
-She saw Resident #2 go outside and sit on the porch prior to receiving a call that the resident was confused in a neighboring building.
-The front door alarm was turned off by the front desk attendant for the resident to go outside.
-She did not know why the front desk attendant allowed Resident #2 to leave the facility and go to the neighboring building.
-Whoever was at the front desk was supposed to let the MAs know if a resident with a wanderguard alarm bracelet went out the front door.
-Residents with wanderguard alarm bracelets were not supposed to go outside unless staff went with the resident and stayed with the resident.
-She was supposed to be documenting hourly checks on Resident #2, but she had not started documenting the hourly checks for today (08/30/22).
-She was making sure today (09/30/22) that Resident #2 was always in her view.
-She was not sure if there was a written supervision policy but had been informed by the facility manager about the need for hourly checks for Resident #2.

Interview with the RCC/LHPS RN on 08/30/22 at 3:00pm revealed:
-She did not know how Resident #2 exited the facility on 08/27/22 with the wanderguard alarm bracelet on.
-Resident #2 was not trying to leave the facility.
-Resident #2 got confused and did not know how to get back.

Interview with the Administrator on 08/30/22 at 3:20pm revealed:
-She thought a wanderguard alarm bracelet was implemented for Resident #2 on 08/19/22 as a

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preventative measure.
-On 08/19/22, Resident #2 went to a church service in a neighboring building and instead of making a right turn to return to the facility, the resident made a left turn in the neighboring building with other residents and ended up in the neighboring building.
-On 08/27/22, Resident #2 did the same thing.
-The resident liked to go to a church service on Sunday's and would follow the crowd.
-She received a call from security on 08/27/22 informing her that Resident #2 was in a neighboring building.
-The resident was not supposed to go out of the facility alone.
-An "aide" was supposed to take Resident #2 to the church service and go back to get her and she did not believe that happened.
-Resident #2 walked out of the front door and the wanderguard alarm bracelet sounded until it was turned off.
-She contacted Resident #2's Power of Attorney (POA) about obtaining a sitter for the resident.
-A facility aide had not been assigned for Resident #2 because the facility did not have the staffing to assign anyone.
-If the resident needed a sitter, the family was responsible for the additional one to one supervision.
-She was aware of the rule indicating the facility had the responsibility to supervise residents based on current symptoms.
-She was not sure if the facility had a supervision policy or a policy for wanderguard alarms but would check for the policies.

Interview with the front door attendant on 08/30/22 at 4:12pm revealed:
-He worked on 08/27/22 from 1:00pm to 7:00pm.
-When Resident #2 approached the exit door, the

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door alarm sounded.
-He silenced the door alarm with a key card that he placed under the wanderguard wall unit.
-He did not know Resident #2 was not supposed to go outside.
-He did not know Resident #2 had exhibited wandering behavior because she used to go outside alone.
-He did not know Resident #2 was wearing a wanderguard alarm bracelet until the resident approached the door.
-He had not had any instructions about residents with wanderguard alarm bracelets.
-He understood the MAs were supposed to come to the door when they heard the wanderguard alarm bracelet sound.
-No one reported to the door at the front desk when the wanderguard alarm bracelet sounded.
-He was not aware of any other times that Resident #2 left the facility and had to have assistance returning.
-He was used to Resident #2 coming up to the front desk and going out of the facility prior to the wanderguard alarm placement, and had not had any problems with Resident #2 until this incident occurred.
-He did not receive any reports on residents when he arrived for work.
-He was told when he was hired at the facility that he was not allowed to stop residents from going out.

Interview with Resident #2 on 08/30/22 at 4:40pm revealed:
-She had a wanderguard alarm bracelet on her left ankle.
-She could not think who put the wanderguard alarm bracelet on her ankle.
-Some of the "girls" working at the facility drove her to church.

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D 270	Continued From page 17 -She did not know why she had to wear the "ankle thing" but thought it was in case she got lost. -She denied ever being lost. -She denied walking to a neighboring building for church services. Telephone interview with the Primary Care Provider's (PCP) call center nurse on 08/31/22 at 10:25am revealed: -The wanderguard alarm bracelet was ordered for Resident #2 after receiving a call from the facility nurse on 08/19/22 who reported the resident had been wandering, left the facility four times, and was unable to find her way back. -There was nothing in Resident #2's record regarding wandering behavior or elopement but the resident did have dementia. 2. Review of Resident #1's current FL-2 dated 08/26/22 revealed: -Diagnoses included dementia, hypertension, and osteoporosis. -The current level of care was documented as a Special Care Unit (SCU). -The recommended level of care was documented as a Skilled Nursing Facility (SNF). -The resident was constantly disoriented, ambulatory, and had aphasia (a reading, speaking, or writing disorder resulting from a brain injury). -There was no documentation regarding inappropriate behaviors. Review of Resident #1's previous FL-2 dated 03/14/22 revealed: -Diagnoses included dementia, hypertension, and osteoporosis. -The facility was documented as a SCU with the current level of care a rest home. . -The recommended level of care was a rest	D 270		

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home.
-The resident wandered, was constantly disoriented, and ambulatory.
-The resident communicated her needs verbally without documentation of aphasia.

Review of Resident #1's electronic physicians order sheet dated 08/05/22 revealed there was an order to check the resident every two hours for safety.

Review of Resident #1's previous electronic physicians order sheet dated 06/06/22 revealed there was an order to check the resident every two hours for safety.

Review of Resident #1's current care plan dated 07/12/22 revealed:
-There was documentation under the section "social and health history" consisting of: alert to self only, she had fallen several times resulting in head and facial injuries requiring sutures/staples,
-She was instructed to ambulate with the walker but did not remember the walker, she did not understand the need to use the walker for ambulation, she ambulated frequently with her eyes closed which compromised her safety even further.
-She had difficulty communicating due to expressive aphasia.
-She needed frequent queuing and prompting by staff.
-Staff were to assist the resident with activities of daily living (ADLs) as needed.
-Staff were to monitor for changes or concerns.
-She was always disoriented and had significant memory loss requiring direction.
-She required limited staff assistance with ambulation.
-The facility's contracted Resident Care

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D 270	Continued From page 19 Coordinator (RCC)/Licensed Health Professional Support (LHPS) Registered Nurse (RN) was the assessor. Review of Resident #1's undated monthly nursing assessment revealed: -The resident ambulated independently without a device and was independent with transfers. -She was confused, wandered, and had poor memory. a. Review of Resident #1's Incident and Accident (IA) report dated 06/21/22 revealed: -The resident was found on the floor of an unoccupied room at 4:40pm. -There was documentation the resident was confused prior to the incident. -The resident sustained abrasions to her forehead and nose. -There was documentation of a laceration, but the site was not specified. -The resident was transferred to the local hospital emergency room (ER) by Emergency Medical Services (EMS) because of injuries sustained during the fall. -There was no documentation in the section titled "additional comments and/or steps taken to prevent reoccurrence". -The form was signed by the Executive Director (ED). Review of the facility's Current Summary Fall Event dated 06/22/22 revealed: -On 06/21/22 at 4:40pm, staff found the resident on the floor of an empty room. -The resident was bleeding from under her left eye. -The RN assessed the resident to have an abrasion to the center of her forehead, bridge of nose, and right wrist.	D 270		

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-Preventive measures documented were to redirect the resident to use the walker at all times and remind the resident to open her eyes while walking.
-The form was signed by the ED.

Review of the facility's transfer form for Resident #1 dated 06/21/22 revealed:
-The resident was transferred to the hospital on 06/21/22 due to bleeding under the left eye.
-The resident's usual functional status was documented as independent with ambulation.
-The resident's usual mental status was documented as alert, disoriented, and could not follow simple instructions.
-The resident was at risk for falls.

Review of Resident #1's local hospital ER diagnostic results sheet dated 06/21/22 revealed:
-Diagnostic imaging was performed for acute fall with head and face injury, and neck, pelvis, and wrist pain.
-The resident had a moderate sized left frontal scalp hematoma.
-She had swelling to the left eye with a laceration to the side of the left eye.

Review of Resident #1's local hospital ER ophthalmologist consultation note dated 06/21/22 revealed:
-The resident was treated for an examination and laceration repair sustained during a fall on 06/21/22.
-The resident received stitches to repair the lacerated lower eyelid that was split from side to side.
-Erythromycin (an antibiotic used to treat topical infections) ointment was ordered to be applied four times a day for one week to the left lower lid skin.

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-Keflex 500mg (used to treat infection) was ordered twice a day for one week.
-She was to follow up with ophthalmology on 06/27/22.

Review of Resident #1's Primary Care Provider (PCP) visit note dated 06/28/22 revealed:
-Diagnoses included left eyelid laceration and history of recent fall.
-Resident #1 was treated as an acute visit for an ER follow up where she was treated on 06/21/22 due to a fall.
-The resident had cognitive impairment with a medical history of dementia, right hip replacement, and muscle weakness.
-Staff did not report resident concerns.
-The resident had a repaired laceration under the left eyelid and bruising to her left temple and under her left eye.
-The resident was alert and oriented to self only, had nonsensical speech, and was unable to answer simple questions.
-There were no new orders as a result of the visit.

Review of Resident #1's electronic clinical charting notes for June 2022 revealed:
-On 06/21/22 at 6:01pm, there was documentation Resident #1 was found on the floor in another resident's room.
-The resident was bleeding under her left eye and was sent to the ER.
-The facility's nurse was notified.
-On 06/21/22 at 11:12pm, there was documentation Resident #1 returned from the hospital at 10:45pm.
-There was no documentation of supervision interventions to include increased supervision implemented for Resident #1.
-On 06/22/22 at 1:56pm, there was documentation Resident #1 complained of

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discomfort around the left eye and had slept most of the shift.
-Resident #1 was currently "napping" in the common area.
-On 06/23/22 at 5:42pm, there was documentation the resident was sleeping off and on throughout the day.
-Staff assisted the resident as needed with toileting and ambulation.
-The resident's eye was dark red/purple in color.
-On 06/24/22 at 12:31am, there was documentation the resident was assisted with ADLs and ambulation to the room.
-On 06/26/22, 06/27/22, and 06/29/22 there was documentation the resident was assisted with ADLs.

Review of Resident #1's June 2022 treatment administration record (TAR) revealed:
-There was an entry to check the resident every two hours for safety to be performed 12 times daily.
-There was documentation Resident #1 was checked on for safety every two hours from 06/17/22 to 06/30/22.

Refer to interview with the medication aide (MA) on 08/30/22 at 9:15am.

Refer to interview with a second MA on 08/30/22 at 10:29am.

Refer to telephone interview with Resident #1's PCP on 08/30/22 at 4:20pm.

Refer to interview with the Administrator on 08/30/22 at 5:04pm.

Refer to telephone interview with Resident #1's family member on 08/31/22 at 10:42am.

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Refer to second interview with the Administrator on 08/31/22 at 3:09pm.

Refer to telephone interview with the Executive Director (ED) on 08/31/22 at 4:45pm.

b. Review of Resident #1's Incident/Accident report dated 08/14/22 revealed:
-On the morning of 08/14/22 (the time was not documented), Resident #1 sustained skin tears to the right and left elbow.
-The location of the incident/accident was documented as the resident's bathroom.
-There were no specifics documented as to how the injuries occurred.
-The resident was confused prior to the incident.
-The resident was transferred to the local hospital.
-The form was signed by the facility's Resident Care Coordinator (RCC) /Licensed Health Professional Support (LHPS) Registered Nurse (RN) and the Administrator/Manager.

Review of the facility's current summary fall event report for Resident #1 dated 08/16/22 revealed:
-The resident sustained a fall on 08/14/22 at 11:00am in her room.
-The resident was ambulating unsupervised when the fall occurred.
-Staff found the resident on the floor of her room.
-The resident could not recall the incident.
-The Preventative Measures and/or corrective actions to take was documented as "the resident was evaluated and sent to the hospital".
-Not specified was documented under the section titled "Follow-up Actions".
-The form was completed by the RCC/LHPS RN.

Review of Resident #1's local hospital emergency

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room (ER) visit note dated 08/14/22 revealed:
-Resident #1 was treated for a fall with bilateral arm injuries.
-The resident sustained an unwitnessed fall and was found on the ground at the facility.
-The resident had a diagnosis of dementia and was unable to provide information.
-The resident sustained skin tears to her left and right elbows.
-Emergency Medical Services (EMS) reported the resident was normally ambulatory with assistance because she ambulated with her eyes closed.

Review of Resident #1's Primary Care Provider (PCP) visit note dated 08/15/22 revealed:
-Diagnoses included history of recent fall and skin tear to forearms.
-The resident had cognitive impairment.
-Staff did not report resident concerns.
-The resident was seen for a follow up appointment from the
ER due to a fall.
-The resident had healing, but red and swollen bilateral forearm skin tears status post fall.
-The resident was alert and oriented to self only, unable to answer simple questions, and had nonsensical speech.
-Physical Therapy and Occupational Therapy were ordered due to generalized muscle weakness resulting from history of a stroke and a right hip replacement.
-Skilled nursing was ordered due to generalized weakness, increase in falls, unsteady gait, and inability to use a walker.

Review of Resident #1's electronic clinical notes for August 2022 revealed:
-On 08/14/22, staff found the resident on the floor of her room and notified the RCC/LHPS RN.
-The resident was transferred to the hospital ER.

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-The facility nurse was notified.
-On 08/16/22 and 08/17/22, staff assisted the resident with ADLs (the specified ADLs were not documented).
-There was no documentation of supervision interventions to include increased supervision implemented for Resident #1.

Refer to interview with the medication aide (MA) on 08/30/22 at 9:15am.

Refer to interview with a second MA on 08/30/22 at 10:29am.

Refer to telephone interview with Resident #1's PCP on 08/30/22 at 4:20pm.

Refer to interview with the Administrator on 08/30/22 at 5:04pm.

Refer to telephone interview with Resident #1's family member on 08/31/22 at 10:42am.

Refer to second interview with the Administrator on 08/31/22 at 3:09pm.

Refer to telephone interview with the Executive Director (ED) on 08/31/22 at 4:45pm.

c. Review of Resident #1's Incident/Accident report dated 08/30/22 revealed:
-At 3:24pm, the resident fell from a standing position to the floor hitting her head on the living room floor.
-The resident sustained a frontal head injury and first aid was needed.
-There was no documentation of first aide provided to the resident.
-The resident was disoriented prior to the incident.

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-The resident was transferred to the local hospital by Emergency Medical Services (EMS).

Review of Resident #1's current summary fall event report dated 08/31/22 revealed:
-On 08/30/22 at 3:30pm, the resident fell from a standing position in the living room of the SCU hitting her head on the floor.
-Resident transferred to the hospital and referral for a Skilled Nursing Facility pending a bed offer was documented in the section titled "Preventative Measures and/or corrective actions taken".
-Follow up actions was documented as not specified.
-The form was signed by the Administrator.

Review of the facility's transfer form for Resident #1 dated 08/30/22 revealed:
-The resident fell hitting her head on the floor.
-The resident was at risk for falls.

Review of Resident #1's local hospital emergency room (ER) report dated 08/30/22 revealed:
-Diagnoses included fall, scalp laceration, and dementia.
-The resident was transferred to the ER due to injuries sustained from a fall at the facility.
-The resident was confused and could not recall the incident.
-The resident sustained a three centimeter (cm) long by one cm deep laceration to the side and top of her head.
-Bleeding was controlled with direct pressure, the wound was cleaned and irrigated, and five staples applied to close the laceration.

Review of Resident #1's electronic clinical notes for August 2022 revealed:
-There was no documentation provided from

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08/21/22 to 08/29/22.
-On 08/30/22, Resident #1 fell from a standing position striking her head on the floor.
-The resident was transferred to the ER due to a head injury sustained during the fall.
-There was no documentation of increased supervision for Resident #1.

Review of Resident #1's electronic treatment record for August 2022 revealed:
-There was an entry to supervise Resident #1 every two hours for safety.
-There was no documentation Resident #1 was supervised at 8:00am from 08/12/22 to 08/14/22.
-There was no documentation Resident #1 was supervised every two hours from 12:00pm to 4:00pm on 08/13/22 and 08/14/22.
-There was no documentation Resident #1 was supervised at 4:00pm on 08/29/22 and 08/30/22.
-There was no documentation Resident #1 was supervised every two hours at 6:00pm and 8:00pm on 08/14/22.

Observation of Resident #1 on 08/30/22 at 9:10am revealed:
-The resident's room was located by the double doors upon entrance to the SCU away from the nurse's desk and common living room.
-The resident was lying in bed with her eyes closed.
-She was confused, and speech mumbled keeping her eyes closed.

Observation of the SCU common living room on 08/30/22 from 3:10pm to 3:30pm revealed:
-Resident #1 was sitting in a chair with her eyes closed.
-The MA was at the medication cart participating and was facing the resident.
-The MA yelled out to Resident #1 and ran

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towards the resident.
-Resident #1 was standing, leaning forward, and her eyes were closed.
-Resident #1 fell forward striking the right side of her head on the floor as she took a step.
-The MA approached the resident as she laid on the floor and lifted the residents head.
-Blood began pouring from the resident's right side of her head.
-At 3:30pm, Emergency Medical Services (EMS) arrive.
-Resident #1 was transferred to the local hospital.

Interview with Resident #1's Physical Therapist Assistant (PTA) on 08/30/22 at 3:25pm revealed:
-He was scheduled to perform a therapy visit with the resident today.
-The resident was just opened to therapy this month and had two visits.
-Resident #1 was initially unsteady when standing.
-Resident #1 required maximum staff assistance when standing and ambulating to keep her safe from falls.
-Resident #1 needed to be within eyesight of staff in order to keep the resident safe.

Telephone interview with Resident #1's current Physical Therapist on 08/31/22 at 11:15am revealed:
-Resident #1 was admitted to PT on 08/17/22 for gait instability.
-Resident #1 required verbal and tactile ques for tasks.
-The resident closed her eyes with ambulation.
-The resident required minimum assistance of one staff to safely stand.
-The resident required staff to be at the resident's side or at times, staff to have one or two hands on her body to steady her body and help with

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balance in order to ambulate safely.
-The resident needed constant staff supervision.
-Resident #1 should not be left in a room unsupervised because she would attempt to stand up alone which was not safe for the resident.

Interview with the RCC/LHPS RN on 08/31/22 at 3:32pm revealed:
-She completed Resident #1's care plan dated 07/12/22.
-She did not know when Resident #1 began ambulating with her eyes closed.
-She did not answer when asked why Resident #1's supervision needs were not documented in the resident's care plan per policy.
-She told SCU staff to constantly supervise Resident #1 when she was not sleeping and to keep the resident in the common areas of the SCU unless sleeping.
-One staff should always be in the common area of the SCU.
-Resident #1 was on every two-hour supervision checks by staff.
-Every one-hour supervision checks by staff were for resident's who wandered in other resident rooms.
-She expected staff to have supervised Resident #1 every 15 minutes to 30 minutes when the resident was not in the common area of the SCU when the resident began walking with her eyes closed.
-SCU staff could determine on their own to increase supervision for residents without a PCP order.
-Resident #1 was not able to understand how to use a walker with ambulation.
-Resident #1 needed staff to ambulate with her to keep her safe.

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Refer to interview with the medication aide (MA) on 08/30/22 at 9:15am.

Refer to interview with a second MA on 08/30/22 at 10:29am.

Refer to telephone interview with Resident #1's PCP on 08/30/22 at 4:20pm.

Refer to interview with the Administrator on 08/30/22 at 5:04pm.

Refer to telephone interview with Resident #1's family member on 08/31/22 at 10:42am.

Refer to second interview with the Administrator on 08/31/22 at 3:09pm.

Refer to telephone interview with the Executive Director (ED) on 08/31/22 at 4:45pm.

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Interview with the MA on 08/30/22 at 9:15am revealed:
-Resident #1 was a falls risk and had frequent falls.
-Resident #1 was total care and dependent upon staff for all activities of daily living (ADLs).
-Since the first of August 2022, Resident #1 required staff assistance with ambulation at times because she walked with her eyes closed and would push on tables.
-Since the first of August 2022, staff ambulated beside Resident #1 at times or placed her in a wheelchair and pushed her because she ambulated with her eyes closed.

Interview with a second MA on 08/30/22 at 10:29am revealed:
-She checked on residents in the SCU every hour to be sure they were safe.

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-The safety checks were documented electronically in the resident's record.

Telephone interview with Resident #1's PCP on 08/30/22 at 4:20pm revealed:
-Resident #1 ambulated with her eyes closed and had a history of falls.
-Resident #1 required constant staff supervision daily while awake to keep the resident safe from falls.
-Resident #1 required supervision every 30 minutes to one hour while sleeping.
-The facility did not need an order to increase supervision.

Interview with the Administrator on 08/30/22 at 5:04pm revealed:
-Resident #1 ambulated with her eyes closed which placed her at risk for falls.
-Staff were expected to be certain Resident #1 was not in her room alone.
-There should always be one staff with Resident #1 either with the resident sitting in a chair in the common living room or in a wheelchair wherever the MA went in the SCU.
-Resident #1 required staff to walk with her to prevent falls when ambulating.
-She did not know if Resident #1's supervision requirements were documented in her care plan per the supervision policy.
-She did not know if the facility needed a physician's order to increase supervision.

Telephone interview with Resident #1's family member on 08/31/22 at 10:42am revealed:
-The resident had a diagnosis of dementia, was confused, and wandered.
-The resident kept her eyes closed while ambulating.
-The resident had fallen several times while at the

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facility over the last six months.
-He did not know if the facility had implemented any interventions to keep the resident safe from falls.
-No one from the facility had spoken with him regarding transferring the resident to a skilled nursing facility.

Second interview with the Administrator on 08/31/22 at 3:09pm revealed:
-Every morning, the facility had a stand-up meeting consisting of the Administrator, the acting RCC/LHPS nurse, the medical records coordinator, Chaplin, Activities Coordinator, secretary, and marketing director.
-Two weeks ago, she determined during a morning stand up meeting that Resident #1 needed a higher level of care than what the facility could provide in order to keep the resident safe.
-Resident #1 needed constant supervision by staff to guide the resident with her activities of daily living (ADLs) and to keep her safe when ambulating.
-The RCC/LHPS RN and the medical records coordinator called Resident #1's PCP for an order to transfer the resident to a skilled nursing facility (SNF).
-On 08/29/22, she submitted the new 08/26/22 FL-2 indicating the need for transfer to a SNF and referral packet to the social worker at the SNF to process and was waiting for the admissions director to contact her regarding the status.
-She was not certain of any supervision interventions put in place by the facility for Resident #1 to keep her safe until transferred to the SNF.
-She thought the SCU staff had increased supervision checks on Resident #1 and made certain the resident was not in her room alone

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without staff.
-The facility could not keep Resident #1 safe unless she brought in extra staff to constantly supervise the resident.
-She did not tell the SCU staff to provide constant supervision to Resident #1, or bring in other staff to provide constant supervision to the resident, because every time she had been in the SCU she had observed Resident #1 in the common living room with staff, even during the night.
-She did not have extra staff to provide constant supervision to Resident #1 on 08/26/22 when the new FL-2 was completed because she had open slots in the staffing schedule for the facility she had to fill.

Telephone interview with the Executive Director (ED) on 08/31/22 at 4:45pm revealed:
-Resident #1 spent a lot of time in the common area of the SCU.
-Resident #1 would fall as soon as staff walked out of the room.
-She expected, if Resident #1 needed constant staff supervision, the Administrator would have discussed with her to determine how to have made that happen.

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The facility failed to provide supervision for Resident #2 who had exhibited wandering behavior and was unable to safely return to the facility unsupervised resulting in the resident found confused in a neighboring building and needing an escort to return to the assisted living facility, and for Resident #1 who resided in the Special Care Unit and ambulated with her eyes closed resulting in falls on 08/14/22 and on 08/30/22 where she sustained a head injury. This failure placed residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation.

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D 270	Continued From page 34 ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 01, 2022.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to respond to a fall in accordance to the facility's policy and procedure for 1 of 5 sampled residents (#1) who resided in the Special Care Unit related to a fall with a head injury requiring emergency treatment. The findings are: Review of the facility's Falls Policy dated 09/01/03	D 271		

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D 271	Continued From page 35 and revised on 06/22/07 revealed: -For suspected serious injury, call 911 for assistance if the fall involves any head or neck injury. -Do not let the resident move if the fall involves any head or neck injury. -If there appeared to be no injury, and the resident thought they could get up, place a chair or other supporting device within the resident's reach; do not lift the resident; Stabilize the chair or device while the resident attempted to stand; call 911 if the resident experienced pain trying to get up and stop the resident from moving. 1. Review of Resident #1's current FL-2 dated 08/26/22 revealed: -Diagnoses included dementia, hypertension, and osteoporosis. -The current level of care was documented as a Special Care Unit (SCU). -The recommended level of care was documented as a Skilled Nursing Facility (SNF). -The resident was constantly disoriented, ambulatory, and had aphasia (a reading, speaking, or writing disorder resulting from a brain injury). Review of Resident #1's current care plan dated 07/12/22 revealed: -There was documentation under the section "social and health history" consisting of: alert to self only, she had fallen several times resulting in head and facial injuries requiring sutures/staples, she was instructed to ambulate with the walker but did not remember the walker, she did not understand the need to use the walker for ambulation, she ambulated frequently with her eyes closed which compromised her safety even further, she had difficulty communicating due to expressive aphasia, she needed frequent	D 271		

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queuing and prompting, staff were to assist with activities of daily living (ADLs) as needed, staff were to monitor for changes or concerns.
-She was always disoriented and had significant memory loss requiring direction.
-She required limited staff assistance with toileting, ambulation, dressing, grooming, and transfers.
-She required extensive staff assistance with bathing.
-The
Resident Care Coordinator (RCC)/Licensed Health Professional Support (LHPS) Registered Nurse (RN) was the assessor.

Review of Resident #1's monthly nursing summary dated 08/03/22 revealed:
-The resident was confused and wandered.
-She ambulated independently and did not require staff assistance for transfers.
-Her vision was poor, hearing good, and speech clear.
-The resident was dependent upon staff for grooming and required staff assistance for showering.

Observation of the Special Care Unit (SCU) common living room on 08/30/22 from 3:04pm to 3:30pm revealed:
-At 3:04pm, Resident #1 was sitting in a chair with her eyes closed.
-At 3:10pm, Resident #1 was standing, leaning forward, and her eyes were closed.
-Resident #1 fell forward striking the right side of her head on the floor as she took a step.
-The medication aide (MA) approached the resident as she laid on the floor and lifted the residents head.
-The right side of Resident #1's head was bleeding.

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-The MA stood and ran to the nurses' station yelling for the second MA to help.
-The resident laid partially on her right side and stomach with her eyes closed and not moving.
-At 3:12pm, the second MA and a Physical Therapy Assistant (PTA) responded to Resident #1.
-The second MA spoke to Resident #1; the resident did not respond.
-The second MA lifted the resident's head and applied gauze to the residents bleeding head wound.
-The PTA asked the second MA if they could lift the resident from the floor.
-The second MA told the PTA they could if the Resident #1 was able to get up.
-At 3:16pm, the second MA and the PTA lifted Resident #1's upper body from the floor and held her against the PTA as he sat in the floor; the resident did not respond.
-The second MA held the gauze to Resident #1's head wound.
-The PTA told Resident #1 he was going to sit her up.
-Resident #1's speech was mumbled and incomprehensible.
-At 3:18pm, the PTA crossed Resident #1's arms and the second MA and PTA lifted the resident to a standing position.
-Resident #1's body was limp.
-Blood continued to drip from Resident #1's head wound.
-The PTA turned and pivoted Resident #1 and sat her in the chair.
-Resident #1 sat in the chair with her eyes closed.
-The second MA held a gauze pad to the right of Resident #1's head wound.
-Resident #1's right elbow was bleeding.
-The first MA applied a gauze pad to the resident's right elbow.

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-At 3:28pm, the second MA and the RCC/LHPS RN picked up and stood Resident #1 from the chair, pivoted the resident and transferred her to a wheelchair.
-Resident #1 required maximum staff assistance for the transfer into the wheelchair.
-The second MA and the RCC/LHPS RN pushed Resident #1 in the wheelchair down the hall towards the SCU dining room.
-At 3:30pm, Emergency Medical Services (EMS) arrived.
-Resident #1 was transferred from the wheelchair to the EMS stretcher by EMS; the resident's eyes remained closed.

Interview with the PTA on 08/30/22 at 3:23pm revealed he asked the second MA if they could assist the resident off the floor to help her be more comfortable.

Interview with the RCC/LHPS RN on 08/30/22 at 3:45pm revealed:
-She and the second MA transferred Resident #1 to the wheelchair from the chair in the common living area because there were two residents who were beginning to fight.
-The fall policy was to obtain vital signs, call management to assist, and call 911 for the need of EMS.
-If the resident was unresponsive, staff were to leave the resident where the resident was because of possible head or neck injuries.

Review of Resident #1's local hospital emergency room (ER) visit note dated 08/30/22 revealed:
-Diagnoses included fall, scalp laceration, and dementia.
-The resident was transferred to the ER due to injuries sustained from a fall at the facility.
-The resident was confused and could not recall

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the incident.
-The resident sustained a three centimeter (cm) long by one cm deep laceration to the side and top of her head.
-Bleeding was controlled with direct pressure, the wound was cleaned and irrigated, and five staples applied to close the laceration.

Observations of the SCU common living room on 08/30/22 from 3:10pm to 3:28pm revealed:
-There were three to five residents in the common living room.
-One resident with a walker kept asking what time dinner was going to be served.
-There were no residents who were agitated or presenting with any behavior issues.

Interview with the Administrator on 08/30/22 at 4:10pm revealed:
-Staff were to leave residents on the floor without moving the resident because of questionable injuries when responding to falls.
-Staff who picked a resident up from the floor who had fallen placed the resident at risk by worsening their condition.
-One staff was to obtain vital signs while the other staff called EMS.
-The resident was not to be left unattended by staff.
-EMS staff were professionals trained in responding to trauma, able to assess residents for injuries, and were more qualified than facility staff to pick residents up from the floor.

Interview with a MA on 08/30/22 at 4:30pm revealed:
-She ran to check on Resident #1 when she saw her falling.
-Resident #1 was on the floor, and she asked the resident if she was okay.

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-Resident #1 looked at her and did not speak.
-Resident #1 was bleeding from her head.
-She called for the second MA to help.
-She was trained to call EMS, the resident's family, the Administrator, and the acting RCC when responding to a resident accident or incident.
-She did not answer when asked if she was trained in any other steps when responding to a resident accident or incident.

Interview with a second MA on 08/30/22 at 4:40pm revealed:
-She was in the SCU dining room putting away lunch when she heard the first MA call for help.
-She was trained when responding to resident accidents or incidents to assist the resident from the floor if the resident was moving, talking, and able to get up.
-She asked Resident #1 if she wanted to get up from the floor.
-After one to two minutes of asking, Resident #1 responded yes.
-She and the PTA then assisted Resident #1 from the floor to the chair.
-It was okay to move Resident #1 because she responded to her even though it was one to two minutes after she asked the resident if she wanted to get up.
-The PTA helped her sit up Resident #1 from the floor to get the resident in a more comfortable position.
-She and the PTA then stood the resident and transferred Resident #1 to a chair.
-She held pressure to Resident #1's head wound while waiting for EMS to respond.
-The RCC/LHPS RN responded and they transferred Resident #1 to a wheelchair to remove the resident from other residents in the common living room.

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Telephone interview with a Paramedic from the local EMS agency on 08/30/22 at 6:15pm revealed:
-She was the Paramedic who responded to Resident #1's fall on 08/30/22.
-Resident #1 was sitting in a wheelchair with two staff at her side in the dining room when EMS arrived.
-Staff should have not moved the resident from the floor because the resident could have sustained injuries which could have been worsened by moving the resident such as neck or other spinal injuries.
-EMS was trained in responding to emergencies.
-She would have performed a complete trauma assessment on the resident and stabilized her cervical spine if she had been on the floor when EMS arrived.

____

The facility failed to follow policies and procedures for Resident #1, who fell and sustained a head injury and was unresponsive. Staff moved the resident from the floor to a chair, then from the chair to a wheelchair without knowing the extent of the injuries before EMS arrived putting the resident at risk for increased injuries. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/22 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022

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D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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:
FOLLOW-UP TO TYPE B VIOLATION.
The Type B Violation was abated.
Non-compliance continues.

Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider was notified for 2 of 5 (#1, #2) sampled residents related to TED hose application and Physical Therapy referrals (#1) , and a resident with ordered blood pressure parameter notifications (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 08/26/22 revealed:
-Diagnoses included dementia, hypertension, and osteoporosis.
-The current level of care was documented as a Special Care Unit (SCU).
-The recommended level of care was documented as a Skilled Nursing Facility (SNF).
-The resident was constantly disoriented, ambulatory, and had aphasia (a reading, speaking, or writing disorder resulting from a brain injury).
-There was no documentation regarding inappropriate behaviors.

Review of Resident #1's previous FL-2 dated 03/14/22 revealed:
-Diagnoses included dementia, hypertension, and

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D 273	Continued From page 43 osteoporosis. -The facility was documented as a SCU with the current level of care a rest home. . -The recommended level of care was a rest home. -The resident wandered, was constantly disoriented, and ambulatory. -The resident communicated her needs verbally without documentation of aphasia. Review of Resident #1's current care plan dated 07/12/22 revealed: -She was always disoriented and had significant memory loss requiring direction. -She required limited staff assistance with toileting, ambulation, dressing, grooming, and transfers. -She required extensive staff assistance with bathing. a. Review of Resident #1's electronic physician's order sheet dated 07/06/22 revealed there was an order to refer the resident to home health Physical Therapy (PT) due to muscle weakness and gait instability related to diagnosis of fecal impaction and acute kidney injury. Review of Resident #1's electronic physician's order sheet dated 08/05/22 revealed there was an order to refer the resident to home health PT due to muscle weakness and gait instability related to diagnosis of fecal impaction and acute kidney injury. Review of Resident #1's physician's orders dated 08/15/22 revealed there was an order for home health PT due to generalized muscle weakness resulting from hypertension and a history of a stroke and a right hip replacement.	D 273		

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Review of Resident #1's facility record revealed there was no documentation of a PT evaluation or visit from 07/06/22 to 08/16/12.

Review of the facility's Incident and Accident (IA) reports for Resident #1 from 06/21/22 to 08/30/22 revealed:
-The resident was found on the floor of an unoccupied room on 06/21/22 at 4:40pm sustaining facial abrasions and a laceration to an undocumented site.
-The resident sustained skin tears to both elbows in her bathroom the morning of 08/14/22; specifics of the injuries were not documented.
-The resident fell from a standing position in the common living area of the SCU sustaining a head injury on 08/30/22.

Telephone interview with the Branch Manager of the facility's contracted PT provider on 08/31/22 at 8:40am revealed:
-They did not have a PT order for Resident #1 dated 07/06/22 or 08/05/22.
-They received a PT order for Resident #1 dated 08/15/22.
-The resident was opened for PT on 08/17/22.
-Resident #1 did not have PT between 07/06/22 and 08/16/22.
-It was the responsibility of the facility and/or the residents PCP to fax therapy orders.
-Once received, the resident would be evaluated within 24 to 48 hours after receipt of the order.
-She expected the facility to have faxed the 07/06/22 and 08/05/22 orders for PT and called to check the status.
-The PT provider had a public representative in the facility weekly the facility staff could have given the order to or spoken with about the PT referral.

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D 273	Continued From page 45 Interview with the Resident Care Coordinator (RCC)/Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 08/31/22 at 9:14am revealed: -The electronic physician's sheets were printed based on what orders were in the computer. -She printed the orders then would send to the Primary Care Provider (PCP) asking the PCP if she wanted to continue all the orders listed. -If so, the PCP would sign and date the orders then send back to the facility. -The PCP would draw a line through, marking out the orders on the physician's order sheet of any orders she did not want. -The PT orders on the 07/06/22 and 08/05/22 physician order sheets were originally entered on 06/02/22 and carried over to the physician order sheets. -The PCP signed Resident #1's 07/06/22 and 08/05/22 physician order sheets without striking out the orders for PT. -She did not consider the 07/06/22 and 08/05/22 physician order sheets indicating PT for Resident #1 were new orders even though the PCP did not draw a line through those orders. Telephone interview with Resident #1's family member on 08/31/22 at 10:49am revealed: -Resident #1 had a diagnosis of dementia and was confused. -The resident had a history of falls while ambulating and from chairs with head injuries while at the facility. -He did not know the resident was ordered PT. Telephone interview with Resident #1's current Physical Therapist on 08/31/22 at 11:15am revealed: -Resident #1 would have been treated by PT for gait instability with methods to increase the	D 273		

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resident's strength, balance, functional mobility, transfers, and ambulation would have been initiated had the facility sent the 07/06/22 PT order to the home health agency.
-Interventions could have been put in place that would have prevented the resident's falls at the facility.
-She would have instructed staff to increase Resident #1's supervision had the facility sent residents 07/06/22 and/or 08/05/22 PT orders to the home health agency.

Interview with the Administrator on 08/31/22 at 11:46am revealed:
-The RCC/LHPS RN and the medical records coordinator were responsible for reviewing physician order sheets and processing the orders.
-The medical records coordinator took the orders to the PCP for signature then picked up the orders and returned them to the facility after they were signed.
-The RCC/LHPS RN, medical records coordinator, or the MA entered PT orders in the electronic system to print on the physician order sheets.
-The physician order sheets were the same as medication/treatment orders.
-She expected Resident #1's physician order sheets dated 07/06/22 and 08/05/22 to be processed and the resident to receive PT as ordered.
-It was the responsibility of the medical records coordinator to send the 07/06/22 and 08/05/22 PT orders to the therapy department.

Interview with the medical records coordinator on 08/31/22 at 2:45pm revealed:
-She generated resident orders every month, printed as the physician order sheet and gave the

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physician's order sheets to the PCP for review and signature.
-The PCP marked out any orders on the physician order sheets they did not want.
-She gave the signed orders to the RCC/LHPS RN to review.
-Once the RCC/LHPS RN reviewed the orders, she gave them to her to file in the resident's facility record.
-She did not know Resident #1 had PT orders on the 07/06/22 and 08/05/22 physician order sheets until prompted by the survey.
-It was the responsibility of the RCC/LHPS RN to review physician order sheets for orders.

Telephone interview with Resident #1's PCP on 08/31/22 at 3:05pm revealed:
-The resident's previous PCP order PT on the 07/06/22 and 08/05/22 physician order sheets.
-The facility was responsible to send the resident's 07/06/22 and 08/05/22 physician order sheets to the home health company to initiate the PT orders.
-PT would have aided the resident in safe ambulation and gait stability.
-If the 07/06/22 PT order was initiated by the facility, Resident #1's falls could have been prevented.

Telephone interview with the Executive Director (ED) on 08/31/22 at 4:45pm revealed:
-She expected Resident #1's physician order sheets dated 07/06/22 and 08/05/22 to have been sent to therapy as to started PT for the resident per orders.
-The MA, RCC/LHPS RN, or the Administrator could process orders for therapy.
-She did not know Resident #1 had a 07/06/22 or 08/05/22 physicians order sheet documenting the need for therapy that was not initiated.

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D 273	Continued From page 48 -It was the responsibility of the RCC/LHPS RN to review and process the physician order sheets. b. Review of Resident #1's current FL-2 dated 08/26/22 revealed there was an order for compression hose on every morning and off every night. Observation of Resident #1 on 08/30/22 at 9:10am revealed: -She was lying in her bed with her eyes closed. -Her speech was mumbled, and she kept her eyes closed. -The resident was not wearing compression hose. Second observation of Resident #1 on 08/30/22 at 3:04pm revealed: -The resident was sitting in a chair located in the common living room of the SCU. -The resident was not wearing compression hose. Review of Resident #1's electronic treatment administration record (eTAR) for 08/30/22 revealed: -There was an electronic entry for compression hose twice daily to be applied every morning at 8:00am to bilateral lower extremities and removed every night at 8:00pm for edema management. -There was documentation compression hose were applied to the resident on 08/30/22 at 8:00am. Interview with the medication aide (MA) on 08/30/22 at 3:04pm revealed: -Resident #1 had an order for compression hose. -It was the responsibility of the staff who assisted the resident up and dressed every morning to	D 273		

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apply the compression hose.
-Compression hose application was documented in the resident's electronic record.
-Resident #1 was already dressed when she arrived to work today, 08/30/22, at 6:00am.
-Resident #1 did not have on compression hose when she arrived for work this morning, 08/30/22.
-She did not apply the compression hose to Resident #1 because she was already dressed.
-She did not remember documenting she applied compression hose to Resident #1 this morning, 08/30/22.
-Resident #1 had two pairs of compression hose.
-One pair of Resident #1's compression hose was dirty, and they were washed today, 08/30/22.
-She could not locate Resident #1's second pair of compression hose.

Observation of the MA on 08/30/22 at 3:06pm revealed:
-She searched Resident #1's room for a second pair of compression hose.
-She could not locate Resident #1's second pair of compression hose.

Interview with the Administrator on 08/30/22 at 4:00pm revealed:
-The 6:00am to 6:00pm MA assigned to the medication cart for Resident #1 was responsible to put on Resident #1's compression hose.
-Compression hose orders were on the electronic medication treatment record (eMAR) and staff were to document when the hose were applied.
-The 6:00am to 6:00p MA for today, 08/30/22, should have applied compression hose to Resident #1's legs even though the resident was dressed when she arrived for work today, 08/30/22.
-The MA should not have documented compression hose were applied to Resident #1's

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legs if she did not apply them.

Telephone interview with Resident #1's current Primary Care Provider (PCP) on 08/30/22 at 4:15pm revealed:
-She was filling in for Resident #1's PCP who was on medical leave.
-She had only seen Resident #1 once or twice since taking over her care.
-She did not know the reason compression hose was ordered for the resident.
-Compression hose normally was ordered to treat lower extremity edema.
-Increased edema, especially when in a dependent position, could occur if the compression hose was not applied.
-Increased edema could cause skin integrity issues which could lead to an infection.
-She expected staff to have placed the compression hose on the resident as ordered.

2. Review of Resident 2's current FL-2 dated 07/13/22 revealed:
-Diagnoses included dementia, asthma, hyperlipidemia, and essential hypertension.
-There was an order to check the resident's blood pressure daily and call physician if systolic blood pressure was greater than 160. (According to the National Institute of Health, a person is considered hypertensive if the systolic blood pressure is 140 or higher and diastolic is 90 or higher).

Review of Resident #2's physician orders revealed:
-There was a handwritten physician's order dated 03/15/22 to please check blood pressures daily and call office if systolic is greater than 160.
-There was a physician's order on the physician order sheets dated 05/02/22, 06/02/22, 07/08/22,

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and 08/04/22 order to check blood pressure daily and call physician if systolic blood pressure was greater than 160.

Review of Resident #2's June 2022 electronic medication administration records (eMARs) revealed:
-There was an entry to please check blood pressure daily and call physician if systolic is greater than 160, scheduled for 8:00am.
-Resident #2's systolic blood pressure was documented as 170 on 06/02/22, 167 on 06/08/22, 180 on 06/14/22, 173 on 06/26/22, and 179 on 06/29/22.

Review of Resident #2's July 2022 eMARs revealed:
-There was an entry to please check blood pressure daily and call physician if systolic is greater than 160, scheduled for 8:00am.
-Resident #2's systolic blood pressure was documented as 188 on 07/07/22, 167 on 07/10/22, 173 on 07/21/22, and 183 on 07/27/22.

Review of Resident #2's August 2022 eMARs revealed:
-There was an entry to please check blood pressure daily and call physician if systolic is greater than 160, scheduled for 8:00am.
-Resident #2's systolic blood pressure was documented as 165 on 08/06/22, 169 on 08/23/22, 180 on 08/24/22, and 166 on 08/25/22.

Review of Resident #2's June 2022, July 2022, and August 2022 eMARs treatment notes revealed there was no documentation that Resident #2's primary care provider (PCP) had been notified of the systolic blood pressure reading greater than 160.

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Review of Resident #2's eMARs Clinical Notes Report from 06/08/22 through 08/27/22 revealed there was no documentation that Resident #2's PCP had been notified of the systolic blood pressure reading greater than 160.

Interview with the Medication Aide (MA) on 08/31/22 at 8:55am revealed:
-She checked Resident #2's blood pressure every morning before administering medication to the resident.
-She had never had to call Resident #2's PCP since being employed at the facility in April 2022.
-Resident #2's blood pressure usually was between 120 to 140.
-If the PCP was contacted, staff would document the PCP contact in the resident progress notes.
-There was no other place staff would document the PCP contacts.

Telephone interview with a second MA on 08/31/22 at 9:34am revealed:
-She checked Resident #2's blood pressure daily.
-She had not contacted the PCP regarding Resident #2's systolic blood pressure being "too high".
-She considered "too high" to be 200/140 and had never had that occur.
-She was aware of the instructions to call the PCP for a systolic blood pressure greater than 160 for Resident #2 but did not remember if the instructions populated on the eMARs.
-She thought the only thing that populated on the eMAR was "just pops up as blood pressure check".

Interview with the Administrator on 08/31/22 at 9:11am revealed:
-She expected the MAs to call the PCP and document the PCP contact.

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THE COVENTRY	**105 GOSSMAN DRIVE SOUTHERN PINES, NC 28387**

(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 273	Continued From page 53	D 273		

-The MAs could document the contact in the electronic MAR system or in the red binder kept on the medication cart.

Review of the red binder with the Administrator on 08/31/22 at 9:16am revealed there was no documentation of PCP contact for systolic blood pressures greater than 160 for Resident #2.

Continued interview with the Administrator on 08/31/22 at 9:16am revealed she expected the contracted nurse for the facility and the Medical Records Coordinator to check, follow up and ensure there was accurate documentation for physician contacts for ordered parameters.

Telephone interview with the PCP's call center nurse on 08/31/22 10:45am revealed the last notes, prior to today's (08/31/22) note that she saw in their electronic system about Resident #2's blood pressure readings was from March 17, 2022.

Telephone interview with the office nurse for Resident #2's PCP on 08/31/22 at 3:25pm revealed she did not recall any contact from the facility regarding blood pressure readings for Resident #2.

D 466 | 10A NCAC 13F .1308(b) Special Care Unit Staffing | D 466

10A NCAC 13F .1308 Special Care Unit Staffing
(b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063016	A. BUILDING: ____ B. WING ____	R-C 09/01/2022

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D 466	Continued From page 54	D 466		

This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to ensure a care coordinator was on duty in the special care unit (SCU) at least eight hours a day, five days a week.

The findings are:

Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 60 beds which included 14 beds for the special care unit (SCU).

Observations in the SCU on 08/30/22 at 9:10am revealed:
-There were 12 residents residing in the SCU.
-There were 2 medication aides (MA) on duty in the SCU.
-There was no personal care aide (PCA).
-There was no Special Care Coordinator (SCC) on duty.

Observations in the SCU on 08/31/22 at 8:10am revealed:
-There were 12 residents residing in the SCU.
-There was 1 PCA on duty in the SCU.
-There was 1 MA on duty in the SCU.
-The MA was feeding a resident who required constant staff supervision in the dining room of the SCU.
-There was no SCC on duty.

Interview with the MA on 08/31/22 at 8:10am revealed:
-She was the only MA on duty in the SCU today, 08/31/22, for the 6:00am to 6:00pm shift.
-She was the assigned MA for all 12 residents in

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D 466	Continued From page 55	D 466		

the SCU today.
-The resident kept her eyes closed and would not eat unless fed.
-There was 1 PCA on duty in the SCU today, 08/31/22, for the 6:00am to 6:00pm shift.
-There was no designated SCC on duty.

Interview with the facility's contracted acting Resident Care Coordinator (RCC) on 08/30/22 at 3:45pm revealed:
-The facility did not have a SCC in the six months she had been working at the facility.
-She did not know how long the facility had been without a SCC prior to her arrival.
-She was responsible for the acting RCC, Licensed Health Professional Support (LHPS) nurse, new employee orientation, and clinical skill check offs.
-She did not perform SCC duties.

Interview with the Administrator on 08/31/22 at 8:36am and 11:46am revealed:
-She had been the Administrator for one month.
-The facility did not have a SCC during that one-month time frame she had been at the facility.
-She did not know how long the facility had been without a SCC.
-She worked Monday through Friday from 9:00am to 5:00pm.
-She was available on call 24 hours a day/seven days a week.
-SCU staff last called her around 9:30pm on 08/30/22 regarding a resident bleeding from a wound.

Telephone interview with the Executive Director (ED) on 08/31/22 at 12:09pm revealed:
-The last time the facility had a SCC was the fall of 2021.

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D 466	Continued From page 56 -The acting RCC/LHPS nurse was responsible to assist in the entire facility to manage all clinical concerns, including in the SCU. -The facility contracted a second nurse to cover for the acting RCC/LHPS nurse when she was not on duty. -There were a couple of people she was considering hiring as the SCC but had not done so yet. -She had been looking for a SCC for a long time; she did not specify the length of time. -The SCU staff were to contact the Administrator, the acting RCC/LHPS nurse, or herself with any needs. Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings.	D 466		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and housekeeping and furnishings. The findings are:	D912		

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D912	Continued From page 57 1. Based on observations, interviews, and record reviews, the facility failed to ensure the Special Care Unit was free of hazards related to razors, scissors, hair spray, lotions, powder, shaving cream, perfume and other personal care items being stored in resident rooms; hand sanitizer and disinfectant wipes were stored unsecured on top of the medication carts. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision to 2 of 5 (#1, #2) residents sampled related to a resident with 2 falls within two weeks (#1) and a resident who wandered (#2). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to respond to a fall in accordance to the facility's policy and procedure for 1 of 5 sampled residents (#1) who resided in the Special Care Unit related to a fall with a head injury requiring emergency treatment. [Refer to Tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type B Violation)].	D912		