DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL 092209**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/04/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CARY	**1206 WEST CHATHAM STREET CARY, NORTH CAROLINA 27513**

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on September 28 and 29, 2022, desk survey on September 30, 2022, and onsite October 3 and 4, 2022.	D 000		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and	D 189		

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D 189	Continued From page 1 do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure personal care aides responsible for providing direct care including supervision and assistance during meals were not assigned dietary aide duties including setting tables, pouring beverages, plating food, serving meals, clearing dishes, washing dishes, cleaning dining tables and cleaning the dining room floor. The findings are: Observations during the breakfast meal in one of the two special care unit (SCU) dining rooms on 09/29/22 from 8:46am until 10:15am revealed: -At 8:46am, there were 15 residents in the SCU dining room with one personal care aide (PCA) who was setting the tables with silverware and drinking glasses. -Two additional PCAs brought the food cart into the dining room and then left. -At 8:48am, a fourth PCA was in the hallway with a resident and the first PCA was pouring beverages for the residents in the dining room. -At 8:52am, a fifth PCA was in and out of the dining room, getting and returning with orange juice. -The fourth PCA remained in the dining room.	D 189		

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D 189	Continued From page 2 -At 9:00am, the fourth PCA left the dining room and the fifth PCA returned with milk and then left. -The first PCA was in the prep kitchen with the door closed from 9:00am until 9:08am when she returned to the dining room with plated food on a cart that she began serving to residents. -At 9:11am, there was a total of 17 residents in the dining room. -At 9:12am, the second PCA left the dining room, the fifth PCA was passing out napkins to residents and the first PCA was serving plates of food to residents. -A resident was staring, not eating and unable to follow verbal prompts to eat. -A second resident was sleeping in his wheelchair and not eating. -The first and fifth PCAs continued to serve plates to residents in the dining room until 9:18am. -The fourth PCA was in and out of the dining room. -At 9:20am, the first PCA began serving coffee to residents and stopped to give a verbal prompt to the resident staring and not eating. -The resident was not able to follow the prompt and continued staring and grabbing onto his plate. -The fifth PCA left the dining room. -The second resident not eating continued sleeping in his wheelchair and not eating. -At 9:24am, the fifth PCA gave verbal prompts to the resident staring and the resident sleeping; neither resident started eating. -At 9:28am, the first PCA started clearing plates from tables in the dining room and the fifth PCA was assisting a resident with more coffee. -At 9:30am, the fifth PCA assisted the resident who was staring and holding onto his plate to eat a piece of bacon. -The resident then started eating bacon placed in his	D 189		

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D 189	Continued From page 3 hand by the PCA. -At 9:32am, the first and fifth PCAs were clearing dishes from the tables in the dining room. -After eating the bacon, he attempted to lift the plate and drink out of it until redirected by the fifth PCA passing by as she cleared dishes from tables. -By 9:52am, the resident had stopped eating the bacon and was dosing off at the table. -The second resident continued sleeping in his wheelchair at the table. -At 9:54am, the first PCA stopped cleaning up the dining room and placed a pancake in the hand of the resident who had dosed off after eating bacon. -The first PCA then took the resident who had been sleeping out of the dining room. -From 10:02am through 10:15am, the first and fifth PCAs continued cleaning tables, sweeping the dining room floor and washing dishes. Interview with a PCA on 09/29/22 at 11:22am revealed: -There were five residents in the second SCU dining room who required staff assistance to eat all meals. -There were 10 residents in the SCU who required two staff for toileting, bathing and transfers. -There were 9 to 10 residents who required the use of a hydraulic lift for transfers in and out of bed. -Two staff were needed to use the hydraulic lift and all residents using it were transferred to their beds for incontinence care. -She was responsible for setting tables and pouring drinks. -The meal carts came up from the facility kitchen with food in pans, so she was responsible for plating food. -The residents in the SCU dining room were mostly independent with eating, there were 3 residents who needed staff to prompt and encourage them.	D 189		

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D 189	Continued From page 4 -There were 5 residents in the second SCU dining room who required staff assistance to eat. -Staff were responsible setting tables, pouring drinks, plating and serving food, cleaning dishes, cleaning tables and sweeping the floor in the second SCU dining room as well. -On average, on one shift out every five first shifts, she was responsible for washing, drying, folding and putting away residents' clothing and linens. Telephone interview with a family member on 10/04/22 at 1:46pm revealed: -She visited with her family member on a weekly basis. -She observed the PCAs on the SCU performing dietary duties. -The PCAs had to plate the meal and serve the meal to residents. -The PCAs cleared the dining room tables and washed the dishes. -There was a day when she asked a PCA for assistance with her family member's personal care, but the PCA was unable to assist due to cleaning the dishes. Interview with the Dining Services Director on 10/04/22 at 12:20pm revealed: -Meals were delivered to the SCU in serving pans stored in the heated food cart by the dietary staff. -SCU staff was responsible for plating and serving food. -SCU staff was responsible for washing the dishes on the SCU. Interview with the Resident Care Director (RCD) on 10/04/22 at 5:53pm revealed: -She was not aware that PCAs were primarily for resident care and should not be assigned dietary aide duties.	D 189		

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D 189	Continued From page 5 -It was a corporate model to have universal PCAs who provided all services to a group of residents. Interview with the Administrator on 10/04/22 at 6:25pm revealed: -He was not aware that PCAs were primarily responsible for resident care and should not be assigned dietary aide duties. -It was a corporate model to have universal PCAs who provided all services to a group of residents.	D 189		
D 269	10 A 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 ensure 1 of 7 sampled residents (#6) had personal care provided by staff including incontinence care and getting the resident up, dressed, and ready for breakfast on 10/04/22. The findings are: Review of Resident #6's current FL-2 dated 08/09/22 revealed: -Diagnoses included dementia, cerebral infarction, atrial fibrillation, anemia, and Vitamin D deficiency. -The resident was intermittently disoriented. -The resident was semi-ambulatory and used a	D 269		

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D 269	Continued From page 6 wheelchair. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing, dressing, and feeding. Review of Resident #6's assessment and care plan dated 06/09/22 revealed: -The resident had muscle weakness due to partial paralysis from a stroke. -The resident required supervision and cueing by staff for eating. -The resident needed to be reminded and assisted to the dining room during mealtimes. -The resident required physical assistance by one staff for ambulation, dressing, and grooming. -The resident required physical assistance by two staff for transferring. -The resident required "custom assistance" by staff for toileting and bathing due to taking the resident a long time to move his left side. -The resident had a history of fungal infection and pressure related skin breakdown. -The resident needed assistance with turning and repositioning frequently (3 to 4 times per shift) and as needed during the shift while in bed. Observation of Resident #6 on 10/04/22 at 10:12am revealed: -The resident was in his room alone with the door closed. -The resident was lying in a hospital bed in a low position with the covers over his head. -The resident's upper body was positioned near the edge of the bed toward the bed halo near the resident's pillow. -There was a blue fall mat under the resident's bed and	D 269		

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D 269	Continued From page 7 had not been pulled out beside the bed. -There was a wheelchair about 2 feet from the bed with the back of the wheelchair toward the bed. Interview with a personal care aide (PCA) on 10/04/22 at 10:30am revealed: -She had worked at the facility about a week. -She had not provided any care to Resident #6 that morning, 10/04/22. -Resident #9 needed assistance by staff with getting out of bed, dressing, bathing, transferring, and incontinence care. Interview with a medication aide (MA) on 10/04/22 at 10:40am revealed: -She was not sure which PCA was assigned to provide care to Resident #6 during first shift today, 10/04/22. -The PCAs were responsible for providing care to Resident #6, including transferring, bathing, dressing, turning and repositioning, and incontinence care every 2 hours. Interview with a PCA/MA on 10/04/22 at 10:50am revealed: -She usually worked second shift but she was working first shift today to help out. -She was not assigned to provide care to Resident #6 today, 10/04/22. -She was helping in the dining room between 8:00am and 8:30am and had a plate of food for Resident #6 but noticed the resident was not in the dining room. -She went to Resident #6's room between 8:00am and 8:30am that morning and the resident was in bed and said he was not hungry. -She did not know who was assigned to provide personal care to Resident #6 on 10/04/22.	D 269		

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D 269	Continued From page 8 Review of the assignment sheets for the special care unit (SCU) on 10/04/22 at 11:03am revealed: -There was an assignment sheet dated 10/04/22. -Resident #6 was on the “Cherry” assignment sheet. A second interview with the PCA on 10/04/22 at 11:08am revealed: -She was not assigned to provide care to Resident #6 that morning, 10/04/22. -She did not know who the assigned PCA for Resident #6 was for first shift today, 10/04/22. -She was assigned residents on the “Cherry” assignment sheet and that did not include Resident #6. -There were 7 residents for each of the assignments in the SCU. -Staff usually met the Lead PCA/MA in the care manager’s office and the assignment sheets were usually ready at the beginning of the shift. -She did not get an assignment sheet today when she came on duty because she was the first staff on duty for first shift in the SCU. -Staff usually had the same assignment so she was going by her previous assignment. -She did not have a copy of her previous assignment sheet with her. -She did not know who the Lead PCA/MA was for first shift today. -She was not aware Resident #6 was on her assignment sheet for first shift today. -She thought a different resident was on her assignment sheet and she had provided care for that resident instead of Resident #6. -This had not happened before and any other time she had been assigned to Resident #6, she had provided care for him.	D 269		

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D 269	Continued From page 9 Interview with Resident #6 on 10/04/22 at 11:11am revealed: -No staff person came to his room to get him up this morning, 10/04/22. -He was very hungry and no one had offered breakfast to him. -He had been in the bed since staff put him in bed last night (could not specify time). Observation of Resident #6 on 10/04/22 at 11:11am revealed: -The PCA provided incontinence care to Resident #6 by changing the resident's incontinence brief while the resident was lying in bed. -There were 2 circular dark pink areas on the resident's lower back, above the buttock area. -The resident's buttocks had reddened skin on both sides. -The resident's skin in his scrotal area was red and irritated. -The resident's incontinence brief was saturated with urine. -The PCA cleaned the resident, applied barrier cream, and a put on a clean incontinence brief. -The PCA dressed the resident and transferred the resident from the bed to the wheelchair by herself, without calling for assistance. -The PCA groomed the resident's hair and pushed the resident in the wheelchair to the common area. Interview with the Lead PCA/MA on 10/04/22 at 12:26pm revealed: -She was filling in as the Lead PCA/MA that morning, 10/04/22, in the SCU. -She laid out the assignment sheets in the care manager's office that morning, 10/04/22.	D 269		

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D 269	Continued From page 10 -She was not aware staff did not get up Resident #6 this morning and provide personal care to him. -Resident #6 was usually gotten up by staff and taken to the dining room for breakfast. -Resident #6 and another resident were switched on the assignment sheet last week. -The PCAs should get a new assignment sheet every day in case changes were made. Interview with a second Lead PCA/MA on 10/04/22 at 5:14pm revealed: -She worked on 10/03/22 and assisted a PCA in putting Resident #6 to bed between 7:30pm – 7:45pm on 10/03/22. -The last rounds for providing incontinence care to residents on third shift was around 5:00am. -Resident #6 was provided incontinence care between 5:00am and 6:00am on the morning of 10/04/22, prior to first shift staff coming on duty. -First shift staff would be responsible for providing incontinence care after 6:00am. -Resident #6 needed to have incontinence care at least every 2 hours because the resident's skin on his buttocks was usually red. Interview with the Assisted Living Coordinator (ALC) on 10/04/22 at 12:34pm revealed: -The Special Care Coordinator (SCC) usually made assignments for the SCU staff. -Since the SCC position was vacant, a senior float assistant from corporate had been coming to the facility and she moved the assignments around last week. -Staff in the SCU received assignment sheets at the start of each shift. -The PCAs were responsible for getting residents up and	D 269		

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D 269	Continued From page 11 to breakfast for the residents on their assignment sheet. -There were some call outs that morning, 10/04/22, on first shift so staff working in the SCU were not the usual group that worked in the SCU. -She also assisted in the SCU that morning and she received an assignment sheet from the Lead PCA/MA. -The Lead PCA/MA was responsible for making sure the PCAs completed their assignments. -The PCA who failed to provide personal care to Resident #6 that morning was new and should have been using the new assignment sheet. -The PCA should have got the assistance of another staff person to transfer Resident #6 because the resident required two-person assistance for transfers for safety. Review of Resident #6's October 2022 electronic personal care log printed on 10/04/22 at 5:22pm revealed: -Bathroom/Incontinence assistance was documented as provided to the resident on 10/04/22 at 1:17am. -Bathroom/Incontinence assistance was documented as provided to the resident on 10/04/22 at 1:26pm. -There was no other documentation of incontinence care provided to the resident on 10/04/22. A second interview with the ALC on 10/04/22 at 5:46pm revealed: -Resident #6 should be provided incontinence care at least every 2 hours. -It was not acceptable that Resident #6 did not receive personal care and was not gotten up for breakfast by staff on the morning of 10/04/22. -Resident #6 had a history of redness and skin breakdown and needed to be provided incontinence	D 269		

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D 269	Continued From page 12 care at least every 2 hours. -The PCAs were responsible for documenting incontinence care provided to residents on the electronic personal care log. -The PCAs should document on the electronic personal care log after each incontinence care provided. -She thought some staff may only be documenting once at the end of their shift instead of each time they provided care. Interview with the Resident Care Director (RCD) on 10/04/22 at 5:44pm revealed: -The PCAs should provide incontinence care to Resident #6 every 2 hours. -The PCAs should document incontinence care on the electronic personal care logs each time that care was provided to a resident.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: **TYPE A1 VIOLATION** Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 8 sampled residents (#4, #6, and #7) on the special care	D 270		

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D 270	Continued From page 13 unit (SCU) who had histories of impaired mobility requiring staff assistance with transfers and ambulation and had multiple falls with injuries including large bruises (#4), skin tears (#7), abrasions (#7) and a large forehead hematoma (#6) and requiring x-rays, emergency medical services (EMS) and emergency room evaluations. The findings are: Review of the facility's Fall Management Program dated 08/2022 revealed: -The program helped facility team members identify residents at risk of falling, address identified risks in the resident's service/care plan and determine root cause after a fall so interventions could be put into place to prevent recurrence. -Unless there was evidence to suggest otherwise, when a resident was found on the floor, a fall was considered to have occurred. -A resident who has rolled off a bed or mattress that was close to the floor sustained a fall. -The facility was obligated to complete an investigation and put interventions in place to prevent another fall. -This fall program used the assess, plan, implement, and evaluate approach to care giving. -This program helped the resident care team to: identify residents who are at risk of falls; implement interventions to help prevent falls; ensure a focus on a safe environment and reduce the likelihood of injury from a fall; manage falls when they occur; evaluate the effectiveness of interventions through the care planning process and make changes, as necessary, to prevent additional falls; and provide team member education, training, and resources. -The entire interdisciplinary team must ensure that	D 270		

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D 270	Continued From page 14 planned interventions and treatments are carried out as written in the resident's service/care plan. 1. Review of Resident #7's current FL-2 dated 06/13/22 revealed diagnoses included dementia, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hypothyroidism, cerebral vascular accident and subdural hematoma. Review of Resident #7's FL-2 dated 06/13/22 revealed an order for physical therapy (PT) and occupational therapy (OT). Review of Resident #7's current signed care plan dated 07/08/22 revealed: -He had impaired cognitive function related to dementia and needed cues, prompts and simple step by step directions. -He used a wheelchair for mobility and required two staff for transfers in and out of the wheelchair. -He required one staff for assistance with toileting. Observation of Resident #7 on 09/28/22 at 9:13am revealed: -He was sitting in his wheelchair at a table in the kitchen area of the dining room on the special care unit (SCU). -He had a bandage on the right top of his head and on his left forehead. -He had a red dried abrasion on his left cheek under his eye. Interview with a personal care aide (PCA) on 09/28/22 at 9:13am revealed: -PCAs checked all residents on the SCU "all the time". -One PCA was assigned to monitor residents in each	D 270		

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D 270	Continued From page 15 living room on the SCU and one PCA walked the halls constantly. -PCAs completed rounds on all residents every two hours. Observations of Resident #7's room on 09/28/22 at 9:23am revealed there was a hospital with a fall mat underneath the bed. Observations of one of the SCU living rooms from 8:02am until 8:34am revealed: -From 8:02am until 8:09am, Resident #7 was sitting in a wheelchair facing the TV. -He was constantly fidgeting, leaning forward and making attempts to get up unassisted. -At 8:09am, a PCA moved Resident #7 from the TV area and pushed the wheelchair up to a table with a puzzle laying on the surface. -There were 8 residents in the living room including Resident #7 as two PCAs left and went down the hall leaving no staff in the living room at 8:11am. -At 8:17am, one PCA walked in and then back out of the living room. -At 8:21am there were 10 residents in the living room including Resident #7 and no staff. -At 8:32am, there were 11 residents in the living room including Resident #7 and no staff. -At 8:34am, a PCA returned to the living room and started assisting residents to the dining room. -From 8:11am until 8:34am, there was no staff in the living room with 8 to 11 residents. Observations on the SCU on 10/03/22 from 11:02am until 11:30am revealed: -The Lead PCA and a PCA were in the two living room areas on the SCU from 11:02am through 11:08am.	D 270		

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D 270	Continued From page 16 -There was no staff on the hall from the SCU living room to Resident #7's room which was at inset corner end of the hall. -Resident #7 was sleeping in his wheelchair in the living room area of his room at 11:08am. -No staff were on the hall or checked on Resident #7 from 11:08am through 11:30am. Interview with the Lead PCA on 10/03/22 at 11:30am revealed: -She checked Resident #7 every 30 minutes. -He was also on the check and change program which meant he was checked for toileting needs every two hours and before and after meals. -She usually checked Resident #7 more frequently because he was unable to toilet himself. -She was waiting for the podiatrist to finish the visit with the resident before bringing him to the SCU living room. -She did not know the exact time she last checked Resident #7 and did not see the podiatrist leave. -She was not sure of the date when Resident #7 last fell. -The last fall she witnessed was one week ago (approximately 09/26/22). -More frequent safety checks were put in place for Resident #7, but she was not sure when the increased safety checks were implemented. -After a fall, the Care Coordinators reviewed factors contributing to the fall such as trying to go to the bathroom. -He had a fall mat for quite a while; she could not remember when he got it. -Charting safety checks twice per shift was recently implemented for Resident #7. -The safety checks were not timed for frequency, PCAs	D 270		

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D 270	Continued From page 17 just checked on him periodically. -There was no documentation that the fall mat was checked and in place when he was in his bed. -She did not know how Resident #7 got an abrasion on the top of his head. Review of Resident #7's electronic progress note dated 06/18/22 revealed: -He was found on the floor in his room near the bathroom without injury (no time indicated). -There was no documentation of an action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 06/22/22 revealed: -He was found on his floor during rounds laying on his back at bedside with no apparent injury (no time indicated). -There was no documentation of an action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's primary care provider (PCP) order dated 06/23/22 revealed an order for a hospital bed with gel mattress for falls and care needs. Review of Resident #7's electronic progress note dated 06/29/22 revealed: -He was found on the floor next to his bed around 6:15am with no injuries. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated	D 270		

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D 270	Continued From page 18 07/14/22 revealed: -He was found on the floor in his room next to his spouse's bed (no time indicated). -His head was near the wheel of the wheelchair. -He complained of neck and lower back pain and had decreased range of motion. -He was sent to the emergency room (ER). -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note date 07/16/22 revealed: -He was seen for a wellness visit. -He had four falls (since admission on 06/16/22) and scattered bruising on all his extremities. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 07/17/22 revealed: -He was found during rounds lying on the floor next to his bed the night before around 9:00pm. -He complained of pain and emergency medical services (EMS) was called but the family refused transport to the ER. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 08/10/22 revealed: -He was found sitting on top of the fall mat beside his bed (no time indicated). -A draining blister was seen on his right heel and the	D 270		

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D 270	Continued From page 19 primary care provider (PCP) was notified. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's PCP visit note dated 08/11/22 revealed: -He was seen for follow up after a fall in which he struck his head and was seen in the ER on 08/10/22. -He had an abrasion on his scalp and left knee. Review of Resident #7's electronic progress note dated 08/11/22 revealed: -"It was reported" the resident leaned forward and fell out of his wheelchair onto the floor (no time indicated). -He scraped the top of his head and had an abrasion to his left knee. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note date 08/15/22 revealed: -He was seen for a wellness visit. -He was a fall risk and had multiple falls per month due to poor safety awareness. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's PCP visit note dated 08/18/22 revealed: -He had multiple skin tears on all his extremities. -The PCP ordered a referral for home health for management of the skin tears.	D 270		

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D 270	Continued From page 20 Review of Resident #7's home health nurse (HHN) visit note dated 08/19/22 revealed: -Resident #7 was started on HHN visits for wound care. -The resident had multiple wounds including on his left forearm, both heels, top of his left foot, multiple scabbed areas on the top of his head. Review of Resident #7's HHN visit note dated 08/23/22 revealed wound care was provided for unspecified "multiple trauma" wounds from a recent fall. Review of Resident #7's electronic progress note dated 08/28/22 at 12:47pm revealed: -The resident had scattered open areas on the skin to his left lateral lower leg and a second one above the left knee. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 08/28/22 at 2:01pm revealed: -He was found on the floor next to his bed overnight (08/27/22 – 08/28/22) with no apparent injuries. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 08/29/22 revealed: -He was found on the floor in his room with a small abrasion to the right side of his head. -EMS was called and the family refused transport to the ER. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified.	D 270		

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D 270	Continued From page 21 Review of Resident #7's HHN visit note dated 08/30/22 revealed the resident had new wounds on his right head and right forehead from a recent fall. Review of Resident #7's electronic progress note dated 08/31/22 revealed: -The resident had two falls early that (08/31/22) morning. -The first fall occurred during third shift "in the early hours" with no apparent injury. -The second fall occurred around 8:00am resulting in the skin tear to his right lower leg being re-opened. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/01/22 revealed: -The resident was a safety risk and was continuously trying to get out of his wheelchair unassisted. -He was agitated and complained of left arm and shoulder pain. -The resident spit out his as needed medication for pain and agitation and the PCP and mental health provider (MHP) were notified. -There was no documentation of increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/07/22 revealed: -He was found during rounds on the floor next to his bed with no apparent injury. -He was added to the visit list for the PCP and MHP. -There was no documentation of increased supervision. -The author of the note was not identified.	D 270		

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D 270	Continued From page 22 Review of Resident #7's electronic progress note dated 09/08/22 revealed: -The resident was discussed in the at risk meeting due to multiple falls. -He was being referred to hospice. -There was no documentation of increased supervision. -The author of the note was not identified. Review of Resident #7's Hospice Nurse (HN) visit note dated 09/08/22 revealed wound care was provided for right head and left arm wounds. Review of Resident #7's electronic progress note dated 09/10/22 revealed: -He was found on the floor next to his bed around 10:30pm on 09/09/22 with no apparent injury. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/12/22 revealed: -He was found on the floor beside his bed that morning (09/12/22) with no apparent injuries. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/13/22 revealed: -He fell in the common area and complained of right hip pain. -EMS and hospice were called but the resident remained at the facility. -There was no documentation of action, intervention or increased supervision.	D 270		

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D 270	Continued From page 23 Review of Resident #7's PCP order dated 09/13/22 revealed an order for a right hip and pelvis x-ray due to pain after a fall. Review of Resident #7's electronic progress note dated 09/14/22 revealed: -The resident continued to have falls and was now on hospice. -The plan was to discuss private sitters with the family member for additional supervision, redirection and safety. -There was no documentation of increased supervision implemented by facility staff. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/19/22 revealed: -He fell that morning with no apparent injury. -EMS and hospice were called but the resident remained in the facility. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/22/22 revealed: -He was found on the floor in his living room at 11:30pm on 09/21/22. -He had an abrasion to the left side of his forehead and scattered bruising on his upper extremities. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/27/22 revealed:	D 270		

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D 270	Continued From page 24 -He was found on the floor at 7:00am with a re-opened abrasion on the left side of his forehead. -His service plan (care plan) was reviewed, and no updates were needed. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's electronic progress note dated 09/28/22 revealed: -He was found on the floor with an abrasion on the right side of his forehead. -There was no documentation of action, intervention or increased supervision. -The author of the note was not identified. Review of Resident #7's external accident/incident report dated 09/28/22 revealed: -The resident had a fall on 09/17/22 without injury. -The resident was found that morning (09/28/22) with a new open area on his forehead of unknown origin. Upon request on 09/28/22, 09/29/22 and 10/04/22 there were no accident/incident reports except 09/28/22 available for review. Review of Resident #7's "Documentation Survey Report" dated September 2022 revealed: -There was an entry for AM safety check every shift with only one row for 6:00am to 2:00pm. -There was documentation of safety checks at 12:28pm on 09/28/22, 10:57am on 09/29/22 and 7:56am on 09/30/22. Interview with a Supervisor/medication aide (MA) on 10/03/22 at 4:40pm revealed:	D 270		

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D 270	Continued From page 25 -Resident #7 was currently on documented safety checks because he was a fall risk. -She did not know when the safety checks had been put in place or how frequently he was checked. -The electronic tablets that PCAs used to identify care tasks listed safety checks as a task. Second interview with the Supervisor/MA 10/04/22 at 1:45pm revealed: -Resident #7 was not able to get out of bed and place himself on the floor. -He had a fall mat and there had been instances where she remembered seeing the fall mat and some where she did not see the fall mat. -A lot of Resident #7's falls occurred around last rounds between 4:00am and 6:00am for unknown reasons because he was not able to tell staff what he was trying to do. -When there were three PCAs working on the SCU staff were able to do safety checks on Resident #7 but not as frequently as it should have been. -Staff might be in another resident's room and not able to get down to check on Resident #7. -Staff was not able to be everywhere at one time. Interview with Resident #7's Hospice Nurse on 10/04/22 at 11:35am revealed: -Resident #7 was transferred from another hospice service and his first visit was last Monday (09/26/22). -Resident #7 had increased agitation in the morning and would get out of bed and fall. -On 09/27/22, staff reported the resident fell at bedside and re-opened the abrasion on the top of his head. -On 09/28/22, staff reported the resident fell before first shift and was found sitting on the floor next to his bed.	D 270		

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D 270	Continued From page 26 -She got the resident a low bed and instructed staff to check on him every 30 minutes when he was not in the common area. -She implemented medication changes to decrease his agitation after the fall on 09/28/22. -He did not have any falls since the medication change. -Anything prior to 09/26/22 would have been covered by the previous hospice agency. Telephone interview with Resident #7's former PCP on 10/04/22 at 2:54pm revealed: -She had been on leave since 08/31/22. -Resident #7 was admitted with a known history of falls (06/16/22). -A hospital bed (06/23/22) and fall mat (unsure of date) were immediately implemented to reduce potential injury related to falls. -Additionally, she reviewed his medications and initiated PT and OT. -At the end of August 2022 towards the beginning of September 2022 Resident #7 had started experiencing mental status and behavior changes. -The PCP made more medication changes, referred him for mental health services and made a second referral to hospice. Interview with the Resident Care Director (RCD) on 10/04/22 at 5:53pm revealed: -Prior to 09/28/22, fall prevention interventions included hydration, bed in low position, fall mat in place when the resident was in bed, encouraging participation in activities in common areas, clutter free environment and medication review. -There had been ongoing discussions with Resident #7's family member to implement a private sitter for supervision of the resident.	D 270		

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D 270	Continued From page 27 -Standard checks on the SCU were every two hours. -Safety checks for Resident #7 were initiated on 09/28/22. -PCAs reported resident falls so they should know which residents needed increased safety checks. -Safety checks did not have a set frequency; the checks were done based on the fluctuations of the resident's needs three to four times each eight-hour shift. -All activity of daily living (ADL) needs including supervision were communicated via electronic tablets used by staff. -She or the Care Coordinator entered interventions like safety checks onto the electronic version of the resident's care plan. -The electronic charting system automatically entered interventions/tasks from the care plan onto the electronic tablets used by staff. -Staff were assigned tasks from the care plan and documented completion of the tasks on the electronic tablet. -She was not sure if agency staff had access to the electronic tablets. -There was no alternative to the tablet of communicating changes and updates. Interview with the Administrator on 10/04/22 at 6:25pm revealed: -Residents at risks for falls were discussed weekly at facility risk meetings. -Interventions were planned in the risk meetings and reviewed regularly by care teams. -Interventions were put on the care plans and available to staff through the electronic tablets. -Documentation was tracked as a means of monitoring staffs' ability to carry out interventions. -If a task was not documented then adjustments were	D 270		

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D 270	Continued From page 28 made. -During daytime business hours, the SCC and Wellness staff were able to observe staff supervise residents. -On evening, night and weekend shifts it was an honor system. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. 2. Review of Resident #6's current FL-2 dated 08/09/22 revealed: -Diagnoses included dementia, Alzheimer's disease, hemiplegia, hemiparesis, anemia, paroxysmal atrial fibrillation, cerebral infarction due to embolism of cerebral artery, non-traumatic chronic subdural hemorrhage, and Vitamin D deficiency. -The resident was documented as intermittently disoriented. -The resident was semi-ambulatory and used a wheelchair. -The resident required assistance with bathing, feeding, and dressing. Review of Resident #6's assessment and care plan dated 06/09/22 revealed: -The resident had a history of stroke that affected one side of the body causing muscle weakness and paralysis. -The resident used a wheelchair for mobility. -The resident required physical assistance by 1 staff person with ambulation, dressing, and grooming. -The resident required physical assistance by 2 staff persons with transferring. -The resident had a toilet chair, shower seat, high low bed, halo, and a fall mat. -The resident was at risk for potential falls due to his	D 270		

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D 270	Continued From page 29 history of stroke, with left sided weakness, periods of increased agitation, dementia disease process, and medication side effects. -The resident often rolled off the bed so a fall mat was needed at bed side at all times when the resident was alone. -The resident's hospital bed was to always be in the lowest position. -The resident preferred the bed to be against the wall to help him feel secure and comfortable. -The resident had falls on 04/09/22 and 04/14/22 without injury and the interventions were to continue to keep the bed in the lowest position the fall mat by the bedside at all times when in bed. Review of Resident #6's accident/incident (A/I) reports, resident progress notes, provider communication and visit notes, and hospital visit notes revealed: -Resident #6 had 9 falls from 04/10/22 – 09/28/22. -The resident required evaluation by emergency medical services (EMS) and transport to the emergency department (ED) for one of the falls that resulted in a large hematoma (blood pooling under the skin) and closed head injury. Review of Resident #6's electronic resident progress note entered on 04/10/22 at 9:44am revealed: -The resident was found on the floor in his room during rounds. -The time the resident was found on the floor was not documented. -No apparent injuries were sustained. -The resident was assisted off the floor by staff and vital signs were within normal limits. -The area on the progress note for action/intervention was blank.	D 270		

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D 270	Continued From page 30 Review of Resident #6's electronic resident progress note entered on 04/15/22 at 11:27am revealed: -The resident was found on the floor in his bedroom by staff around 7:00pm on 04/14/22. -Staff documented the Wellness Nurse was to follow up for more information. -The area on the progress note for action/intervention was blank. Review of Resident #6's electronic resident progress note entered on 04/15/22 at 1:36pm revealed: -The resident was alert and denied pain when asked. -The resident was able to move all extremities without experiencing pain or discomfort. Review of Resident #6's electronic resident progress note entered on 06/17/22 at 3:07pm revealed: -The resident was discovered by staff on the floor next to his bed on top of the fall mat. -The time the resident was found was not documented in the progress note. -No apparent injury. -The area on the progress note for action/intervention was blank. Review of Resident #6’s hospice note revealed the resident was admitted to hospice on 07/07/22. Review of Resident #6’s hospice skilled nursing visit note dated 07/12/22 at 3:30pm revealed: -Upon arrival, the resident was on the floor near the bed. -The resident had an unwitnessed fall with no injury noted.	D 270		

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D 270	Continued From page 31 -The resident did not complain of pain. -Per the medication aide (MA), the resident fell “almost daily”. Review of Resident #6’s electronic resident progress notes revealed there was no progress note for the resident’s fall on 07/12/22. Review of Resident #6’s primary care provider (PCP) note dated 07/19/22 revealed the resident was to continue proper use of bed halo to improve bed mobility/transfers with decreased risk for falls. Review of Resident #6's electronic resident progress note entered 08/19/22 at 11:13am revealed: -The resident was found during rounds laying on the floor in his room complaining of head pain. -The time the resident was found on the floor was not documented in the progress note. -EMS was called and the resident was transported to the hospital ED for further evaluation. -All parties were notified. -The area on the progress note for action/intervention was blank. Review of Resident #6's electronic resident progress note entered on 08/19/22 at 11:14am revealed: -The resident returned the same day from the ED with no new orders. -The time of the resident’s return to the facility was not documented. -Scans of his head and neck were negative for any acute injury. -The resident had a hematoma to the left side of his forehead.	D 270		

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D 270	Continued From page 32 -The resident was added to the list to follow up with the PCP during next facility visit. -The resident was seen by the hospice nurse today. Review of Resident #6's ED hospital discharge visit note dated 08/19/22 revealed: -The resident was admitted to the ED on 08/18/22 and discharged on 08/19/22. -The resident was seen for an unwitnessed fall. -The resident was receiving a blood thinner for atrial fibrillation. -The resident was diagnosed with a closed head injury and traumatic hematoma of the forehead. Review of Resident #6's A/I report dated 08/19/22 revealed: -The resident was found during rounds on the floor in his room complaining of pain to his head. -EMS was called and transported the resident to the ED for further evaluation. -All parties were notified. -The family and PCP were notified. Review of Resident #6's electronic resident progress note entered on 08/23/22 at 9:44am revealed: -It was reported on 08/22/22 at 9:45pm, the resident was found on the floor in his room at bedside. -No apparent injuries were found. -The resident was assisted off the floor and back into bed. -All parties were notified. -The resident would be seen today by PCP for follow-up. -The area on the progress note for action/intervention was blank.	D 270		

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D 270	Continued From page 33 Review of Resident #6's electronic resident progress note entered on 08/29/22 at 9:33am revealed: -It was reported that on 08/29/22 at 1:09am, the resident was found in a sitting position on his fall mat at bedside on the floor. -The resident was assisted off the floor and into bed. -No apparent injuries were found. -All parties were notified. -The area on the progress note for action/intervention was blank. Review of Resident #6's electronic resident progress note entered on 09/12/22 at 10:21am revealed: -The resident was found early this morning in his room on the floor at bedside. -The time the resident was found on the floor was not documented in the progress note. -No apparent injuries were sustained. -The resident was assisted off the floor and back into bed. -The resident's vital signs were withing normal limits. -All parties were notified. -The area on the progress note for action/intervention was blank. Review of Resident #6's electronic resident progress note entered on 09/29/22 at 1:37pm revealed: -The resident was found on the floor in his room next to the bed on 09/28/22 around 2:45pm. -The resident reported he was trying to get something without staff assistance. -The resident denied any pain and no observable injuries were sustained. -The PCP and responsible party were notified. Observation of Resident #6 on 10/04/22 at 10:12am	D 270		

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D 270	Continued From page 34 revealed: -The resident was in his room alone with the door closed. -The resident was lying in a hospital bed in a low position with the covers over his head. -The resident's upper body was positioned near the edge of the bed toward the bed halo near the resident's pillow. -There was a blue fall mat under the resident's bed that had not been pulled out beside the bed. -There was a wheelchair about 2 feet from the bed with the back of the wheelchair toward the bed. Interview with Resident #6 on 10/04/22 at 10:12am revealed: -The fall mat was usually on the floor beside the bed or underneath the bed. -He fell on the fall mat one time "a while ago". -He went to the hospital because he had a "bump" on his head. -The resident had not been gotten up for breakfast yet. Interviews with a MA on 10/04/22 at 10:21am and 10:50am revealed: -All residents were on routine 2-hour checks and she had not been instructed to supervise Resident #6 more often than every 2 hours. -About a month or two ago, another staff member notified her that Resident #6 was found on the floor. -The resident had an abrasion on his head and he was taken to the ED by EMS. -The resident had a fall mat that was supposed to be pulled out on the floor beside the bed when the resident was in bed. -She was not sure why the fall mat was not pulled out that morning on 10/04/22.	D 270		

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D 270	Continued From page 35 -She checked with Resident #6 that morning between 8:00am and 8:30am but the resident refused breakfast. -She did not recall if the resident's fall mat was pulled out beside the bed when she was in the room between 8:00am and 8:30am. Interview with a second MA on 10/04/22 at 10:40am revealed: -Resident #6 had fallen "quite a bit" because he tried to get out of bed without assistance. -The fall mat was supposed to be pulled out on the floor beside the bed at all times when the resident was in bed. -If the resident was sitting up for a long time in the wheelchair, he would lean over and tumble out of the chair. -The resident required two staff person assistance with transfers. -When the resident fell in August 2022, he had a knot on his forehead between the size of a golf ball and a baseball and his left eye was swollen shut. -The personal care aides (PCAs) were responsible for doing routine 2-hour checks on all of the residents in the special care unit (SCU). -There had been no instructions to check Resident #6 more often than the routine 2-hour checks. Interview with Assisted Living Coordinator (ALC) on 10/04/22 at 12:34pm revealed: -In the SCU, staff checked on residents every 2 hours. -The facility was assisted living and could not do more frequent checks like 15-minute checks because there was not enough staff. -Resident #6's fall mat should be in place on the floor by the bed when the resident was in bed.	D 270		

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D 270	Continued From page 36 Interview with Resident #6's PCP on 10/04/22 at 11:51am revealed: -Resident #6 had been receiving hospice services since July 2022 and had continued to decline. -The resident had a fall with a head injury in August 2022. -The resident was receiving a blood thinning medication so he was sent to the ED after the fall due to an increased risk of bleeding. -Many of the resident's falls were related to falling out of bed. -The resident had a hospital bed that should be in the lowest position. -The resident's fall mat should be pulled out on the floor beside the bed when the resident was in bed. -The resident should be checked at least every 2 hours or more often because of the continued falls or the resident could be in the common areas more often. 4. Review of Resident #4's current FL-2 dated 08/04/22 revealed diagnoses included dementia, conversion disorder with seizures, hypertensive heart disease with heart failure, overactive bladder, spinal stenosis and peripheral neuropathy. Review of Resident #4's signed care plan dated 08/05/22 revealed: -She required assistance with transferring and mobility. -She required assistance with toileting when she woke up and 2 – 3 times per shift. -She was at an increased risk for falls in the mornings and should be checked in the mornings to prevent independent transfers. -She had an actual fall on 09/08/22 while looking for her family and the intervention was for the staff to evaluate her for changes in range of motion.	D 270		

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D 270	Continued From page 37 Review of an electronic progress note for Resident #4 dated 09/08/22 at 9:52am revealed: -She was observed sitting on the floor in the doorway of her apartment while she was looking for her family. -She sustained a skin tear to her left hand. -Her PCP, hospice provider and responsible party were notified of the incident. -There were no interventions documented. Review of an electronic progress note for Resident #4 dated 09/08/22 at 1:27pm revealed: -She was discussed with the interdisciplinary team (IDT) meeting due edema in her lower legs and a fall on 09/08/22. -She was being evaluated for a urinary tract infection (UTI). Review of a hospice provider note for Resident #4 dated 09/08/22 revealed: -She was being evaluated after a fall that occurred on 09/08/22 and sustained a skin tear to the left hand. -She complained of discomfort during urination at times. -There was a new order received to obtain a urinalysis to evaluate for a UTI. Review of an electronic progress note for Resident #4 dated 09/10/22 at 7:33am revealed her urinalysis results were negative. Review of Resident #4's medical record revealed there was no incident report for the fall on 09/08/22. Review of an electronic progress note for Resident #4 dated 09/12/22 at 10:59am revealed: -She had a fall that morning that resulted in a bruise to	D 270		

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D 270	Continued From page 38 her right forearm. -She was assisted from the floor back to bed and the PCP, hospice provider and responsible party were notified. -There were no interventions documented. Review of an electronic progress note for Resident #4 dated 09/14/22 revealed she was discussed during the IDT meeting related to the fall on 09/12/22 with no injuries. Review of an electronic progress note for Resident #4 dated 09/16/22 at 3:01pm revealed the facility communicated with her family member and morning safety checks were added to the plan of care for falls. Review of Resident #4's medical record revealed there was no incident report for the fall on 09/12/22. Review of an electronic progress note for Resident #4 dated 09/19/22 at 2:27pm revealed: -A caregiver reported that Resident #4 had a fall that morning and no injuries were sustained. -The hospice provider was notified of the event. -There were no interventions or notification of the responsible party documented. Review of a hospice provider note dated 09/19/22 revealed: -She was evaluated after a fall on 09/19/22 at 5:30am. -It was suspected that she was attempting to get up and go to the bathroom. Review of Resident #4's medical record revealed there was no incident report for the fall on 09/19/22.	D 270		

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D 270	Continued From page 39 Review of an electronic progress note for Resident #4 dated 09/22/22 revealed she had a fall on 09/19/22 without injury. Telephone interview with Resident #4's family member on 10/04/22 at 1:46pm revealed: -On 09/14/22 during the 2nd shift, she visited her family member on the SCU. -There was 1 PCA on the SCU and she was assisting residents with the supper meal. -There was a resident who asked for assistance and the PCA told the resident she was not able to assist at that time. -A staff person from a different assignment floated to the SCU to assist the PCA. -Her family member had multiple falls on 3rd shift. -When the staff called to notify her of the falls, she asked who the staff were that worked at the time of the incident. -She was not notified by the facility of the fall that occurred on 09/14/22, the hospice provider contacted her and informed her of the incident. Interview with the hospice nurse for Resident #4 on 10/04/22 at 11:38am revealed: -While she was at the facility on 09/14/22, a staff reported to her that Resident #4 had a fall on that date. -She visited with Resident #4 on the same date for follow up after the fall with no new injuries noted. -She could not remember what staff alerted her of the fall on 09/14/22. -It was the responsibility of the facility to notify the facility's clinical team of incidents and then notify the hospice provider. -It was the responsibility of the hospice provider to offer a facility visit after a resident had an incident.	D 270		

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D 270	Continued From page 40 Interview with the Resident Clinical Director (RCD) on 10/04/22 at 10:48am revealed: -It was the responsibility for the Assisted Living Coordinator (ALC) and the Special Care Coordinator (SCC) to review the incident reports and implement appropriate interventions. -The IDT included the SCC, the ALC, the RCD and the Administrator and met weekly to discuss recent falls, current interventions and the effectiveness of the interventions. -The ALC reviewed and discussed the incidents that occurred on the SCU with the IDT since the SCUC position was vacant. Based on observations, record reviews, and interviews, it was determined that Resident #4 was not interviewable. [Refer to Tag D 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing.] _____ The facility failed to provide supervision for 3 residents in the special care unit (SCU) with significant histories of falls (#4, #6, and #8). The facility's failure to provide supervision for the three residents in the SCU resulted in Resident #8 experiencing 18 falls, 2 emergency room evaluations, 4 emergency medical services (EMS) evaluations and injuries including bruises, skin tears and hip pain; and Resident #6 experiencing 9 falls with one resulting in a large forehead hematoma causing closure of the left eye. This failure resulted in serious physical harm of Residents #6 and #8 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/04/22 for this violation.	D 270		

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D 270	Continued From page 41 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2022.	D 270		
D 297	10A NCAC 13F .0904(d)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there were 10 hours between the breakfast and dinner meals for 34 residents on the special care unit. The findings are: Observation of undated postings inside resident rooms on the special care unit (SCU) revealed: -The postings were taped to the wall near the entrance and exit door. -Meal times were listed: Breakfast at 8:30am, lunch at 11:30am and dinner at 4:30pm. Review of the facility's undated dining room hours revealed the dining room hours where 7:30am to 9:00am for breakfast, 11:30am to 12:30pm for lunch and 4:30pm to 5:30pm for dinner. Observations on the SCU on 09/29/22 from 7:45am until 9:08am revealed:	D 297		

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D 297	Continued From page 42 -At 7:45am, a resident was sitting in an armchair in the living room with a walker in front of her sating, "I'm so hungry, I want something to eat so bad" repeatedly. -Staff would tell her breakfast was coming soon as the passed by getting other residents up and to the living room. -No one offered the resident anything to eat or drink until breakfast was served in the Chatham dining room at 9:08am. Interview with a personal care aide (PCA) on 09/29/22 at 11:22am revealed breakfast was at 8:30am, lunch at 11:30am and dinner at 4:30pm on the SCU. Observations on the SCU on 09/29/22 at 4:52pm revealed the dinner meal was being served in both dining rooms. Observations on the SCU on 10/03/22 at 5:00pm revealed the dinner meal was being served in both dining rooms. Observations on the SCU on 10/04/22 at 9:15am revealed residents were eating the breakfast meal in both dining rooms. Interview with the Dining Services Director on 10/04/22 at 12:20pm revealed: -Meal times posted were the same for assisted living (AL) and the SCU. -The SCU sometimes was delayed in starting meals due to get residents up and to the dining room. -He was aware there should have been 10 hours between the breakfast and dinner meals. -He inherited the mealtimes posted for the facility. -Sandwiches and snacks were available for residents	D 297		

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D 297	Continued From page 43 during hours when the kitchen was closed. -Sandwiches were not routinely stocked in the refrigerators on the SCU; staff needed to request sandwiched and kitchen staff would deliver. Interview with the Administrator on 10/04/22 at 6:25pm revealed: -He was aware of the regulation for 10 hours between the breakfast and dinner meals. -He was able to observe breakfast in the SCU and most days staff started serving plates at 8:30am. -He had miscounted the hours between breakfast and dinner.	D 297		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a therapeutic diet as ordered for 1 of 1 sampled resident (#7) who had orders for a nutritional supplement three times a day. The findings are: Review of Resident #7's current FL-2 dated 06/13/22 revealed diagnoses included dementia, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hypothyroidism,	D 310		

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D 310	Continued From page 44 hyperlipidemia, depression, factor V Leiden protein S deficiency, cerebral vascular accident, subdural hematoma and benign prostate hypertrophy. Review of Resident #7's primary care provider (PCP) order dated 06/28/22 revealed an order for one can of a name brand nutritional supplement three times daily for supplement. Review of Resident #7's current signed care plan dated 07/08/22 revealed there was no documentation of a nutritional supplement three times daily. Review of Resident #7's electronic progress note dated 09/14/22 revealed: -He had nutritional supplements in place between meals. -The author of the note was not identified. Review of Resident #7's July, August and September 2022 electronic medication administration records (eMARs) revealed there was no entry for nutritional supplements. Review of Resident #7's PCP visit note dated 09/22/22 revealed: -Resident #7 had lost 15 pounds or 9.1% of his body weight since 07/04/22. -On 07/04/22 he weighed 164.2 pounds; on 08/01/22 154 pounds; and on 09/01/22 he weighed 149.2 Observation of Resident #7 during the breakfast meal on 09/29/22 from 8:38am until 10:15am revealed: -At 8:38am, he was seated in the dining room on the special care unit (SCU). -At 8:48am, he was served cranberry juice and milk.	D 310		

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D 310	Continued From page 45 -At 9:08am, he was served the breakfast meal of pancakes, bacon and sausage. -At 10:15am, the personal care aides (PCAs) were cleaning tables and sweeping the dining room floor as the resident finished eating his sausage. -He was not served a nutritional supplement. Interview with a Lead personal care aide (PCA) on 10/03/22 at 11:30am revealed: -She was not sure when Resident #7 was given the nutritional supplement. -The medication aides (MAs) usually gave nutritional supplements to the residents. Interview with a Supervisor/MA on 10/03/22 at 4:40pm revealed nutritional supplements were usually given with meals by PCAs. Observations on the SCU on 10/04/22 from 9:25am until 9:46am revealed: -Resident #7 was sitting at the table in the dining room eating breakfast. -There was a glass of orange juice and a glass of water at the resident's place setting. -There was no nutritional supplement on the table with Resident #7. -There was a box of chocolate nutritional supplements in the dining room refrigerator. -The box had a pharmacy label with Resident #7's name and indicated three boxes of 28 cartons were dispensed on 06/28/22. -There were four cartons of chocolate nutritional supplement remaining in the box. Interview with a second PCA on 10/04/22 at 9:45am revealed:	D 310		

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D 310	Continued From page 46 -PCAs were responsible for giving nutritional supplements with meals. -She did not know when Resident #7 was given his nutritional supplement because she did not normally work in that dining room of the SCU; she normally worked in the second dining room on the SCU. -Nutritional supplements were kept in the refrigerators in the dining rooms on the SCU. Interview with the Dining Services Director on 10/04/22 at 12:20pm revealed: -Diet orders and nutritional supplement orders were included in the information on the electronic tablets that staff used for resident care. -He did not order, store or deliver brand named nutritional supplements. Telephone interview with Resident #7's former PCP on 10/04/22 at 2:54pm revealed: -She did note Resident #7 was experiencing weight loss July and August 2022. -He was started on an appetite stimulating medication and a nutritional supplement due to the concern for his weight loss. -She did not remember Resident #7's exact order for the nutritional supplement. Interview with the Resident Care Director (RCD) on 10/04/22 at 5:53pm revealed: -PCAs were responsible for giving ordered nutritional supplements as a drink with meals. -A 30 day supply was sent from the pharmacy on request. -The nutritional supplement was listed on Resident #7's care plan and showed up on the electronic tablets staff used.	D 310		

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D 310	Continued From page 47 -Staff did not document administering nutritional supplements to residents. Interview with the Administrator on 10/04/22 at 6:25pm revealed he was not sure whether PCAs or MAs were responsible for giving residents ordered nutritional supplements. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide assistance including prompting and staff assistance with meals for 1 of 1 sampled resident (#7) on the special care unit who had cognitive decline and required varied levels of assistance from meal to meal. The findings are: Review of Resident #7's current FL-2 dated 06/13/22 revealed diagnoses included dementia, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hypothyroidism,	D 312		

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D 312	Continued From page 48 hyperlipidemia, history of myocardial infarction, depression, factor V Leiden protein S deficiency, cerebral vascular accident, subdural hematoma and benign prostate hypertrophy. Review of Resident #7's current signed care plan dated 07/08/22 revealed: -He had impaired cognitive function related to dementia and needed cues, prompts and simple step by step directions. -He was independent with eating meals. Review of Resident #7's electronic progress note dated 09/14/22 revealed: -He required reminders during meals. -The author of the note was not identified. Observations of Resident #7 during the breakfast meal on 09/29/22 from 9:08am until 10:15am revealed: -He was served the breakfast meal of pancakes, bacon and sausage links with cups of milk and cranberry juice at 9:08am by a personal care aide (PCA). -At 9:12am, he was sitting staring at the resident seated across from him with his hands grabbing the edges of the plate as if to pick it up where the food would fall away from him. -He was unable to follow verbal prompts to eat from staff as they passed by. -At 9:20am, a PCA began serving coffee to residents and said to him, "[name], eat your food". -He was not able to follow the prompt and continued staring and grabbing onto his plate. -At 9:24am, a PCA said, "[name], you want some bacon?" and he replied, "yeah" while looking around to receive bacon from the PCA. -He did not recognize the bacon and food on his plate.	D 312		

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D 312	Continued From page 49 -PCAs did not assist him with identifying the food on his plate and to start eating. -At 9:30am, a PCA assisted him with eating a piece of bacon. -He had sat with his plate in front of him without the cognitive ability to process eating the food for 22 minutes before staff was able to place food in his hand and raise his hand to his mouth. -He then started eating bacon placed in his hand by the PCA. -After eating the bacon given to him by the PCA, the resident asked for more bacon as the PCA passed by the table; staff reminded him he still had bacon on his plate. -He attempted to lift the plate and drink out of it until redirected by the fifth PCA passing by as she cleared dishes from tables. -By 9:52am, the resident had stopped eating the bacon and was dosing off at the table. -At 9:54am, the first PCA stopped cleaning up the dining room and placed a pancake in the resident's hand. -He had sat for an additional 24 minutes (after assistance with a piece of bacon) before staff was able to place a pancake in his hand. -He began eating the pancake without stopping. -By 10:10am, he had eaten all the pancakes, drank all the milk, cranberry juice and water, and ate more than half the bacon. -At 10:15am, he was eating one of two sausage links. Interview with a PCA on 09/29/22 at 11:22am revealed: -The residents in the SCU dining room were mostly independent with eating, there were 3 residents who needed staff to prompt and encourage them including Resident #7. -He was usually able to eat all meals independently.	D 312		

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D 312	Continued From page 50 -He had good days and bad days, today (09/29/22) must have been a bad day. -She did the best she could to serve the meals and assist residents. Interview with a Lead PCA on 10/03/22 at 11:30am revealed: -At times Resident #7 needed assistance with eating meals. -His diet was just changed to finger foods in the last few days. Interview with a Supervisor/medication aide (MA) on 10/03/22 at 4:40pm revealed: -Resident #7 required assistance with all activities of daily living (ADLs) except eating. -He was able to eat all his meals independently; he just ate slowly. -Needs reminders as documented in the 09/14/22 progress note meant he needed staff to encourage him. -Most of the time his spouse (also a resident on the SCU) ate with him and provided the encouragement. -Most of the time he ate well and if not the PCAs would assist him with verbal prompts and physically helping him to eat. Interview with the Administrator on 10/04/22 at 6:25pm revealed the Special Care Coordinator (SCC) and Lead PCA were responsible for ensuring residents needing staff assistance to eat were assisted to eat. Based on observations, interviews, 3 and record reviews, it was determined Resident #7 was not interviewable.	D 312		

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	Continued From page 51			
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 ensure medications were administered as ordered for 1 of 3 residents (#9) observed during the medication pass including errors with a topical gel for pain and inflammation and a liquid medication for cough and congestion. The findings are: The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the morning medication pass on 09/29/22. Review of Resident #9's current FL-2 dated 08/11/22 revealed diagnoses included dementia, osteoarthritis, hypertension, hyperlipidemia, depression, and gastroesophageal reflux disease. a. Review of Resident #9's current FL-2 dated 08/11/22 revealed an order for Voltaren Gel 1% apply topically to right knee three times a day. (Voltaren Gel is a topical medication used to treat pain and inflammation.)	D 358		

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D 358	Continued From page 52 Review of Resident #9's physician's order dated 09/15/22 revealed an order for Voltaren Gel 1% apply 2gm topically to left shoulder and right knee 3 times a day due to pain. Review of Resident #9's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Voltaren Gel 1% apply to right knee/left shoulder 3 times a day related to osteoarthritis. -Voltaren Gel 1% was scheduled for 7:00am, 2:00pm, and 7:00pm. -Voltaren Gel 1% was documented as administered from 09/01/22 – 09/28/22. Interview with the medication aide (MA) on 09/29/22 at 8:24am revealed: -There was no Voltaren Gel 1% available to administer to Resident #9. -When she last worked on Monday, 09/26/22, Voltaren Gel 1% was available and administered to the resident. -She was not sure if a refill request for the Voltaren Gel had been sent to the pharmacy. Observation of the morning medication pass on 09/29/22 revealed Voltaren Gel 1% was not administered to Resident #9 at 8:36am when he received his other scheduled morning medications due to the medication being unavailable. Interviews with the Wellness Nurse on 09/29/22 at 9:13am and 12:55pm revealed: -There was no Voltaren Gel 1% available in the facility for Resident #9. -She ordered the Voltaren Gel from the pharmacy that morning, 09/29/22, so it should be delivered in the	D 358		

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D 358	Continued From page 53 pharmacy tote that night. -The MAs were responsible for ordering refills from the pharmacy before the medication ran out. -The MAs should notify her if a medication was unavailable and had not been received from the pharmacy. Interview with Resident #9 on 09/29/22 at 1:25pm revealed: -His knee and shoulder hurt “a little bit”. -He did not remember when Voltaren Gel was last applied to his knee and shoulder. -The Voltaren Gel usually helped some with his pain. Telephone interview with a pharmacy technician at the facility’s contracted pharmacy on 10/04/22 at 9:50am revealed: -Resident #9’s Voltaren Gel 1% was dispensed on 05/23/22, 07/28/22, and 09/15/22. -There were no refills remaining after the supply dispensed on 09/15/22. -A new order was received and dispensed on 09/29/22. Interview with the Resident Care Director (RCD) on 09/29/22 at 1:31pm revealed: -The MAs were responsible for reordering medication 1 week prior to the medication running out. -The MAs could either fax the request to the pharmacy or click a refill button in the eMAR system. -If a medication needed refills, the MAs should let the primary care provider (PCP) know so they could obtain a new prescription. -The MAs should notify her if a medication was unavailable, and they were not able to get it from the pharmacy.	D 358		

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D 358	Continued From page 54 Telephone interview with Resident #9's PCP on 10/04/22 at 2:54pm revealed: -Resident #9 was using Voltaren Gel for arthritis pain and for chronic pain management. -The Voltaren Gel was used for pain in his knee and shoulder. -The resident was receiving hospice services and received other medications for pain that may have helped when he did not receive the Voltaren Gel. b. Review of Resident #9's physician's order dated 08/18/22 revealed an order for Guaifenesin Liquid 200mg/5ml give 5ml (200mg) 3 times a day for chronic cough. (Guaifenesin is used to treat cough and congestion.) Review of Resident #9's printed October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Guaifenesin Liquid 200mg/5ml give 5ml 3 times a day for chronic cough scheduled for 7:00am, 2:00pm, and 7:00pm. -Guaifenesin was documented as administered from 09/01/22 – 09/29/22. Observation of the morning medication pass on 09/29/22 revealed: -The medication aide (MA) prepared and administered 5ml (100mg) of Guaifenesin 100mg/5ml at 8:36am. -The resident as administered 100mg instead of 200mg, half the dose ordered. Observation of the computer monitor with Resident #9's eMAR on the screen on 09/29/22 at 12:48pm revealed: -There was an entry for Guaifenesin Liquid 200mg/5ml	D 358		

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D 358	Continued From page 55 give 5ml 3 times a day for chronic cough. -There a second line with instructions for the dispensed supply of Guaifenesin Liquid 100mg/5ml to "**NOTE DOSE**", give 10ml (200mg) 3 times daily for chronic cough. Observation of Resident #9's medications on hand on 09/29/22 at 12:47pm revealed: -There was a 4-ounce bottle of Guaifenesin Liquid 100mg/5ml dispensed on 09/19/22. -The instructions on the prescription medication label included: **NOTE DOSE** give 10ml (200mg) 3 times a day for chronic cough. Interview with the MA on 09/29/22 at 12:45pm revealed: -She did not notice the strength of Guaifenesin on the eMAR did not match the label on the bottle. -She did not notice the wording on the screen of the eMAR or the medication label to note the dose was 10ml to equal the ordered amount of 200mg. Interview with Resident #9 on 09/29/22 at 1:25pm revealed he did not feel congested and he denied having a current cough. Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 09/29/22 at 9:50am revealed: -The pharmacy did not keep Guaifenesin 200mg/5ml Liquid in stock. -The pharmacy dispensed 4 ounces of Guaifenesin 100mg/5ml Liquid on 09/19/22 and 10/03/22. -The pharmacy keyed in the orders into the eMAR system. -A warning to note the dose was entered in the eMAR	D 358		

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D 358	Continued From page 56 system and on the directions of the medication label. -The facility was responsible for approving the orders prior to the orders becoming active in the eMAR system. Interview with the Wellness Nurse on 09/29/22 at 12:55pm revealed: -The information on the eMARs and the medication label should match. -If the eMARs and the medication label did not match, the MAs should notify her or the Resident Care Director (RCD). Interview with the RCD on 09/29/22 at 1:31pm revealed: -The MAs should read and compare the eMARs and the medication labels when administering medications. -If there was a discrepancy or something the MAs did not understand, they should notify her or the Wellness Nurse. Telephone interview with Resident #9's primary care provider (PCP) on 10/04/22 at 2:54pm revealed: -Resident #9 was taking Guaifenesin for a chronic cough and wheezing that he had for as long as she had been seeing the resident. -She ordered a chest x-ray on 09/29/22 to make sure there was no change in his condition related to the wheezing and cough. Review of Resident #9's chest x-ray results dated 09/29/22 revealed no acute cardiopulmonary process.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 57 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to submit accident and incident reports to the local Department of Social Services for 3 of 6 sampled residents (#6, #7, and #8) who experienced incidents that required evaluation by the primary care provider (PCP) with x-rays, emergency medical services (EMS) or the local emergency room. The findings are: 1. Review of Resident #7's current FL-2 dated 06/13/22 revealed diagnoses included dementia, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hypothyroidism, hyperlipidemia, history of myocardial infarction, depression, factor V Leiden protein S deficiency, cerebral vascular accident, subdural hematoma and benign prostate hypertrophy. a. Review of Resident #7's electronic progress note dated 07/14/22 revealed: -He was found on the floor in his room next to his spouse's bed. -His head was near the wheel of the wheelchair.	D 451		

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D 451	Continued From page 58 -He complained of neck and lower back pain and had decreased range of motion. -He was sent to the emergency room (ER). Review of Resident #7's ER discharge instructions dated 07/14/22 revealed: -He was evaluated for a fall and diagnoses included inflammation of the bladder and anemia. -The ER completed laboratory analysis of blood and urine and administered intravenous antibiotics and fluid. -A computed tomography (CT) scan of his head and spine and x-rays of his chest and pelvis were done. Upon request on 09/28/22, 09/29/22 and 10/03/22 an accident/incident report for Resident #7 dated 07/14/22 was not available for review. b. Review of Resident #7's ER discharge instructions dated 08/10/22 revealed: -He was evaluated for a fall and diagnosed with a closed head injury. -A blood glucose test and CT scan of his head were done. Review of Resident #7's primary care provider (PCP) visit note dated 08/11/22 revealed: -He was seen for follow up after a fall in which he struck his head and was seen in the ER on 08/10/22. -He had an abrasion on his scalp and left knee. Review of Resident #7's electronic progress note dated 08/11/22 revealed: -"It was reported" the resident leaned forward and fell out of his wheelchair onto the floor. -He scraped the top of his head and had an abrasion to	D 451		

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D 451	Continued From page 59 his left knee. Review of Resident #7's electronic progress note dated 08/12/22 revealed a large skin tear was found on his left arm and had moderate drainage. Upon request on 09/28/22, 09/29/22 and 10/03/22 accident/incident reports for Resident #7 dated 08/10/22, 08/11/22 and/or 08/12/22 were not available for review. c. Review of Resident #7's PCP visit note dated 08/18/22 revealed: -He had multiple skin tears on all his extremities. -The PCP ordered a referral for home health for management of the skin tears. Review of Resident #7's home health nurse (HHN) visit note dated 08/19/22 revealed: -Resident #7 was started on HHN visits for wound care. -The resident had multiple wounds including on his left forearm, both heels, top of his left foot, multiple scabbed areas on the top of his head. Review of Resident #7's HHN visit note dated 08/23/22 revealed wound care was provided for unspecified "multiple trauma" wounds from a recent fall. d. Review of Resident #7's electronic progress note dated 08/29/22 revealed: -He was found on the floor in his room with a small abrasion to the right side of his head. -EMS was called and the family refused transport to the ER. Review of Resident #7's HHN visit note dated 08/30/22	D 451		

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D 451	Continued From page 60 revealed the resident had new wounds on his right head and right forehead from a recent fall. Upon request on 09/28/22, 09/29/22 and 10/03/22 an accident/incident report for Resident #7 dated 08/29/22 was not available for review. e. Review of Resident #7's electronic progress note dated 09/13/22 revealed: -He fell in the common area and complained of right hip pain. -EMS and hospice were called but the resident remained at the facility. Review of Resident #7's primary care provider (PCP) order dated 09/13/22 revealed an order for a right hip and pelvis x-ray due to pain after a fall. Upon request on 09/28/22, 09/29/22 and 10/03/22 an accident/incident report for Resident #7 dated 09/13/22 was not available for review. f. Review of Resident #7's electronic progress note dated 09/19/22 revealed: -He fell that morning with no apparent injury. -EMS and hospice were called but the resident remained in the facility. Upon request on 09/28/22, 09/29/22 and 10/03/22 an accident/incident report for Resident #7 dated 09/19/22 was not available for review. Telephone interview with the local Department of Social Services (DSS) worker on 10/03/22 at 11:40am revealed DSS had not received accident/incident reports for Resident #7 dated between 04/01/22 and	D 451		

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D 451	Continued From page 61 10/03/22. Refer to interview with a Lead personal care aide (PCA) on 10/03/22 at 11:30am. Refer to interview with a Lead personal care aide/medication aide (PCA/MA) on 10/04/22 at 2:04pm. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. 2. Review of Resident #8's current FL-2 dated 12/28/21 revealed diagnoses included dementia, conjunctivitis, dermatitis, anemia, type II diabetes mellitus, hyperlipidemia, hypertension and anxiety disorder. a. Review of Resident #8's electronic progress note dated 05/08/22 revealed: -She fell overnight on 05/07/22 while getting up from the couch in the common area and hit the back of her head causing a laceration. -She was sent to the emergency room (ER) and returned to the facility with two staples in the back of her head. Review of Resident #8's accident/incident report dated 05/07/22 revealed: -She fell sitting up from the couch and hit her head. -The family member and primary care provider (PCP) were notified. -There was no documentation the report was sent to the Department of Social Services (DSS).	D 451		

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D 451	Continued From page 62 b. Review of Resident #8's electronic progress note dated 06/04/22 revealed: -She was found on the floor inside the bathroom in her room. -She told staff she hit her head and emergency medical services (EMS) evaluated her at the facility. -Transport to the ER was deemed unnecessary. Upon request on 09/28/22, 09/29/22 and 10/03/22 an accident/incident report for Resident #8 dated 06/04/22 was not available for review. c. Review of Resident #8's electronic progress note dated 07/25/22 revealed: -The resident had a fall on 07/24/22. -She was complaining of pain but was still able to walk. -She had a large bruise on her right hip and buttock. Review of Resident #8's hospice nurse visit note dated 07/24/22 revealed: -Resident #8 was seen for complaints of left hip pain after an unwitnessed fall. -She was unable to bear weight on her left side. -An order for an x-ray was submitted. Upon request on 09/28/22, 09/29/22 and 10/03/22 an accident/incident report for Resident #8 dated 07/24/22 was not available for review. Telephone interview with the local Department of Social Services (DSS) worker on 10/03/22 at 11:40am revealed DSS had not received accident/incident reports for Resident #8 dated 05/07/22-05/08/22, 06/04/22 and 07/25/22. Refer to interview with a Lead personal care aide (PCA)	D 451		

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D 451	Continued From page 63 on 10/03/22 at 11:30am. Refer to interview with a Lead personal care aide/medication aide (PCA/MA) on 10/04/22 at 2:04pm. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. 3. Review of Resident #6's current FL-2 dated 08/09/22 revealed diagnoses included dementia, cerebral infarction, atrial fibrillation, anemia, and Vitamin D deficiency. Review of Resident #6's electronic progress notes dated 08/19/22 revealed: -The resident was found during rounds laying on the floor in his room complaining of pain to his head. -Emergency medical services (EMS) were call and the resident was taken to the hospital emergency department (ED). -The resident returned to the facility the same day with no new orders. -The resident had a hematoma on the left side of his forehead. Review of Resident #6's ED hospital discharge visit note dated 08/19/22 revealed: -The resident was discharged on 08/19/22. -The resident was seen for an unwitnessed fall. -The resident was receiving a blood thinner for atrial fibrillation. -The resident was diagnosed with a closed head injury	D 451		

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D 451	Continued From page 64 and traumatic hematoma of the forehead. Review of Resident #6's accident/incident report dated 08/19/22 revealed: -The resident was found during rounds laying on the floor in his room complaining of pain to his head. -EMS was called and the resident was transported to the ED for further evaluation. -The resident's responsible party and the primary care provider (PCP) were notified. -The report was signed by the Administrator and the Resident Care Director (RCD). -There was no documentation the county department of social services (DSS) was notified of the accident/incident. Telephone interview with the Adult Home Specialist (AHS) from the county DSS on 10/03/22 at 11:59am revealed: -The facility had not notified her of Resident #6's fall on 08/19/22. -She had not received an accident/incident report for Resident #6's fall and ED visit with injury on 08/19/22. Interview with the RCD on 10/04/22 at 5:10pm revealed: -There should be a fax confirmation page when the accident/incident reports were faxed to the county DSS. -She could not locate a fax confirmation page indicating the accident/incident report for Resident #6's fall with injury on 08/19/22 had been faxed to the county DSS. Refer to interview with a Lead personal care aide (PCA) on 10/03/22 at 11:30am. Refer to interview with a Lead personal care	D 451		

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D 451	Continued From page 65 aide/medication aide (PCA/MA) on 10/04/22 at 2:04pm. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. _____ Interview with a Lead personal care aide (PCA) on 10/03/22 at 11:30am revealed: -Whoever discovered the incident was responsible for completing the incident report. -The staff who discovered the incident checked range of motion for the resident, notified the family, primary care provider (PCP) and the Resident Care Director (RCD). Interview with a Lead personal care aide/medication aide (PCA/MA) on 10/04/22 at 2:04pm revealed: -Accident/incident reports were filled out electronically by staff who witnessed or discovered an incident. -Lead PCA/MAs were responsible for overseeing to make sure the family and providers were notified. -She thought the accident/incident reports went to the RCD and the RCD sent the reports to the county DSS. Interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm revealed: -She had not been sending accident/incident reports to the local Department of Social Services (DSS) for medical evaluation and treatment greater than first aid. -She did not think an emergency medical services evaluation (EMS), x-rays, evaluation by the PCP and/or hospice nurse (HN) and wound care requiring a home health referral were considered treatments greater	D 451		

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D 451	Continued From page 66 than first aid. -The staff who discovered the incident was responsible for completing the facility's internal accident/incident report. -The Lead PCA completed the internal accident/incident report if the staff was an agency staff person. -The Assisted Living Coordinator (ACL) or the Special Care Coordinator (SCC) reviewed the internal accident/incident report to ensure it was complete and to implement interventions. -After the accident/incident report was reviewed by the ALC or SCC, she and the Administrator reviewed the report. -Either she or the Wellness Nurse faxed the external accident/incident report to DSS for falls where the resident was sent to the emergency room within 48 hours. -The facility had been having problems with faxing so they started emailing the reports but now they were back to faxing the reports to DSS. Interview with the Administrator on 10/04/22 at 6:25pm revealed: -The RCD and Wellness Nurse reviewed all accident/incident reports for completion and accuracy. -Reportable accidents/incidents should be reported to the county DSS. The RCD and Wellness Nurse were responsible for faxing required incident reports to DSS.	D 451		
D 452	10A NCAC 13F .1212(b)(c) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents	D 452		

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D 452	Continued From page 67 (b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information: (1) resident's name; (2) name of staff who discovered the accident or incident; (3) name of the person preparing the report; (4) how, when and where the accident or incident occurred; (5) nature of the injury; (6) what was done for the resident, including any follow-up care; (7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and (8) signature of the administrator or administrator-in-charge. (c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure completed accident and incident reports included information on who discovered the event, when, where and how the event occurred and what follow up was done for 5 of 8 sampled residents (#2, #3, #6, #7, and #8) with accident and incident reports reportable to the local Department of Social Services (DSS). The findings are:	D 452		

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D 452	Continued From page 68 1. Review of Resident #3's current FL-2 dated 07/19/22 revealed diagnoses included depression, dementia, back pain, hypertension, benign prostate hypertrophy, gastro-esophageal reflux disease and hyperlipidemia. a. Review of Resident #3's accident/incident report dated 04/05/22 revealed: -He stood, lost his balance and fell into the corner of the table causing a laceration on the back of his head. -He was sent to the emergency room (ER) and returned to the facility with medical glue for wound closure. -The family member and primary care provider (PCP) were notified. -There was no documentation of who discovered the accident/incident, where the resident was found and what follow up was done for the resident. b. Review of Resident #3's accident/incident report dated 08/15/22 revealed: -A skin tear was found om his upper right arm. -The family member and PCP were notified. -There was no documentation of who discovered the accident/incident, where the resident was found and what follow up was done for the resident. c. Review of Resident #3's accident/incident report dated 08/30/22 revealed: -He fell around 5:00am in the bathroom hitting his head on the wall. -He was sent to the ER and returned to the facility with sutures. -The family member and PCP were notified. -There was no documentation of who discovered the accident/incident and what follow up was done for the resident.	D 452		

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D 452	Continued From page 69 Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. 2. Review of Resident #7's current FL-2 dated 06/13/22 revealed diagnoses included dementia, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hypothyroidism, hyperlipidemia, history of myocardial infarction, depression, factor V Leiden protein S deficiency, cerebral vascular accident, subdural hematoma and benign prostate hypertrophy. Review of Resident #7's external accident/incident report dated 09/28/22 revealed: -The resident had a fall on 09/17/22 without injury. -The resident was found that morning (09/28/22) with a new open area on his forehead of unknown origin. -There was no documentation of who discovered the accident/incident, where the resident was found, what time it occurred and what follow up was done for the resident. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. 3. Review of Resident #8's current FL-2 dated 12/28/21 revealed diagnoses included dementia, conjunctivitis, dermatitis, anemia, type II diabetes mellitus, hyperlipidemia, hypertension and anxiety disorder.	D 452		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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D 452	Continued From page 70 a. Review of Resident #8's accident/incident report dated 05/07/22 revealed: -She fell sitting up from the couch and hit her head. -The family member and primary care provider (PCP) were notified. -There was no documentation of who discovered the accident/incident, where the resident was found, what time it occurred and what follow up was done for the resident. b. Review of Resident #8's accident/incident report dated 08/28/22 revealed: -She was found on the floor with a left head laceration and large bruise on her left hip. -She was sent to the emergency room (ER) and returned to the facility with 12 staples. -The family member and primary care provider (PCP) were notified. -There was no documentation of who discovered the accident/incident, where the resident was found and what follow up was done for the resident. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. 4. Review of Resident #6's current FL-2 dated 08/09/22 revealed diagnoses included dementia, cerebral infarction, atrial fibrillation, anemia, and Vitamin D deficiency. Review of Resident #6's electronic progress notes dated 08/19/22 revealed: -The resident was found during rounds laying on the	D 452		

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D 452	Continued From page 71 floor in his room complaining of pain to his head. -Emergency medical services (EMS) were call and the resident was taken to the hospital emergency department (ED). -The resident returned to the facility the same day with no new orders. -The resident had a hematoma on the left side of his forehead. Review of Resident #6's computer printed accident/incident report dated 08/19/22 revealed: -The resident was found during rounds laying on the floor in his room complaining of pain to his head. -EMS was called and the resident was transported to the ED for further evaluation. -The time of the accident/incident was not documented on the report. -There was no documentation of the staff who discovered the accident/incident. -The resident's responsible party was notified but the date and time of notification was not documented. -The resident's primary care provider (PCP) was notified on 08/20/22 but no time of notification was documented. -The report included a computer printed name for the Administrator and the Resident Care Director (RCD) with a computer printed date of 08/20/22 beside each name. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm.	D 452		

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D 452	Continued From page 72 5. Review of Resident #2's current FL-2 dated 07/21/22 revealed diagnoses included dementia due to Parkinson's disease with behavioral disturbances, anxiety, benign prostatic hyperplasia, dyskinesia due to Parkinson's disease, Barrett esophagus, Parkinson's disease, gastroesophageal reflux disease without esophagitis and hypokalemia. Review of Resident #2's accident/incident report dated 08/26/22 revealed: -He had a fall on 08/23/22 and there was no time documented that the event occurred. -The primary care provider (PCP) was notified, and new orders received for x-rays to the right arm and right leg on 08/23/22. -The x-rays were completed on 08/25/22 and the PCP and responsible party were notified. -There was no documentation of who discovered the accident/incident, where the resident was found, what time it occurred and what follow up was done for the resident. Refer to interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm. Refer to interview with the Administrator on 10/04/22 at 6:25pm. _____ Interview with the Resident Care Director (RCD) on 10/04/22 at 3:30pm revealed: -Staff who discovered the incident were responsible for completing the facility's internal accident/incident report. -The Lead PCA completed the internal accident/incident report if the staff was an agency staff person. -The Assisted Living Coordinator (ACL) or the Special	D 452		

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D 452	Continued from page 73 Care Coordinator (SCC) reviewed the internal accident/incident report to ensure it was complete and to implement interventions. -The internal accident/incident report had more detailed information about the event than the external report. -After the accident/incident report was reviewed by the ALC or SCC, she and the Administrator reviewed the report. -She completed the external accident/incident report from information on the internal report. -The external report was sent to DSS. -She did not create the external accident/incident report that was faxed to the local Department of Social Services (DSS). -She was not aware the accident/incident reports were supposed to include who discovered the accident/incident; where when and how the accident/incident occurred; and what follow up was done. Interview with the Administrator on 10/04/22 at 6:25pm revealed: -The RCD and Wellness Nurse reviewed all accident/incident reports for completion and accuracy. -He was not aware information in the facility's external accident/incident reports did not meet the standard.	D 452		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall	D 465		

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D 465	Continued from page 74 there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: **TYPE A2 VIOLATION** Based on observations, interviews, and record reviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 6 of 23 shifts sampled in August 2022 and September 2022. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 85 beds including 50 beds for the assisted living (AL) area and 35 beds for the special care unit (SCU). Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 08/10/22 revealed: -The SCU census was 34 residents which required 34 hours of aide duty on second shift. -There was a total of 33 hours and 24 minutes of staff hours provided in the SCU for second shift, a shortage of 36 minutes. Review of the facility's resident census report,			

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D 465	Continued from page 75 weekly staff assignment sheet, and staff time cards for 08/27/22 revealed: -The SCU census was 34 residents which required 27 hours and 15 minutes of aide duty on third shift. -There was a total of 24 hours and 30 minutes of staff hours provided in the SCU for third shift, a shortage of 2 hours and 45 minutes. Interview with the Assisted Living Coordinator (ALC) on 10/03/22 at 12:05pm revealed: -On 08/27/22, third shift for the SCU was short of staff so the Supervisor/MA for the facility had a direct assignment on the SCU. -There was no further time card information. Review of Resident #8's current FL-2 dated 12/28/21 revealed diagnoses included dementia, conjunctivitis, dermatitis, anemia, type II diabetes mellitus, hyperlipidemia, hypertension and anxiety disorder. Review of Resident #8's external accident/incident report dated 08/28/22 revealed the resident was found on the floor with a laceration on her left scalp and a hematoma on her left hip, was sent to the emergency room (ER) and returned with 12 staples to her left scalp. Review of Resident #8's electronic progress note dated 08/28/22 revealed: -The resident fell around 6:00am that morning (08/28/22). -She was ambulating in the hall with a walker a fell from standing. -She hit her head on the wall in the hallway causing a large laceration to the left scalp and a large hematoma on her left hip.	D 465		

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D 465	Continued from page 76 -She was sent to the ER. Interview with a Supervisor/medication aide (MA) on 10/03/22 at 4:40pm revealed: -She was working third shift which started on 08/27/22 at 11:00pm and remembered Resident #8's fall. -The resident fell towards the morning (08/28/22) because she was in the process of administering 5:00am medications to residents. -The fall happened between 4:30am and 5:00am because she had not finished administering the 5:00am medications. -A personal care aide (PCA) found the resident on the floor in the hallway between the SCU dining room and living room. -Resident #8 would frequently get up at night and walk with her walker looking for her spouse. -That night (08/27/22), they were short of staff, and she was assigned to work on the SCU. -Normally, she worked third shift as the Supervisor/MA for the entire facility. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 08/29/22 revealed: -The SCU census was 34 residents which required 27 hours and 15 minutes of aide duty on third shift. -There was a total of 23 hours and 45 minutes of staff hours provided in the SCU for third shift, a shortage of 3 hours and 30 minutes. Review of Resident #3's current FL-2 dated 07/19/22 revealed diagnoses included major depressive disorder, dementia, back pain, hypertension, benign prostate hypertrophy, gastro-esophageal reflux disease and hyperlipidemia.	D 465		

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D 465	Continued from page 77 Review of Resident #3's external accident/incident report dated 08/30/22 revealed: -The resident fell around 5:00am in the bathroom. -He hit his head on the wall and was sent to the ER and returned with sutures. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 09/10/22 revealed: -The SCU census was 34 residents which required 27.2 hours of aide duty on third shift. -There was a total of 25 hours and 17 minutes of staff hours provided in the SCU for third shift, a shortage of 1 hour and 55 minutes. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 09/11/22 revealed: -The SCU census was 34 residents which required 27.2 hours of aide duty on third shift. -There was a total of 24 hours and 55 minutes of staff hours provided in the SCU for third shift, a shortage of 2 hours and 17 minutes. Interview with a medication aide (MA) on 09/28/22 at 9:55am revealed: -She usually worked first shift from 6:00am – 2:00pm. -She was the MA assigned to administer medications to residents in the SCU and in the AL for room 201 – 210. -There were usually 5 personal care aides (PCAs) working in the SCU on first shift. -For third shift, there was usually only 1 MA for the SCU and the AL. -There was not enough staff in the facility. -Sometimes medications were administered late and residents had to wait for assistance with personal care.	D 465		

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D 465	Continued from page 78 Interview with a Supervisor/MA on 10/04/22 at 2:04pm revealed: -She worked as a MA during the day on first and second shifts. -She also worked on third shift to help out with staffing and she usually administered medications. -She worked double shifts every other weekend and every other Monday and Friday. -She usually worked third shift 3 to 5 days pers week to fill in for staffing. -There was usually 3 to 4 PCAs in the SCU on third shift and 1 MA. -The third shift MA worked in the SCU and the AL. -Staffing had always been an issue at the facility and that was why they used agency staff to help but agency staff did not always show up for their shifts. -If facility staff called out or agency staff did not show up on third shift, they could not always get coverage to help because it was late at night. -About once every 3 weeks, they had less than 3 PCAs in the SCU when she worked. -When she worked as the MA on third shift, she tried to work half of the time in the SCU and half of the time in the AL. -The pharmacy delivered medications each night (except Sundays) between 11:00pm and 2:00pm -It usually took 2 to 3 hours to check in the medications so she was not available to help on the floor during that time. -When they were short staffed and there were only 3 staff in the SCU, there was not enough staff to check on the residents in a timely manner and it was "impossible" to be everywhere at once. Review of the facility's resident report, weekly staff assignment sheet, and staff time cards for 09/14/22	D 465		

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D 465	Continued from page 79 for 09/14/22 revealed: -The SCU census was 34 which required 34 hours of aide duty on second shift. -There were a total of 25 hours and 39 minutes of staff hours provided in the SCU for second shift, a shortage of 8 hours and 21 minutes. Telephone interview with a family member on 10/04/22 at 1:46pm revealed: -On 09/14/22 during the 2nd shift, she visited her family member on the SCU. -There was 1 PCA on the SCU and she was assisting residents with the supper meal. -There was a resident who asked for assistance and the PCA told the resident she was not able to assist at that time. -A staff person from a different assignment floated to the SCU to assist the PCA. -Once the meal was served, the residents were assisted from the dining room to the TV room. -The staff cleared and washed the dishes, cleaned the dining room and assisted residents with personal care. -Her family member had multiple falls on 3rd shift. -When the staff called to notify her of the falls, she asked who the staff were that worked at the time of the incident. Interview with a Lead PCA on 10/03/22 at 11:30am revealed: -She normally worked second shift from 2:00pm until 10:00pm. -The previous Special Care Coordinator (SCC) left the SCU understaffed several times before she left (09/14/22). -There were usually three PCAs for 35 residents, ideally there should five including one Lead PCA and four other	D 465		

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D 465	Continued from page 80 PCAs assigned to residents. -PCAs were responsible for the entire meal service and washing dishes on the SCU. -There were eight residents who required the use of a hydraulic lift for transfers in and out of bed. -Two staff were required to use the hydraulic lift. -There were approximately 11 residents who needed assistance with meals in the two dining rooms on the SCU plus an additional resident in her room. -There were a few other residents who needed two staff for assistance with bathing, dressing and toileting due to behaviors. -There were quite a few residents who needed constant attention. -Staff were not able to meet the needs of the residents on the SCU when there were three or less PCAs, even with four PCAs it was a challenge to meet the needs. Interview with the ALC on 09/29/22 at 3:44pm revealed: -Usually the Supervisor/ MA for the whole facility on third shift did not have an assignment. -There was usually a Lead PCA on the SCU that was also a Supervisor/MA. -The Supervisor/MA for the whole facility usually spent half of the eight hour shift on the SCU. Interview with the Resident Care Director (RCD) on 09/29/22 at 3:30pm revealed: -The Assisted Living Coordinator (ALC) and Special Care Coordinator (SCC) were responsible for scheduling all the personal care aides (PCAs) on all shifts and medication aides (MAs) for thirds shift only. -She was responsible for scheduling first and second shift MAs.	D 465		

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D 465	Continued from page 81 Interview with the Resident Care Director (RCD) on 10/04/22 at 5:53pm revealed: -There had been Senior Float Nurses from the corporate office covering the role of the SCC since March 2022 except for the three months the former SCC worked at the facility. -The Senior Float Nurses arrived at the facility on Monday and left on Thursday or Friday every week. -The SCC was expected to work on the floor with staff assisting in providing direct care to residents the same as the Lead PCA. -The Lead PCA was expected to float where the resident care need was and was not assigned a group of residents. -She and the SCC assessed the care needs of the residents. Interview with the Administrator on 10/03/22 at 9:00am revealed: -The ALC and SCC were responsible for staff schedules and coordinating agency staff for call outs and holes in the schedule. -In the absence of the SCC, the ALC was responsible for staff schedules and coordinating agency staff. -The Business Office Manager (BOM) was responsible for confirming staff time and any missed punches. A second interview with the Administrator on 10/04/22 at 6:25pm revealed: -The ALC was aware of needed staff hours and current resident needs for the schedule. -He was assisting with scheduling the staffing hours for the SCU. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision]	D 465		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL 092209**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/04/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF CARY	**1206 WEST CHATHAM STREET CARY, NORTH CAROLINA 27513**

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D 465	Continued from page 82 The facility failed to ensure there was enough staff in the Special Care Unit (SCU) to meet the required staffing hours and the needs of the residents for 6 of 23 shifts sampled, resulting in the supervision and personal care needs of residents not being met or being delayed. On 08/27/22, when third shift was short staffed, a resident had a fall resulting in a head laceration requiring 12 staples. On 08/30/22, when third shift was short staffed, a second resident had a fall resulting in a head laceration requiring 6 staples. On 09/14/22, when second shift was short staffed, there was not enough staff to provide the care needed to the residents. The facility's failure resulted in a substantial risk of serious physical harm and constitutes a Type A2 Violation. **The facility provided a plan of protection in accordance with G.S. 131D-34 10/04/22 for this violation.** **THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2022.**	D 465		

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