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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 9/21/22 to 09/23/22.	D 000		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (Residents #1, #2 and #4) related to a resident who had four falls resulting in injuries (#1), a resident who eloped from the facility (#2), and a resident who had 3 falls resulting in injuries (#4). The findings are: 1. Review of the facility's policy on falls/incidents and accidents dated September 2021 revealed: -If a resident fell, the medication aide (MA) was to complete a fall accident/incident report including the correct time that the fall occurred along with a short description specifying the date, time, location, and if there was an injury. -A progress note was to be completed stating if the resident was sent to the Emergency Room (ER) or not.	D 270		

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-The MA was to initiate 72-hour follow-up orders, vital signs and a shift note to be completed every shift for 72 hours.
-A fall risk intervention care plan was to be created within 24 hours of the incident/accident by either the Resident Care Coordinator (RCC) or Administrator.
-The fall intervention was to be added to the resident's orders by the RCC or Administrator.

Review of Resident #1's current hospital FL2 dated 08/01/22 revealed:
-Current level of care was hospital with a discharge plan of domiciliary.
-Diagnoses included fall in elderly patient, contusion, Alzheimer's disease, and displaced fracture of right femoral neck.
-Resident #1 was constantly disoriented.
-She was non-ambulatory and wheelchair bound.

Review of Resident #1's previous FL2 dated 04/25/22 revealed:
-Diagnoses included anxiety, developmental delay, and osteoarthritis.
-There was no documentation for orientation status.

Review of Resident #1's care plan dated 08/11/22 revealed:
-Resident #1 had a documented decline due to failure to thrive and received new orders for hospice.
-Resident #1 required complete assistance with activities of daily living (ADLs).
-She was non-ambulatory and used a wheelchair.
-She had limited strength and limited range of motion (ROM).
-She was sometimes disoriented, was forgetful and needed reminders.
-She required extensive assistance with toileting,

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ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.

Review of Resident #1's Licensed Health Professional Support (LHPS) assessment dated 04/21/22 revealed:
-She was a 1-person assist with use of her walker.
-There was a note documenting Resident #1 used her walker for independent ambulation but needed as-needed (PRN) assistance with walking and transfers.
-She was a 1-person assist with transfers.

Review of Resident #1's LHPS assessment dated 07/14/22 revealed:
-She was a 1-person assist with use of her wheelchair.
-There was a note documenting Resident #1 was forgetful, used her wheelchair for ambulation and needed assistance with transfers.
-She was a 1-person assist with transfers.

Review of Resident #1's LHPS assessment dated 08/11/22 revealed:
-She was a 2-person assist with use of her wheelchair.
-There was a note documenting Resident #1 was forgetful, used her wheelchair for ambulation and needed assistance with transfers because she was non-ambulatory.
-She was a 1-person assist with transfers.

Observation of Resident #1's room on 09/21/22 at 2:53pm revealed:
-Her room was at the end of the hall closest to the nurse's station on the left side of the hallway.
-Resident #1 was laying in bed; her wheelchair was parked with wheels locked next to the bed.
-There was a cushion on the seat of her

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wheelchair.
-There was no fall mat on the floor next to the bed.
-There was a bed-control remote on the bed next to Resident #1 which controlled elevating the head of the bed and the foot of the bed.
-There was a call light system on the wall next to the bed; the string to pull to activate the call light was approximately 14 inches long.
-The length of the pull string for the call light did not reach the top of the bed mattress and did not reach the recliner.

Observation of Resident #1's room on 09/21/22 at 5:20pm revealed:
-Resident #1 was not in the room.
-There was a blue padded fall mat in place next to Resident #1's bed.

Observation of Resident #1 on 09/22/22 at 9:00am revealed:
-Resident #1 was laying in bed on her left side.
-The right half of her face from the bottom of her cheek to her temple was bruised and yellow in color.
-She had reddish-purple bruising around both of her eyes.
-There was a light purple bruise the size of a half-dollar to her forehead.
-There was a cut along her right eyebrow that was one centimeter in length with three stitches in place.

Observations of Resident #1 on 09/22/22 at 11:35am and on 09/23/22 at 11:40am revealed she was sitting in her wheelchair outside of the dining room with socks on her feet that did not have any grips on them.

a. Review of an incident/accident report dated

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04/18/22 revealed:
-Resident #1 had an unwitnessed fall in her room at 3:45pm.
-She was found by a housekeeper.
-She was observed in her room on the floor with complaints of right wrist and hand pain.
-She reported to staff that she had lost her balance.
-There was swelling observed to her right wrist.
-She was not taken to the emergency room (ER).
-Orders were received from Resident #1's primary care provider (PCP) to have mobile x-rays taken of her right wrist and hand.
-There was documentation that the Falls Prevention Program was initiated (an order set that included monitoring resident status for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall).
-There was an evaluation note documenting Resident #1 was back to baseline and awaiting the mobile x-ray.

Review of Resident #1's Post Fall Care Plan Evaluation for Interventions dated 04/18/22 revealed there was documentation to monitor and remind resident appropriate use of assistive devices.

Review of Resident #1's Mobile x-ray report dated 04/19/22 revealed she had slightly displaced fractures involving the distal radius and the ulnar styloid (the distal portion of the arm by the wrist).

Review of Resident #1's physician's order dated 04/21/22 revealed she had an appointment with an orthopedic surgeon who advised surgical repair of the right wrist on 04/27/22.

Review of Resident #1's physician's order dated

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05/23/22 revealed:
-An order for physical therapy for strengthening.
-Resident #1 was deconditioned due to surgical repair of right wrist fracture, non-surgical repair of right hip fracture, and the hospitalization.

Review of Resident #1's physical therapy clinical note dated 05/31/22 revealed:
-The appointment was a re-visit and the physical therapist (PT) was already familiar with Resident #1 at the time of the visit.
-Resident #1 reported to the PT that her wrist hurt every once in a while.
-Resident #1's mobility was limited due to a recent fall with fractures to her right hip and right wrist.
-Resident #1 transferred with maximum assistance to her wheelchair.
-She had limited use of her right arm which was in a splint.
-She had general weakness, decreased endurance, unsteady standing balance, increased fall risk and she had significant dementia.
-Resident #1 was non-weight bearing to her right upper extremity and touch-down weight bearing to her right lower extremity.

Telephone interview with Resident #1's orthopedic surgeon's nurse on 09/23/22 at 10:35am revealed:
-On 04/26/22 Resident #1 was evaluated in the ER for abnormal blood laboratory values and a re-check of her right wrist fracture.
-Resident #1 had a closed fracture of her right distal radius and had been wearing a Velcro wrist splint.
-She had been admitted to the hospital with diagnoses of acute renal failure, hyperkalemia (high blood potassium levels), a fracture to the greater trochanter of her right femur (hip), and

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wrist fracture.
-The History and Physical completed by the orthopedic surgeon documented Resident #1 had a plan to surgically repair the right wrist fracture after treatment for her renal failure was complete.
-Resident #1 underwent an open reduction and internal fixation (ORIF) surgery to repair her right wrist fracture on 05/02/22.
-On her discharge summary from the hospital, the orthopedic surgeon documented that Resident #1's hip (femur) fracture was non-operable and he recommended touch-down weight bearing to that leg upon discharge on 05/06/22.

Interview with a medication aide (MA) on 09/23/22 at 9:11am revealed:
-She had completed the incident/accident report for Resident #1's fall on 04/18/22.
-The housekeeper had found Resident #1 and yelled down the hall that she was on the floor.
-Resident #1 had been trying to get herself up from her recliner and fell.
-Resident #1 previously been independent and walked the hallways in the facility non-stop.
-Prior to the fall on 04/18/22, Resident #1 had been independent with her care except for supervision with bathing.
-Resident #1 had gone to the hospital after an appointment with the orthopedic surgeon and pre-surgery labwork was drawn and had been abnormal.
-Resident #1 had surgery on her wrist and went to a rehabilitation center for a few weeks.
-Resident #1 had tried PT after she returned from the rehabilitation center, but the therapy was difficult for because of her previous injuries and the impact they had on her mobility.
-The fall prevention intervention she had implemented was to monitor Resident #1 more closely and make sure that she had the pull string

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for her call light near her.
-She did not know Resident #1's call light pull string was so short.
-She had initiated the 72-hour shift monitoring on the electronic medication administration record (eMAR) which stared the day Resident #1 returned from the hospital.
-Increased supervision for a resident just meant to check on them more frequently than every two hours; there was no place to document increased supervision checks.

Telephone interview with PT on 09/22/22 at 3:00pm revealed:
-Resident #1 had received PT services after her fall in April 2022, and was discharged from service upon her hospitalization in August 2022 with no new referral orders since.
-Resident #1 had initially been referred to PT due to her fall with right wrist and right femur fractures.
-She had worked with Resident #1 to assist her with strengthening so she could bear weight to her injured extremities.
-Resident #1 had a significant decline in her mobility since her fall in April 2022, because her femur fracture caused a difference in length between her two legs, and they decided not to surgically repair the femur fracture.
-Resident #1 had been walking independently prior to her fall with a femur fracture on 04/18/22.
-Resident #1 was discharged from PT services on 08/01/22 when she was admitted to the hospital.
-Prior to her hospitalization on 08/01/22, Resident #1 had been transferring with 1-2-person assistance.
-She had attempted to assist Resident #1 with ambulation, but it had been too difficult for Resident #1.

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-Resident #1 also had a fall in June 2022 and she did not know if fall preventions had been addressed between PT and the facility staff after that fall.
-She had discussed with the Resident Care Coordinator (RCC), the MAs and personal care aides (PCAs) after Resident #1's initial fall in April 2022 that if Resident #1 was in her recliner she should be in a reclined position so that she would not fall forward out of the chair.
-She had always seen a cushion on the seat of Resident #1's wheelchair but had never seen a fall mat in place next to Resident #1's bed.

Interview with the RCC on 09/23/22 at 4:30pm revealed:
-Resident #1 had been ambulatory prior to her fall on 04/18/22.
-She would walk laps around the facility.
-She had declined a lot in the past year.
-As a fall prevention intervention after her fall on 04/18/22, was that staff increased supervision of her until she went to the hospital for surgery on her wrist.
-The increased supervision intervention did not specify how often to check on Resident #1 and did not require staff to document their checks of Resident #1.
-Resident #1 went to a rehabilitation facility for a couple weeks after her surgery.
-Physical therapy was ordered for Resident #1 upon her return to the facility in May 2022.

Attempted telephone interview with the housekeeper on 09/22/22 at 2:35pm was unsuccessful.

b. Review of an incident/accident report dated 06/16/22 revealed:
-Resident #1 had an unwitnessed fall in her room

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at 7:00pm.
-She was found by a personal care aide (PCA).
-She was observed on her room floor with her head bleeding.
-She had told the PCA that she fell out of her wheelchair.
-There was documentation that Resident #1 would be seen by her primary care provider (PCP) during his next visit to the facility.
-Resident #1 was able to state her name and answer staff.
-She left for the Emergency Room (ER) on 06/16/22 at 7:20pm.
-She returned from the ER with stitches to the left side of her head; no new orders were received from the PCP.
-The Resident Care Coordinator (RCC) who completed the report documented that she spoke with the resident about interventions but did not document what the fall prevention interventions were.
-There was documentation that the Falls Prevention Program was initiated which included monitoring resident status for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall.
-There was an evaluation note documenting Resident #1 had no complaints of pain from the fall.

Review of Resident #1's Fall Risk Intervention Care Plan dated 06/17/22 revealed:
-Resident #1 had not been admitted to the hospital.
-The medical conditions listed as possible causal factors included recent weight loss and recent gait disturbances/decreased mobility.
-There was a care plan meeting on 06/17/22 to discuss planned interventions.
-There were no documented fall prevention

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interventions.

Review of Resident #1's Monthly Review of Resident Care dated 07/13/22 revealed:
-Resident #1 had no recent falls or new orders.
-She had no PCP visits during June 2022.
-There had not been any new labwork or imaging ordered.
-The assistive device Resident #1 was using was a wheelchair.
-There was documentation that no preventative measures were in place for safety such as interventions for falls.
-There was documentation that Resident #1 did not require increased supervision for any current or new symptoms.

Review of Resident #1's physician order dated 09/21/22 revealed:
-There was a note sent to Resident #1's PCP on 09/21/22 that a fall prevention intervention was completed on 06/17/22 for a wheelchair cushion that he had signed off on, but was never added to the Intervention Care Plan.
-There was a request to continue using the wheelchair cushion as a fall prevention intervention.
-The PCP agreed to the order request via verbal order to staff on 09/21/22.

Observation of Resident #1's wheelchair on 09/21/22 at 2:53pm revealed:
-The wheelchair was parked with wheels locked next to Resident #1's bed.
-There was a cushion on the seat of the wheelchair with soft cloth material on the top and a rubbery plastic material on the bottom side that touched the wheelchair seat.

Interview with a medication aide (MA) on

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D 270	Continued From page 11 09/23/22 at 9:11am revealed she had not been working when Resident #1 fell on 06/16/22 but was familiar with Resident #1 and she did not remember a new fall prevention intervention being implemented after that fall. Interview with the RCC on 09/23/22 at 4:30pm revealed: -She was not at the facility when Resident #1 fell on 06/16/22 but she completed the incident/accident report for the fall the next day. -For a fall prevention intervention, she implemented adding a non-slip grippy material to the top of Resident #1's wheelchair cushion to prevent her from slipping from out of her wheelchair. -She forgot to document the non-slip material on the Post-fall intervention care plan. -Resident #1 had no complaints of hip pain after her fall and no x-ray imaging was done of her hip. Attempted telephone interview with the PCA on 09/22/22 at 2:45pm was unsuccessful. c. Review of an incident/accident report dated 07/31/22 revealed: -Resident #1 had an unwitnessed fall in her room at 5:50pm. -She was found by a personal care aide (PCA). -She was observed on the floor with a "knot" by her right eye. -She had told the PCA that she slipped out of her recliner chair. -She was alert and oriented at the time of the fall. -She left for the Emergency Room (ER) on 07/31/22 at 6:00pm and was admitted to the hospital for a right hip fracture. -There was documentation that the Falls Prevention Program was initiated which included monitoring resident status for 72 hours for	D 270		

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bruising, change in mental status/condition, pain or other injuries related to fall.

Review of Resident #1's Fall Risk Intervention Care Plan dated 08/01/22 revealed the Administrator who completed the care plan documented the facility was able to continue to meet the resident's needs.

Review of Resident #1's hospital discharge summary dated 08/10/22 revealed:
-Resident #1 presented to the ER following a fall.
-She was observed to have a shortened right lower extremity and an x-ray of the pelvis revealed a displaced right femoral neck (hip) fracture.
-The right hip fracture was felt to be at least 2 weeks old given imaging findings and recommended nonoperative management by the orthopedic surgeon.
-Resident #1's hospital course was complicated by acute hypoxia (not enough oxygen to sustain bodily functions) following a possible aspiration event, along with positive troponin laboratory values which indicated Type 2 non-STEMI (a type of minor heart attack caused by a lack of enough oxygen to the heart muscle).
-She was discharged on 08/10/22 with a recommendation to begin hospice care due to her poor prognosis.

Review of Resident #1's Monthly Review of Resident Care dated 08/14/22 revealed:
-Resident #1 had new orders for hospice.
-She needed a "little more help" with her activities of daily living (ADLs).
-The only assistive device she had been using was her bed, there was no documentation that she had also used her wheelchair.
-There was documentation that no preventative

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measures were in place for safety such as interventions for falls.
-There was documentation that Resident #1 did not require increased supervision for any current for new symptoms.

Interview with a medication aide (MA) on 09/23/22 at 9:11am revealed:
-She had completed the incident/accident report after Resident #1's fall on 07/31/22.
-Resident #1 had fallen around 6:00pm.
-Resident #1 had been trying to get up from her recliner and fell; she had not yelled for help and staff found her while doing rounds.
-She had a "goose-egg" on her head but that was the only visible injury.
-She sent Resident #1 to the ER because she hit her head during the fall.
-Resident #1 was hospitalized because she had been having heart attack symptoms, not because of any injury from her fall.
-Resident #1 did not have any heart attack symptoms before her fall or while she was doing the post-fall assessment on her.
-She had returned from the hospital with a new order for hospice and initially was bed-ridden and had no strength from being in the hospital for so long.
-The fall prevention intervention implemented after every fall was to increase supervision, but there was no specification for how often to check on Resident #1.
-The blue floor mat next to Resident #1's bed was something new from the last couple of days.

Telephone interview with the orthopedic surgeon's nurse on 09/23/22 at 10:35am revealed:
-Resident #1 was evaluated in the ER on 07/31/22.
-The orthopedic History and Physical

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documented that Resident #1 had a displaced right femoral neck fracture which was a different, and new fracture from the hip fracture in April 2022.
-The orthopedic surgeon did not operate on the right hip fracture because he felt it was at least two weeks old.

Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 4:30pm revealed:
-The cause of Resident #1's fall on 07/31/22 was that she used her recliner remote to completely raise the back of her recliner chair which tipped her out of the chair onto the floor.
-There was no visible injury to Resident #1 after her fall on 07/31/22, but she went to the ER because she reported hitting her head.
-Resident #1 was admitted to the hospital due to her labwork indicating she might be having heart attacks.
-Resident #1 had no complaints of pain to her hip so she thought the hip fracture observed on the x-ray from the hospital was from her fall in April 2022.
-Resident #1 was fragile and could have re-fractured her hip just from rolling over in her bed.
-Resident #1 was discharged from the hospital with orders for hospice due to her cardiac issues.
-Upon Resident #1's return to the facility from the hospital, she had staff monitor her closely; she was bed-bound for a while due to her hospitalization making her weak.
-The MAs did 72-hour shift supervision after a resident had a fall which they documented on the eMAR.
-The PCAs did not document whenever they checked on a resident.

Attempted telephone interview with the PCA on

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D 270	Continued From page 15 09/22/22 at 2:40pm was unsuccessful. d. Review of an incident/accident report dated 09/18/22 revealed: -Resident #1 had an unwitnessed fall in her room at 8:20am. -She was found by a medication aide (MA). -She was observed on the floor with bleeding from the right side of her head. -She left for the Emergency Room (ER) on 09/18/22 at 8:30am. -Hospital staff reported to the facility that Resident #1 was being treated for a laceration to her face, periorbital contusion of her right eye (bruising around the eye), left shoulder subluxation (a partial dislocation of the shoulder joint), and left rotator cuff tear arthropathy (arthritis to the shoulder with a left rotator cuff tear). -There was documentation that the Falls Prevention Program was initiated which included monitoring resident status for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall. -There was an evaluation note which documented Resident #1 received three stitches to her right eyebrow and was seen by her Primary Care Provider (PCP) on 09/19/22 with no new orders received. Review of Resident #1's Fall Risk Intervention Care Plan dated 09/18/22 revealed: -Resident #1 was not admitted to the hospital. -She had no medication conditions which contributed as factors to her recent fall. -The fall did not appear to be safety (assistive device, lighting, call bell) related. -Resident #1 was cognitively impaired. -The fall prevention intervention documented was to increase supervision.	D 270		

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D 270	Continued From page 16 -There was documentation that a care plan meeting was held on 09/16/22 to discuss planned interventions. Review of Resident #1's Emergency Room visit report dated 09/18/22 revealed: -Resident #1 was evaluated for laceration of the face, periorbital contusion of her right eye, fall, left shoulder subluxation and left rotator cuff tear arthropathy. -Three sutures needed to be removed from Resident #1's eyebrow in 5 days. Review of Resident #1's PCP progress note dated 09/19/22 revealed: -Resident #1 was under hospice care. -She had a fall in the facility on 09/18/22. -She had been sent to the ER due to a small laceration above her right eyebrow. -She had some bruising and contusion to the area. -Upon evaluation in the ER she was found to also have a left shoulder subluxation. -She had three stitches in place by her right eyebrow which would be removed in 3 to 5 days by the hospice nurse. -There was no bleeding or drainage noted. -She had no complaints other than a dull headache. -She had shown increased debility and weakness and was a fall risk. Interview with Resident #1's roommate on 09/21/22 at 3:00pm revealed: -Resident #1 had multiple falls. -She had been the one to find Resident #1 after her most recent fall because it happened while they were both in their room eating breakfast. -Her back was turned to Resident #1 because she was facing her meal tray table, and Resident	D 270		

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D 270	Continued From page 17 #1 was sitting in her recliner. -She heard a loud sound behind her, so she turned around to see Resident #1 had fallen from her recliner and was on the floor. -Resident #1 was bleeding from her face, and now she had two black eyes. -She went to the door of their room and the MA was nearby passing medications, so she told her that Resident #1 fell. -The MA came into their room and helped Resident #1 to get off the floor. Interview with a MA on 09/21/22 at 3:05pm revealed: -She had been outside of Resident #1's room passing medication the morning of 09/18/22. -Resident #1's roommate had come to the room door and told her that Resident #1 fell from her chair and was on the floor. -Resident #1 was observed to be laying on the floor on her right side in front of her recliner which was in an elevated position. -She had Resident #1 go to the ER because they always sent residents with head injuries out to the ER. -Resident #1 needed stitches to the laceration on her face and she had also injured or dislocated her shoulder. -Resident #1 was given a sling for her injured arm but she refused to wear it. -She was not aware of any new fall prevention interventions that were implemented after Resident #1's fall on 09/18/22. -The MAs always did increased supervision and post-fall vital signs on all residents who had a fall. -Resident #1's call light string was too short to reach her when she was sitting in her recliner, so staff just checked on her a lot whenever she was up sitting in her recliner. -She did not know if anyone had requested that	D 270		

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maintenance lengthen the call light string.
-The staff monitored all the residents every two hours but did not document that because it was a general expectation.
-Resident #1 had been on increased supervision, but she did not know how often staff were supposed to check on her or what increased supervision specifically meant.
-She assumed increased supervision meant to check on Resident #1 more frequently than every two hours.
-Staff were always in the halls checking on residents and they always checked on Resident #1 more frequently than the baseline of every two hours.

Interview with a MA Supervisor on 09/21/22 at 3:20pm revealed:
-She had been working on the morning of 09/18/22.
-She heard Resident #1's roommate yell that Resident #1 was on the floor.
-The other MA working got to Resident #1 first and said that Resident #1 had been laying on her side and asked for help up.
-The MA applied pressure to Resident #1's face laceration and stayed in the room with her while she went to call emergency medical services (EMS).
-After Resident #1's fall on 09/18/22, staff were told to check on Resident #1 more often when she was sitting in her recliner and to help position her with pillows.
-Resident #1 never asked staff for help with anything, but if she did need help while in her room she would need to pull the string on her call light, and if she could not reach the string her roommate would get staff to come help her.
-There was no documentation from the staff about how often they checked on Resident #1.

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-Increased supervision was something all the staff knew they were expected to do.
-The facility did not have any residents with bed or chair alarms, so it had not been discussed as a fall prevention intervention for Resident #1.
-As far as she knew, there had been no new fall prevention interventions implemented after Resident #1's falls or any additional documentation.
-Resident #1 had been ambulating independently with either a cane or a walker but after a fall she had in the Spring of 2022 she stopped being able to walk.
-Resident #1 had worked with physical therapy in the past but that was discontinued once she was admitted to hospice in August 2022.

Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 10:43am revealed:
-If a resident fall occurred during the day shift, the MA and the supervisor assessed the resident and attempted to perform range of motion (ROM) on the resident to detect if an injury was present.
-If the resident had no complaints of pain and did not hit their head, the MA would help the resident off the floor and monitor them for increased pain or bruising.
-If a resident fall occurred during the evening/night shift, the MA would call her at home and tell her what happened, and she would give them guidance on how to proceed.
-If there was no injury present from the fall, she expected staff to monitor the resident every 30 minutes, keep the resident's door open and look in at the resident every time they walk past the room; notifications to the resident's power of attorney (POA) or guardian, along with the PCP should be completed.
-MAs were not expected to document the 30-minute checks they did on a resident after a

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fall.
-The MAs were expected to complete the 72-hour shift monitoring on residents who had a fall, which was added to the electronic medication administration record (eMAR).
-During the 72-hour shift monitoring, once per shift the MA was supposed to document during their shift they went in the resident's room every hour or every half hour, asked the resident if they needed anything, and assessed for any new bruising or injury.
-The MA knew whether they were supposed to check on a resident every hour or every half hour because the supervisor would give them that information.

Telephone interview with a representative from Resident #1's hospice agency on 09/22/22 at 11:05am revealed:
-Resident #1 was admitted to hospice services on 08/11/22.
-Her admission diagnoses were Alzheimer's disease late onset, and dementia.
-Resident #1 had been evaluated in the ER for a fall on 09/18/22 and received stitches to her right eyebrow.
-The hospice nurse would be removing the stitches at some point that day, 09/22/22.
-A hospice nurse visited Resident #1 on Monday, 09/19/22.
-Fall prevention measures that the hospice nurse documented discussing with staff included having Resident #1 wear non-skid socks or shoes while out of bed, having her call light string in reach, and a night light on at night.

Telephone interview with Resident #1's guardian on 09/22/22 at 11:20am revealed:
-She became Resident #1's full guardian on 09/08/22.

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-Resident #1 had been her own decision-maker until her hospitalization from 08/01/22 through 08/10/22; she had been critically ill, and discussions took place which lead her to becoming her guardian.
-She thought Resident #1 had been hospitalized for so many days in August 2022 because of cardiac events she was having, and not because of the fall that occurred 07/31/22.
-The MAs and supervisors were good about calling her if Resident #1 had any changes or updates, like a fall.
-Resident #1 used to be independent at the facility and she thought Resident #1 fell because she did not realize she needed help with transfers now.
-Resident #1 seemed to be falling whenever she tried to get out of her recliner without help.
-Due to the current bruising to Resident #1's face, she thought Resident #1 probably fell from her recliner right onto her face.
-She had discussed with either the MA supervisor or the RCC that maybe they should remove Resident #1's recliner from her room to prevent her from falling out of it, but ultimately decided against that because Resident #1 enjoyed her recliner and it was a matter of quality of life.
-She had also discussed either getting Resident #1 a fall mat or a pressure sensor alarm, but she did not know if those interventions had been implemented or not.
-She did not think Resident #1 would benefit from therapy due to her dementia and inability to remember new things.

Telephone interview with a personal care aide (PCA)/MA on 09/22/22 at 4:15pm revealed:
-If a resident had a fall, the MA was supposed to complete 72-hour shift monitoring on the eMAR.
-Monitoring the resident post-fall included

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checking on the resident every so often (every hour, plus whenever they were walking down the hall) to make sure the resident was okay.
-Fall prevention interventions that were in place for Resident #1 included making sure she was either in her bed or her recliner, not sitting in her wheelchair in her room.
-If Resident #1 needed staff assistance while she was in her room, she would have to pull the string on her call light.
-If Resident #1 could not reach the string for her call light she would have to yell out for help and staff would hear her since her room was close to the nurse's station.
-Resident #1 has never had a hand-held bell to call for staff.
-Resident #1 has never had an alarm to her bed or her chair.
-She thought that Resident #1 had a fall mat next to her bed at one point in time but could not remember if that was a current intervention or not.
-She could not think of any other fall prevention interventions in place for Resident #1.
-Resident #1 used to be able to walk independently with her cane or walker but she could not remember when she stopped being able to walk.

Telephone interview with Resident #1's PCP on 09/23/22 at 1:40pm revealed:
-Prior to Resident #1's fall in April 2022 she had been independent with her personal care and ambulation.
-After her fall on 04/18/22 and the right wrist and hip fractures she sustained, she was provided a hospital bed to help her get in and out of bed.
-He was aware of Resident #1's falls on 06/16/22, 07/31/22, and 09/18/22.
-Resident #1 had been admitted to hospice care

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in August 2022 due to failure to thrive.
-He thought Resident #1 had multiple falls due to her dementia, and Resident #1 still thought she was able to get up independently, but she could not.
-The only fall prevention intervention he recommended to the facility was to make sure her bed was always in the lowest position when she was laying down on it.
-He expected the facility to increase supervision for Resident #1 after her falls, but left it up to the facility to decide how often to check on Resident #1.

Interview with the RCC on 09/23/22 at 4:30pm revealed:
-On 09/18/22, Resident #1 fell out of her recliner during breakfast while staff were passing meal trays.
-There were no new fall prevention interventions implemented aside from the 72-hour shift supervision the MAs documented on the eMAR.
-She had a discussion with Resident #1's guardian about removing the recliner from her room but decided not to because Resident #1 enjoyed her recliner.
-If Resident #1 was in her room and needed assistance from staff she would need to yell for help; there was no call bell that reached her recliner and they did not have hand-held bells she could ring.
-Resident #1 had the floor mat by her bed for a while; the staff folded the floor mat up and slid it under her bed when it was not in use.
-Resident #1 was a 2-person assist with transfers and staff had to extensively help her with all aspects of her care.

Interview with the Administrator on 09/23/22 at 6:00pm revealed:

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-She was aware of all four of Resident #1's falls.
-After a resident fell, she expected the MA or supervisor to notify the resident's PCP.
-The resident was automatically added to the list of residents for the PCP to see at their next visit to the facility.
-The facility would follow any recommendations given to them by the PCP for fall prevention interventions.
-After a resident fell, they always increased supervision of that resident which meant they tried to keep the resident in view of staff by having them sit by the nurse's station or in a common area.
-There were no scheduled checks in place for residents on increased supervision; the MAs were expected to complete the 72-hour shift monitoring in the eMAR and all staff were responsible for checking on the resident at least hourly.

2. Review of Resident #2's current FL2 dated 05/26/22 revealed:
-Diagnoses included dementia.
-Her ambulatory status was listed as ambulatory with no assistive devices needed.
-Her orientation was listed as intermittently oriented.

Review of Resident #2's Resident Register revealed she was admitted on 05/27/22.

Review of Resident #2's primary care provider's (PCP) progress note dated 06/02/22 revealed:
-Resident #2 wandered away from home on 2 different occasions prior to admission to the facility.
-Wandering behavior was one of the diagnoses listed on the progress note.

Review of Resident #2's care plan dated 06/13/22

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revealed:
-Resident #2 had no problems with ambulation.
-Resident #2's orientation was listed as sometimes disoriented.
-Resident #2 was independent with ambulation and transferring.

Review of Resident #2's incident/accident report dated 07/04/22 revealed:
-Resident #2 was located outside, not on facility grounds at 3:45pm.
-Resident #2 removed her bedroom window screen, climbed out her bedroom window, and eloped from the facility on 07/04/22.
-Resident #2 was observed walking down the road alone by a staff member.
-There was documentation that the local Department of Social Services (DSS), Resident #2's family member and PCP were notified.

Review of Resident #2's physician's order dated 07/07/22 revealed:
-Resident #2 was moved to the Special Care Unit (SCU).
-There were no medication changes recommended by Resident #2's PCP.

Review of Resident #2's updated care plan dated 07/14/22 revealed:
-She was moved to the SCU from Assisted Living (AL).
-Wandering was listed on the care plan.

Observation on 09/22/22 from 3:54pm to 4:09pm at the entrance to the local park where Resident #2 was found revealed:
-The park was located about 0.3 miles away from the facility.
-There was no posted speed limit sign along the side of the road.

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-There was a yellow traffic sign located directly across from the park entrance that indicated a curvy road ahead and advised a maximum speed of 30 miles per hour.
-There was a total of three vehicles that passed the entrance to the park during the 15 minute observation period.
-There was a total of two vehicles that entered the park during the 15 minute observation period.
-There was one vehicle that exited the park during the 15 minute observation period.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Interview with a personal care aide (PCA) on 09/22/22 at 1:58pm revealed:
-Resident #2 wandered the halls in the facility after lunch in the afternoon on 07/04/22.
-Resident #2 went to her room and staff thought that Resident #2 was taking a nap.
-Staff went to Resident #2's bedroom and found that the window was open, the screen was off, and Resident #2 was gone.
-Resident #2 was found somewhere between the end of the facility's driveway and a park located on the same road.
-She was not sure how long Resident #2 was gone from the facility or exactly what time she was found.
-She thought Resident #2 was found sometime before 4:00pm.
-Resident #2's normal behavior was to wander the halls after meals.
-The facility's normal procedure for a resident elopement was to try to locate the resident, assess for possible injuries, notify the PCP, family or responsible person, and the Administrator.
-Resident #2 resided in Room #5 when she lived

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on the AL side of the facility at the time of the elopement.
-Resident #2 did not have a roommate at the time of elopement.

Interview with a medication aide (MA) on 09/22/22 at 2:47pm revealed:
-She worked on 07/04/22.
-One of the facility housekeepers clocked out at 3:30pm and left the facility to return to her home.
-The housekeeper saw Resident #2 walking on the side of the road in the grass directly across from a park located about 0.3 miles from the facility.
-The housekeeper called the facility to inform staff of Resident #2's location.
-She left the facility in a vehicle to pick up Resident #2 and to bring her back to the facility.
-The housekeeper waited with Resident #2 until the MA arrived.
-She thought that she and Resident #2 returned to the facility sometime between 3:45pm and 4:00pm on 07/04/22.
-She thought Resident #2 was in her room at 2:00pm on 07/04/22.
-Resident #2 was agitated and wanted to go home when the MA transported her in a vehicle.
-She drove in a circle and made a loop back to the facility and tried to calm Resident #2 down before she returned to the facility with Resident #2.
-Resident #2 normally returned to her room in the afternoons and took a nap.
-Resident #2 would occasionally walk the facility hallways in the afternoons.
-Resident #2's family expressed concern that Resident #2 might wander when she first moved into the facility.
-The facility's normal process for elopement was to locate the resident, perform a head count of all

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D 270	Continued From page 28 the other residents to make sure no other resident was missing, check for injuries and do a full assessment, and to notify the Resident Care Coordinator (RCC), family or responsible person, and the PCP. -Resident #2's bedroom window screen was out and the window was still up when the elopement was discovered. Interview with a facility housekeeper on 09/22/22 at 3:18pm revealed: -She worked at the facility and clocked out at 3:30pm on 07/04/22. -She left the facility to drive home in her vehicle. -She saw Resident #2 walking on the right shoulder of the road at 3:33 pm, in the grass across from a local park. -She slowed down, rolled down her vehicle window, and called Resident #2's name. -Resident #2 responded to her name being called and Resident #2 said she was going home. -Resident #2 tried to keep walking while the housekeeper drove alongside her and encouraged her to get in the vehicle. -She called the facility to let staff know that she found Resident #2 outside of the facility. -One of the MAs came to pick up Resident #2 to return her to the facility. -She was not sure how long Resident #2 was gone from the facility. -The Supervisor answered the phone when she called regarding Resident #2. -She thought Resident #2 had not tried to leave the facility or elope before 07/04/22. -She thought Resident #2 may have had a roommate when she first moved into the facility. -She thought Resident #2 wanted her own room and ended up having a private bedroom sometime after she moved in.	D 270		

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D 270	Continued From page 29 Interview with the Supervisor on 09/22/22 at 3:30pm revealed: -She worked at the facility on 07/04/22. -A facility housekeeper called and told her that she found Resident #2 walking on the side of the road near a local park. -She sent one of the MAs to pick up Resident #2 and return to the facility. -Resident #2 had opened her window, taken out the screen, and the screen was lying down outside on the ground on 07/04/22. -Resident #2's room door was closed and she had climbed out of her bedroom window on the ground level on 07/04/22. -Staff had seen Resident #2 in the afternoon after lunch on 07/04/22. -The lunch meal service was normally served at 12:00pm. -Staff thought Resident #2 was taking a nap in the afternoon as she normally did. -She thought Resident #2 was found at the entryway to the local park. -She thought the housekeeper tried to keep Resident #2 engaged in conversation until the MA arrived. -She thought Resident #2 was found about a ten minute walk away from her bedroom window at the facility. -She thought Resident #2 walked quickly after she eloped from the facility because she was out of breath when the MA and Resident #2 returned to the facility. -Resident #2 was upset upon returning to the facility. -Resident #2's family was concerned about elopement upon Resident #2's admission to the facility. -The normal process for the Supervisor when a resident eloped or was missing was to call the Resident Care Coordinator (RCC), do a head	D 270		

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count of the other residents to ensure all other residents were accounted for in the facility and search the property for the missing resident.
-She notified the RCC if a resident eloped, and if she was unable to reach the RCC, she notified the Administrator and vice versa.
-She notified Resident #2's family and PCP of the elopement on 07/04/22.
-Resident #2's bedroom was room #5 at the time of elopement and she did not have a roommate.
-Resident #2 was moved to the facility's SCU after she returned to the facility on 07/04/22 to ensure that she could not elope again.

Interview with a second Supervisor on 09/23/22 at 9:45am revealed:
-The facility's normal process when a resident eloped was to locate the resident and return them to the facility and to notify the PCP and responsible person of the elopement.
-When Resident #2 lived on the AL side of the facility, Resident #2 would sit on the enclosed porch.
-She thought that Resident #2 had never tried to elope from the facility prior to 07/04/22.

Telephone interview with the primary care provider (PCP) on 09/23/22 at 1:57pm revealed:
-He was aware and notified by facility staff that Resident #2 eloped from the facility on 07/04/22.
-He thought that Resident #2 was a more appropriate placement for AL when she was first admitted to the facility rather than the SCU.
-Resident #2's cognition declined over time after she was admitted to the facility.
-He thought that Resident #2's change in environment from her home prior to admission to the facility contributed to her cognitive decline.

Interview with the RCC on 09/23/22 at 4:12pm

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revealed:
-She had not worked at the facility on 07/04/22.
-Staff called her at home and informed her that Resident #2's window was open and Resident #2 was found walking across from a local park entrance in the grass.
-She told staff to take Resident #2 to the SCU and notify the Administrator.
-She told SCU staff that Resident #2 needed to be in the unit for monitoring after the elopement.
-Resident #2 was more confused than her baseline on 07/04/22.
-She thought Resident #2 walked from her bedroom window to the place where she was found on 07/04/22 in ten minutes or less.
-Resident #2 had never tried to elope prior to 07/04/22.
-The facility's normal process for elopement was to locate the resident, call law enforcement if staff was unable to locate a resident, notify the PCP and responsible party, take the resident to the SCU, ask the PCP for an order for a urinalysis (UA) if the resident had increased confusion, and have the PCP to review the resident's medications.

Interview with the Administrator on 09/23/22 at 5:38pm revealed:
-She had not worked at the facility on 07/04/22.
-She received a telephone call on 07/04/22 that Resident #2 had eloped from the facility.
-Staff informed her that Resident #2 went out through her room window and one of the staff saw Resident #2 walking and called the facility.
-A MA left to pick up Resident #2 in a vehicle, but Resident #2 did not want to return to the facility.
-The MA drove in a circle and made a loop back to the facility and tried to calm Resident #2 down before the MA returned to the facility with Resident #2.

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D 270	Continued From page 32 -Staff moved Resident #2 to the SCU for increased safety. -Her room window in the SCU opened to an enclosed courtyard in the SCU. -She notified her immediate Supervisor and the local DSS Supervisor of the elopement. -She thought Resident #2 eloped sometime between 3:00pm and 4:00pm on 07/04/22. -She thought Resident #2 was a fast walker and was able to reach the location where she was found in no more than 10 to 15 minutes from her bedroom window. -Resident #2's family member shared with the Administrator that Resident #2 was agitated when her family would leave after visiting her because Resident #2 wanted to go home with them. -She was not aware and was not informed that Resident #2 was angry after family visitations until after Resident #2 eloped the facility on 07/04/22. -The normal process for a resident elopement was for staff to search for and locate the resident and to notify the RCC, family or responsible party, PCP and the Administrator. -The Supervisor was responsible to locate a resident who eloped and to notify the RCC, responsible party, PCP and the Administrator. -Staff sometimes asked the PCP for an order for a UA if the resident had increased confusion. -She and the RCC assessed residents prior to admission to ensure they were appropriate for AL. -She and the RCC assessed Resident #2 at a hospital prior to her admission to the facility. -She thought Resident #2 was appropriate for AL placement when she was assessed. -Resident #2 did not give any indication that she would wander when she was assessed prior to admission. Attempted telephone interview with Resident #2's family member on 09/22/22 at 1:50pm	D 270		

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D 270	Continued From page 33 unsuccessful. 3. Review of the facility's policy on incidents and accidents dated September 2021 revealed: -If a resident fell, the medication aide (MA) was to complete a fall incident/accident report including the correct time that the fall occurred along with a short description specifying the date, time, location, and if there was an injury. -A progress note was to be completed stating if the resident was sent to the Emergency Room (ER) or not. -The MA was to initiate 72-hour follow-up orders, vital signs and a shift note to be completed every shift for 72 hours. -A fall risk intervention care plan was to be created within 24 hours of the incident/accident by either the Resident Care Coordinator (RCC) or Administrator. -The fall intervention was to be added to the resident's orders by the RCC or Administrator. Review of Resident #4's current FL2 dated 06/09/22 revealed: -Diagnoses included mitral valve prolapse, hyperlipidemia, pulmonary hypertension, post-menopausal osteoporosis, prediabetes, and vitamin D deficiency. -Resident #4 was semi-ambulatory and intermittently disoriented. Review of Resident #4's care plan dated 07/22/22 revealed: -Resident #4 needed a walker to ambulate. -Resident #4 was sometimes disoriented, forgetful, and needed reminders. -Resident #4 was independent with ambulation and transferring. Review of Resident #4's licensed health	D 270		

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professional support (LHPS) review dated 07/29//22 revealed Resident #4 used a walker and could ambulation with a 1 person assist.

Review of Resident #4's Monthly Review of Resident Care dated 08/10/22 revealed:
-Resident #4 had not had any falls.
-She used a walker to ambulate.
-There had not been any preventive measures put in place for safety such as interventions for falls.
-Resident #4 did not require increased supervision for any current or new symptoms identified.

Observation of Resident #4's room on 09/21/22 at 4:48pm revealed:
-Resident #4 was laying in her bed on her right side.
-The head of her bed and right side of her bed were against a wall with the foot of her bed extending halfway along the windowsill.
-There was no visible floor mat.
-The room was uncluttered.

a. Review of Resident #4's progress notes dated 08/17/22 revealed:
-Resident #4 was found on the floor.
-Resident #4 was transported by emergency medical services (EMS) to the local hospital emergency room (ER).

Review of Resident #4's incident/accident reports revealed there was no incident accident report dated 08/17/22.

Attempted telephone interview with the Supervisor who documented the progress noted dated 08/17/22 on 09/22/22 at 2:24pm was unsuccessful.

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D 270	Continued From page 35 Review of Resident #4's hospital discharge summary dated 08/17/22 revealed Resident #4 was seen in the ER for a fall and hematoma of the scalp. Review of Resident #4's physician's order form dated 08/17/22 revealed there was documentation Resident #4 was observed on the floor, sent to the ER for evaluation and had a large hematoma on the back of her head. Review of Resident #4's Fall Risk Intervention Care Plan dated 08/18/22 revealed: -Resident #4 had a fall with injury in the hallway on 08/17/22. -Resident #4 was cognitively impaired. -Increased supervision was implemented as an intervention; there was no documentation of how often Resident #4 was to be supervised. Review of Resident #4's PCP's Progress Note dated 08/18/22 revealed: -The PCP saw Resident #4 on 08/18/22 as a follow-up to a fall in the hallway on 08/17/22. -Resident #4 hit her head and was sent out to the ER. -Resident #4 was evaluated through the ER on 08/17/22 and was felt to have a hematoma of the scalp and was sent back to the facility with no medication changes; the ER recommended the facility monitor Resident #4. -Resident #4 denied pain, but she had some minimal bruising to her scalp. -There were no neurological or mental status changes noted by staff. -Staff was to continue to monitor for any neurological or mental status changes and keep the provider aware. -Resident #4 was to continue with her current	D 270		

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D 270	Continued From page 36 medications and plan of care. Review of Resident #4's electronic Medication Administration Record (eMAR) for August 2022 revealed: -There was an entry for Increased Supervision on every shift to prevent falls; supervision was scheduled for between 6:00am and 6:00pm and between 6:00pm and 6:00am. -There was documentation from 08/18/22 through 08/31/22 from 6:00am to 6:00pm and from 6:00pm to 6:00am, but there was no documentation of how often supervision was increased for Resident #4 during each shift. -There was an entry for Fall: Check Vital Signs every shift for 72 hours each shift scheduled for between 6:00am and 6:00pm and between 6:00pm and 6:00am. -There was documentation Resident #4's pulse, respirations, and blood pressure were checked on each shift on 08/17/22, 08/18/22, and on 08/19/22. Review of Resident #4's Monthly Review of Resident Care dated 09/09/22 revealed: -Resident #4 had a fall on 08/17/22 and had a hospital visit due to the fall. -Resident #4's fall on 08/17/22 resulted in a hematoma to the scalp. -Resident #4 had a follow-up visit with her primary care physician (PCP), but the date was not documented. -There had not been any referrals made for home health services. -Resident #4 used a walker to ambulate. -Increased supervision was put in place as a preventive measure for safety, but there was no documentation of how often Resident #4 was to be supervised. -Resident #4 did not require increased	D 270		

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supervision for any current or new symptom identified.

Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 10:41am revealed:
-Resident #4 fell in front of her bed on 08/17/22 and had a hematoma to the back of her head.
-She had staff to send Resident #4 to the ER.
-When Resident #4 returned from the hospital, she was put on 72-hour precautions where staff monitored for pain, bruising, or changes, and documented once per shift for 72 hours.
-She told staff to monitor for changes in Resident #4's mental status and no changes were noted.
-She could not remember any other interventions put in place for Resident #4 after her fall on 08/17/22.
-If a resident had a fall, staff was to call for the supervisor on duty, and she (RCC) would also go to check on the resident.
-If the resident did not have any pain or did not hit his/her head, staff monitored the resident throughout the day.
-Staff checked on all residents at least every 2 hours.
-PCAs and MAs were responsible for checking on residents after a fall.
-She determined whether staff were to check on residents every hour or every 30 minutes according to their situation.
-The facility used to document 30-minute checks after a fall, but they stopped documenting the 30-minute checks under the new ownership.
-Staff were good about checking on the residents.
-Staff documented checking on a resident after a fall once per shift for 72 hours; staff documented any pain, bruising, or changes.
-She thought staff did not need to document 30-minute checks anymore because they were now documenting the 72-hour precautions on the

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electronic Medication Administration Record (eMAR).

Second interview with the RCC on 09/2/22 at 4:47pm revealed:
-"Increased Supervision" was supposed to be documented on Residents' eMARs after a fall.
-She did not know how often staff should have checked on Resident #1 when they documented "Increased Supervision" on the eMAR.
-She just told staff to monitor Resident #1 continuously throughout the shift.

Interview with Resident #4's family member on 09/22/22 at 11:41am revealed:
-He as notified several weeks ago Resident #4 fell after walking down the hall with her walker.
-Resident #4 was transported via EMS to the hospital ER and returned the same day.
-The facility told him they would keep an eye on her.

Interview with Resident #4's PCP on 09/23/22 at 1:46pm revealed:
-He knew about Resident 4's fall on 08/17/22
-He did not remember recommending any fall interventions to the facility after Resident #4's fall on 08/17/22.
-He expected the facility to increase supervision for Resident #5 after her falls, but he left it up to the facility to decide how often to check on Resident #4.

Interview with the Administrator on 09/23/22 at 5:32pm revealed:
-When a resident fell, staff was to notify the resident's PCP to see if he or she wanted the resident sent out to the hospital.
-The resident was automatically seen by the facility PCP during his next visit to the facility.

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-Interventions included following up with the PCP to see what he wanted to do after a fall.
-Usually, if there was a concern, staff would sit the resident at the staff desk for closer supervision.
-Residents were usually not placed at the staff desk after a first fall.
-There used to be scheduled supervision after a resident fell prior to the change in ownership of the facility, but the scheduled supervision was not in place now.
-She expected staff to check on residents after a fall at least once every hour.
-Staff were also to document residents were checked on every shift (2 shifts) for 72 hours.

b. Review of Resident #4's progress note dated 09/19/21 revealed:
-The progress note was made due to a follow-up to a fall.
-There was no additional information regarding the fall.

Review of Resident #4's incident/accident reports revealed there were no incident/accident reports for any falls between 09/01/22 and 09/20/22.

Interview with the Supervisor who documented the progress note dated 09/19/22 on 09/23/22 at 9:30am revealed:
-On 09/16/22, Resident #4 was found on the floor in front of her bed.
-When she got to Resident #4's room, she was trying to get herself up from the floor; her right hip and hands were on the floor.
-Resident #4 said that she had tripped over her shoes.
-She had a knot on the back side of her head, but it was not red.
-She contacted Resident #4's PCP and he said to

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keep checking on the knot.
-Resident #4's family member declined for her to go the hospital ER.
-Staff started monitoring her very closely after the fall on 09/16/22.
-For 72 hours, staff went into her room to check on her every hour or every 2 hours.
-After 72 hours, staff just kept a close eye on her.
-Staff did not document hourly checks or any additional checks for Resident #4.
-She did not know if any other interventions were put in place for Resident #4.
-She had forgotten to document the fall on 09/16/22.

Review of Resident #4's Primary Care Provider's (PCP) Progress Note dated 09/19/22 revealed:
-Resident #4 had a fall in the facility the previous week with a nodule to her posterior scalp.
-Staff contacted Resident #4's family member about sending her to the ER, and the family member did not want her to be sent out.
-Staff monitored Resident #4 with neuro checks and she had not shown any changes.
-Resident #4 did not remember a fall and did not have any complaints.
-Staff was to monitor for changes and keep the PCP and family aware of any changes.

Review of Resident #4's electronic Medication Administration Record (eMAR) for September 2022 revealed:
-There was an entry for Increased Supervision every shift to prevent falls; supervision was scheduled for between 6:00am and 6:00pm and between 6:00pm and 6:00am.
-There was documentation from 09/18/22 through 09/21/22 from 6:00am to 6:00pm and from 6:00pm to 6:00am, but there was no documentation of how often supervision was

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increased for Resident #4 during each shift.
-There was an entry for Fall: Check Vital Signs every shift for 72 hours each shift scheduled for between 6:00am and 6:00pm and between 6:00pm and 6:00am.
-There was no documentation Resident #4's pulse, respirations, and blood pressure were checked on each shift for 72 hours after her fall on 09/16/22.

Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 10:41am revealed:
-Resident #4 was found on 09/16/22 in front of the window in her room in a sitting position.
-It looked to her like Resident #4 was sitting on the foot of her bed looking out the window and she just slid down to the floor.
-Resident #4 said she was "alright."
-Resident #4 had a knot on the back right side of her head, but there was no bruising or swelling.
-She did not know whether the knot was there previous or as a result of the fall.
-The Supervisor called Resident #4's family member and he said he did not want Resident #4 sent to the hospital.
-Resident #4's PCP was contacted, and he said to put her on the list for him to see when he came to the facility and to monitor her for changes; Resident #4 was seen by the PCP on 09/19/22.
-Resident #4 was monitored for changes and staff made hourly monitoring visits to check on her.
-There were no other interventions put in place for Resident #4 after her fall on 09/16/22.
-Resident #4 had recently been admitted to the facility (07/07/22); staff were still trying to "figure her out" and see how independent she was.

Interview with a personal care aide (PCA) on 09/22/22 at 4:13pm revealed:

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-She was walking by Resident #4's room on 09/15/22 and saw Resident #4 sitting on the floor.
-Her back was against the window at the foot of her bed, but she did not appear to have any injuries.
-She went to get the Supervisor on duty that day to assess her.
-Resident #4 was not sent out to the hospital.
-She was told to "keep an eye" on Resident #4.
-Staff were to conduct 72 hour well checks where the PCAs would check on her every so often to make sure Resident #4 was not on the floor.
-Sometimes the PCAs would check on Resident #4 every hour or when walking down the hall.
-She did not know of any interventions put in place for Resident #4 after her fall on 09/15/22.

Interview with Resident #4's PCP on 09/23/22 at 1:46pm revealed:
-He knew about Resident 4's fall on 09/16/22
-He did not remember recommending any fall interventions to the facility after Resident #4's fall on 09/16/22.
-He expected the facility to increase supervision for Resident #5 after her falls, but he left it up to the facility to decide how often to check on Resident #4.

Interview with the Administrator on 09/23/22 at 5:32pm revealed she did not know about Resident #4's fall on 09/16/22.

c. Review of Resident #4's incident/accident report dated 09/21/22 revealed:
-Resident #4 was found laying on her bathroom floor and she was alert and oriented.
-Resident #4 did not know what happened, but she complained of back pain and pain in her left arm.
-Resident #4 was sent out to the ER via

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D 270	Continued From page 43 emergency medical services (EMS). Review of Resident #4's progress notes dated 09/21/22 revealed: -Resident #4 was found on the floor and was transported via EMS to the local hospital ER. -Resident #4's PCP and family member were informed Resident #4 was sent to the ER via EMS with possible injury. Attempted telephone interview with the Supervisor who documented Resident #4's progress note dated 09/21/22 on 09/22/22 at 2:28pm was unsuccessful. Interview with the Resident Care Coordinator on 09/22/22 at 10:41am revealed: -Staff called her at home on the night of 09/21/22 regarding Resident #4 falling. -Staff told her Resident #4 complained of pain in her back, hip, and leg. -She told staff to notify Resident #4's PCP, family member and call EMS. -Resident #4 typically got up during the middle of the night to go to the rest room. -Resident #4 normally ambulated independently and did not want help. -Resident #4 did not like to leave her door open and would close it if staff left it open. -She had told staff to monitor Resident #4 every 30 minutes and to check on her any time they pass by her room. Interview with Resident #4's family member on 09/22/22 at 11:41am revealed: -He received a call from the facility between 10:00pm and 10:15pm on 09/21/22. -Staff informed him Resident #4 was found in the bathroom on the floor. -Resident #4 complained of pain so they sent her	D 270		

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D 270	Continued From page 44 to the hospital. -The hospital staff told him Resident #4 had fractured ribs and a fractured vertebrae. Interview with Resident #4's PCP on 09/23/22 at 1:46pm revealed: -He knew about Resident 4's fall on 09/19/22. -He expected the facility to increase supervision for Resident #5 after her falls, but he left it up to the facility to decide how often to check on Resident #4. Interview with the Administrator on 09/23/22 at 5:32pm revealed Resident #4 was still hospitalized and had fractures as a result of her fall on 09/21/22. _____ The facility failed to ensure supervision for 3 residents (#1, #2, and #4) including a resident who was constantly disoriented, had a history of falls, and had 4 falls resulting in a right arm fracture, a right hip fractured on two different occasions, a knot by her right eye, a laceration to her face, contusion of the right eye with bruising, dislocation of her left shoulder joint, and left rotator cuff tear (#1); a resident who had a diagnosis of dementia, was intermittently disoriented and had a history of wandering behaviors, climbed out of her bedroom window and was found walking down a curvy road 0.3 miles from the facility (#4); and a resident who had 3 unwitnessed falls resulting in a hematoma to her scalp, a knot on the back of her head, and fractured ribs and vertebrae. The failure resulted in serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on September 22, 2022.	D 270		

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D 270	Continued From page 45 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION WILL NOT EXCEED OCTOBER 23, 2022.	D 270		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and	D 484		

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D 484	Continued From page 46 (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment for the use of bedrails and care planning through a team process and attempted alternatives prior to the use of restraints for 4 of 4 sampled residents (#1, #5, #6, and #7) with half bedrails. The findings are: Review of the census in the Special Care Unit (SCU) revealed a census of 25 residents. Observations of the SCU on 09/22/22 between 1:32pm and 1:40pm revealed: -There were 9 beds with bedrails. -There were 2 residents in bed with the bedrail in the up position. Review of the census in the assisted living (AL)	D 484		

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side of the facility revealed a census of 30 residents.

Observations of the AL side of the facility on 09/22/22 between 1:41pm and 1:12pm revealed:
-There were 21 beds with bedrails.
-There were 5 residents in bed with the bedrail in the up position.

1. Review of Resident #1's current FL2 dated 08/01/22 revealed:
-Diagnoses included fall in elderly patient, contusion, Alzheimer's disease, and displaced fracture of right femoral neck.
-Resident #1 was constantly disoriented.
-She was non-ambulatory and wheelchair bound.

Review of Resident #1's care plan dated 08/11/22 revealed:
-Resident #1 had a documented decline due to failure to thrive and received new orders for hospice.
-Resident #1 required complete assistance with activities of daily living (ADLs).
-She was non-ambulatory and used a wheelchair.
-She had limited strength and limited range of motion (ROM).
-She was sometimes disoriented, was forgetful and needed reminders.
-She needed extensive assistance with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.

Review of Resident #1's physician's order dated 09/22/22 revealed:
-There was documentation Resident #1 had a previous order for a hospital bed with half rails for mobility purposes and the order was missing from her record.
-The question was documented: Do you agree to

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continue the hospital bed with half rails for mobility?
-The primary care physician's (PCP) responded with a telephone order for a hospital bed with half rails for mobility purposes.

Observation of Resident #1 on 09/22/22 at 2:15pm revealed Resident #1 was laying in her bed and the bedrail was in the up position.

Based on observations, record reviews and interviews, it was determined Resident #5 was not interviewable.

Interview with a personal care aide (PCA) on 09/23/22 at 3:39pm revealed:
-Resident #1 tried to hold onto the bedrail to assist with mobility, but her ability to hold onto the bedrail depended on whether she was having a good day.
-Resident #1 was not able to get out of bed by herself and she was not sure if Resident #1 was able to raise or lower the bedrail.
-She was not sure if Resident #1 would be able to free herself if she became entangled in the bedrail or between the bedrail and the mattress.

Interview with a second PCA on 09/23/22 at 3:58pm revealed:
-PCAs assisted Resident #1 with all activities of daily living (ADLs) and was a 2 person assist.
-Resident #1 was not able to get in and out of bed by herself or raise and lower the bedrail.
-Resident #1 held onto the bedrail to assist with incontinence care.
-Resident #1 was able to roll slightly in the bed.
-She did not feel like Resident #1 had the strength to free herself if she became entangled in the bedrail or between the bedrail and the mattress.

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Telephone interview with the facility's contracted PCP on 09/23/22 at 1:46pm revealed:
-Resident #1 was able to use her bedrail to assist staff with repositioning.
-He did not think Resident #1 moved enough in the bed, because of weakness, to become entangled in the bedrail.

Interview with the Resident Care Coordinator on 09/23/22 at 5:10pm revealed:
-Resident #1 received bedrails when she got her hospital bed through hospice.
-When a resident received a hospital bed with bedrails, she automatically requested an order for bedrails for bed mobility.
-She had never been told she needed to complete an assessment for bedrails.
-Resident #1 had a cognitive and physical decline since getting the bedrails.
-Resident #1 was a 2-person assist and required assistance with all activities of daily living (ADLs).
-She could not raise or lower the bedrail.
-She did not think Resident #1 would be able to free herself if she became entangled in the bedrail or between the bedrail and the mattress because she did not have the strength.

Attempted telephone interview with Resident #1's guardian on 09/23/22 at 5:46pm was unsuccessful.

Refer to interview with a Special Care Unit (SCU) Supervisor on 09/23/22 at 10:18am.

Refer to interview with the SCU Coordinator (SCUC) on 09/23/22 at 10:53am.

Refer to telephone interview with the Assistance Director of Patient Services from the facility's

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contracted hospice provider on 09/23/22 at 12:01pm.

Refer to telephone interview with the facility's contracted PCP on 09/23/22 at 1:46pm.

Refer to interview with the Administration on 09/23/22 at 3:12pm.

2. Review of Resident #5's current FL2 dated 04/25/22 revealed:
-Diagnoses included Alzheimer's dementia, cerebral palsy, chronic subdural hematoma, congenital kyphosis (a condition where the front of one or more of the bones in the upper back does not develop properly), depression and hyperlipidemia.
-Resident #5 was non-ambulatory and used a wheelchair.
-Resident #5 was intermittently disoriented and needed assistance with bathing, feeding, and dressing.

Review of Resident #5's care plan dated 06/22/22 revealed:
-Resident #5 was non-ambulatory and used an electric scooter.
-She had limited range of motion in her upper extremities, specifically the joints of her arms and legs.
-Resident #5 was totally dependent upon staff to assist her with toileting, ambulation, bathing, dressing, and transferring; she required extensive assistance with grooming/personal hygiene.

Review of Resident #5's physician's order dated 02/10/15 revealed an order for a hospital bed with half rails to assist with mobility.

Observation of Resident #5's room on 09/22/22 at

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D 484	Continued From page 51 2:18pm revealed: -There was a bedrail on Resident #5's bed in the down position. -Resident #5 was sitting in her wheelchair in her room. Based on observations, record reviews and interviews, it was determined Resident #5 was not interviewable. Interview with a Supervisor on 09/23/22 at 9:30am revealed: -Resident #5 was not able to turn from side to side and she did not move around in the bed. -Resident #5's bedrail was up when she was in the bed. -Resident #5 could take her right hand and hold onto the bedrail when she turned to her right side; otherwise, staff had to turn her. -She did not know if Resident #5 could free herself from the bedrail if she became entangled. Interview with a personal care aide (PCA) on 09/23/22 at 3:39pm revealed: -Resident #5 could not get in and out of bed by herself and staff had to turn her from side to side. -Resident #5 held onto the bedrail when they got her up into her chair. -Resident #5 could not raise or lower the bedrail. -She was not sure if Resident #5 would be able to free herself if she became entangled in the bedrail or between the bedrail and the mattress. Interview with a second PCA on 09/23/22 at 3:58pm revealed: -Resident #5 required assistance with all of her activities of daily living (ADLs) and she was a 2 person assist. -Resident #5 did not use the bedrail to assist with care or transfers.	D 484		

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D 484	Continued From page 52 -She did not think Resident #5 was physically able to raise or lower the bedrail and she did not know if she would have enough strength to free herself if she became entangled in the bedrail or between the bedrail and the mattress. Telephone interview with the facility contracted PCP on 09/23/22 at 1:46pm revealed: -Resident #5 did not have bedrails until she became a hospice patient and received bedrails with her hospital bed. -The hospital bed with bedrails were used for hospice comfort reasons. -He did not think Resident #5 moved enough in the bed, because of weakness, to become entangled in the bedrail. Interview with the Resident Care Coordinator on 09/23/22 at 5:10pm revealed: -Resident #5 required total assistance with all activities of daily living (ADLs). -Resident #5 was only able to move around in the bed with assistance. -She could grab the bedrail to assist with turning from side to side. -Resident #5 had an order for bedrails date 2015. -Her physical ability had declined since she obtained the order for bedrails. -Resident #5 was not able to raise or lower the bedrail. -Resident #5 would not be able to free herself if she became entangled in the bedrail or between the bedrail and the mattress. Telephone interview with Resident #5's family member on 09/23/22 at 5:42pm revealed: -He knew Resident #5 had a bedrail. -Resident #5 had cerebral palsy and the bedrail was used to keep her from rolling out of bed.	D 484		

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Refer to interview with a Special Care Unit (SCU) Supervisor on 09/23/22 at 10:18am.

Refer to interview with the SCU Coordinator (SCUC) on 09/23/22 at 10:53am.

Refer to telephone interview with the Assistance Director of Patient Services from the facility's contracted hospice provider on 09/23/22 at 12:01pm.

Refer to telephone interview with the facility's contracted PCP on 09/23/22 at 1:46pm.

Refer to interview with the Administration on 09/23/22 at 3:12pm.

3. Review of Resident #6's current FL2 dated 08/25/22 revealed:
-Diagnoses included Alzheimer's dementia, major neurocognitive disorder, Parkinson's disease, generalized anxiety disorder, major depressive disorder and scoliosis.
-Resident #6 was ambulatory.
-Resident #6 was constantly confused and required assistance with bathing and dressing.

Review of Resident #6's care plan dated 10/12/21 revealed:
-Resident #6 required a Special Care Unit (SCU) due to poor decision making regarding her safety.
-She was confused and needed redirecting and reminders.
-Resident #6 required extensive assistance with bathing/grooming/personal hygiene, dressing, and toileting; She required limited assistance with mobility/ambulation/transfers and eating.
-There was no documentation regarding bedrails.

Review of Resident #6's physician's order dated

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D 484	Continued From page 54 09/22/22 revealed: -There was documentation Resident #6 was missing the order for a hospital bed with half rails for mobility purposes. -The question was documented: Do you want to continue this order? -The physician's response was an order for a hospital bed with half rails for mobility purposes Observation of Resident #6's room on 09/22/22 at 11:18am revealed: -Resident #6 resided in the SCU. -There was a bedrail on Resident #6's bed in the up position. -Resident #6 was sitting in a recliner in the room. Interview with Resident #6 on 09/22/22 at 11:19am revealed: -She was able to get in and out of bed by herself, but she was not able to raise or lower the bedrail by herself. -Staff pulled the bedrail up when she got in the bed at night. -She did not use the bedrail otherwise. Interview with a personal care aide (PCA) on 09/23/22 at 9:52am revealed: -Resident #6 had a bedrail to keep her from trying to get out of bed and falling. -Resident #6 tried to move a lot by herself. -The bedrail was usually in the up position when she arrived in the morning and was placed in the down position when staff got her out of bed and dressed. -If Resident #6 were to take a nap during the day, staff would place her bedrail in the up position. -Resident #6 sometimes used the bedrail to turn from side to side. -Resident #6 would not be able to free herself if she became entangled in the bedrail or between	D 484		

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the bedrail and mattress.

Interview with a second PCA on 09/23/22 at 10:04am revealed:
-Resident #6 was able to get in and out of bed by herself, but she was not able to put the bedrail up and down by herself.
-Resident #6 would not be able to free herself if she became entangled in the bedrail or between the bedrail and mattress.

Interview with a SCU Supervisor on 09/23/22 at 10:18am revealed:
-Resident #6 was able to get in and out of bed by herself, but she was not able to raise and lower the bedrail.
-Resident #6 had a hospital bed to keep her feet elevated while she was in the bed and the bedrail came with it.
-Resident #6's bedrail was used to keep her in the bed, but it also helped her to get in and out of the bed.
-She thought Resident #6 would be able to free herself if she became entangled in the bedrail or between the bedrail and the mattress.

Interview with the SCU Coordinator (SCUC) on 09/23/22 at 10:53am revealed:
-Resident #6 had bedrails for mobility.
-She had a hospital bed to assist her with getting in and out of bed and to assist with repositioning while in bed.
-She could raise and lower her bedrail and she would be able to free herself if she became entangled in the bedrail or between the bedrail and the mattress.

Telephone interview with the facility's contracted PCP on 09/23/22 at 1:46pm revealed:
-He thought the facility requested a bedrail for

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Resident #6 to assist with ADLs and transfers.
-He was made aware of Resident #6's bedrails when conducting rounds at the facility.
-If Resident #6 was minimally entangled in the bedrail, he would think she would be able to free herself.
-If Resident #6 had a major entanglement in the bedrail, then she would not be able to free herself.

Attempted telephone interview with Resident #6's responsible party on 09/23/22 at 5:48pm was unsuccessful.

Refer to interview with a Special Care Unit (SCU) Supervisor on 09/23/22 at 10:18am.

Refer to interview with the SCU Coordinator (SCUC) on 09/23/22 at 10:53am.

Refer to telephone interview with the Assistance Director of Patient Services from the facility's contracted hospice provider on 09/23/22 at 12:01pm.

Refer to telephone interview with the facility's contracted PCP on 09/23/22 at 1:46pm.

Refer to interview with the Administration on 09/23/22 at 3:12pm.

4. Review of Resident #7's current FL2 dated 02/14/22 revealed:
-Diagnoses included Alzheimer's dementia, neurocognitive disorder, osteoarthritis, and dizziness.
-Resident #7 was semi-ambulatory with a wheelchair.
-Resident #7 was constantly disoriented and needed assistance with bathing, feeding, and

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dressing.

Review of Resident #7's care plan dated 02/11/22 revealed:
-Resident #7 required a Special Care Unit (SCU) due to poor decision making regarding his safety.
-Resident #7 required extensive assistance with bathing/grooming/personal hygiene, dressing, and toileting; he required limited assistance with mobility/ambulation/transfers.
-There was no documentation related to bedrails.

Review of Resident #7's physician's order dated 09/22/22 revealed:
-There was documentation Resident #7 was missing the order for a hospital bed with half rails for mobility.
-The question was documented: Do you want to continue this order?
-The physician's response was an order for a hospital bed with half rails for mobility purposes.

Observation of Resident #7's room on 09/22/22 at 11:25am revealed:
-Resident #7 resided in the SCU.
-There was a bedrail on Resident #7's bed in the up position
-Resident #7 was seated in a recliner in the room.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Interview with a personal care aide (PCA) on 09/23/22 at 9:52am revealed:
-Resident #7 required assistance with all activities of daily living (ADLs).
-Resident #7 had a bedrail on his bed that was raise at night when he was in bed.
-The bedrail was raised at night to keep him from

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falling out of the bed and from getting hurt.
-The bedrail was put down when the PCAs provided incontinence care so they could get to him better.
-Resident #7 grabbed the bedrail at times when staff tried to get him out of bed.
-Resident #7 squirmed in the bed, but he was not able to turn from side to side by himself.
-Resident #7 was not able to raise or lower the bedrail by himself.
-Resident #7 would not be able to free himself if he became entangled in the bedrail or between the bedrail and the mattress.
-Resident #7 was not cognitively aware enough to use the call bell.

Interview with a second PCA on 09/23/22 at 10:04am revealed:
-Resident #7 required total assistance with all ADLS; he could not do anything by himself.
-Resident #7 had a bedrail for about a year.
-The bedrail was used to keep Resident #7 from falling out of bed onto the floor.
-Resident #7 could move from side to side in the bed with assistance.
-He did not use the bedrail at all to maneuver in the bed.
-Resident #7 was not able to raise or lower the bedrail by himself.
-Resident #7 would not be able to free himself if he became entangled in the bedrail or between the bedrail and the mattress; he would not be able to use the call bell to call for help.

Interview with a SCU Supervisor on 09/23/22 at 10:18am revealed:
-Resident #7 required total care with all ADLs.
-Resident #7 had a bedrail to keep him from falling out of the bed.
-She did not know how long Resident #7 had the

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bedrail.
-The bedrail was usually in the up position when Resident #7 was in the bed.
-She did not know if Resident #7 was able to grab the bedrail or use it to turn from side to side.
-Resident #7 was not able to get in and out of bed by himself.
-Resident #7 did not have the cognitively ability to free himself if he became entangled in the bedrail or between the bedrail and the mattress.

Interview with the SCU Coordinator (SCUC) on 09/23/22 at 10:53am revealed:
-Resident #7 required total care and had cognitive impairment.
-Resident #7 was receiving hospice care and when they ordered a hospital bed for Resident #7, the medical equipment provider also brought out a bedrail.
-Resident #7 has had the hospital bed and bedrail for a few months.
-The bedrails were normally in the up position when Resident #7 was in the bed, but not always.
-If Resident #7 was in the bed and was moving around a lot, staff would raise the bedrail to keep him from falling out of the bed.
-Some days Resident #7 was able to turn from side to side using the bedrail and some days he was able to get in and out of bed by himself.
-She did not know if Resident #7 would be able to raise or lower the bedrail.
-She thought Resident #7 would be able to free his arm if his arm got entangled in the bedrail, but she did not know if he would be able to free himself if he fell between the bedrail and the mattress.

Telephone interview with the facility's contracted PCP on 09/23/22 at 1:46pm revealed:
-Resident #7 had delirium associated with

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D 484	Continued From page 60 dementia. -He was noted to get in and out of bed by himself. -If he became entangled in the bedrail or between the bedrail and mattress, he may be able to free himself. Attempted telephone interview with Resident #7's responsible party on 09/23/22 at 5:51pm was unsuccessful Refer to interview with a Special Care Unit (SCU) Supervisor on 09/23/22 at 10:18am. Refer to interview with the SCU Coordinator (SCUC) on 09/23/22 at 10:53am. Refer to telephone interview with the Assistance Director of Patient Services from the facility's contracted hospice provider on 09/23/22 at 12:01pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/23/22 at 1:46pm. Refer to interview with the Administration on 09/23/22 at 3:12pm. _____ Interview with a SCU Supervisor on 09/23/22 at 10:18am revealed: -Residents usually received a bedrail when they received a hospital bed. -She had seen some hospital beds in the facility without a bedrail, but it was rare. -Bedrails were used for safety reasons: to keep the residents from falling out of the bed and some residents could assist staff with care by holding onto the bedrail and using it to sit up. Interview with the SCUC on 09/23/22 at 10:53am	D 484		

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revealed:
-Full bedrails usually came with hospital beds when hospital beds were ordered.
-Half bedrails were used for mobility in the bed and to help residents stand up.
-Residents who understood, used the bedrail to assist them with rolling from side to side in the bed to assist with incontinence care.
-The bedrails also kept residents from rolling out of the bed if they were able to roll.
-Some residents may have understood how to use the bedrails when they first got them, but they may not understand how to use the bedrails now.
-She had never been told any type of assessment needed to be completed for residents with bedrails.
-There may have been times when bedrails were removed from residents' bed when they were not able to use them any longer.

Telephone interview with the Assistance Director of Patient Services from the facility's contracted hospice provider on 09/23/22 at 12:01pm revealed:
-When a resident started receiving hospice services, a hospital bed was usually offered for the resident depending on their mobility.
-The hospital beds usually came with bedrails unless a facility told them they did not want the bedrail.

Telephone interview with the facility contracted PCP on 09/23/22 at 1:46pm revealed:
-If he wrote orders for bedrails, the bedrails were to be used for mobility and to assist with transfers in and out of bed.
-Some of the bedrails in the facility may be a part of the hospital beds ordered by a hospice provider.

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D 484	Continued From page 62 Interview with the Administration on 09/23/22 at 3:12pm revealed: -Hospital bed with full bedrails were considered restraints. -She was told hospital beds with half bedrails were okay to use in the facility. -Staff consulted with the residents' primary care provider (PCP) to get orders for bedrails to assist with bed mobility. -The bedrails were not used as an attempt to keep residents in bed. -If a bedrail was ordered through the hospice provider, the resident was educated by the medical equipment provider on proper use of the bedrail. -There had been no assessments for residents' ability to use a bedrail or the ability free him or herself if entanglement occurred; no one ever told her residents needed to be assessed for bedrails. -The facility did not have a tool for assessment of bedrail use. -She thought the residents had physician's orders for bedrails for mobility. -If staff had questions or concerns regarding a resident having a bedrail, they would call her or the Resident Care Coordinator (RCC) to let them know the resident having a bedrail was not a good idea. _____ The facility failed to ensure 4 residents who had half bedrails were assessed and provided care planning through a team process for the use of the bedrails which could have resulted in entanglement in the bedrail or between the bedrail and mattress without the residents being able to free themselves. This placed residents with bedrails at risk of becoming entangled in the bedrails. This failure was detrimental to the health, safety and welfare of of the residents which constitutes a Type B Violation.	D 484		

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D 484	Continued From page 63 The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on September 23, 2022. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION WILL NOT EXCEED NOVEMBER 7, 2022.	D 484		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect related to personal care and supervision and use of restraints and alternatives. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (Residents #1, #2 and #4) related to a resident who had four falls resulting in injuries (#1), a resident who elopement from the facility (#2), and a resident who had a history of falls (#4). [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment for the use of	D914		

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TWELVE OAKS	1297 GALAX TRAIL MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 64 bedrails and care planning through a team process and attempted alternatives prior to the use of restraints for 4 of 4 sampled residents (#1, #5, #6, and #7) with half bedrails. [Refer to Tag 0484, 10A NCAC 13F .1501(c) Use of Restraints and Alternatives (Type B Violation).]	D914		