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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 04/18/23-04/20/23.	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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision according to needs of the resident for 1 of 2 sampled residents (#1) who had an episode of choking on food in the dining room one week prior to being found unresponsive in the dining room and 14 documented falls over 10 weeks. The findings are: Review of Resident #1's current FL-2 dated 12/01/23 revealed diagnoses included Alzheimer's dementia, depression, anxiety, hypothyroidism, polyneuropathy, restless leg syndrome and ataxia with frequent falls. Review of Resident #1's Resident Register revealed she was admitted to the facility on 07/06/20. Review of Resident #1's current care plan dated	D 270		

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02/07/23 revealed:
-She was sometimes disoriented, forgetful and needed reminders.
-She was ambulatory with a rolling walker or wheelchair, was independent with transfers and required limited assistance from staff with ambulation.
-She had limited range of motion to both upper extremities.
-She did not have any dietary restrictions and required limited assistance from staff to eat meals.
-She had a pressure wound on her buttocks with unspecified wound care.
-She was continent of bowel and bladder and required limited assistance with toileting.

a. Review of Resident #1's electronic progress note dated 03/12/23 at 3:34pm revealed:
-She choked on food at lunch on 03/12/23.
-Her primary care provider (PCP) was contacted and suggested she did not eat for dinner and drink only clear liquids or juice.

Review of Resident #1's physician order dated 03/12/23 revealed:
-There was documentation that an order was received for clear liquids or juice by a medication aide (MA).
-The order was not signed by the PCP.

Review of the facility's Death Report for Resident #1 dated 03/20/23 revealed:
-Another resident alerted staff that Resident #1 was slumped over.
-Staff found the resident unresponsive and pulseless on 03/20/23 at 12:26pm.
-Resident #1 had a do not resuscitate (DNR) order.
-Emergency medical services (EMS) pronounced

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her time of death on arrival.

Review of Resident #1's electronic incident report dated 03/23/23 revealed:
-She was found at 12:15pm on 03/20/23 in the dining room leaning over to the side in her wheelchair.
-She was unresponsive and had passed away.

Interview with a MA on 04/19/23 at 3:47pm and 04/20/23 at 12:40pm revealed:
-She documented the electronic progress note dated 03/12/23.
-She did not remember what Resident #1 was eating when she started choking at lunch on 03/12/23.
-She spoke directly to Resident #1's PCP about the choking incident.
-The PCP instructed her to give the resident clear liquids for dinner on 03/12/23.
-Staff did not have to supervise Resident #1 during meals following the choking incident.
-Staff were always present and monitoring all residents in the dining room for meals.

Interview with a personal care aide (PCA) on 04/19/23 at 10:44am revealed:
-Resident #1 required assistance with eating meals at times.
-Sometimes the resident needed staff to place the spoon or fork in her hand properly because she was holding the utensil in the wrong direction.
-She was more confused and "talking out of her head" the week before she died.
-She did not know what was happening, talked about her deceased husband and mistook staff for family members.
-She was fine the day she died (03/20/23).
-She had gotten Resident #1 up into her wheelchair and took her to the dining room for

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lunch on 03/20/23.
-The last time she saw Resident #1, the resident was looking down and reaching for the side of her wheelchair.
-The resident told her she was trying to make sure the wheelchair was locked.
-Her lunch meal was on the table in front of her and she was eating without problem.
-She was called away from the dining room by another resident.
-When she returned to the dining room, the MA was pushing Resident #1 in her wheelchair out of the dining room.
-Resident #1 was pale and not breathing.
-She and 2 MAs assisted Resident #1 back to her bed.
-The resident turned blue after she was placed in the bed.
-The MAs tried to obtain vital signs but did not get any readings.
-Resident #1 had a DNR order.
-It all happened out of the blue and was a shock to everyone.

Second interview with the MA on 04/19/23 at 10:29am revealed:
-Resident #1 was on a regular diet with chopped meats and ate independently.
-Resident #1 was fine the morning of 03/20/23 and the week before.
-She did not remember the resident experiencing any changes in condition.
-The PCA brought the resident to dining room for the lunch meal on 03/20/23.
-She assumed Resident #1 had been eating just before she saw her at the lunch meal on 03/20/23.
-Another resident asked her to check on Resident #1.
-When she saw Resident #1, the resident was

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slumped over in her wheelchair and her face was blue.
-She assisted Resident #1 in her wheelchair back to her room.
-Another MA assisted and called EMS.
-Upon checking the resident, she found the resident was not breathing and still had unchewed food around the front part of her gums.
-It took approximately 30 seconds to transport the resident from the dining room to her room in her wheelchair.

Interview with a resident on 04/19/23 at 3:05pm revealed:
-She had been in the dining room with Resident #1 on 03/30/23 at lunch.
-Resident #1 always came to the table in her wheelchair saying "I'm starving to death".
-Resident #1 would eat her meal and as soon as she was finished eating, she would leave the dining room.
-Resident #1 fed herself and sometimes would pick up her food with her fingers, "not the best table manners".
-That day at lunch, Resident #1 was eating lunch when she told the other resident sitting at the table to "hit me in my back".
-The other resident sitting at the table with her was also in a wheelchair and was not able to help Resident #1.
-Resident #1 kept saying 'hit me in my back" and then all of a sudden she went limp.
-I could see something was wrong with Resident #1 and told a MA that she needed help.
-The MA came over and "rushed" Resident #1 out of the dining room in her wheelchair.
-I was not sure what was happening with her but it happened in an "instant".

Telephone interview with Resident #1's family

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member on 04/27/23 at 4:06pm revealed:
-Staff had called him twice in the 3 months before Resident #1 died (03/20/23) and reported she choked while eating.
-Resident #1 had a history of choking while eating because she had a hiatal hernia and narrow esophagus.
-She died in the dining room, but her death certificate said she died from Alzheimer's.
-No autopsy was done so he did not know if she choked on food she was eating.

Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed:
-She was aware of Resident #1's choking incident on 03/12/23.
-The PCP ordered a clear liquid diet that evening.
-There were no other orders.
-Staff were not instructed to specifically supervise Resident #1 at meals.
-Staff were always present to supervise all residents in the dining room during meals.
-She did not think an electronic incident report was completed for the choking incident on 03/12/23.
-An electronic incident report should have been completed for a medical incident with increased supervision implemented because the choking incident was an event.
-Resident #1 should have been supervised during meals for any changes.

Interview with the Administrator in Training (AIT) on 04/20/23 at 1:54pm revealed:
-The PCP only ordered a clear liquid diet for the dinner meal on 03/12/23.
-The MA should have clarified when to return to her regular diet.
-An electronic incident report should have been completed so all staff would have been aware,

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and Resident #1 would have been monitored for 72 hours, especially during those meals.

b. Review of Resident #1's electronic progress note dated 01/03/23 at 6:38pm revealed her primary care provider (PCP) was notified of a fall at 6:23pm with no injuries.

Review of Resident #1's electronic progress note dated 01/07/23 at 1:55am revealed her family member was notified at 6:30am that she was found on the floor.

Review of Resident #1's electronic progress note dated 01/14/23 at 3:28pm revealed her PCP was notified she fell without injury trying to transfer to her wheelchair.

Review of Resident #1's electronic progress note dated 01/17/23 at 11:09pm revealed she was found on the floor and sent to the emergency room (ER) at 9:05pm.

Review of Resident #1's electronic incident report dated 01/17/23 revealed:
-She was found lying on her back with her feet on the bed at 8:39pm.
-She told staff "it" moved and she fell
-She reported hitting her head and left shoulder.
-She was sent to the ER and her PCP was notified.
-72 hour fall monitoring was implemented.

Review of Resident #1's increased supervision check sheet dated 01/17/23 revealed:
-There was documentation of her location every 10 minutes from 3:00pm until 8:50pm.
-There were columns where staff documented the time, location, and their initials.
-There was documentation she was in her

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bedroom from 7:20pm until 8:50pm.
-On the side margin "floor" was documented with a line to 8:40pm and 8:50pm.

Review of Resident #1's electronic progress note dated 01/18/23 at 9:34am revealed her PCP was notified she fell without injury.

Review of Resident #1's electronic progress note dated 01/20/23 at 4:08am revealed her PCP was notified she fell without injury.

Review of Resident #1's electronic progress note dated 01/20/23 at 8:51pm revealed she had right lower leg bruising since the fall.

Review of Resident #1's electronic progress note dated 01/21/23 at 2:26am revealed:
-There was documentation that the note was recorded on 02/03/23 at 9:27am.
-Resident #1 fell on 01/21/23 at 2:26am and her PCP was notified.

Review of Resident #1's electronic progress note dated 01/21/23 at 3:15am revealed the PCP and family member were notified she was found on the floor and sent to the ER at 2:56am.

Review of Resident #1's electronic progress note dated 01/21/23 at 3:18am revealed there was documentation the MA spoke to the PCP regarding the resident being sent to the ER after being found on the floor and complaining of right hip pain.

Review of Resident #1's electronic incident report dated 01/21/23 revealed:
-She was found lying on the floor at the foot of her bed at 2:22am.
-She complained of right hip pain.

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-She was sent to the ER and her PCP was notified.
-72 hour fall monitoring was implemented.

Review of Resident #1's emergency medical services (EMS) report dated 01/21/23 revealed the resident was alert, answering questions appropriately and reported to technicians she fell out of her wheelchair reaching for her call bell.

Review of Resident #1's increased supervision check sheet dated 01/20/23 to 01/21/23 revealed:
-There was documentation of her location every 10 minutes from 9:00pm on 01/20/23 until 2:50am on 01/21/23.
-There were columns where staff documented the time, location, and their initials.
-There was documentation she was in her bedroom from 9:00pm on 01/20/23 until 2:20am on 01/21/23.
-There was documentation that she was out of the facility from 2:30am to 2:50am on 01/21/23.
-There was no documentation that she fell.

Telephone interview with a third shift medication aide (MA) on 04/19/23 at 9:55pm revealed:
-She normally wrote everything that happened in a notebook.
-She did not have her notebook and could not remember Resident #1's falls on 01/07/23, 01/17/23 and 01/21/23.
-The resident was falling frequently for a while and then she got better and did not have more falls.
-She could not remember the timeframe when Resident #1 fell and when the falls stopped.
-Residents were sent to the ER for unwitnessed falls where the resident reported hitting their head or complained of pain.
-The PCP had to order things like a fall mat and

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concave mattress.
-Resident #1 required staff assistance with getting in and out of bed.
-She would "throw" herself into her wheelchair.
-She did not look before sitting down, she hopped up out of the bed and plopped down hard into her wheelchair.
-Resident #1 required staff assistance with toileting and bathing.
-She was able to assist Resident #1 by herself, but some staff preferred two staff to assist the resident.
-When Resident #1 fell she either called the PCP's office in the morning before leaving work or faxed the PCP's office.

Interview with the Administrator in Training (AIT) on 04/20/23 at 1:54pm revealed:
-Resident #1 had a history of confusion and therefore she questioned the accuracy of statement documented in the resident's EMS report dated 01/21/23.
-She did not know why the resident was awake at that time.

Review of Resident #1's electronic progress note dated 01/25/23 at 4:05pm revealed her PCP was notified she fell without injury and her blood pressure was a little elevated.

Review of Resident #1's increased supervision check sheet dated 01/25/23 revealed:
-There was documentation of her location every 10 minutes from 3:00pm until 8:50pm.
-There were columns where staff documented the time, location, and their initials.
-There was documentation that she was in the parlor from 3:00pm until 4:10pm.
-There was documentation that she was in the bathroom at 4:20pm, returned to the parlor at

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4:30pm and was in the dining room from 4:40pm until 5:50pm.
-There was no documentation that she fell.

Review of Resident #1's electronic progress note dated 02/01/23 at 3:36pm revealed:
-She fell reaching for a piece of candy.
-She complained of hitting her head and pain in her head, back and bottom.
-She was sent to the ER and her PCP was notified.

Upon request on 04/18/23 and 04/19/23, Resident #1's electronic incident report dated 02/01/23 was not provided for review.

Review of Resident #1's increased supervision check sheet dated 02/01/23 revealed:
-There was documentation of her location every 15 minutes from 3:00pm until 11:00pm.
-There were columns where staff documented the time, location, and their initials.
-There was documentation that she was on the floor at 3:00pm and 3:15pm and out of the facility from 3:30pm until 7:30pm.

Review of Resident #1's electronic progress note dated 02/14/23 at 5:25pm revealed:
-She slid out of her wheelchair looking for candy.
-She did not have any injuries but had a high blood pressure reading.
-Her PCP was notified.

Review of Resident #1's increased supervision check sheet dated 02/14/23 revealed:
-There was documentation of her location every 30 minutes from 5:00pm until 11:00pm.
-There were columns where staff documented the time, location, and their initials.
-There was documentation that she was on the

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floor at 5:00pm and in the dining room from 5:30pm until 6:00pm.

Review of Resident #1's electronic progress note dated 02/16/23 at 7:23am revealed her PCP was notified she was found on the floor at 6:03am.

Review of Resident #1's increased supervision check sheet dated 02/15/23 to 02/16/23 revealed:
-There was documentation of her location every 15 minutes from 11:00pm on 02/15/23 until 7:00am on 02/16/23.
-There were columns where staff documented the time, location, and their initials.
-There was documentation that she was on in her bedroom from 11:00pm on 02/15/23 until 7:00am on 02/16/23.
-There was no documentation she fell.

Review of Resident #1's electronic progress note dated 02/20/23 at 5:17pm revealed her PCP was notified she was found on the floor at 4:20pm on 02/20/23.

Review of Resident #1's increased supervision check sheet dated 02/20/23 revealed:
-There was documentation of her location every 15 minutes from 3:00pm until 11:00pm.
-There were columns where staff documented the time, location, and their initials.
-There was documentation that she was on the floor in her bedroom at 4:15pm and in the parlor at 4:30pm.

Review of Resident #1's electronic progress note dated 02/20/23 at 5:21pm revealed she had arm pain since the fall.

Review of Resident #1's electronic progress note dated 02/20/23 at 10:30pm revealed her PCP

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was sent a fax notification of shoulder pain since the fall.

Review of Resident #1's electronic progress note dated 02/20/23 at 5:18pm revealed her PCP was notified she had a fall with an injury.

Interview with a MA on 04/19/23 at 3:47pm revealed:
-She was working when Resident #1 fell on 02/20/23, but she could not remember what happened.
-Resident #1 had an assist rail on her bed and was placed on every 15- or 30-minute checks.
-There were no other or additional fall and injury prevention interventions such as keeping the resident in sight of staff while she was awake, a fall mat or concave mattress.

Upon request on 04/18/23 and 04/19/23, Resident #1's electronic incident report dated 02/20/23 was not provided for review.

Review of Resident #1's electronic progress note dated 02/28/23 at 9:30am revealed:
-There was documentation that the note was recorded on 03/08/23 at 7:15pm.
-There was documentation her PCP was notified she fell on 02/28/23 at 9:30am.

Review of Resident #1's electronic progress note dated 03/07/23 at 9:11pm revealed her PCP was notified that she fell out of bed without injury.

Review of Resident #1's increased supervision check sheet dated 03/07/23 revealed:
-There was documentation of her location every 15 minutes from 3:00pm until 11:00pm.
-There were columns where staff documented the time, location, and their initials.

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-There was documentation that she was in her bedroom from 8:00pm until 11:00pm.
-On the side margin "fell at 9:10pm" was documented.
Review of Resident #1's electronic progress note dated 03/16/23 at 3:30pm revealed:
-There was documentation that the note was recorded on 03/23/23 at 3:31pm.
-There was documentation her PCP was notified she was found on the floor at 3:55pm on 03/16/23.

Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed:
-Resident #1's electronic progress note dated 03/16/23 was marked late entry because she wrote the note on 03/23/23 for a fall that occurred on 03/16/23.
-She documented the fall because the MA on duty at the time of the fall did not contact the resident's PCP.

Review of Resident #1's electronic incident report dated 03/16/23 revealed:
-She was found sitting on the bathroom floor at 3:50pm.
-She forgot to press the call bell and did not have any injuries.
-72 hour fall monitoring was implemented.

Review of Resident #1's increased supervision check sheet dated 03/16/23 revealed:
-There was documentation of her location every 30 minutes from 6:00am until 11:00pm.
-There were columns where staff documented the time, location, and their initials.
-There was documentation that she was on in her bedroom from 2:30pm until 3:30pm, in the bathroom at 4:00pm and in the dining room from 4:30pm until 5:30pm.

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D 270	Continued From page 14 -There was no documentation she fell. Interview with a personal care aide (PCA) on 04/20/23 at 2:46pm revealed: -She was not working at the time Resident #1 fell on 03/16/23. -She initially denied her initials were documented from 3:00pm to 11:00pm on the increased supervision check sheet dated 03/16/23 for Resident #1. -Her initials were documented on the sheet, but she did not remember the resident falling. Telephone interview with the Office Manager at Resident #1's PCP's office on 04/19/23 at 9:40am revealed: -She had spoken directly to the staff who was caring for the resident when she fell in the bathroom. -The staff had left the resident in the bathroom for more than 30 minutes because she had to assist other residents. -She had discussed her concerns with a manager at the facility several times. -She did not remember the names of staff and managers because there was frequent turnover in staff. Telephone interview with Resident #1's family member on 04/27/23 at 4:06pm revealed: -Resident #1 was mentally sharp when he talked to her. -He did not think she had dementia. -She was no longer able to stand on her own because of neuropathy in her legs. -She normally spent all day in her bed. -She got up into her wheelchair to use the bathroom and then back to bed and up into her wheelchair for meals and then back to bed. -She fell frequently because she would get up out	D 270		

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her bed on her own.

Interview with a second PCA on 04/19/23 at 10:44am revealed:
-Resident #1 required staff assistance with getting in and out of bed, toileting, and bathing.
-The resident was able to stand and pivot with transfers.
-She fell frequently trying to get out of bed or reaching for candy on her nightstand.
-After each fall, she was placed on every 15- or 30-minute checks for 3 days.
-She continued to fall because as soon as she was off the 15- or 30-minute checks she fell again.
-She was more confused and "talking out of her head" the week before she died.
-She did not know what was happening, talked about her deceased husband and mistook staff for family members.

Telephone interview with a MA on 04/20/23 at 11:34am revealed:
-PCAs were responsible for checking to make sure the call light was within reach and assist with any needs such as toileting when doing every 15- or 30-minute checks.
-She was responsible for rounding every 2 hours and ensuring PCAs were completing every 30-minute checks.

Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed:
-She was responsible for ensuring PCAs and MAs were completing their assigned tasks.
-She observed residents, PCAs and MAs when she completed rounds every 2 hours.
-After a fall the resident was placed on every 30-minute checks for 3 days.
-If a resident continued to fall then they would

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D 270	Continued From page 16 work with physical therapy (PT). -PCAs were responsible for checking the resident's location and if the resident was breathing. -If the PCA documented the resident's location was in the bathroom, that meant the staff assisted the resident to the bathroom. -Completed increased supervision check sheets went to the Administrator in Training (AIT) office. -A urinalysis and unspecified other interventions were done when a resident had consecutive falls within 72-hour monitoring period. -Other interventions were documented in progress notes. -She did not see documentation in Resident #1's electronic progress notes of other interventions. -MA were responsible for completing an electronic incident report which initiated an event and fall monitoring in the electronic charting system after a resident fell. -She was responsible for reviewing the report and ensuring the fall monitoring was initiated. -If the resident was sent to the ER, she was responsible for documenting follow up with the PCP and other fall and injury prevention interventions. -She did not know what other interventions were implemented to reduce falls and injury for Resident #1. -She was responsible for reviewing electronic incident reports to ensure complete documentation. -If there was no documentation the PCP was contacted on the electronic incident report, then she contacted the PCP and documented an electronic progress note. -The Administrator in Training (AIT) was responsible for reviewing the completed electronic incident report and closing the event in the system.	D 270		

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D 270	Continued From page 17 Interview with the AIT on 04/20/23 at 1:54pm revealed: -MAs were responsible for checking a resident's vital signs, checking for any injuries, sending the resident to the ER if needed, contacting the PCP, and initiating the electronic incident report. -MAs were responsible for initiating 72-hour monitoring and supervision following a fall. -PCAs were responsible for completing every 30-minute checks for 72 hours after a fall. -PCAs were responsible for checking the resident's location and any needs the resident might have. -PCAs were expected to ensure the resident's call bell was within reach with each 30-minute check. -Resident #1 had a history of confusion and therefore she questioned the accuracy of statement documented in the resident's EMS report dated 01/21/23. -She did not know why the resident was awake at that time. -MAs were responsible for monitoring residents every shift for 72 hours after a fall. -Monitoring included checking vital signs and checking for bruises and any changes in condition. -MAs were responsible for contacting the PCP and documenting any changes in condition. -MAs either faxed a PCP notification form or called the PCP. -If the PCP was contacted by phone there would be an electronic progress note documenting the PCP notification. -Completed electronic incident reports were available for the RCC and her to review. -The RCC was responsible for reviewing the electronic incident report and completing the post fall intervention care plan.	D 270		

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D 270	Continued From page 18 -The RCC was responsible for communicating to MAs any interventions added to the post fall intervention care plan. -PCAs were responsible for carrying out post fall interventions. -MAs were responsible for ensuring PCAs were carrying out post fall interventions. -The RCC was responsible for rounding and ensuring PCAs and MAs were performing assigned tasks. -She rounded randomly 3-4 times daily to ensure all staff accountability. -She was responsible for ensuring the fall intervention care plan process was complete. -She had been busy with other Administrator duties and relied on the RCC for completing the fall intervention care plan process. -Every 30-minute check documentation sheets were placed in her box and she reviewed them daily. Attempted telephone interview with Resident #1's home health nurse on 04/19/23 at 3:36pm was unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider on 04/20/23 at 10:18am was unsuccessful. _____ The facility failed to provide supervision for Residents #1 who experienced an episode of choking on food in the dining room 1 week prior to being found unresponsive during the lunch meal and had 14 documented falls over 10 weeks resulting in head and hip injuries and 3 emergency room evaluations. The facility's failure was detrimental to the health, safety and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in	D 270		

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D 270	Continued From page 19 accordance with G.S. 131D-34 on 04/19/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 4, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure follow up with the primary care provider (PCP) following three emergency room evaluations for falls with injuries, obtain a shoulder x-ray following a fall as ordered by the PCP and a urinalysis ordered by the PCP for 1 of 2 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 12/01/23 revealed diagnoses included Alzheimer's dementia, depression, anxiety, hypothyroidism, polyneuropathy, restless leg syndrome and ataxia with frequent falls. Review of Resident #1's Resident Register revealed she was admitted to the facility on 07/06/20. a. Review of Resident #1's electronic progress note dated 01/17/23 at 11:09pm revealed the	D 273		

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PCP was notified she was found on the floor and sent to the emergency room (ER) at 9:05pm.

Review of Resident #1's ER discharge instructions dated 01/17/23 revealed instructions to contact the primary care provider (PCP) for follow up within 2-4 days (by 01/21/23).

Review of Resident #1's electronic progress note dated 01/18/23 at 5:15am revealed she had increased confusion since the fall.

Review of Resident #1's electronic progress note dated 01/21/23 at 2:26am revealed:
-There was documentation that the note was recorded on 02/03/23 at 9:27am.
-Resident #1 fell at 2:26pm and her PCP was notified.

Review of Resident #1's electronic progress note dated 01/21/23 at 3:15am revealed the PCP and family member were notified she was found on the floor and sent to the ER at 2:56am.

Review of Resident #1's electronic progress note dated 01/21/23 at 3:18am revealed there was documentation the MA spoke to the PCP regarding the resident being sent to the ER after being found on the floor and complaining of right hip pain.

Review of Resident #1's ER discharge instructions dated 01/21/23 revealed instructions to contact the PCP for follow up within 2-4 days (by 01/25/23).

Review of Resident #1's electronic progress note dated 01/21/23 at 6:03am revealed she had increased confusion since the fall.

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Review of Resident #1's electronic progress note dated 01/23/23 at 7:38pm revealed she had increased confusion since the fall.

Review of Resident #1's electronic progress note dated 01/24/23 at 5:06am revealed she had increased confusion since the fall.

Review of Resident #1's electronic progress note dated 01/25/23 at 4:05pm revealed her PCP was notified she fell without injury and her blood pressure was a little elevated.

Review of Resident #1's electronic progress note dated 01/26/23 at 7:35pm revealed she had increased confusion since the fall.

Review of Resident #1's electronic progress note dated 02/01/23 at 3:36pm revealed:
-She fell reaching for a piece of candy.
-She complained of hitting her head and pain in her head, back and bottom.
-She was sent to the ER and her PCP was notified.

Review of Resident #1's ER discharge instructions dated 02/01/23 revealed instructions to contact the PCP for follow up within 1-2 days (by 02/03/23).

Review of Resident #1's electronic progress note dated 02/28/23 at 9:30am revealed:
-There was documentation that the note was recorded on 03/08/23 at 7:15pm.
-There was documentation her PCP was notified she fell on 02/28/23 at 9:30am.

Review of Resident #1's electronic progress note dated 03/02/23 at 2:22am revealed she had increased confusion since the fall.

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D 273	Continued From page 22 Review of Resident #1's electronic progress note dated 03/19/23 at 9:23pm revealed she had increased confusion since the fall. Telephone interview with a third shift medication aide (MA) on 04/19/23 at 9:55pm revealed: -She normally wrote everything that happened in a notebook. -She did not have her notebook and could not remember Resident #1's falls on 01/07/23, 01/17/23 and 01/21/23. -Residents were sent to the emergency room (ER) for unwitnessed falls where the resident reported hitting their head or complained of pain. -The PCP had to order things like a fall mat and concave mattress. -She did not know about follow up with the PCP because she worked at night. -She documented Resident #1 had increased confusion on 03/19/23 and several other times following falls. -Resident #1 was confused for a while then she "snapped out of it". -The last week of Resident #1's life she was more confused. -Resident #1 knew who she was, where she was and when it was when she was at her baseline. -When she was confused, she would ask the MA to ride her bicycle and thought the MA was her mother. -She did not know if Resident #1's PCP was contacted about the episodes of increased confusion. -She was documenting the increased confusion as part of the fall monitoring. -When Resident #1 fell she either called the PCP's office in the morning before leaving work or faxed the PCP's office. -Faxed notification with the confirmation were	D 273		

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D 273	Continued From page 23 supposed to be filed in the resident's chart. Interview with a MA on 04/19/23 at 10:29am revealed: -MAs were responsible for contacting the resident's PCP when a resident was sent to the ER following a fall. -MAs were responsible for placing ER discharge instructions in the Resident Care Coordinator's (RCC's) or Administrator's box outside their offices. Telephone interview with Resident #1's family member on 04/27/23 at 4:06pm revealed: -Staff took Resident #1 to appointments in the facility van. -He thought staff tried to take her for all of her follow up appointments. -He did not know of any missed appointments. Telephone interview with the Office Manager at Resident #1's PCP's office on 04/19/23 at 9:40am revealed: -She had concerns about Resident #1's care due to the resident missing several appointments. -The resident was last seen in the office on 12/29/22. -Historically the resident was a "well put together lady" and at her last visit she looked weak and distraught. -It was concerning the resident was not brought to the PCP's office because the PCP needed to be able to evaluate her and write appropriate orders for her care. -She had discussed her concerns with a manager at the facility several times. -She did not remember the names of staff and managers because there was frequent turnover in staff. -The PCP's was not notified Resident #1 was	D 273		

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sent to the ER on 01/17/23, 01/21/23 and 02/01/23 for falls.
-Resident #1 was not seen for follow up visits following ER visits on 01/17/23, 01/21/23 and 02/01/23.

Second telephone interview with the Office Manager at Resident #1's PCP's office on 04/20/23 at 10:18am revealed:
-The PCP last saw Resident #1 at the facility on 01/04/23 to write orders for a home health (HH) nurse to provide sacral wound care.
-HH was still providing services to the resident when she died on 03/20/23.
-HH recertification orders were being done when the staff reported an episode of choking on 03/11/23.
-There was a note dated 03/11/23 that staff reported the resident had a cold and was choking at lunch.
-Staff were instructed to resume her normal diet if there were no further choking episodes.
-The office received a faxed request for a clear liquid diet on 03/16/23 that did not specify why.
-There were no notes in the resident's office chart of notifications of ER visits on 01/17/23, 01/21/23 and 02/01/23.
-There were no notes in the resident's office chart of falls on 01/14/23, 01/17/23, 01/21/23, 01/25/23, 02/01/23, 02/14/23, 03/07/23, and 03/16/23.
-The PCP's office attempted to get an appointment for Resident #1 to be seen by the PCP but the appointment was scheduled for 03/23/23.
-She had reviewed all notes for Resident #1's office chart and there were none related to the resident having increased confusion.

Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed:

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-She was responsible for ensuring residents had follow up and referral appointments.
-MA were responsible for completing an electronic incident report which initiated an event and fall monitoring in the electronic charting system after a resident fell.
-If the resident was sent to the ER, she was responsible for documenting follow up with the PCP and other fall and injury prevention interventions.
-She documented in the resident's electronic progress notes the date of follow up appointments and transport arrangements.
-Resident #1's electronic progress note dated 03/16/23 was marked late entry because she wrote the note on 03/23/23 for a fall that occurred on 03/16/23.
-She documented the fall because the MA on duty at the time of the fall did not contact the resident's PCP.
-She contacted Resident #1's PCP on 03/16/23 at 3:55pm regarding the resident's fall.
-Normally, MAs were responsible for contacting the PCP after a fall.
-She was responsible for reviewing electronic incident reports to ensure complete documentation.
-If there was no documentation the PCP was contacted on the electronic incident report, then she contacted the PCP and documented an electronic progress note.
-The Administrator in Training (AIT) was responsible for reviewing the completed electronic incident report and closing the event in the system.
-MAs were responsible for putting ER discharge instructions in her office box.
-She was responsible for giving appointments to the transporter for scheduling.
-There was an electronic calendar to track

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resident appointments.
-She did not know if Resident #1 had follow up appointments scheduled with her PCP following ER visits on 01/17/23, 01/21/23 and 02/01/23.
-The staff documenting increased confusion with fall monitoring were responsible for contacting the PCP.
-She did not know if Resident #1's PCP was contacted regarding increased confusion on 01/18/23, 01/21/23, 01/23/23, 01/24/23, 01/26/23, 03/01/23, 03/02/23 and 03/19/23.
-She did not review post fall documentation between January and March 2023.
-She started weekly reviews of post fall documentation beginning in April 2023.

Interview with the Administrator in Training (AIT) on 04/20/23 at 1:54pm revealed:
-ER discharge instructions were placed in the RCC's box.
-The RCC reviewed discharge instructions and gave a copy to the transportation person.
-The transportation person was responsible for scheduling the appointment and documenting the appointment on the calendar and in an electronic progress note.
-The RCC had access to the appointment calendar to track follow-up and referral appointments.
-The process was broken and not followed with Resident #1.
-Resident #1 should have had follow up appointments with her PCP following each ER visit.
-She was responsible for ensuring the follow appointment process was carried out completely.

b. Review of Resident #1's provider notification dated 02/19/23 revealed:
-The resident complained of right shoulder pain

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following a fall earlier that day (02/19/23).
-There was a notation for a right shoulder x-ray with the facility's fax number.

Review of Resident #1's imaging order dated 02/21/23 revealed an order for a right shoulder x-ray.

Review of Resident #1's electronic progress note dated 02/20/23 at 5:17am revealed her primary care provider (PCP) was notified she was found on the floor at 4:20pm on 02/20/23.

Review of Resident #1's electronic progress note dated 02/20/23 at 5:21pm revealed she had arm pain since the fall.

Review of Resident #1's electronic progress note dated 02/20/23 at 10:30pm revealed her PCP was sent a fax notification of shoulder pain since the fall.

Review of Resident #1's electronic progress note dated 02/20/23 at 5:18pm revealed her PCP was notified she had a fall with an injury.

Review of Resident #1's electronic progress notes revealed there was no documentation of a fall on 02/19/23.

Review of Resident #1's electronic progress notes revealed there was no documentation an x-ray was ordered, scheduled, or completed.

Telephone interview with a medication aide (MA) on 04/20/23 at 11:34am revealed:
-She remembered seeing the order for the shoulder x-ray for Resident #1.
-She did not know what happened; she thought the resident refused the x-ray.

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-Usually, when a resident refused something MAs just sent a faxed notification to the PCP.

Second telephone interview with the Office Manager at Resident #1's PCP's office on 04/20/23 at 10:18am revealed:
-Staff reported on 02/20/23 Resident #1 had shoulder pain following a fall on 02/19/23.
-A shoulder x-ray was ordered and faxed to the local hospital's imaging department on 02/21/23.
-The order was faxed to the facility.
-There was no x-ray result in the resident's office record.
-The local hospital did not have an x-ray result, so the x-ray was not done.

Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed it was not clear what happened with Resident #1's order for a shoulder x-ray dated 02/21/23.

Interview with the Administrator in Training (AIT) on 04/20/23 at 1:54pm revealed:
-The MA notified the PCP of Resident #1 having shoulder pain.
-The PCP sent the order to the imaging center.
-The PCP did not notify staff of the x-ray order.
-The x-ray was scheduled on the facility's transport calendar.
-The transportation person reported that she did not take Resident #1 for an x-ray.
-She was investigating why Resident #1 did not get the shoulder x-ray.

c. Review of Resident #1's physician order dated 03/08/23 revealed an order for urinalysis, culture and sensitivity.

Upon request on 04/18/23, 04/19/23 and 04/20/23, results of a urinalysis for Resident #1

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was not provided for review.

Telephone interview with the Office Manager at Resident #1's PCP's office on 04/20/23 at 10:18am revealed the PCP ordered a urinalysis on 03/08/23 and there was no result in Resident #1's office chart.

Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 12:56pm revealed:
-Urinalysis orders were given to MAs to collect the specimen.
-If the MA was not able to collect the specimen on that shift, they were responsible for communicating the task to the oncoming MA until the specimen was collected.
-Normally she checked to make sure the specimen was collected and sent to the laboratory.
-She did not know if the order for Resident #1's urinalysis got lost on an evening, night, or weekend shift.
-There was no definite system of follow up to ensure specimen collection was completed.

Interview with the Administrator in Training (AIT) on 04/20/23 at 1:54pm revealed:
-The RCC received PCP orders for urinalysis and communicated the order to the MA.
-The MA collected the sample and contacted the laboratory to pick up the specimen.
-On review of what happened with Resident #1's urinalysis order, she found the MA should include the RCC on the laboratory pick up request.
-Normally, the RCC was not notified until there was a laboratory result.
-She did not have a response on whether a urinalysis specimen was collected for Resident #1.

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D 273	Continued From page 30 Upon request on 04/20/23, the January, February and March 2023 transport calendar was not provided for review. Attempted telephone interview with Resident #1's home health nurse on 04/19/23 at 3:36pm was unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider on 04/20/23 at 10:18am was unsuccessful. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care & Supervision] _____ The facility failed to ensure follow up with the primary care provider (PCP) for Resident #1 following three emergency room evaluations for falls with injuries, obtain a shoulder x-ray following a fall as ordered by the PCP and a urinalysis ordered by the PCP. The facility's failure to follow up with Resident #1's PCP resulted in continued falls without care coordination and demonstrated substantial risk of serious injury and neglect of Resident #1 which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/19/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 20, 2023.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure a reasonable response to Resident #4's who was newly admitted to the facility and requested staff assistance in identification of medications administered to him.

The findings are:

Review of Resident #4's current FL-2 dated 03/08/24 revealed diagnoses included atrial fibrillation, congestive heart failure, anxiety, coronary heart disease, diabetes mellitus, hypertension, hyperlipidemia, depression, and lower extremity edema.

Interview with Resident #4 on 04/18/23 at 9:35am revealed:
-He was trying to figure out what medications he was taking.
-He knew the names of some of his medications.
-He had no problems taking his medications when he was at home because he knew what each pill was.
-He did not recognize the tablets and capsules the medication aide (MA) left him with.
-He did not know what he was taking.
-He did not know what a small clear pink capsule was.
-He did not know what a small yellow tablet was.
-He was going to have to call the MA back into the room because he could not take the medications not knowing what they were.

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D 338	Continued From page 32 Observations of Resident #4 and the MA on 04/18/23 at 9:39am revealed: -The MA told the resident the primary care provider was just in the room to answer his questions. -The MA walked out of the room and returned a moment later with a white liquid in a medicine cup. -The resident said to the MA, "I just want to know what I am taking." -The MA took the medication cup with the tablets and capsules. -The MA said to the resident, "I am just going to take these because I cannot leave them." -The MA left the room and went to the medication cart. -The PCP was coming out of another resident's room. -The MA told the PCP Resident #4 was not taking his medications and she was going to document that he refused. Interview with the MA on 04/18/23 at 9:41am revealed: -She could not review Resident #4's medications with him because she was not a nurse. -She could not review the identification of each medication with the pictures on the multidose pack (MDP) because she did not know what he was taking them for. -Each medication could have multiple uses and she did not know what each medication was being used for. -Reviewing the medications was the responsibility of the PCP. Second iterview with Resident #4 on 04/18/23 at 9:44am revealed: -No one had gone over what medication each pill	D 338		

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was.
-The tablets and capsules looked different from the ones he took at home.
-He just wanted to know what each tablet and capsule were.

Interview with the PCP on 04/18/23 at 9:48am revealed:
-She had just reviewed Resident #4's medications with him.
-He was confused over one medication his insurance would not pay for, Symproic. (Symprioc is used to treat opioid induced constipation.)
-She was unable to discuss concerns related to Resident #4 any further.

Third interview with Resident #4 on 04/18/23 at 3:20pm revealed:
-He took his morning medications after the PCP went over a list of what each tablet and capsule was in the medication cup.
-All he asked was for someone to tell him what each tablet and capsule were and that was all he needed.
-That morning he was upset and frustrated from not knowing what was going on.
-He was also experiencing constipation and needed to move his bowels.
-He had a bowel movement, someone came and talked to him, and he felt much better.

Interview with the Administrator in Training (AIT) on 04/19/23 at 12:41pm revealed:
-It was her understanding Resident #4 was confused about what his medications were prescribed for.
-MAs were not expected to discuss what each medication was prescribed for.
-She did not know the resident was asking for the identification of each medication.

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D 338	Continued From page 34 Interview with another resident on 04/18/23 at 8:55am revealed: -He had problems with the staff being "short" to him when he asked any questions. -It was not all the staff; some were very nice. -They act like they do not have time to take care of us. -I had to remind them at different times about medications that were given on certain days for them to remember to give them since they were not given every day. Interview with the Administrator on 04/19/23 at 12:41pm revealed: -MAs were expected to identify medications being administered. -There was an image of each tablet or capsule on the MDP for the purpose of identifying the medication. -MAs were expected to listen to a resident's request to clearly identify the concern. -It was important for the MA to help Resident #4 recognize the tablets and capsules he was taking rather than marking all his morning medications as refused. -Resident #4's medications such as amlodipine (antihypertensive), Cilostazol (treats lower extremity blood flow problems), duloxetine (antidepressant), Eliquis (blood thinner), isosorbide (cardiac medication), Jardiance (diabetes medication), losartan (antihypertensive), metoprolol (cardiovascular medication), rosuvastatin (cholesterol medication), and lubiprostone (bowel medication) were important to take as ordered by the PCP. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration]	D 338		

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D 338	Continued From page 35 The facility failed to ensure a reasonable response to Resident #4's who was newly admitted to the facility and requested staff assistance in identification of medications administered to him. The facility's failure resulted in prolonged symptoms of constipation and delay in taking medications used for cardiovascular disease and hypertension which was detrimental to the health, safety and welfare of Resident #4 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/19/23 for this violation. QIC REVIEW ENDS HERE THANKS TBN	D 338		
[redacted]	~~10A NCAC 13F .1004(a) Medication Administration~~ ~~10A NCAC 13F .1004 Medication Administration~~ ~~(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:~~ ~~(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and~~ ~~(2) rules in this Section and the facility's policies and procedures.~~ ~~This Rule is not met as evidenced by:~~	[redacted]		
~~D 366~~	~~10A NCAC 13F .1004 (i) Medication Administration~~ ~~10A NCAC 13F .1004 Medication Administration~~ ~~(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication~~	~~D 366~~		

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D 366	Continued From page 36 ~~immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.~~ ~~This Rule is not met as evidenced by:~~	D 366		