STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VINTAGE INN RETIREMENT COMMUNITY	826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892

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D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted an Annual, Follow Up Survey and Complaint Investigation on 05/10/23 to 05/11/23. The complaint investigation was initiated by the Martin County Department of Social Services on 03/20/23.	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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 7 sampled residents (#1, #6) as evidenced by a resident with cognitive impairment (dementia) who eloped from the facility's locked special care unit (SCU) (#1) and a resident who had multiple falls that resulted in serious head injuries and a bruised and fractured hip (#6). The findings are: 1. Review of the facility's Missing Residents Policy (policy not dated) revealed: -A resident is considered missing when he/she are not in the facility and their whereabouts are unknown.	D 270		

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-The Supervisor and all other staff will be notified immediately.
-Complete a search of the building and the immediate areas outside of the building.

Review of the facility's Identification and Supervision of Wandering Residents Policy (policy not dated) revealed:
-The facility will identify residents who walk or when around the facility unrestricted and are a threat to leaving facility unattended due to their confusion.
-A list of residents who wander will be implemented and given to the staff.
-Supervise and complete routine checks, monitoring devices and/or techniques based on the residents' needs.

Review of Resident #1's current FL-2 dated 01/19/23 revealed:
-Diagnoses included dementia, anxiety, diabetes type II, hypertension, hyperlipidemia, history of seizures and chronic obstructive pulmonary disease (COPD).
-The resident was ambulatory.
-The resident was intermittently disoriented.

Review of Resident #1's care plan dated 01/09/23 revealed the resident was independent with ambulation and transferring.

Review of Resident #1's incident and accident report (I/A) dated 05/04/23 revealed:
-The A/I occurred on 04/29/23 at 1:00pm.
-The type of event was elopement/wandering.
-There were no injuries or vitals for Resident #1 documented.

Interview with Resident #1 on 05/11/23 at 3:45 pm revealed:

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-He left the facility a couple of Saturdays ago (date and time not provided) to go to a fast-food restaurant located across the street from the facility.
-He had gone outside to sit on the patio of the SCU.
-Staff had allowed two other residents to go outside.
-There was no staff present when he was outside and when he left the facility.
-Two staff came to the fast-food restaurant and escorted him back to the facility.
-He had been sitting on the curbside street leading into the restaurant's parking lot.

Observation of the location of the facility on 05/11/23 at 2:05pm revealed:
-The facility was located on a 4-lane highway with a median.
-The street had 2 lanes on each side of the median traveling in opposite directions.
-The parking lot entrance of the facility was connected to the 4-lane highway.
-The was no crosswalks or crossing signals located at the entrance of the facility which led to the highway.

Review of a distance map on 05/11/23 revealed:
-The facility was a 6-minute walk away from the fast-food restaurant.
-The facility was located approximately 900 feet away from the fast-food restaurant.
-The facility was 0.3 miles away from the fast-food restaurant.
-The speed limit was posted at 45 miles per hour.

Observation of the SCU patio and gazebo areas on 05/11/23 at 10:39am revealed:
-The patio on the SCU was located on the backside of the facility.

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D 270	Continued From page 3 -The patio was not secured by a gate/fence and leads to a driveway area around the facility. -The gazebo area was fenced in. -The fence gate around the gazebo was not locked or secured. Interview with a personal care aide (PCA) on 05/11/23 at 4:18pm revealed: -She worked on the SCU on 04/29/23. -She did not know who had allowed the residents outside to smoke. -The two residents were allowed to be outside on the patio to smoke without staff supervision. -There were no staff outside supervising the two residents smoking. -A resident who had been outside smoking informed staff that Resident #1 had walked away from the facility. -The PCA and another staff found Resident #1 across the street sitting on the curbside leading into the restaurant parking lot. -The PCA and other staff walked Resident #1 back to the facility. Interview with a second PCA on 05/11/23 at 5:40pm revealed: -She did not work on 04/29/23 on the SCU. -The PCAs or another staff had to be outside with the SCU residents when they wanted to go outside and smoke or to sit outside on the patio. -The PCAs had to inform the medication aide (MA) immediately if a resident from the SCU could not be located. Interview with a Medication Aide (MA) on 05/11/23 at 5:08pm revealed: -She had worked on 04/29/23 on the SCU. -She learned Resident #1 was not in his room or the TV sitting area around 1:30pm on 04/29/23 during the time of medication pass.	D 270		

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D 270	Continued From page 4 -She answered a knock on the door and when opened was informed by a resident who had been outside that "the other man" left the facility. -She was told by the two PCAs on duty they had let Resident #1 outside. -There were only two residents on the SCU who were allowed to be outside on the patio area without staff supervision per the Executive Director (ED). -Resident #1 was not allowed to be outside of the facility without supervision. -There was a PCA that had let two residents outside to smoke. -There were not any staff outside supervising the residents. -The PCAs left the facility to search for Resident #1. -Resident #1 was found across the street sitting on a curbside street leading to a fast-food restaurant. -Resident #1 was brought back to the facility. -Resident #1 had been out of the facility about 10 minutes from the time she had learned he had learned of his leaving the facility. -She did not complete vitals but examined Resident #1's legs because he was wearing slippers. -Residents on the SCU were to be always supervised when outside on the patio or sitting in the gazebo. -PCAs did not have to get permission from the Supervisors to take residents outside. Interview with the Special Care Coordinator (SCC) on 05/11/23 at 10:27am revealed: -She did not work on 04/29/23 when Resident #1 eloped from the facility. -She learned of the elopement on 05/04/23 from the ED. -She informed the ED that she had not been	D 270		

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contacted by staff and did not have any knowledge of Resident #1's elopement.
-The ED completed an investigation and she only sat in on the meeting with the staff who had worked on the SCU on 04/29/23 and did not ask questions.
-The doors on the SCU were to always remain locked even when residents were outside on the patio or the gazebo.
-Residents were not given the codes to the keypads to the secured doors.
-Staff were to always supervise residents when they were outside.
-Staff were to notify the supervisor when leaving the unit with a resident.

Interview with the ED on 05/11/23 at 12:57pm revealed:
-She learned of Resident #1's elopement from a staff member.
-She completed an investigation on 05/04/23 to learn Resident #1 walked away from the facility on 04/29/23 when he went out to smoke.
-Resident #1 had not been monitored by the staff when he went out to smoke.
-She expected the staff to always monitor the residents when they were outside in the gazebo or patio area.

Telephone interview with Resident #1's family member on 05/11/23 at 2:30pm revealed:
-She had not been informed of Resident #1 elopement on 04/29/23 or on 05/04/23.
-Resident #1 had not smoked in about 8 months.
-Resident #1 "mind comes and goes" and he was not capable of walking across the street without any supervision from staff.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/11/23 at 8:36 am

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revealed:
-She had not been informed of Resident #1 elopement.
-Resident #1 was not capable of leaving the facility on his own.
-Resident #1 could not walk as far as a few feet because of his COPD and swelling of the legs.
-She expected residents on the SCU to be supervised when outside.
-Not supervising the residents would lead to safety issues of their wandering off the premises, hurting themselves or hurting others.

2. Review of the facility's falls policy (policy not dated) revealed:
-Residents who have 3 falls in one month will have a falls assessment completed.
-All residents who are identified to be a falls risk will be on be falls management program.
-The Supervisor in Charge (SIC) completes a fall investigation summary immediately after assessing the resident's needs.
-SIC notifies the Primary Care Physician (PCP) and document the contact with the PCP.
-The investigation summary is reviewed by the special care coordinator (SCC) or their Designee within 24-72 hours of the fall.
-SCC will ensure all follow ups are completed.
-The SCC will complete a falls risk assessment.
-Residents are added to the falls risk program based on the falls risk assessment.
-The resident's PCP will be notified of the resident being placed on the falls management program and will seek further preventative measures from the PCP.
-The resident's care plan will be updated.

Review of Resident #6's current FL-2 dated 03/13/23 revealed:
-Diagnoses included Alzheimer's/dementia, gout,

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type II diabetes, coronary artery disease, degenerate disc disease, dysphagia, chronic fatigue, hypertension, obesity, osteoarthritis with back pain and history and cerebral vascular.
-He was semi-ambulatory with a wheelchair.
-The resident was intermittently disoriented.

Review of Resident #6's care plan dated 10/27/22 revealed:
-He required total assistance with bathing, grooming, dressing and toileting.
-He required limited assistance with ambulating and transferring.

Review of Resident #6's resident record revealed there was no falls risk assessment documented in the record.

a. Review of Resident #6's care notes dated 12/13/22 revealed:
-Resident #6 had a fall (location not documented)
-Resident #6 was treated for a small skin tear on his right elbow area.
-An as needed (PRN) medication was given (name and dosage of medication was not documented.)
-The Primary Care Provider (PCP) was notified.

Review of Resident #6's resident record revealed there was no incident and accident (I/A) report for 12/13/22 or documentation of interventions implemented to ensure the resident's safety after he fell on 12/12/22.

b. Review of Resident #6's care note dated 02/05/23 revealed:
-Resident #6 had a fall and bruised his right hip.
-Resident was transported to the emergency room (ER) and was admitted to the hospital.

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D 270	Continued From page 8 Review of the I/A report dated 02/05/23 at 06:15pm revealed: -Resident #6 had a fall in his room. -First aid was not rendered to Resident #6. -A 911 call was placed. -Resident #6 was transported to the ER. -Resident #6 was admitted to the hospital. Requested the 02/05/23 hospital summary report but was not received prior to exit. c. Review of Resident #6's care note dated 03/11/23 revealed: -Resident #6 was heard yelling down the hallway from his room. -Resident #6 was found on the floor. -Resident #6 told staff he fell trying to transfer to his recliner. -Resident #6 injured his right hip. -A previous skin tear on Resident #6 right elbow was bleeding. -Resident #6 requested to go to the hospital. Interview with the SCC on 05/10/23 at 2:25pm revealed there was not an I/A report completed for Resident #6 fall incident on 03/11/23. d. Review of Resident #6's care note dated 04/05/23 revealed: -Resident #6 had leaned forward while seated in his wheelchair and fell hitting his head on the floor. -A knot on Resident #6's head formed quickly. -It was not documented if the fall was witnessed or unwitnessed. -Resident #6 was sent to the hospital. Review of the I/A report dated 04/05/23 at 12:00pm revealed: -Resident #6 had a fall in the day room.	D 270		

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D 270	Continued From page 9 -Resident #6 had a head injury which resulted in a knot. -First aid was not rendered to Resident #6. -A 911 call was placed. -Resident #6 was transported to the ER. -Resident #6 was admitted to the hospital. Review of a treating physician hospital attestation notes dated 04/06/23 revealed: -Resident #6 was seen and evaluated on 04/05/23 corrections were made. -Resident #6 had slipped and fell when standing. -Resident #6 was oriented to self but could follow commands. -Resident was admitted for trauma services due to head injury. Review of Resident #6's hospital discharge summary dated 04/14/23 revealed: -Resident #6 was admitted to the hospital on 04/05/23 and was discharged on 04/14/23. -Resident #6 was diagnosed with traumatic intracranial subdural hemorrhage and acute on chronic subdural hematoma. -The acute on chronic subdural hematoma was 3.7 centimeters (cm) temporal lobe hematoma and 2.0 cm right cerebral with 7-millimeter leftward midline shift and no progress of transtentorial herniation. -Resident #6 had fallen from his wheelchair. -Resident #6 was discharged with hospice/comfort care. -The discharge disposition was back to the assisted living facility. Interview with Resident #6's family member on 05/10/23 at 11:23am revealed: -Resident #6 passed away on 04/23/23. -She learned Resident #6 was in the hospital due to a fall.	D 270		

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D 270	Continued From page 10 -Resident #6 had a severe brain bleed and did not regain consciousness. -Resident #6 had a history of falls. -Resident #6 previous falls resulted in injuries related to a broken hip and bruises on his elbow. -During her visits with Resident #6 she never observed staff coming in to check on him. -She had not been made aware of Resident #6 being placed on increased supervision. Interview with a Medication Aide (MA) on 05/10/23 at 3:11pm revealed: -She did not witness Resident #6 fall on 02/05/23. -She had been notified by a Primary Care Provider (PCP) of the fall. -Resident #6 verbalized that he had pain in his hip. -She did not know if Resident #6's had a fall history. -She had the PCAs to complete 30-minute checks on Resident #6 but did not document the checks. -There were 30 minutes checks completed for residents who had a falls history, but the checks were not documented. -She or the PCAs completed routine supervision checks every 1 to 2 hours. -Residents who had a fall history were also seated in the day room to be supervised. -She did not know of Resident #6 03/11/23 fall. -Residents had to have an order for 15-to-30-minute supervision checks. Interview with a second MA on 05/11/23 at 8:14am revealed: -She was aware of Resident #6 falls. -She was not aware of the 03/11/23 falls. -She could not remember if Resident #6 had increased supervision. -The 15-minute or 30-minute checks had to be an	D 270		

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order from the PCP.
-She had not suggested or recommended Resident #6 be placed on increased supervision.
-Routine supervision checks were completed every 2 hours for all residents.

Interview with Resident's #6's PCP on 05/11/23 at 8:36am revealed:
-Resident #6 had a fall on 02/05/23 and was sent to the ER.
-Resident #6 suffered a broken hip from the 02/05/23 fall.
-She was aware of the 03/11/23 fall where Resident #6 had a contusion of the head.
-She completed a follow up visit with Resident #6 on 03/16/23.
-Resident #6 was sent to the ER on 03/11/23 due to confusion and was treated with anti-psychotic medications.
-A verbal order for increased 15-minute checks was given to staff on 03/01/23 when staff asked by the facility staff.
-She had not received additional recommendations for increased supervision for Resident #6 but had for other residents.
-She had documented Resident #6 as a fall risk after his 02/05/23 fall.
-The staff did not need an order to increase supervision for residents.
-She expected 2-hour supervision checks to occur for all residents.

Interview with the SCC on 05/10/23 at 4:39pm revealed:
-Resident #6 returned from the hospital on 04/14/23.
-She could not remember the date of Resident #6's death.
-Resident #6 passed away at the facility around 12pm.

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D 270	Continued From page 12 -Resident #6 had a fall on 04/05/23 and was sent to the local ER and was later transferred to another hospital. -A fall risk assessment had not been completed for Resident #6. -She made referrals for falls risk assessments that would be sent to the PCP. -The falls risk assessment was completed by the PCP. -She did not make a falls risk assessment referral for Resident #6. -Resident #6 had not been placed on increased supervision. -Increased supervision for 15- or 30-minute checks had to be an order from the PCP. -She did not request a 15-minute or 30-minute check for Resident #6 when the PCP was notified of Resident #6 falling. Interview with the Executive Director (ED) 05/11/23 at 12:17pm revealed: -She was not aware if Resident #6 had increased supervision for 15-minute or 30-minute checks. -She had been aware of Resident #6's falls. -The MAs and PCAs were expected to complete 2-hour supervision checks for all residents. -The PCP had to give an order for 15- or 30-minute supervision checks and for fall assessments. -Routine 2-hour checks were to be completed for all residents by the MAs or PCAs. _____ The facility failed to provide supervision for 2 of 7 sampled residents (#1, #6) including a resident diagnosed with dementia who eloped from the facility's locked special care unit (SCU) and crossed a busy four lane highway and was later found by staff sitting on the curb in the parking lot of a nearby food establishment (#1); and a	D 270		

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D 270	Continued From page 13 resident who had multiple falls that resulted in injuries including a bruised and broken hip and two head injuries, one of which was diagnosed as a subdural hematoma (bleeding in the brain) that resulted in a hospital stay for 9 days. (#6). Resident #6 passed away at the facility 15 days after being discharged from the hospital. This failure resulted in serious injury and neglect for the residents and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 10, 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 A1 VIOLATION Based on record reviews and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 6 sampled residents (#3) related to failing to inform a primary care provider (PCP) of a change in condition. The findings are: Review of Resident #3's current FL-2 dated 03/09/23 revealed:	D 273		

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-Diagnoses included Alzheimer's dementia and type 2 diabetes.
-His recommended level of care was Special Care Unit (SCU).
-The resident was incontinent of urine at times.
-There was an order for Metformin 500mg (used to lower blood sugar) 2 tablets twice a day.
-There was an order for Toujeo Solostar (a long-acting insulin used to lower blood sugar) administer 20 units under the skin every day.
-There was an order for fingerstick blood sugars (FSBS) three times a day before meals.

Review of Resident #3's FL-2 dated 03/01/23 revealed:
-There was an order for Metformin 500mg 2 tablets twice a day.
-There was an order for Toujeo Solostar administer 20 units under the skin every day.
-There was no order for FSBSs.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 03/03/23.

Review of Resident #3's facility care notes revealed:
-There was an entry dated 03/10/23 signed by a medication aide (MA) with no time documented.
-The MA was told by the previous MA on duty that Resident #3 was awake all night and finally went to sleep around 6:00am.
-The MA was able to administer Resident #3's 8:00am medications but the resident refused breakfast.
-There was a second entry dated 03/10/23 signed by a MA with no time documented.
-The MA tried to feed Resident #3 lunch, but the resident was still asleep.
-There was a third entry dated 03/10/23 signed by

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a MA with no time documented.
-A personal care aide (PCA) checked on Resident #3 and found that he had vomited and was unresponsive.
-Emergency Management Services (EMS) was called for Resident #3.

Review of Resident #3's electronic medication administration record (eMAR) revealed:
-There was an entry for Metformin 500mg 2 tablets twice daily scheduled for administration at 8:00am and 8:00pm.
-Metformin 500mg 2 tablets was documented as administered at 8:00am on 03/10/23.
-There was an entry for Toujeo Solostar inject 20 units every day scheduled for administration at 8:00am.
-Toujeo Solostar was documented as administered at 8:00am on 03/10/23.

Telephone interview with Resident #3's family member on 05/09/23 at 11:45am revealed:
-On 03/10/23 another one of Resident #3's family members visited him at the facility around lunch time and could not arouse him.
-Around 5:30pm to 6:00pm on 03/10/23 another family member received a phone call that Resident #3 had vomited and had been taken to the hospital.
-On 03/11/23 or 03/12/23, Resident #3 was transferred from the local hospital to another hospital for more treatment.
-On 03/15/23, Resident #3 was transferred to an inpatient hospice facility.
-Resident #3 expired at the inpatient hospice facility on 03/28/23.

Second telephone interview with Resident #3's family member on 05/10/23 at 2:45pm revealed the resident needed to be assisted with his meals

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D 273	Continued From page 16 because he had trouble seeing. Review of Resident #3's death certificate revealed: -Resident #3 expired on 03/28/23. -The cause of death was anoxic brain injury (An anoxic brain injury is caused by a lack of oxygen to the brain for an extended period of time). Telephone interview with Resident #3's other family member on 05/10/23 at 3:52pm revealed: -She visited Resident #3 at the facility around 11:00am on 03/10/23. -When she arrived at the facility Resident #3 was not talking and was not opening his eyes. -She splashed water on Resident #3's face and he still did not awaken. -She asked a staff member if Resident #3 had eaten and was told that he had not. -She did not report to the staff member that she could not awaken Resident #3. -She was not sure how long she stayed at the facility, but she was "there for a little while". -She still could not get Resident #3 to awaken when she left the facility. Interview with a MA on 05/11/23 at 3:40pm revealed: -She was Resident #3's MA on 03/10/23. -The third shift MA reported to her that Resident #3 did not sleep all night the night before and that he fell asleep around 6:00am. -This was reported to her because the third shift staff would normally get Resident #3 up and ready for breakfast, but they did not do so on 03/10/23 because the resident had not slept the night before and was still asleep. -She administered Resident #3's 8:00am dose of Metformin and Toujeo Solostar to him on 03/10/23.	D 273		

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-She thought she had heard before that Metformin should be administered with food, but she did not know why.
-She administered Resident #3's Metformin and Toujeo Solostar to him before breakfast was served.
-Breakfast was usually served at the facility between 7:45am to 8:00am.
-Resident #3 refused to eat breakfast.
-When the PCA tried to assist Resident #3 with eating lunch she told the MA that the resident was still asleep.
-She was not sure who the PCA was.
-The MA then went to Resident #3's room and he was in bed and snoring.
-Resident #3 was "acting like he didn't want to wake up".
-She nudged Resident #3's shoulder and called his name and the resident groaned so she left him alone and let him continue to sleep.
-She did not report to anyone that she could not awaken Resident #3 to eat lunch.
-She had not worked with Resident #3 much since he was new to the facility, but she had never known the resident to not wake up when nudged or when his name was called.
-At dinner time Resident #3 was still asleep.
-Dinner was usually served to residents between 5:00pm to 5:30pm.
-She checked on Resident #3 before dinner and he was in his bed snoring.
-She nudged Resident #3's shoulder and called his name and he grunted but did not awaken.
-She did not report to anyone that she could not awaken Resident #3 to eat dinner.
-She did not think to call and report to the primary care provider (PCP) that she could not awaken Resident #3 because she thought he was sleeping because he had been awake all night.
-It did not occur to her that Resident #3's FSBS

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could be low and that was why he did not awaken because she did not recall the resident having FSBS checks ordered, and he did not have a blood glucose monitor.
-She normally checked on all residents in the SCU every hour.
-She checked on Resident #3 at least every one to two hours during her shift on 03/10/23.
-When she checked on Resident #3, she "stuck my head in the door to make sure he was breathing".
-She did not try to awaken Resident #3 when she checked on him throughout the day.
-Routine checks were not normally documented anywhere in the resident's record.
-She started to get concerned that Resident #3 was still not awake around dinner time but still did not think much of it because there was another resident on SCU that would sleep all day too if she was up all night the night before.
-Not long after she started to feel concern that Resident #3 was still asleep a PCA came to her sometime in the evening after dinner and reported that she had checked on Resident #3 and found that he had vomited and was unresponsive.
-She could not remember who the PCA was.
-The MA went to check on Resident #3 and he was lying on his side in bed and had vomit on his shirt.
-Resident #3 did not have a hospital bed, so the head of the bed was not elevated.
-The vomit was yellow and "looked like stomach bile, like when someone vomits and they have nothing in their stomach".
-Resident #3 was unresponsive and sounded like he was snoring and his "eyes seemed off".
-The PCA lifted Resident #3's eyelids and his eyes "did not look normal".
-She called 911 for Resident #3 at that time.

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D 273	Continued From page 19 Review of Resident #3's emergency department documentation revealed: -Resident #3 was brought into the emergency room (ER) by EMS at 7:25pm on 03/10/23. -EMS reported that when they arrived at the facility Resident #3 was unresponsive and his FSBS was 41 (A normal FSBS for someone who has not eaten is between 70 to 130. A FSBS below 70 could cause signs and symptoms of hypoglycemia such as sweating, shakiness, irritability or anxiety, and fatigue. A FSBS below 55 is considered severe hypoglycemia and can cause unresponsiveness and seizures). -EMS administered a dextrose injection to Resident #3 prior to arrival to the ER and his FSBS was 75 when he arrived at the ER (A dextrose injection is used to immediately raise FSBS levels). -When Resident #3 arrived at the ER he was not responsive to verbal or painful stimuli. -Resident #3 was "allegedly sleeping all day". -It was unclear when the last time Resident #3 was in his usual state of health but it was suspected that it was very early in the morning or approximately 10 plus hours prior to his ER visit. -Resident #3 was transferred to another hospital to receive a higher level of care on 03/11/23. -Resident #3 was intubated by EMS on 03/11/23 before he was transported to another facility (Intubation is the process of inserting a tube into a person's airway to hold it open. Once in place, the tube is connected to a ventilator to push air in and out of the lungs). -Resident #3's diagnoses when he was discharged to the other facility was bilateral pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, diabetes with hypoglycemia, altered mental status, and dyspnea (shortness of breath).	D 273		

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D 273	Continued From page 20 Review of Resident #3's admission to discharge notes from the second hospital revealed: -Resident #3 was admitted on 03/12/23 with a diagnoses of aspiration pneumonia (inflammation and infection of the lungs caused when food or liquid is breathed into the airways or lungs instead of being swallowed). -Resident #3 had not been responsive to verbal or painful stimuli at any point since he was first evaluated by EMS on 03/10/23. -A brain Magnetic Resonance Imaging (MRI) was performed on Resident #3 on 03/12/23 which showed findings consistent with an anoxic brain injury. -Resident #3 was transitioned to comfort care on 03/12/23 (Comfort care is used to optimize quality of life and mitigate suffering for those with a terminal illness). -Resident #3 was transferred to a hospice facility on 03/14/23 with diagnoses of comfort measures only, anoxic brain injury, and aspiration pneumonia. Interview with the Special Care Coordinator (SCC) on 05/11/23 at 5:05pm revealed: -Facility staff should have reported to her that Resident #3 could not be awakened on 03/10/23. -Facility staff should have also reported to Resident #3's primary care provider (PCP) that they were unable to awaken the resident so the PCP could advise staff what to do. Interview with the Executive Director (ED) on 05/11/23 at 4:53pm revealed: -She did not know much about Resident #3 because he was not at the facility for long. -She did know that Resident #3 liked to take a lot of naps, but she had never known the staff to not be able to wake up the resident.	D 273		

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-Even though Resident #3 liked to nap she expected facility staff to wake up the resident to eat meals.
-She expected facility staff to check on residents in the SCU every 2 hours.
-When facility staff checked on residents, she expected them to perform incontinence care if needed, check for residents who wandered, check to make sure that residents had not fallen, and to make sure residents were not in any distress.
-She knew Resident #3 was sent out with EMS on 03/10/23 because he was found with vomit on him and had been asleep most of the day.
-She was not aware that facility staff had not been able to awaken Resident #3 when they checked on him throughout the day on 03/10/23.
-She knew that Resident #3's family member had visited with him around lunchtime, so she assumed the resident was awake at that time.
-Resident #3 had diabetes and was on medication for his diabetes so she expected facility staff to wake him up to eat meals so his FSBS would not go too low.
-If facility staff was unable to wake up Resident #3 to eat meals, she expected the staff to let her know as well as the PCP.
-Facility staff should have contacted Resident #3's PCP at lunchtime at the latest when they could not awaken him to eat lunch.
-Facility staff should have contacted the PCP so the PCP could advise staff what to do for Resident #3.

Telephone interview with Resident #3's PCP on 05/11/23 at 8:36am revealed:
-She had only seen Resident #3 once and that was on 03/09/23.
-When she saw Resident #3 on 03/09/23 he was up in his wheelchair, and she had facility staff

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D 273	Continued From page 22 assist her to help the resident stand so she could observe his skin. -When she saw Resident #3 on 03/09/23 he did not have a good speech pattern and was difficult to understand. -Resident #3 did not appear to be in any distress when she saw him on 03/09/23. -She wrote orders for Resident #3 to have FSBS checks three times a day at her visit on 03/09/23. -She did not expect the facility to have the FSBS checks in place yet on 03/10/23 because a FSBS machine would have to be ordered for the resident and it would probably not be there within 24 hours of being ordered. -Resident #3's prior PCP should have ordered FSBSs for the resident when he was admitted to the facility since the resident was on insulin. -The facility had contacted her about ordering FSBSs for Resident #3 prior to her visit on 03/09/23 but she did not give them any orders. -She did not provide orders for residents until she had seen them for the first time. -The facility should have contacted Resident #3's prior PCP for orders for FSBS checks. -She was contacted by the SCC the evening of 03/10/23 and was told that Resident #3 had slept a lot during the day because he had been awake all night and that he had vomited so he was sent to the ER by EMS. -She was not aware that Resident #3's FSBS was 41 when EMS arrived at the facility. -Metformin did not usually cause low FSBSs by itself but it could when given in conjunction with Toujeo Solostar especially since Resident #3 had not eaten all day. -Metformin could cause gastrointestinal (GI) upset especially if it was given without food. -Resident #3 receiving Metformin on an empty stomach and then not eating breakfast or lunch could have contributed to his vomiting.	D 273		

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D 273	Continued From page 23 -If Resident #3 was refusing his meals or not eating she expected facility staff to make her aware. -Facility staff should have made her aware at lunchtime that Resident #3 did not eat breakfast or lunch. -If she had been contacted by facility staff that Resident #3 did not eat breakfast or lunch and the resident was stable, she would have advised them to hold his evening dose of Metformin and see if there was a way for them to check his FSBS. -If she had been contacted by facility staff that Resident #3 did not eat breakfast and lunch and that he was lethargic she would have advised them to call 911. -She was not aware that facility staff had not been able to awaken Resident #3 at all on 03/10/23. -She expected facility staff to check on residents in the SCU at least every 2 hours. -If facility staff could not awaken Resident #3 at lunchtime, she would have expected them to notify her so that she could advise them on what to do. -If she had been contacted by facility staff and was told that they could not awaken Resident #3 at lunchtime she would have advised them to call 911. -Facility staff should not have waited until the evening to send Resident #3 out or to seek treatment for him. -Not being able to awaken a resident should be considered an emergency for which the resident needed immediate medical assessment. Attempted telephone interview with Resident #3's former PCP on 05/11/23 at 3:30pm was unsuccessful. The facility failed to notify the primary care	D 273		

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D 273	Continued From page 24 provider (PCP) that a resident (#3) could not be awakened several times throughout the day or that the resident, who was on medications that could lower his fingerstick blood sugars (FSBS), had not eaten, and not being able to awaken the resident was considered an emergency for which the resident needed immediate medical assessment. The resident was found unresponsive and had vomited and his FSBS was 41 when Emergency Management Services (EMS) arrived at the facility. Medical evaluation at the hospital revealed the resident was found to have suffered an anoxic brain injury which was listed as the cause of death on the death certificate. The facility's failure to notify the PCP that the resident was unable to be awakened or that the resident had not eaten after taking medications that lower FSBSs resulted in a delay in treatment for the resident. The failure of the facility resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 10, 2023.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	D 276		

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D 276	Continued From page 25 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure physician orders were implemented for 2 of 5 sampled residents who had an order for anti-embolism stockings (TED Hose) (#1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated 01/19/23 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, and diabetes mellitus type II. -Resident #1 was ambulatory. Review of Resident #1's resident record revealed there was not a Licensed Health Professional Support (LHPS) documented in the record to reveal the task for TED hose. Review of a physician's consultation report dated 03/16/23 revealed it was recommended to send Resident #1 to the emergency room (ER) due to swelling and pain in right leg. Review of a physician's consultation report dated 04/13/23 revealed: -Resident #1's had an order to wear TED hose (compression socks). -The staff were to place the TED hose on in the morning and the TED hose at bedtime daily. Review of Resident #1's April 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose at 6:00am and remove at 8:00pm.	D 276		

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D 276	Continued From page 26 -There was documentation of an "x" where the TED hose had not been applied at 8:00am 04/15/23. -There was an entry documented where the TED Hose had been removed at 8:00pm on 04/15/23. -There was an entry documented where the TED Hose had been applied and removed at 6:00am and 8:00 pm on 04/16/23 to 04/30/23. Review of Resident #1's May 2023 eMAR revealed: -There was an entry to apply TED hose at 6:00am and remove at 8:00pm. -There was an entry documented where the TED Hose had been applied and removed at 6:00am and 8:00 pm on 05/01/23 to 05/09/23. -There was an entry documented where the TED Hose had been applied at 6:00am 05/10/23. Observation of Resident #1 on 05/11/23 at 5:35pm revealed: -Resident #1 was not wearing his TED hose. -Both of Resident #1's legs were swollen. Interview with Resident #1 on 05/11/23 at 5:34pm revealed: -Staff had placed the TED hose on 05/10/23. -Resident #1 removed the TED hose on the evening of 05/10/23. -No one had placed the TED hose on the morning of 05/11/23. -Staff would put the TED hose on sometimes and sometimes the staff would not. -He kept the TED hose in his room. -He knew he was to wear the TED hose every day. -He knew his legs were swallow. Interview with a personal care aide (PCA) on 05/11/23 at 5:38pm revealed:	D 276		

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-She has observed Resident #1 putting his TED Hose on and off without Medication Aides (MA) help.
-The MAs were responsible for placing and removing the TED hose.

Interview with a second PCA on 05/11/23 at 5:40pm revealed:
-She did not know Resident #1 wore TED hose.
-She has assisted other residents who wore TED hose in taking them off and given to the MA.

Interview with a MA on 05/11/23 at 5:55pm revealed:
-She had worked the morning of 05/11/23.
-She had applied and removed TED hose for Resident #1 when she worked.
-She had not worked the morning shift.
-She knew Resident #1 had issues with swelling legs.

Interview with the Special Care Coordinator (SCC) on 05/11/23 at 6:01pm revealed:
-She knew that Resident #1 had worn TED hose.
-Resident #1 was aware of his need to wear TED hose.
-She was not aware of Resident #1 not wearing his TED hose.
-The MAs were responsible for placing on and removing the TED hose.
-She expected the MAs to place and remove the TED hose.
-TED hose were to be worn to help with swelling of the legs and feet.

2. Review of Resident #2's current FL-2 revealed:
-Diagnoses included Alzheimer's dementia, type II diabetes mellitus, essential hypertension, acute reaction to stress, osteopenia, bursitis of shoulder, senile nuclear sclerosis malignant

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neoplasm
-Resident #2 was semi-ambulatory and needed a walker as an assistive device.
-Resident #2 was intermittently disoriented.
-Resident #2 had an order to apply and remove TED hose in the morning and the evening.

Review of Resident #2's March 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to apply TED hose at 6:00am and remove at 8:00pm.
-There was documentation of TED hose being applied and removed on 05/01/23 to 05/31/23.

Review of Resident #2's April 2023 eMAR revealed:
-There was an entry to apply TED hose at 6:00am and remove at 8:00pm.
-There was documentation of TED hose being applied and removed on 04/01/23 to 04/30/23.

Review of Resident #2's May 2023 eMAR revealed:
-There was an entry to apply TED hose at 6:00am and remove at 8:00pm.
-There was documentation of TED hose being applied and removed on 05/01/23 to 05/10/23.

Observation of Resident #2 on 5/11/23 at 6:28pm revealed Resident #2 was not wearing TED hose.

Interview with Resident #2 on 05/11/23 at 6:28pm revealed:
-There were times when the staff would not put the TED hose on.
-She did not wear the TED hose every day.

Interview with the Special Care Coordinator (SCC) on 05/11/23 at 6:01pm revealed:

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D 276	Continued From page 29 -The Medication Aide's (MA) were responsible for placing on and removing the TED hose. -She expected the MAs to place and remove the TED hose. -TED hose were to be worn to help with swelling of the legs and feet.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to plated food and beverages being left uncovered. The findings are: Observation of the kitchen area on 05/11/23 at 5:53pm revealed: -There was a three shelf cart with 11 plates of	D 283		

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D 283	Continued From page 30 food. -There was a cart with cups filled with tea and water. -The food cart was in a connecting kitchen hallway to the special care unit (SCU). -The plates of food and beverages were not covered. -There were two plates that were semi-stacked on one another. Interview with the Medication Aide (MA) on 05/11/23 at 6:03pm revealed: -She was the only person working in the kitchen for the evening. -She had prepared the food and placed it on the food cart to take to the special care unit. -There were no plate covers for the food. -She was trained by one of the dietary staff to cook and prepare food. -She did not have any formal food service training. Interview with the Executive Director (ED) on 05/11/23 at 6:04pm revealed: -The MA was cross-trained in dietary services. -The MA had signed up to work in the kitchen for the 05/11/23 dinner meal. -She was not aware the dietary staff had left for the evening. -She expected the food to be properly covered until served to the residents to prevent any type of particles going into the food. -The MA had completed a food handlers' certification. -The food handlers' certification was not provided upon request.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service	D 287		

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D 287	Continued From page 31 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were maintained hot until residents were ready to eat their meals. The findings are: Observation of the breakfast meal on the Special Care Unit (SCU) on 05/11/23 at 8:33am revealed: -The breakfast meal had been placed on the tables. -The breakfast meal was scrambled eggs, 2 link sausages, grits, orange, and water. -The residents were called to come to the dining room. Observation of the kitchen during the dinner meal on 05/11/23 from 5:43pm to 6:15pm revealed: -There were 11 hot food plated uncovered on a three shelves cart at 5:43pm. -The cart sat in a connecting kitchen hallway to the SCU.	D 287		

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D 287	Continued From page 32 -The first plates of food were served at 6:15pm. -There was not a food temperature log for the dinner meal. Observation of the food temperature on 05/11/23 at 5:45pm revealed: -The plating of the green beans and hotdogs with buns sat uncovered. -The touch of the bottom of the plate had a warm feel. Observation of the dinner meal on the SCU on 05/11/23 at 5:42pm revealed: -The dinner meal was placed on a cart in the walkway from the kitchen leading to SCU dining area. -The dinner menu was hot dogs in buns, green beans, chips, tea and water. -The dinner meal was served to the residents at 5:53pm. Interview with a resident on 05/10/23 at 8:50am revealed: -The food was "horrible." -The food was always cold at meal times. Interview with a second resident on 05/11/23 at 3:15pm revealed: -The door to the dining area was closed until the food was placed on the dining table. -She did not know how long the food was on the table before residents were allowed to enter the dining area. -The food was often cold. -Sometimes she would take her plate back to her room and heat it in her microwave. Interview with a third resident on 05/11/23 at 3:30pm revealed sometimes the food was cold at meal times.	D 287		

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D 287	Continued From page 33 Interview with a medication aide (MA) 05/11/23 at 6:03pm revealed: -She was the only person working in dietary for the evening. -She had prepared the food and placed it on the cart to take to the special care unit. -There were no plate covers for the food to keep it warm. -She had been trained by one of the dietary staff to prepare the food and place the food on the cart. -She did not have any formal food service training. -She served the residents once they were seated in the SCU dining hall. Interview with a second MA on 05/11/23 at 5:00pm revealed: -Residents' food was plated from a hot tray. -She did not recall residents complaining to her about the food being cold at meal times. -She had been told by other staff that residents had complained about the food being cold at meal times. Interview with a personal care aide (PCA) on 5/11/23 at 5:15pm revealed: -She had been told by residents that sometimes the food was cold at meal times. -If residents were late coming to the dining area, the food was cold. -If they come to the dining area on time, the food should be warm. -The staff in the dining area would warm the plate up for them if asked. Interview with the Executive Director (ED) on 05/11/23 at 6:04pm revealed: -The MA was crossed trained in dietary services.	D 287		

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D 287	Continued From page 34 -The MA has signed up to help the dietary staff. -The MA had completed a food handlers' certification. -The food handlers' certification was not provided upon request.	D 287		
D 323	10A NCAC 13F .0906 (c) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services (c) Laundry. (1) Laundry services shall be provided to residents without any additional fee; and (2) It is not the home's obligation to pay for a resident's personal dry cleaning. The resident's plans for personal care of clothing shall be indicated on Form DSS-1865, the Resident Register. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide laundry service in a timely manner for residents residing on the assisted living unit. The findings are: Review of the license of the facility dated 01/01/23 revealed: -The facility was licensed for a total of 122 residents. -The facility consisted of an assisted living unit and a special care unit. -The census in the facility on 05/10/23 was 57 residents. -The assisted living unit had 35 residents.	D 323		

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D 323	Continued From page 35 Observation of the laundry room on 05/10/23 at 8:55am revealed: -The laundry room door was opened. -There were no staff present attending the laundry room. -The laundry machines were not in operation. Observation of the laundry room on 05/10/23 at 4:47pm revealed: -The laundry room door was opened. -There were no staff present attending the laundry room. -The laundry machines were not in operation. Observation of the laundry room on 05/11/23 at 10:26am revealed: -The laundry room door was opened. -There were no staff present attending the laundry room. -The laundry machines were not in operation. Interview with a resident on 05/11/23 at 2:50pm revealed: -The facility often ran short on laundry detergent. -Sometimes the facility was out of laundry detergent and residents' clothes could not be washed in a timely manner. -Residents often were told their laundry could not be done because there was no laundry detergent. -Some residents would buy their own laundry detergent and other supplies. Interview with a second resident on 05/11/23 at 3:05pm revealed residents had been told multiple times that their laundry could not be done because there was no laundry detergent. Interview with a resident on 05/11/23 at 3:15pm revealed: -Residents' laundry was supposed to be done	D 323		

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once a week.
-Residents usually had to take their own clothes to the laundry room to be washed.
-If you ask staff to take the laundry basket/hamper to the laundry room for you, staff would have an "attitude."
-There was 3 or 4 days before you got your laundry back.
-When you got your laundry back, the clothes had a smell as if they had been sitting in the washing machine wet for several days before being placed in the dryer.
-Sometimes your clothes maybe mixed in with other residents when they were returned.

Interview with a third resident on 05/11/23 at 3:30pm revealed:
-The facility did not have laundry detergent to wash residents' clothes.
-He had worn the same clothes for "about" 4 days because he had no clean clothes.
-When he took a bath, he had to put back on the same clothes because he had no clean clothes.

Interview with a fourth resident on 05/11/23 at 3:35pm revealed:
-The facility ran out of laundry detergent often.
-Once, it took about a week to get clothes back from the laundry.
-Sometimes she had to put the same clothes back on after taking a bath because there were no clean clothes.
-There were time she did not have clean night clothes to sleep in.
-She reported it to the Business Office Manager (BOM).

Interview with a personal care aide (PCA) on 05/11/23 at 5:15pm revealed:
-The PCAs were responsible for washing

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D 323	Continued From page 37 residents' clothes. -There were usually two PCAs on the unit. -She was aware residents' clothes were not being washed because there was no laundry detergent. -She had observed residents wearing the same clothes because of not having clean clothes. Interview with a medication aide (MA) on 05/11/23 at 5:00pm revealed: -She was aware of resident's clothes not being washed in a timely manner due to no laundry detergent. -She would notify the BOM because sometimes she would go to a nearby store and purchase supplies. Interview with the Executive Director (ED) on 05/11//23 at 5:00pm revealed: -The PCAs on each shift were responsible for doing the laundry for residents. -She recalled about a month ago, they had problems with the line that ran from the detergent receptacle to the washing machine not working properly. -She did not recall any other time residents' laundry was not being done due to not having laundry detergent. -Staff had to use a cup to measure out laundry detergent for the washing machine for about 2-3 weeks until the line was repaired. -Staff was overusing the detergent due to using a cup causing it to run out sooner than usual. -She was responsible for ensuring laundry detergent was ordered and in the facility.	D 323		
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:
Based on observations and interviews the facility failed to ensure 1 of 1 (#9) sampled resident's rights were maintained related to a resident not eating at the dining table.

The findings are:

Review of Resident #9's FL2 dated 02/28/23 revealed:
-Diagnosis included fracture of neck with left femur, anemia, alcohol abuse, cannabis abuse, hyponatremia, paranoid schizophrenia, major depression and hypertension.
-Resident #9 was semi ambulatory with the use of a walker and wheelchair.

Observation of the breakfast meal on 05/11/23 at 7:46am revealed:
-Resident #9 was seated in her wheelchair in the assisted living dining room.
-She was not seated at a dining table.
-She was eating scrambled eggs from a plate was seated on her lap.
-She had a large drinking cup placed beside her wheelchair on the floor.
-There were four to six tables connected in three separate spaces in the dining hall.
-There was space in the dining room where at least two single tables could be placed.

Interview with Resident #9 on 05/11/23 at 7:47am revealed:
-She ate from her lap because the tables were too crowded.
-She could not get her wheelchair around the

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tables.
-She had not asked to be seated at a separate single table.
-She had not been offered to sit at a separate single table.

Interview with a dietary wait staff on 05/11/23 at 7:59am revealed:
-Resident #9 had been asked to sit at the connected tables.
-Resident #9 did not like sitting with the other residents.
-She had not offered to seat Resident #9 at a single table.
-The dining room did have enough space to place a single table to accommodate her.
-She did not have any concerns about Resident #9 having to sit her drinking cup on the floor.

Interview the dietary supervisor on 05/11/23 at 8:06am revealed:
-She was aware of Resident #9 eating from her lap while seated in her wheelchair when she was in the dining room.
-Resident #9 had been asked to sit and the connecting tables to eat her meals.
-Resident #9 had refused to sit at the connecting tables to eat her meals.
-Resident #9 would sit at the doorway and eat her food.
-Resident #9 kept her drinking cup placed in her lap when she ate, and she had not observed Resident #9's drinking sitting on the floor.
-Resident #9 could not be seated at a single table in the dining room because there was not enough room to accommodate a single table.

Interview with Special Care Coordinator (SCC) on 05/11/23 at 10:07am revealed:
-She was aware of Resident #9 eating her meals

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D 338	Continued From page 40 from her lap while seated in her wheelchair per the dietary staff. -She did not know why Resident #9 preferred to eat not seated at a table. -She had not addressed the matter with Resident #9. -She was not aware if the dietary staff offered to seat Resident #9 at a separate single table. -There was enough space in the dining room to place a single table to accommodate Resident #9. -She did not think it was unsanitary for Resident #9 drink to be placed on the floor while she dined. Interview with Executive Director on 05/11/23 at 10:15am revealed: -She was not aware of Resident #9 having to eat from her lap while in the dining room. -Resident #9 could be accommodated while eating in the dining room. Observation of dinner meal on 05/11/23 at 6:23pm revealed Resident #9 was seated at a single table in the dining room.	D 338		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by:	D 451		

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Based on interviews, and record reviews, the facility failed to notify the County Department of Social Services (DSS) of incidents resulting in injury requiring medical treatment and referral to a local hospital for emergency medical evaluation for 4 of 7 Residents sampled (#1, #3, #4 and #6).

The findings are:

1. Review of Resident #1's current FL-2 dated 01/19/23 revealed:
-Diagnoses included dementia, anxiety, diabetes type II, hypertension, hyperlipidemia, history of seizures and chronic obstructive pulmonary and disease.
-The resident was ambulatory.
-The resident orientation was intermittent.

Review of Resident #1's incident and accident report (I/A) dated 05/04/23 revealed:
-The I/A occurred on 04/29/23 at 1:00pm.
-The type of event was elopement/wandering.
-There were no injuries or vitals for Resident #1 documented.
-The Executive Director (ED) completed and signed the report on 05/04/23.
-There was not a fax confirmation sheet attached to the 05/04/23 I/A report.

Interview with the Adult Home Specialist (AHS) on 05/11/23 at 2:26pm revealed:
-She had only received an Initial Allegation Report via fax on 05/04/23 noting an elopement had been reported to the Health Care Personnel Registry (HCPR) but was not provided with any detailed information.
-She had not received an A/I report of Resident #1's elopement.

Interview with the SCC on 05/10/23 at 4:39pm

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revealed:
-The ED completed the I/A report on Resident #1 elopement.
-It was the responsibility of the MAs to complete the I/A reports and submit the reports to her.
-She or the ED were responsible for submitting all I/A reports to DSS.
-She did not submit the 04/29/23 elopement I/A to DSS because the ED had completed the investigation and the I/A report.

Interview with the ED 05/11/23 at 12:17pm revealed:
-She learned of Resident #1 elopement from a staff member on 05/04/23.
-She completed an investigation with the staff who had worked on 04/29/23.
-She notified Resident #1's family member and his PCP.
-She completed the I/A report and submitted to the AHS.

Refer to the interview with a Medication Aide (MA) on 05/11/23 at 8:14am.

Refer to interview with Department of Social Services (DSS) staff on 05/11/23 at 6:02pm.

Refer to interview with the SCC on 05/11/23 at 10:27am.

Refer to the interview with the ED on 05/10/23 at 12:57pm.
2. Review of Resident #3's current FL-2 dated 03/09/23 revealed diagnoses included Alzheimer's dementia and type 2 diabetes.

Review of Resident #3's record revealed there was an emergency room (ER) discharge dated 03/06/23 with a diagnosis of accidental fall with

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D 451	Continued From page 43 facial or scalp contusion (bruise). Review of Resident #3's emergency department physician documentation dated 03/06/23 revealed: -Resident #3 was brought in after a fall at the facility. -Resident #3 fell forward out of his wheelchair and struck his forehead. Telephone interview with Resident #3's family member on 05/10/23 at 2:45pm revealed the facility had made her aware that the resident fell on 03/06/23 and was sent to the emergency room (ER). Interview with the Executive Director (ED) on 05/11/23 at 5:43pm revealed: -The local Department of Social Services (DSS) should be notified of any falls with injury, elopements, resident to resident abuse, and staff to resident abuse. -It was the ED's responsibility to make sure that DSS staff were notified of these things. -She usually sent an email to DSS staff to make them aware. -Resident #3 had a urinary tract infection (UTI) on 03/06/23 but he did not have a fall. -There was no incident/accident report (I/A) completed on Resident #3 for 03/06/23 because he did not fall nor did he have an injury so DSS was not notified of the incident. Refer to interview with a medication aide (MA) on 05/11/23 at 8:14am. Refer to interview with DSS staff on 05/11/23 at 6:02pm. Refer to interview with the Special Care	D 451		

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D 451	Continued From page 44 Coordinator (SCC) on 05/11/23 at 10:27am. Refer to the interview with the ED on 05/10/23 at 12:57pm. 3. Review of Resident #4's current FL-2 dated 03/30/23 revealed diagnoses included chronic pain, congestive heart failure, chronic obstructive pulmonary disease, anxiety, lumbar radiculopathy, and malignant hypertension. Review of an Incident and Accident (I/A) Report dated 03/21/23 revealed: -Resident #4 had an injury (cut) to the left leg due to a fall on 03/21/23 at 8:00pm. -The facility notified the family member and the primary care provider (PCP). -The Emergency Medical Service (EMS) was called and Resident #4 was transported to the emergency room (ER). -There was no documentation of time when the local department of social services (DSS) was notified. Review of Resident #4's hospital discharge summary dated 03/21/23 revealed: -The resident was seen in the ER on 03/21/23. -The admission diagnosis was a laceration to the lower right leg. -The treatment was suture repair to the leg. Interview with the Executive Director (ED) on 05/11/23 at 5:30pm revealed: -She was aware Resident #4 had a fall with injury and was sent to the ER. -She was aware the local Department of Social Service (DSS) was not notified. -She was aware the local DSS had to be notified of an injury that resulted in a resident being sent to the ER within 24 hours. -The medication aide (MA) or the lead MA could	D 451		

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D 451	Continued From page 45 complete the I/A report and carry out the appropriate notifications. -Ultimately, it was her responsibility to ensure I/A reports were completed and the local DSS was notified. Interview with the SCC on 05/10/23 at 2:25pm revealed there was not an I/A report completed for Resident #6's fall Refer to the interview with a Medication Aide (MA) on 05/11/23 at 8:14am. Refer to the interview with DSS staff on 05/11/23 at 6:02pm. Refer to the interview with the Special Care Coordinator (SCC) on 05/10/23 at 10:27am. Refer to the interview with the ED on 05/10/23 at 12:57pm. _____ Interview with a Medication Aide (MA) on 05/11/23 at 8:14am revealed: -The MAs completed incident/accident (I/A) reports and submitted them to the Special Care Coordinator (SCC). -She did not know who submitted the I/A reports to the Department of Social Services (DSS). Interview with DSS staff on 05/11/23 at 6:02pm revealed: -She expected the facility to report any falls with injury or elopements to her within 24 to 48 hours of the incident. -It was important to receive reports of these things so she could track the incidents and make a visit to the facility if she saw a pattern. -She did not receive notification from the facility that Resident #3, Resident #4, or Resident #6	D 451		

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D 451	Continued From page 46 had sustained falls with injuries. -She did not receive notification from the facility that Resident #1 had eloped from the facility. Interview with the SCC on 05/11/23 at 10:27am revealed: -The MAs completed the I/A reports and gave them to her or the Executive Director (ED). -Reports were submitted via fax. -She or the ED were responsible for submitting the reports to DSS. Interview with the ED on 05/11/23 at 12:57pm revealed: -The MAs were responsible for completing the I/A reports. -Once the I/A reports were completed the MAs placed the reports in a folder for review by the SCC or ED. -Once the reports were reviewed, the SCC or ED submitted the reports via fax to DSS.	D 451		