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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on November 16 - 17, 2023. | D 000 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 4 sampled residents (#1, #2, #4) who had multiple falls with injuries including multiple hospital emergency department visits (#1, #2, #4), a closed femur fracture (#2), closed fracture of the sacrum and right hip fracture (#4), and a resident who eloped from the free-standing memory care facility (#2).<br><br>The findings are:<br><br>Review of the facility Fall Management Policy revealed:<br>-The policy effective date was October 2013.<br>-The policy last review date was October 2023.<br>-The facility had "identified universal fall precautions applicable to residents".<br>-A fall risk evaluation was completed at the time of move in/admission or per state regulations. | D 270 | | |

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-A witnessed or reported unwitnessed fall, with or without injury, was reported in the facility's incident reporting system.
-Residents who sustained a fall should have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury.
-A fall referred to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury.
-When a fall occurred, the Service Plan was to be reviewed for potential interventions and updated as necessary.

Review of the facility Disclosure Statement revealed the facility would work with residents determined to be at risk for falls to bring in restorative therapy to evaluate and intervene where appropriate.

1. Review of Resident #4's current FL-2 dated 09/29/22 revealed:
-Diagnoses included situational hypertension, mixed dementia, adjustment disorder with mixed anxiety, and depressive disorder.
-The resident was documented as intermittently disoriented.
-The resident was documented as ambulatory.
-The resident required assistance with bathing and dressing.

Review of the Resident Register for Resident #4 revealed:
-The resident was admitted to the facility on 10/07/22 from another residence.
-The resident's activity interest included exercises to strengthen the left arm, pelvis and legs.

Review of a Fall Risk Evaluation for Resident #4 dated 10/11/22 revealed:

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-The resident had experienced one fall without injury in the last 12 months.
-The resident had a history of cognitive decline.
-The resident was listed as a "level 3" fall risk.

There were no additional Fall Risk Evaluations in Resident #4's record for review.

Review of Resident #4's Personal Service Plan addendum assessment dated 01/20/23 revealed:
-The resident had fallen in the last twelve months.
-The resident had fallen two times in December and once in October with no injuries noted.
-The facility's universal fall precautions applied to all facility residents.
-Interventions included in the resident's personal service plan included considering request for further evaluation by the Primary Care Provider (PCP) regarding changes and observations that may include labs and medication reviews and consider involvement of physical therapy and/or occupational therapy to consult regarding strength, gait training, cognition, and adaptive equipment.
-The resident used a rollator walker.
-The resident was independent with ambulation and transferring.
-The resident required standby assistance with bathing.

Review of Resident #4's Personal Service Plan addendum assessment dated 09/20/23 revealed:
-The resident required supervision with toileting, eating, ambulation, personal hygiene, and transferring.
-The resident required limited assistance with bathing, dressing, and grooming.
-There were no interventions for falls prevention documented.

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Review of Resident #4's record revealed there were no physical therapy notes or occupational therapy notes available for review.

Review of accident/incident (A/I) reports for Resident #4 revealed the resident had six documented falls from 06/05/23 through 10/31/23.

a. Review of Resident #4's A/I report dated 06/05/23 revealed:
-Resident #4 had an unwitnessed fall in the residents' room at her bedside.
-There was documentation she had no apparent injury.
-The resident complained of back pain.
-It "appears resident hit her head".
-The resident was sent to the hospital emergency department (ED) for evaluation.
-The Administrator, family, and PCP were notified.
-"No follow up entries exist" was documented in the section of the I/A for follow-up information.

Review of the hospital After Visit Summary dated 06/05/23 for Resident #4 revealed:
-The reason for Resident #4's visit was documented as fall, trauma green, and covid positive.
-The resident was diagnosed with a closed fracture of sacrum, unspecified portion of sacrum.

Review of Resident #4's electronic progress notes entered 06/06/23 through 06/08/23 revealed:
-Resident #4 returned from the hospital on 06/06/23 around 2:30am and was resting in her room.
-There were no Alert Charting Notes documented on 06/06/23 for the 3-11pm shift

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| D 270 | Continued From page 4<br>-There were no Alert Charting Notes documented on 06/07/23 for the 7:00am-3:00pm shift, 3:00pm-11:00pm shift, or 11:00pm-7:00am shift.<br>-There were no Alert Charting Notes documented on 06/08/23 7:00am-3:00pm shift, 3:00pm-11:00pm shift, or 11:00pm-7:00am shift.<br>-There were no fall risk interventions documented for Resident #4.<br><br>Interview with the Administrator on 11/17/23 at 2:19pm revealed:<br>-She thought Resident #4 tried to pick something up from the floor when she fell on 06/05/23.<br>-Staff checked on Resident #4 "often, every 30 minutes to one hour".<br>-She did not know that an intervention was put in place after the fall on 06/05/23.<br><br>b. Review of Resident #4's A/I report dated 08/26/23 revealed:<br>-The resident had an unwitnessed fall in the dining room.<br>-There was no apparent injury.<br>-The Administrator, family, and PCP were notified.<br>-"No follow up entries exist" was documented in the section of the I/A for follow-up information.<br><br>Review of Resident #4's electronic progress notes entered 08/26/23 through 08/29/23 revealed:<br>-Resident #4 fell in the kitchenette area of the facility.<br>-There were no injuries noted at the time of the fall.<br>-A staff note documented the residents' family member was notified and did not want the resident to engage in sweeping in the future because the family member did not think the sweeping was safe for the resident. | D 270 | | |

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| D 270 | Continued From page 5<br>-There were no additional fall risk interventions documented for Resident #4.<br><br>Interview with the Administrator on 11/17/23 at 2:19pm revealed:<br>-She talked to Resident #4's family member after the resident fell on 08/26/23.<br>-She thought no more sweeping was implemented as an intervention after the fall on 08/26/23.<br>-Interventions implemented would be documented in the resident's service plan.<br>-There were no interventions documented in Resident #4's next service plan dated 09/20/23.<br><br>c. Review of a Physician's Fax Report of Fall form for Resident #4 dated 09/13/23 revealed:<br>-The resident had a fall in her room beside her bed.<br>-There was no new injury noted.<br>-The caregiver reported the resident had been complaining of pain with a "previously bruised right leg".<br><br>Review of Resident #4's electronic progress notes entered 09/13/23 through 09/16/23 revealed:<br>-Resident #4 was found on the floor in her room beside her bed.<br>-There were no new apparent injuries.<br>-The residents' family member was present in the resident's room.<br>-The PCP was made aware.<br>-There were no Alert Charting Notes documented on 09/14/23 for the 3:00pm-11:00pm shift.<br>-There were no Alert Charting Notes documented on 09/15/23 for the 3:00pm-11:00pm shift, or 11:00pm-7:00am shift.<br>-There were no Alert Charting Notes documented on 09/16/23 for the 11:00pm-7:00am shift. | D 270 | | |

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-There were no fall risk interventions documented for Resident #4.

d. Review of Resident #4's A/I report dated 09/23/23 revealed:
-The resident had an unwitnessed fall in her room beside her bed.
-The resident was sent to the hospital by emergency medical services (EMS) transport.
-The facility nurse, family, and PCP were notified.

Review of the hospital After Visit Summary dated 09/23/23 for Resident #4 revealed:
-The reason for Resident #4's visit was documented as fall, and trauma green.
-The resident was diagnosed with a sprain of the left shoulder, unspecified shoulder sprain type, and sprain of the left wrist.

Review of Resident #4's electronic progress notes entered 09/23/23 through 09/26/23 revealed:
-The resident returned to the facility from the hospital on 09/23/23 at 10:12pm.
-There were no Alert Charting Notes documented on 09/25/23 for the 7:00am-3:00pm shift or 3:00pm-11:00pm shift.
-There were no Alert Charting Notes documented on 09/26/23 3:00pm-11:00pm shift or 11:00pm-7:00am shift.
-There were no fall risk interventions documented for Resident #4.

Interview with the Administrator on 11/17/23 at 2:19pm revealed:
-She did not know what interventions were implemented for Resident #4 after the 09/23/23 fall.
-The facility nurse was responsible for implementing interventions for residents after a

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fall.
-The nurse was responsible for notifying the MAs of the interventions implemented.
-The MAs were responsible for notifying the PCAs of the interventions implemented.
-Sometimes the nurse spoke directly to the PCAs to notify of interventions implemented.
-Interventions implemented would be documented in the resident's progress notes or service plan.

e. Review of Resident #4's A/I report dated 10/06/23 revealed:
-The resident had a witnessed fall in the facility hall.
-The resident had injuries to her right forearm, neck, back of head, and upper back/spine.
-The resident was sent to the hospital by EMS transport.
-The Administrator, family, and PCP were notified.
-"No follow up entries exist" was documented in the section of the I/A for follow-up information.

Review of the hospital After Visit Summary dated 10/06/23 for Resident #4 revealed the reason for Resident #4's visit was documented as fall.

Review of Resident #4's electronic progress notes entered 10/06/23 through 10/09/23 revealed:
-The resident returned to the facility from the hospital via family transport on 10/06/23.
-There were no Alert Charting Notes documented on 10/08/23 for the 7:00am-3:00pm shift, 3:00pm-11:00pm shift, or 11:00pm-7:00am shift.
-There were no Alert Charting Notes documented on 10/09/23 for the 11:00pm-7:00am shift.
-There were no fall risk interventions documented for Resident #4.

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f. Review of Resident #4's A/I report dated 10/31/23 revealed:
-The resident had an unwitnessed fall in the facility dining room.
-The resident injured her right hip and skull/scalp.
-The resident was sent to the hospital via EMS transport.
-The Administrator, family, and PCP were notified.
-"No follow up entries exist" was documented in the section of the I/A for follow-up information.

Review of Resident #4's electronic progress notes entered 10/31/23 revealed:
-Resident #4 was found on the dining room floor.
-The resident had a laceration on the right side of her skull.
-The resident was having pain in her right hip.
-The resident was unable to move.
-The residents' family and PCP were notified.

Review of the hospital discharge summary dated 11/09/23 for Resident #4 revealed:
-The resident was admitted to the hospital on 10/31/23 after suffering a fall.
-X-rays and scans in the emergency department confirmed a right hip fracture.
-The resident was admitted and subsequently underwent right hip surgery on 11/02/23.
-Resident #4 was discharged to a skilled nursing facility on 11/09/23.

Interview with a Personal Care Aide (PCA) on 11/16/23 at 4:43pm revealed:
-Resident #4 had a recent fall in the dining room.
-She saw Resident #4 fall in the dining room.
-The resident liked to sweep the dining room floor.
-Resident had a prior fall about one month ago.

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-She had been given instructions from management to keep an eye on fall risk residents by keeping them in view all the time.
-She had been provided instructions from management to make sure there was nothing there to cause a fall and to put any resident identified as a fall risk to bed first.
-She knew of five residents (Resident #4 not named) who were identified as fall risk.

Interview with a second PCA on 11/17/23 at 2:10pm revealed:
-Resident #4 sometimes used her rollator walker.
-Most of the time when the resident had falls, she was not using her rollator walker.
-Staff had to give Resident #4 her walker.
-She remembered Resident #4 falling over a broom so the staff stopped allowing the resident to sweep.
-She remembered Resident #4 tripping over her rollator walker.
-Interventions put in place for Resident #4 included more frequent checks and making sure the resident was using her rollator walker.
-Resident #4 liked to stay around staff so staff saw her often.
-She remembered the Medication Aide (MA) and Administrator instructed staff to check on Resident #4 every 30 minutes and to check on her during the night because the resident would get up for toileting.
-The PCAs did not document supervision checks for the residents.

Interview with the Administrator on 11/17/23 at 2:19pm revealed:
-She recalled Resident #4 having physical therapy.
-She would look for the physical therapy notes.

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Attempted interviews with the Primary Care Provider (PCP) on 11/17/23 at 12:57pm and 1:58pm were unsuccessful.

Refer to the interview with the Administrator dated 11/16/23 at 4:33pm.

Refer to the interview with the Administrator dated 11/16/23 at 6:03pm.

Refer to the interview with the Administrator dated 11/17/23 at 3:27pm.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 3:08pm.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 4:28pm.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 4:46pm.

2. a. Review of Resident #2's current FL-2 dated 06/16/23 revealed diagnoses included dementia, Parkinson's disease, hypothyroidism, polyneuropathy, age related osteoporosis and chronic kidney disease stage 3.

Review of Resident #2's Resident Register revealed:
-She was admitted to the facility on 06/20/23.
-She required assistance with dressing, bathing, and orientation to time and place.
-She had significant memory loss and required direction.
-She used a rollator for ambulation.

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Review of Resident #2's Fall Risk Assessment dated 07/04/23 revealed:
-The resident was incontinent.
-The resident needed assistance with toileting.
-The resident had Parkinson's disease.
-The resident used a rollator for ambulation.
-The resident had vision deficits.
-The resident took anti-psychotic medications.
-The resident had a history of cognitive decline.
-The resident was listed as a Level 3 fall risk.

Review of Resident #2's current personal service plan dated 09/20/23 revealed:
-She took 7 or more medications.
-She used antipsychotic medications.
-Be alert to medication related fall risk.
-She had Parkinson's disease.
-Resident #2 was slow when ambulating.
-She used a walker.
-She got tired by the end of the day and needed more frequent checks.
-Resident #2's walking became more unsteady by the end of the day.
-Balance was an issue at times, but the resident was able to stand and ambulate on her own with her rollator.
-She was incontinent of bladder and required assistance with pulling her pants up and down and changing protective undergarments.
-Provide staff attention and/or verbal prompts to and from the dining room and/or community activities as needed.
-Memory impairment was one of the reasons for the escort assistance.
-Be alert for heightened risk for falling.
-The Resident has fallen in the last 12 months.
-She used a walker as a mobility aid.
-Resident #2 was not always oriented to place.
-Resident #2 was not always oriented to time.
-Resident #2 got up 1 time per night to go to the

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bathroom.
-Resident #2 would occasionally exit seek because she thought she had appointments "out of the office".

Refer to interview with the Administrator on 11/16/23 at 4:33pm.

a. Review of Resident #2's A/I report dated 10/09/23 at 1:00am revealed:
-The resident had an unwitnessed fall in the resident's apartment, not bedside.
-The resident was checked for injury with no apparent injury.

Review of Resident #2's electronic progress notes entered by the medication aide (MA) dated 10/09/23 revealed:
-At 1:12am, the resident was found in her room sitting on the floor in front of the closet behind the apartment door.
-The resident stated that the only thing that hurt was her ego.
-A body assessment was completed, and no injuries were found.
-At 1:46pm, the resident voiced no complaints of pain or discomfort from fall last night.
-At 10:38pm, the resident did not show any discomfort this evening, the vital signs were not taken because the resident refused.

Review of Resident #2's 10/10/23 electronic progress notes entered by the MA revealed:
-There was no alert charting or progress note for the first shift
-At 10:39pm, the resident was being verbally aggressive with the staff, exit seeking multiple times and became aggressive when re-directed.
-There was no alert charting or progress note for the third shift.

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| D 270 | Continued From page 13<br><br>Review of Resident #2's 10/11/23 electronic progress notes entered by the MA revealed:<br>-At 10:22pm, no complaints of pain or discomfort to previous fall, Resident appears to be fine. No concerns.<br>-There was no documentation of alert charting or progress notes for the third shift.<br>-There was no documentation of alert charting or progress notes for the first shift.<br><br>Review of Resident #2's 10/12/23 electronic progress notes entered by the MA revealed:<br>-At 6:41am, Resident has no complaints of pain or discomfort.<br>-There was no documentation of alert charting or progress notes for the first shift.<br>-There was no documentation of alert charting or progress notes for the second shift.<br><br>b. Review of Resident #2s A/I report dated 10/20/23 at 12:00pm revealed:<br>-The resident had an unwitnessed fall in the hallway, hit her head on the floor, body parts injured hip (left), shoulder (left), skull/scalp.<br>-911 was called and the resident was sent to the emergency department (ED).<br><br>Review of Resident #2's 10/21/23 electronic progress notes entered by the MA revealed:<br>-At 12:10am, the resident returned from hospital via emergency medical services (EMS) transportation, the resident seemed to be in good spirits, no sign of discomfort or pain.<br>-At 5:37am, the resident did not sleep through the night, and she was still a little tired from her hospital stay, she was kept in her room, and was checked on periodically and her vital signs had not changed.<br>-At 10:50am, the resident's family members | D 270 | | |

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preferred resident not see Ortho as hospital discharge papers have suggested.
-Family members requested hospice consult not necessarily because of the recent fall but because the residents Parkinson's and dementia are progressive diseases, and they know she will continue to decline.
-At 8:42pm, the resident was tired, blood pressure (BP) 136/76, pulse (P) 84, temperature 98.0, respirations 18, oxygen saturation 96%, as needed (PRN) tramadol given for general discomfort.
-There was an entry at 10:27pm the tramadol was effective.

Review of resident #2's 10/22/23 electronic progress notes by the MA revealed:
-At 4:11am, the resident rested well tonight and no complaints of pain.
-At 6:23pm, the resident complained of pain and tramadol 50mg 1 tablet was administered.
-At 9:30pm, the tramadol was effective, her pain scale was 2.
-At 9:36pm, the resident's BP was 158/20 and P was 72
-There was no documentation of alert charting or progress notes for the first shift.

Review of Resident #2's 10/23/23 electronic progress note revealed:
-At 4:55am, the resident rested well tonight, no complaints of pain.
-At 5:27am, tramadol 50mg 1 tablet was administered for pain.
-At 7:02am, tramadol was effective, pain scale was 1.
-At 1:59pm, the resident was up for breakfast and lunch walking around with walker. No complaints of pain or discomfort from fall on 10/20/23.
-There was no documentation of alert charting or

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progress notes for the second shift.

c. Review of Resident #2's A/I report dated 10/26/23 at 10:30am revealed:
-The resident had an unwitnessed fall in the hallway with head injury.
-The resident hit the back of her head and was sent to the ED.

Review of Resident #2's 10/26/23 electronic progress notes entered by the MA revealed:
-At 10:30am, the resident hit her head on a wall during the fall and was transferred to hospital.
-At 7:00pm, the resident returned from hospital and appeared tired.

Review of Resident #2's 10/27/23 electronic progress notes entered by the MA revealed:
-At 1:38am, The resident had just returned from the ED and the resident rested well during the night.
-At 11:07am she spoke with a hospice representative who stated the hospice nurse will be here today for initial visit/consult regarding hospice services for resident, and the resident's family member was made aware.
-At 9:09pm, no complaint or signs/symptoms of pain from fall, continued to monitor.

d. Review of Resident #2's A/I report dated 10/27/23 at 11:45pm revealed:
-The resident had an unwitnessed fall in the resident's bathroom, not in the shower or tub.
-The resident was checked for injury with no apparent injury.

Review of Resident #2's 10/28/23 electronic progress notes entered by the MA revealed:
-At 12:30am, the resident was found in the bathroom lying on her left side, a body

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assessment was completed, and she had no complaints of pain.
-At 2:09pm, the resident had no complaints of pain or discomfort from her fall on 10/26/23.
-At 9:27pm, the resident did well this shift, no complaints, or signs/symptoms of pain from her fall, continued to monitor.

Review of Resident #2's 10/29/23 electronic progress notes entered by the MA revealed:
-At 1:46pm, the resident had no complaints of pain or discomfort from her fall on 10/27/23, pain level 0.
-At 8:48pm, the resident has done well this shift, no complaints of or signs/symptoms of pain from her fall on 10/27/23, continued to monitor. The resident's vital signs were BP 142/80, P 78, respirations 22, oxygen saturation 98% on room air, temperature 97.3.
-There was no documentation of alert charting or progress notes for the third shift.

Review of Resident #2's 10/30/23 electronic progress notes revealed:
-There was an entry at 10:10pm, the resident was seen in general discomfort this evening, unable to take vital signs, the resident refused but took all of her scheduled medications
-There was no documentation of alert charting or progress notes for the third shift.
-There was no documentation of alert charting or progress notes for the first shift.

There was no alert charting or electronic progress note provided for 10/31/23.

e. Review of Resident#2's A/I report dated 11/07/23 at 12:10pm revealed:
-The resident had an unwitnessed fall in another resident's room.

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-The resident was checked for injury with no apparent injury.

There was no alert charting or electronic progress notes provided for 11/07/23.

Review of Resident #2's 11/08/23 electronic progress notes entered by the MA revealed:
-At 1:57pm, the resident had no complaints of pain or discomfort from her fall on 11/07/23, pain level 0.
-There was no documentation of alert charting or progress notes for the second shift.
-There was no documentation of alert charting or progress notes for the third shift.

Review of Resident #2's 11/09/23 electronic progress notes entered by the MA revealed:
-At 6:33am, the resident had no complaints of any discomfort from her fall 11/7/23.
-At 8:57pm, the resident had no complaints, appearance of discomfort due to her fall on 11/07/23 and staff continued to monitor the resident.
-There was no documentation of alert charting or progress notes for the first shift.

Review of Resident #2's 11/10/23 electronic progress notes entered by the MA revealed:
-At 2:15am, the resident was resting well with no complaints of pain.
-At 8:41pm, the resident's vital signs were BP 140/82, P 72, R 18, O2 98%, no pain reported or observed at this time.
-At 9:36pm, the hospice nurse came out due to resident falling, the nurse said that resident was impacted and she de-impacted her and will contact the doctor to increase Senna or add another stool softener.
-There was no documentation of alert charting or

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progress notes for the first shift.

f. Review of Resident #2's A/I report dated 11/10/23 at 8:05pm revealed:
-The resident had a fall, witnessed in the family room.
-The resident was checked for injury with no apparent injury.

There was no alert charting or electronic progress notes provided for 11/11/23,

There was no alert charting or electronic progress notes provided for 11/12/23.

There was no alert charting or electronic progress notes provided for 11/13/23.

Review of Resident #2's ED After visit summary dated 10/20/23 revealed:
-Resident #2 was seen for a fall.
-Diagnosis included left hip pain and closed non-displaced fracture of the greater trochanteric of the left femur.
-Findings of X-ray of the pelvis performed 10/20/23 were nondisplaced fracture of the left greater trochanter present and appears new compared to 12/19/22.
-Resident #2 was to follow-up with orthopedic surgery.

Review of Resident #2's primary care provider (PCP) note dated 10/24/23 revealed:
-The resident was seen for ED follow-up for a femur fracture.
-Hospice consult was ordered.

Interview with a personal care aide (PCA) on 11/16/23 at 4:16pm revealed:
-She checked on the residents every 30 minutes

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to an hour.
-They tried to keep the residents in the common area so they could keep an eye on them.
-The PCAs did not document their checks on the residents.
-Resident #2 had a lot of falls when she was first admitted because she was an early riser and would get up by herself.
-The 3rd shift staff started getting Resident #2 up in the mornings and she thought that had helped.
-She did not think Resident #2 had any recent falls.

Interview with a second PCA on 11/17/23 at 2:20pm revealed:
-She checked on the residents every 30 minutes to an hour if they were in their room.
-If they were in the common area, everyone checked on them.
-Resident #2 was a fall risk due to her diagnosis of Parkinson's disease.
-Resident #2 tried to be independent and would not wait for staff to assist her.
-She knew Resident #2 had several falls in the past but could not recall when she last fell.
-She reminded Resident #2 to use her walker and to wait for assistance.

Interview with the MA on 11/17/23 at 7:30am revealed:
-She identified Resident #2 as fall risk.
-The residents were checked at least every 2 hours by the PCAs.
-If the residents were incontinent, they may be checked more frequently.
-Usually, the residents were in the common area but if they were in their room, they were to be checked on every 30 minutes
to an hour.
-The PCP sometimes ordered PT or OT for

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residents that had frequent falls.
-If a resident had a fall, it was communicated by the MA at shift change and the MA would notify the PCAs.
-After a resident had a fall, the MAs were to do alert charting which meant to ask the resident if they were having any pain and to document on the electronic progress note once each shift for 72 hours.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 3:08pm.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 4:28pm

Refer to second interview with the Administrator on 11/16/23 at 6:03pm.

Third Interview with the Administrator on 11/17/23 at 3:27 revealed:
-Fall risk assessments were done on admission only.
-She did not do the fall risk assessments.
-The fall risk assessments were done by the facility's nurse.
-She did not know what the fall risk levels were.
-She assumed the fall risk level would be reflected in the resident's care plan.
-Any fall interventions would be documented in the progress notes, or the care plan would be revised.
-The nurse would be responsible for updating the care plan.
-The nurse would be responsible for making recommendations for fall interventions.
-After a fall the MAs assessed the resident and notified the nurse.
-If a resident hit their head or complained of pain,

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they were sent to the ED.
-The MAs completed the I/A reports.
-After a resident had a fall or returned from the hospital, the MAs were supposed to do alert charting, doing vital signs and a progress note once a shift for 72 hours.
-Hospice had been ordered for Resident #2 after the 10/20/23 fall at her family's request.
-She thought Resident #2 had PT in the past but could not remember for sure.
-No other fall prevention interventions had been put in place for Resident #2.
-Increased monitoring of Resident #2 would have to be ordered by the PCP.
-She expected the MAs to do alert charting after each fall.
-She expected the residents to be supervised based on their level of need.

No physical therapy notes or physical therapy orders for Resident #2 were provided prior to exit.

Based on observation, interviews, and record review, it was determined that Resident #2 was not interviewable.

Phone interview with Resident #2's hospice nurse on 11/17/23 at 1:42pm revealed she could not discuss Resident #2 without a signed release of information document from the resident or her responsible party.

Attempted phone interview with Resident #2's PCP on 11/17/23 at 2:00pm was unsuccessful.

b. Review of Resident #2's Incident/Accident (I/A) report dated 10/15/23 revealed:
-Approximate time of incident was 5:00pm.
-Location of incident was outside of building, on property: outdoors.

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-Nature of incident was elopement
-Type of Injury/Impairment was no apparent injury.
-Blood Pressure 150/82, Pulse 78, Respirations 22, Temperature 97.4 F
-Notified nurse and or executive director.

There were no alert charting or progress notes provided for 10/15/23,

Interview with a PCA on 11/16/23 at 4:16pm revealed:
--She checked on the residents every 30 minutes to an hour.
-They tried to keep the residents in the common area so they could keep an eye on them.
-The PCAs did not document their checks on the residents.
-Resident #2 had not tried to leave the facility that she knew of.
-No residents had gotten out of the facility.
-Some residents would try to open the exit doors, but the doors alarmed and scared the residents, and they left the doors alone.

Interview with a second PCA on 11/17/23 at 2:20pm revealed:
-She checked on the residents every 30 minutes to an hour if they were in their room.
-If they were in the common area, everyone checked on them.
-Resident #2 was a fall risk due to her diagnosis of Parkinson's disease.
-Resident #2 was independent and wanted to wander.
-Resident #2 would sometimes go to the exit doors but she had never gotten out of the facility that she knew of.

Interview with a MA on 11/17/23 at 7:30am

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revealed:
-Resident #2 went to the exit doors often but had never left the facility that she knew of.

Interview with a third PCA on 11/17/23 at 2:27pm revealed:
-The residents were checked every 2 hours for incontinence.
-If a resident did not feel well, she checked on them every 30 minutes.
-She identified Resident #2 as an exit seeker but said she could be re-directed.
-Staff tried to keep Resident #2 in the common area so they could keep an eye on her.
-Resident #2 seemed to have increased exit seeking behavior immediately after family visited her at the facility.
-She worked second shift on 10/15/23.
-Resident #2 tended to sneak away during dinner.
-Resident #2 did not come to the dining room for dinner on 10/15/23.
-She went to Resident #2's room and could not find her.
-She and the other staff immediately started a search for Resident #2.
-Resident #2 was found right outside of the C hall exit door after about 10 or 15 minutes.
-She said the C hall exit door did not alarm.
-She did not know why the C hall exit door did not alarm but said this was corrected.

Attempted phone interview with the 10/15/23 second shift MA on 11/17/23 at 1:40pm was unsuccessful.

Interview with the Administrator on 11/17/23 at 4:02pm revealed:
-The facility is a locked facility.
-Residents identified as exit seekers were watched closely.

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-All the exit doors were locked and had alarms.
-All exit doors were checked periodically by maintenance.
-There was no log kept for checking the exit doors.
-She was out of town when Resident #2 eloped but was notified.
-She did not know why the C hall exit door did not alarm on 10/15/23 but was corrected immediately by maintenance.
-All exit doors were checked daily by either the nurse or the business office manager.
-She expected all exit doors to remain locked and alarmed at all times.

Based on observation, interviews, and record review, it was determined that Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's PCP on 11/17/23 at 2:00pm was unsuccessful.

3. Review of Resident #1's current FL-2 dated 08/16/23 revealed:
-The resident was admitted to the facility in November 2020.
-The resident's diagnoses included cerebral ischemia and hypertension.
-The resident was non-ambulatory.
-The resident required assistance with bathing, dressing and incontinent care.
-The resident was constantly disoriented.
-The resident's required level of care was memory care.

Review of Resident #1's Personal Service Plan dated 09/27/23 revealed:
-The resident was totally dependent on staff to provide assistance for the following activities of daily living (ADL): dining, toileting,

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ambulation/locomotion. bathing, dressing, personal hygiene, grooming and transferring.
-The facility's Universal Fall Precautions were in place (applied to all facility residents).
-The resident used a wheelchair for mobility but must have escorts from staff.
-An order to reposition every hour.
-"The resident has a recliner in the family room rather than sitting in wheelchair."

Review of Resident #1's Fall Risk Assessment dated 09/26/21 revealed:
-The resident was considered a "Level 3 Fall Risk"
-Risk factors for falls included the resident's diagnosis of dementia, the resident was unaware of own safety.
-The resident required total assistance from staff required for transfers, ambulation, ADLs and toileting.
-There were no additional interventions documented in the Fall Risk Assessment.

There were no additional Fall Risk Assessments or Fall Risk Evaluations in Resident #1's record for review.

Review of Resident #1's resident record, Incident Reports and progress notes revealed Resident #1 had eight falls from 05/14/23 through 11/16/23.

a. Review of Resident #1's Incident Report dated 05/14/23 revealed:
-The resident had a un-witnessed fall after she slid off of her wheelchair in the facility's Family Room at 4:30pm.
-No injury was noted.
-"No follow up entries exist" was documented in the section for follow-up information.

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Review of Resident #1's resident record, including the facility's progress notes revealed:
-No alert charting or general progress notes were documented on 05/16/23.
-Alert charting was not documented each shift on 05/17/23.

b. Review Resident #1's Incident Report dated 05/18/23 revealed:
-The resident was found on the floor in front of her wheelchair in the facility's Family Room at 1:55pm
-No injury was noted.
-"No follow up entries exist" was documented in the section for follow-up information.

Review of Resident #1's resident record, including the facility's progress notes, revealed alert charting was not documented each shift on 05/20/23.

c. Review of a progress note dated 06/06/23, at 4:45pm revealed:
-The resident was found on the floor.
-No acute injury noted.

Review of Resident #1's resident record, including the facility's progress notes revealed:
-Alert charting was not documented each shift on 06/07/23.
-There were no alert charting or general progress notes completed 06/08/23 through 06/15/23.

d. Review Resident #1's progress notes and an Incident Report dated 07/11/23 revealed:
-The resident was found on the floor at bedside at 10:30pm.
-The resident appeared to have hit her head with bruising noted on her left eye.
-The resident was sent to the emergency

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department (ED) for further evaluation.
- "No follow up entries exist" was documented in the section for follow-up information of the Incident Report.

Review of Resident #1's progress notes dated 07/12/23 revealed:
-The resident returned to the facility on 07/12/23 and staff documented the hospital reported test results showed no injuries.

Review of Resident #1's primary care provider (PCP) orders dated 07/12/23 revealed :
-There were orders to discontinue a four-inch wheelchair cushion.
-There were orders for a two-inch wheelchair cushion.
-There were orders to "continue q60 min [every 60 minutes] checks for safe positioning".

Review of Resident #1's resident record, including the facility's progress notes revealed:
-There were no alert charting or general progress notes documented on 07/13/23 and 07/14/23.
-The 60-minute checks for safe positioning were added to Resident #1's electronic Medication Record (eMAR) on 07/12/23.
-Information related to the orders for a two-inch wheelchair cushion was not documented in the progress notes.

Review of Resident #1's eMAR dated 09/01/23 through 11/16/23 revealed:
-The resident's eMAR included entries for 60-minute checks for safe positioning with a start date of 07/12/23.
-Staff documented completion of 60-minute checks on the eMAR (09/01/23 through 11/16/23).

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e. Review of Resident #1's progress notes dated 07/23/23 at 11:05am revealed:
-The resident slipped out of her wheelchair and bumped her head.
-The resident was sent to the emergency department for further evaluation.

Review of Resident #1's ED records dated 07/23/23 revealed:
-No apparent injuries.
-No new orders were noted.

Review of Resident #1's resident records. including the facility's progress notes revealed:
-Alert charting was not documented every shift on 07/25/23.
-There were no alert charting or general progress notes 07/26/23- 07/29/23

f. Review of Resident #1's progress notes dated 07/24/23 revealed staff documented the "resident had a fall, she slid out of bed, no apparent injuries from this fall at 9:45pm".

Review of Resident #1's resident records, including the facility's progress notes revealed:
-Alert charting was not documented every shift on 07/25/23.
-There were no alert charting or general progress notes documented 07/26/23- 07/29/23.

Review of Resident #1's PCP orders dated 08/04/23 revealed the resident was ordered home health physical therapy and occupational therapy for multiple falls, seating safety, and equipment review.

Review of Resident #1's resident record revealed there were no home health or therapy provider notes documented.

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| D 270 | Continued From page 29<br><br>Interview with the Administrator on 11/16/23 at 6:10pm revealed:<br>-She knew the resident had received home health therapy services a couple of times in the past.<br>-She was not able to locate the therapy provider's notes and would contact the provider to see if the records could be sent to the facility.<br><br>Review of Resident #1's physical therapy notes revealed:<br>-The therapy notes were dated 03/21/23.<br>-The resident was evaluated and therapy services were not continued at that time.<br>-No therapy notes related to the 08/04/23 order were provided.<br><br>g. Review of Resident #1's progress notes and an Incident Report dated 10/03/23 revealed:<br>-The resident had an unwitnessed fall and was found near her bed.<br>-No injuries were noted.<br>-"No follow up entries exist" was documented in the section for follow-up information of the Incident Report.<br><br>Review of Resident #1's (PCP) orders dated 10/05/23 revealed an order for 30-minute checks when in bed and reposition if needed.<br><br>Review of Resident #1's resident records, including the facility's progress notes revealed:<br>-Alert charting was not documented each shift on 10/04/23 and 10/06/23.<br>-There were no alert charting or general progress notes documented on 10/05/23.<br><br>Review of Resident #1's eMAR dated 09/01/23 through 11/16/23 revealed:<br>-Resident #1's order for 30-minute checks when | D 270 | | |

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in bed and reposition if needed was not documented on the eMAR.

h. Review of Resident #1's Preliminary Draft Notes of a Reported Incident form dated 11/13/23 revealed:
-The resident had a witnessed fall from her wheelchair and noted the "resident was held by another resident's hand slipped off her wheelchair.
-No injury was noted.
-The follow-up information section was left blank.

Review of Resident #1's resident record, including the facility's progress notes revealed alert charting was not documented every shift on 11/15/23 and 11/16/23.

Observations of Resident #1 made on 11/16/23 from 3:40pm to 4:53pm revealed:
-The resident was seated in a recliner in the facility's family room.
-The recliner was in the upright position with the footrest down and not in use.
-Staff was present in the living room from 3:50pm through 4:53pm.
-The resident's upper body was leaning toward the right side of the recliner and not in an upright position throughout the observation.
-The resident rubbed her legs and put them out in front of her in the air on three occasions during the observation.
-Staff did not offer or attempt repositioning of the resident from 3:40pm through 4:53pm.

Attempted to reach Resident #1's (PCP) via phone on 11/17/23 and a voicemail was left at 9:04am.

Interview with Resident #1's PCP on 11/20/23 at

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| D 270 | Continued From page 31<br><br>10:11am revealed:<br>-Resident 1 had a diagnosis of dementia and spoke a language other than English which made communication difficult.<br>-The resident had a diagnosis of left hemiplegia which contributed to left sided weakness.<br>-The resident was not able to safely reposition herself.<br>-The order for 60 minute repositioning checks had been in place for approximately one year.<br>-On 07/12/23, the four- inch wheelchair cushion was discontinued as staff felt it may have been increasing the resident falls.<br>-On 07/12/23 the two-inch wheelchair cushion was ordered to aid in positioning and increased the resident's comfort so she was not trying to reposition herself in an unsafe manner, which could lead to falls.<br>-She was not aware the two-inch cushion was not in use.<br>-She had received confirmation from the home health therapy provider that services had started on 08/12/23.<br>-She did not have access to the facility's full records and therefore did not have access to home health provider notes.<br>-On 10/05/23 she had ordered 30-minute checks and reposition while the resident was in bed as a potential intervention to help prevent falls.<br>-She was not aware the facility had implemented to use of a recliner chair as a fall intervention but repositioning checks should be done when the resident was seated in any type of chair or while in bed.<br>-The main reason for the repositioning checks was to provide monitoring of concerns related to the resident's posture and weakness which could contribute to an increased fall risk.<br>-She would expect the facility to follow all physician orders or contact her for further | D 270 | | |

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clarification.
-She was not aware the 30-minute checks were not in place.
-The resident had a previous and ongoing history of frequent falls,
-Based on the resident's current health diagnosis of dementia and hemiplegia and physical functioning status the resident was at risk for falls.
-Falls could result in serious physical injury such as head trauma, fractures and increased emotional trauma related to the fear of falling.

Interview with a Personal Care Aide (PCA) on 11/16/23 at 3:45pm revealed:
-She had worked at the facility as a PCA for approximately one year.
-Resident #1 required total assist for all activities of daily living.
-Resident #1 required two staff to assist with transfers.
-Resident #1 was not able to reposition herself safely.
-Resident #1 was not able to communicate her needs.
-Fall interventions for Resident #1 included seating the resident in a recliner chair while the resident was in the facility's Family Room and hourly checks for positioning because that was how a lot of the resident falls occurred.
-She had never seen a cushion on Resident #1's wheelchair.

Interview with a second PCA on 11/16/23 at 3:50pm revealed:
-Resident #1 required total assistance from staff for all activities of daily living.
-Resident #1 required two staff to assist with transfers.
-Fall interventions for Resident #1 included a

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recliner chair while the resident was in the facility's Family Room and hourly checks for positioning because the resident tended to slide out of chairs and fall.
-She had never seen a cushion on Resident #1's wheelchair.

Interview with a day shift MA on 11/17/23 at 8:01am revealed:
-She had worked at the facility over three months.
-When a resident fell the facility's process included placing the resident on alert charting for 72 hours. Alert charting was to be completed every shift and documented in the electronic progress notes and if ordered, vital sign were documented in the EMAR.
-Resident #1 required total assist for all activities of daily living.
-Resident #1 required two staff to assist with transfers.
-Resident #1 was not able to propel herself in her the wheelchair.
-Fall interventions for Resident #1 included a recliner chair while the resident was in the facility's Family Room.
-Staff provided hourly checks for positioning and repositioned the resident if she was slumped to the side or sliding down or out of the chair because the resident tended to slide out of chairs and fall.
-She had never seen a cushion on Resident #1's wheelchair.

Telephone interview with a night shift MA on 11/17/23 at 2:32pm revealed:
-Resident #1 required full assistance from staff for activities of daily living.
-Resident #1 required two staff to assist with transfers.
-Resident #1 was not able to reposition herself

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and tended to slide out chairs and bed.
-Fall interventions for Resident #1 were seating the resident in a recliner chair when she was in the family room and the resident had an order for hourly checks.
-The facility staff had been using the recliner in the family room as a fall intervention for approximately two months,
-When the resident was in bed staff checked on the resident at least every hour because that was the order on the eMAR.
-The resident previously had an order for wheelchair cushion, but it had been discontinued several months ago and she had not seen another cushion in place on the resident's wheelchair.
-She was not aware of any orders for 30 minute checks when the resident was in bed, she was only aware of the hourly checks as they were documented on the eMAR.

Interview with the Administrator on on 11/16/23 at 6:11pm revealed:
-She was not aware Resident #1 was ordered hourly checks and repositioning..
-She was not aware the hourly checks were documented on Resident #1's eMAR.
-She was not aware Resident #1 was ordered 30-minute check while in bed.

Interview with the Administrator 11/17/23 at 3:10pm revealed:
-When a resident experienced a fall the MAs assessed the resident for injury and need for further treatment or evaluation.
-The MAs notified the resident's responsible party, physician, and facility nurse of all resident falls.
-The MA then completed an incident report and the staff were to complete alert charting each

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shift for 72 hours.
-A post fall evaluation was to be completed by the Health and Wellness Coordinator or Health and Wellness Director after each fall.
-Fall interventions for Resident #1 included 72 hour alert charting, physical therapy and use of a recliner chair in the facility's family room.
-She was not aware post fall evaluations had not been completed after Resident #1's fall.
-She was not able to locate incident reports for Resident 1's falls that occurred on 06/06/23 and 07/23/23.
-She was not aware of the order for Resident #1 to have a two-inch wheelchair cushion.

Interview with the Regional Clinical Support Nurse on 11/16/23 at 6:11pm
-She was not aware Resident #1 was ordered hourly checks and repositioning..
-She was not aware the hourly checks were documented on Resident #1's eMAR.
-She was not aware Resident #1 was ordered 30-minute check while in bed.

Refer to the interview with the Administrator dated 11/16/23 at 4:33pm.

Refer to the interview with the Administrator dated 11/16/23 at 6:03pm.

Refer to the interview with the Administrator dated 11/17/23 at 3:27pm.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 3:08pm.

Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 4:28pm.

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| D 270 | Continued From page 36<br><br>Refer to the interview with the Regional Clinical Support Nurse (RCSN) dated 11/17/23 at 4:46pm.<br><br>_____<br>Interview with the Administrator on 11/16/23 at 4:33pm revealed:<br>-The residents were checked based on their needs, for example, if a resident was incontinent, then they were checked every 2 to 3 hours.<br>-Fall risk assessments were performed upon admission only.<br>-If a resident had a fall, the medication aide would evaluate them for injuries and or complaints of pain.<br>-Residents were sent out to the ED if they hit their head and if they complained of pain or had obvious injuries.<br>-Any post fall interventions such as increased frequency of monitoring had to be ordered by the resident's primary care provider (PCP).<br>-The MAs were to implement Alert Charting after each fall as an intervention, which consisted of the MA doing vital signs and a progress note on the resident once a shift for 72 hours.<br>-An example of alert charting would be for the MA to ask the resident if they had any pain or increased pain related to the fall once a shift for 72 hours.<br>-A post fall evaluation was to be done by the Health and Wellness Coordinator (LPN) or the Health and Wellness Director (RN).<br>-A post fall analysis was to be performed after each fall by the nurse but was not been implemented yet.<br><br>2nd Interview with the Administrator on 11/16/23 6:03pm revealed:<br>-Most residents were checked every 2 hours<br>-Some residents were checked every 4 hours. | D 270 | | |

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-Residents may be checked more frequently if the PCP ordered more frequent checks such as every 30 minutes.
-The frequency of how often the residents were checked was based on their needs.

3rd Interview with the Administrator on 11/17/23 at 3:27pm revealed:
-Fall risk assessments were done on admission only.
-She did not do the fall risk assessments.
-The fall risk assessments were done by the facility's nurse.
-She did not know what the fall risk levels were.
-She assumed the fall risk level would be reflected in the resident's care plan.
-Any fall interventions would be documented in the progress notes, or the care plan would be revised.
-The nurse would be responsible for updating the care plan.
-The nurse would be responsible for making recommendations for fall interventions.
-After a fall the MAs assessed the resident and notified the nurse.
-If a resident hit their head or complained of pain, they were sent to the ED.
-The MAs completed the I/A reports.
-After a resident had a fall or returned from the hospital, the MAs were supposed to do alert charting, doing vital signs and a progress note once a shift for 72 hours.
-She expected the MAs to do alert charting after each fall.
-She expected the residents to be supervised based on their level of need.

Interview with the Regional Clinical Support Nurse (RCSN) on 11/17/23 at 3:08pm revealed:
-She was responsible for providing clinical

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support to the facility.
-She assumed most of the responsibilities of the facility Health and Wellness Director (HWD) in the absence of the HWD.
-She and the Administrator were currently sharing the responsibilities of the HWD.
-The HWD position at the facility was currently vacant.
-She thought the HWD position had been vacant for about one month.
-The HWD could assign interventions after a fall such as physical therapy, occupational therapy, scoot mattress for bed, fall matts, 1:1 monitoring, and increased supervision.
-Fall interventions could be documented on the resident care plan or handwritten on the resident care plans.
-There was a follow-up section on the incident/accident report (I/A) for documentin fall interventions.
-She did not know why there had not been any interventions documented on the resident I/A reports.

Interview with the Regional Clinical Support Nurse (RCSN) on 11/17/23 at 4:28pm revealed:
-She thought any resident identified as a Level 3 fall risk meant the resident was high risk for falls.
-There probably should be interventions in place for a Level 3 fall risk resident because the resident would be high risk for falls.
-Resident fall risk interventions could be documented on the resident's care plan.
-A fall risk evaluation was only done on admission.
-A post fall evaluation was duplicated information from an I/A report that was documented in the resident progress notes.
-The MAs completed and documented the post fall evaluation.

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| D 270 | Continued From page 39<br>-A post fall analysis was completed by the facility HWD nurse who entered fall interventions.<br>-The facility had not started doing post fall analysis.<br>-She did not know why post fall analysis had not been started at the facility.<br><br>Interview with the Regional Clinical Support Nurse on 11/17/23 at 4:46pm revealed:<br>-MAs were supposed to complete an incident report in the electronic medical records system for all falls.<br>-The MAs were supposed to complete the post fall evaluation in the electronic medical records system, and the information was pulled over from the incident report.<br>-If the fall resulted in injury the facility's HWC or HWD then completed a post fall analysis which would include potential interventions.<br>-The previous HWC and HWD had not been documenting interventions in the follow-up section of the Incident Reports.<br>-The facility was not able to locate any post fall evaluations or post fall analysis for the sampled residents who had falls.<br>-The forme HWC and HWD should have been ensuring the post fall evaluations and post fall analysis were completed after falls.<br><br>_____<br>The facility failed to provide adequate supervision for 3 of 4 sampled residents (#1, #2 and #4). The facility's failure to supervise Resident #1, who was identified as a fall risk, resulted in 8 falls in a 6 month period and Resident #2, who had identified supervision needs for falls and wandering behavior resulted an elopement and 6 falls in a one-month period, one of which resulted in a non-displaced femur fracture and Resident #4 who was identified as a fall risk, resulted in 6 falls in 4 month period, the last fall resulted in a | D 270 | | |

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| D 270 | Continued From page 40<br>fractured hip that required hospitalization and surgical repair. The facility's failure resulted in substantial risk of serious injury and constitutes a Type A2 Violation.<br>_____<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/16/23 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2023. | D 270 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, it was determined the facility failed to ensure implementation of orders for 1 of 3 sampled residents (#1) whose orders for fall interventions were reviewed. Findings include but are not limited to:<br><br>Review of Resident #1's current FI-2 dated 08/16/23 revealed:<br>-The resident was admitted to the facility in November 2020.<br>-The residents diagnosis included cerebral ischemia and hypertension. | D 276 | | |

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-The resident was non-ambulatory.
-The resident required assistance with bathing, dressing and incontinent care.
-The resident was constantly disoriented.

Review of Resident #1's Personal Service Plan dated 09/27/23 revealed the resident was totally dependent on staff to provide assistance for the following activities of daily living (ADL): dining, toileting, ambulation/locomotion. bathing, dressing, personal hygiene, grooming and transferring.

Review of Resident #1's Fall Risk Assessment dated 09/26/21 revealed:
-The resident was considered a "Level 3 Fall Risk"
-Risk factors for falls included the resident's diagnosis of dementia, the resident was unaware of own safety, the resident used a manual wheelchair, and the resident required total assistance from staff for transfers, ambulation, ADLs and toileting.

No additional Fall Risk Assessments or Fall Risk Evaluations were available for review.

Review of Resident #1's primary care provider (PCP) orders dated 07/12/23 revealed:
-There was an order to discontinue a four-inch wheelchair cushion.
-There was an order for a two-inch wheelchair cushion.

Review of Resident #1's PCP orders dated 10/05/23 revealed there was an order for 30-minute checks when in bed and reposition if needed.

Review of Resident #1's Electronic Medication

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| D 276 | Continued From page 42<br><br>Administration Record (eMAR) dated 09/01/23 through 09/16/23 revealed:<br>-An entry for a two-inch wheelchair cushion was not documented on the eMAR.<br>-An entry for 30-minute checks when in bed and reposition if needed was not documented on the eMAR<br><br>Attempted to reach Resident #1's PCP via phone on 11/17/23 and left a voicemail left at 9:04am.<br><br>Resident #1's PCP returned the call on 11/20/23 at 10:11am and the telephone interview revealed:<br>-The resident had a diagnosis of dementia and spoke a language other than English which made communication difficult.<br>-The resident had a diagnosis of left hemiplegia which contributed to left sided weakness.<br>-The resident was not able to safely reposition herself.<br>-The four- inch wheelchair cushion had been discontinued as staff felt it may have been increasing the resident falls.<br>-The two-inch wheelchair cushion had been ordered to aid in positioning and increased the resident's comfort so she was not trying to reposition herself in an unsafe manner which could result in a fall from the wheelchair.<br>-The PCP was not aware the two-inch cushion was not in use.<br>-The resident had a previous and an ongoing history of frequent falls<br>-She had ordered 30-minute checks and reposition while the resident was in bed as a potential invention to help prevent falls.<br>-She would expect the facility to follow all physician orders or contact her for further clarification.<br>-She was not aware the 30-minute checks were not in place | D 276 | | |

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| D 276 | Continued From page 43<br>-Based on the resident's current health diagnosis of dementia and hemiplegia and physical functioning status the resident was at risk for falls.<br>-Falls could result in serious physical injury such as head trauma, fractures and increased emotional trauma related to the fear of falling.<br><br>Interview with a Personal Care Aide (PCA) on 11/16/23 at 3:45pm revealed:<br>-She had worked at the facility as a PCA for approximately one year.<br>-Resident #1 required total assistance for all activities of daily living.<br>-Resident #1 required two staff to assist with transfers.<br>-Resident #1 used a manual wheelchair but the resident was not able to propel self so staff provided assistance for mobility.<br>-Fall interventions for Resident #1 included hourly checks for positioning because that was how a lot of the resident's falls occurred.<br>-Resident #1 was not able to reposition herself safely.<br>-Resident #1 was not able to communicate her needs.<br>-She had never seen a cushion on Resident #1's wheelchair.<br><br>Interview with a second PCA on 11/16/23 at 3:50pm revealed:<br>-Resident #1 required total assist for all activities of daily living.<br>-Resident #1 required two staff to assist with transfers.<br>-Fall interventions for Resident #1 included hourly checks for positioning because the resident tended to slide out of chairs and fall.<br>-She had never seen a cushion on Resident #1's wheelchair. | D 276 | | |

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| D 276 | Continued From page 44<br><br>Interview with a day shift MA on 11/17/23 at 8:01am revealed:<br>-She had worked at the facility for over three months.<br>-Resident #1 required total assistance from staff for all activities of daily living.<br>-Resident #1 required two staff to assist with transfers.<br>-Resident #1 used a manual wheelchair but she was not able to propel self in her the wheelchair.<br>-Staff provided hourly checks for positioning and repositioned the resident if she was slumped to the side or sliding down or out of the chair because the resident tended to slide out of chairs and fall.<br>-She had never seen a cushion on Resident #1's wheelchair.<br><br>Telephone interview with a night shift MA on 11/17/23 at 2:32pm revealed:<br>-Resident #1 required full assistance from staff for activities of daily living.<br>-Resident #1 required two staff to assist with transfers.<br>-Resident #1 was not able to reposition herself and tended to slide out chairs and bed.<br>-Fall interventions for Resident #1 were seating the resident in a recliner chair when she was in the family room and the resident had an order for hourly checks.<br>-When the resident was in bed staff checked on the resident at least every hour because that was the order on the EMAR.<br>-The resident previously had an order for wheelchair cushion, but it had been discontinued several months ago and she had not seen another cushion in place on the resident's wheelchair.<br>-She was not aware of orders for 30-minute | D 276 | | |

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checks when the resident was in bed, she was only aware of the hourly checks as they were documented on the eMAR.

Observations of Resident #1 made on 11/16/23 from 3:40pm to 4:53pm revealed:
-The resident was seated in a recliner in the facility's family room.
-The resident's wheelchair was placed next to the recliner.
-There was no cushion in place on the resident's wheelchair.
-At 4:54 staff transferred the resident to her wheelchair. No cushion was in place on the wheelchair.

Observation of Resident #1 on 11/17/23 at 8:15 am revealed:
-The resident was seated in the Family Room in a recliner.
-The residents wheelchair was placed next to the recliner, there was no cushion observed on the seat of the wheelchair.
-Staff transferred the resident from the recliner to the wheelchair and pushed the wheelchair into the dining room for breakfast. No wheelchair cushion was in use.

Interview with the Administrator on 11/16/23 at 3:10pm revealed:
-The facility's process for implementing orders was:
-The MA reviewed the order upon receipt.
-The MA faxed the order to the pharmacy or supplier.
-The MA entered the order into the facility's (eMAR).
-The facility had a tracking system to show the progress of orders.
-The tracking system was reviewed by the Health

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| D 276 | Continued From page 46<br>and Wellness Coordinator or Health and Wellness Director.<br>-In the absence of a Health and Wellness Coordinator or Health and Wellness Director, the Administrator would assume those responsibilities.<br>-The facility's former Health and Wellness Coordinator and Health and Wellness Director had left those positions approximately a month prior.<br>-She was not aware Resident #1 was ordered a two-inch wheelchair cushion.<br>-She knew the former Health and Wellness Director had been working the physician to discontinue the four-inch wheelchair cushion, but she was not aware of the orders for a two-inch wheelchair cushion.<br>-She was not aware the wheelchair cushion for Resident #1 had not been implemented.<br>-She was not aware Resident #1 was ordered 30-minute checks while in bed.<br>-She was not aware Resident #1's order for 30-minute checks while in bed had not been implemented.<br><br>Interview with the Regional Clinical Support Nurse on 11/16/23 at 6:11pm revealed:<br>-She was not aware Resident #1 was ordered 30-minute checks while in bed. | D 276 | | |