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TERRABELLA SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Brunswick County Department of Social Services conducted an annual survey and complaint investigation on 11/29/23 and 11/30/23. The complaint investigation was initiated by the Brunswick County Department of Social Services on 11/09/23.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 residents sampled (Resident #2) were tested upon admission for tuberculosis (TB) disease. The findings are: 1. Review of Resident #2's current FL-2 dated 06/01/23 revealed diagnoses included abnormalities of gait and mobility, myasthenia gravis, bladder dysfunction, neuromuscular dysfunction of bladder, fracture of left fibula, and generalized muscle weakness.	D 234		

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Review of the Resident Register for Resident #2 revealed there was an admission date of 05/08/23.

Review of Resident #2's record for a tuberculosis (TB) skin test revealed:
-There was documentation of a TB skin test administered on 04/22/23 and read as negative, but no date read was provided.
-There was no documentation of a second TB skin test for Resident #2.

Interview with the Director of Health and Wellness (DHW) on 11/30/23 at 11:16am revealed:
-The Resident #2 was admitted to the facility from another facility, so she was sure the Resident #2 had the 2 step TB skin test.
-She could not locate Resident #2's complete 1st step TB skin test.
-She could not locate Resident #2's complete 2nd step TB skin test.

Second Interview with the DHW on 11/30/23 at 5:23pm revealed:
-She was responsible for making sure the residents had the 2 step TB skin tests.
-She was hired at the facility as of 08/01/23.
-She did not receive any formal training upon hire except for going to a sister facility for 2 days.
-She had not done a full chart audit for Resident #2.
-There was no schedule for resident chart audits.
-The previous nurse would have been responsible for making sure Resident #2 completed the 2 step TB skin tests.
-She was not sure who was responsible for chart audits.

Interview with the Executive Director (ED) on 11/30/23 at 6:00pm revealed:

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D 234	Continued From page 2 -She did not audit residents' admission paperwork for TB compliance. -The facility's Nurse (DHW) was responsible to ensure all residents received 2 TB skin tests upon admission. -Resident #2 should have had a 1st step TB skin test prior to moving in and a 2nd step TB skin test administered by the nurse (DHW) after admission to the facility. -She did not know why the facility's previous nurse did not make sure Resident #2 had the required 2 step TB skin test.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure the personal care needs were met for 1 of 5 sampled residents (#5), a memory care resident who required monitoring and assistance for showering. Review of Resident #5's FL-2 dated 06/19/23 revealed: -Diagnoses of Alzheimer's disease, primary hypertension, and anxiety. -Resident #5 required special care unit (SCU) placement. -Resident #5 was constantly disoriented and	D 269		

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required assistance with bathing.

Review of Resident #5's Resident Assessment and Care Plan dated 06/15/23 revealed Resident #5 was disoriented and needed reminders and assistance for showering.

Review of Resident #5's Licensed Health Professional Support assessment dated 10/06/23 revealed:
-Resident #5 was confused and spoke with a "salad mixture that had no meaning".
-Staff were to assist Resident #5 with her showers and to observe her skin on shower days.

Interview with the Memory Care Director (MCD)on 11/29/23 at 9:45am revealed:
-She was a Licensed Practical Nurse hired and began working as the MCD about three weeks earlier.
-She was somewhat familiar with the forms staff were using to document the personal care services of the SCU residents.
-Showers were to be documented on each resident's Personal Care Logs (PCL's) and on the Skin Assessment Shower Sheet (SASS) forms for completed showers.
The PCL's and SSAS's were kept in two separate binders, with the PCL binder kept at the SCU desk and the SSAS binder kept in the office of the Director of Health and Wellness (DHW) on the Assisted Living side of the building.
-The PCL and SSAS log books were currently a bit disorganized but she was working to get them in order so that it would be easier to review the completed forms to track personal care tasks.
-As far as she knew, Resident #5 has been getting her scheduled showers.
-If any resident refused a shower after at least two or three staff had asked them, the staff were

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supposed to try again the next day.
-She did not know how refusals were viewed for SCU residents with cognitive conditions, but if a resident refused a shower, they tried to honor the request to protect the resident's rights.
-She did not think the staff ever requested assistance from family members if a resident refused to shower but it might be because the family members of the SCU residents were rarely involved and seldom visited the SCU residents.

Review of Resident #5's SCU PCL and SSAS log books for October and November 2023 revealed:
-Resident #5's scheduled shower days were two times weekly on Wednesday and Saturday.
-Resident #5 did not receive a shower from 10/01/23 through 10/10/23 and there was one documented attempt by staff on 10/04/23 with a PCL entry of "refused".
-Resident #5 did not receive a shower from 10/15/23 through 10/24/23 and there was two documented attempts by staff on 10/18/23 and 10/21/23 with PCL entries of "refused".
-Resident #5 did not receive a shower from 10/29/23 through 11/10/23 and there were two documented attempts by staff on 11/01/23 and 11/08/23 with SSAS entries of "refused".
-Resident #5 did not receive a shower from 11/12/23 through 11/24/23 with one documented attempt by staff on 11/22/23 with a PCL entry of "refused".

Interview with a first shift Medication Aide (MA) on 11/29/23 at 10:25am revealed:
-Both Personal Care Aides (PCA's) and MA's were responsible for ensuring SCU residents received their scheduled showers.
-If any resident refused a shower with a PCA, the

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PCA was supposed to try multiple times and if unsuccessful, they were to ask an MA or the Resident Care Director (RCD) for assistance.
-She did not remember if she had been asked recently to assist with getting Resident #5 to shower.
-Any attempts to give a shower to Resident #5 should be documented on her PCL, but if it was not there, some staff might have put it on a SASS instead.
-If efforts to shower Resident #5 on her scheduled shower days were unsuccessful, the PCA's should have tried again the next day if their shower schedule was not too heavy.
-It was difficult to quickly track if a resident had a shower without going back and reviewing old shower logs, which were not always in order.
-There might have been times that Resident #5 refused her shower, and another effort was not made by staff until the next scheduled shower day.
-She did not think any staff had contacted Resident #5's responsible party to try to assist with persuading her to get a shower.

Interview with a first shift personal care aide (PCA) on 11/30/23 at 12:38pm revealed:
-Resident #5's scheduled shower days were Wednesdays and Saturdays.
-Resident #5 did refuse showers sometimes.
-If Resident #5 refused a shower on her shower day, she would let her go and rest a while in an effort not to argue with the resident about her refusal, and after the resident rested, she would go and ask her again.
-If Resident #5 still refused to get a shower, sometimes the next shift would attempt to shower her.
-Any staff who offered Resident #5 a shower would have documented on the PCL, one for

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each shift, to specify if the resident's shower was completed or if she refused.
-If Resident #5 did not get a shower on her scheduled shower day, the only way the staff working on the next day would know, was if they reviewed the shower sheet logs from the previous day.
-Staff did not usually go back and review shower logs from previous days.
-An intervention when a resident refused to shower could be to call their family to try to come and convince them to shower.
-She did not remember ever calling Resident #5's family to come and assist with getting her to shower but any intervention by any staff member should be written on her PCL or SSAS.

Interview with a second first shift PCA on 11/30/23 at 12:43pm revealed:
-She did not have an issue with getting Resident #5 to cooperate on her shower days.
-She worked as a PCA in the SCU regularly.
-She did not know there were long periods in October and November 2023 when Resident #5 did not get a shower.
-The only way to track if Resident #5 did not get her scheduled shower on her scheduled shower days was to review the previous personal care logs kept in a binder at the SCU desk.
-Most staff did not look back at the previous PCL's.
-PCL's could also be cross-referenced with Resident #5's SASS form in case a staff provided a shower and forgot to log in on Resident #5's PCL.
-The binder with the SASSs was kept on the Assisted Living side of the building in the office of the Director of Health and Wellness.
-Sometimes staff might mention to oncoming staff if a resident refused their scheduled shower, but it

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was just a verbal exchange and the next shift was not required to provide the missed shower.
-Interventions for refused showers were supposed to include getting three different staff to try to persuade the resident at a different time within the shift and it was called a "three-person rule" and would include any of the PCAs or Medication Aides.
-If the three-person rule did not work, another intervention would be to enlist the assistance of the MCD, the DHW, the RCC, or the Executive Director (ED).
-Anytime Resident #5 was offered a shower, it should be documented on the PCL that the resident was given a shower or refused and on the SASS after completion of a shower.
-Staff were supposed to share ideas about what techniques worked best for getting Resident #5 to shower.
-If a staff walked up to Resident #5 and asked, "Do you want a shower?", the resident was always going to say "No".
-Staff should have approached Resident #5 and invited her to come with them, without making a big announcement about the shower.
-If any other staff had asked her for assistance with showering Resident #5, she would have given them advice about getting Resident #5 to cooperate with showering, but she did not remember being asked recently.
-There was not a good way for PCAs to easily track how many showers Resident #5 had refused within a period of time.
-Shower refusals were not supposed to be acceptable for Resident #5, because she had dementia and did not understand her decisions.

Interview with the DHW on 11/30/23 at 1:31pm revealed:
-She did not know Resident #5 had not been

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receiving her showers as scheduled or that there had been missed showers for extended periods.
-None of the staff had asked for her assistance in getting Resident #5 to shower.
-There was a morning staff meeting each day that included all leadership staff, and various topics involving residents were discussed, but shower refusals were not one of the topics.
-The RCC had instructed the SCU aides to have at least three different staff to try working to get residents to shower if the resident still refused, included among the staff they could ask for help would be herself, another PCA, the MCD, a MA, the ED, or the RCC.
-Any efforts to shower Resident #5 would be documented on her PCL.
-Anytime a shower was completed, it was to be documented on the SASS.
-She had not been asked by any staff to help with getting Resident #5 to shower.
-As far as she knew, family members were not notified when a resident was consistently refusing personal care such as showers.
-Other than consistently asking the resident to shower, she did not know of any additional interventions by staff.
Interview with the RCC on 11/30/23 at 11:15am revealed:
-On days when Resident #5 refused a shower, the PCA's should have tried again within the same day and had been directed to request assistance from her, the MA, the HWD, the ED, or any other staff who might have had success with getting the resident to accept a shower.
-If the staff were unsuccessful in giving Resident #5 her shower on her scheduled shower day, she should have been added to the next day's schedule.
-If Resident #5 did not receive a shower for so many days that it circled around to her next

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scheduled shower day, the MCD should notify the family.
-As far as she knew, Resident #5's responsible party had not been contacted but he worked a lot and was not someone who was very comfortable helping to address things like that for Resident #5.
-The only way staff would know how many days it had been since Resident #5 received a shower, would be for them to review the previous shower logs.
-She did not know if Resident #5's family had been contacted.

Interview with the Executive Director on 11/30/23 at 3:10pm revealed:
-The facility did not have a written policy or procedures for personal care services or shower refusals, it was more of a verbal best practices type of thing.
-She did not know there had been extended periods of time in which Resident #5 did not get a shower.
-If Resident #5 had been refusing showers, her expectation was for the aides to try again sometime later in the day, or maybe the next day, and to ask another staff member to try and all efforts should have been documented by staff on the PCLs.
-She was aware that Resident #5 could be difficult and was not easily persuaded when her mind was made up because she had heard different staff discuss it.
-She did not remember the exact conversations or when they were, just generally speaking.
-Staff had asked her to assist with different things for difficult residents but she did not remember being asked to help with getting Resident #5 to shower.

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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: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2), who sustained 4 falls in 2 months. The findings are: Review of the facility's Fall Management Program dated 06/2022 revealed: -Team members will be educated on the fall management policy that is aimed at identifying and mitigating fall risks. -This policy provided guidance on mitigation when a resident had a fall and injured themselves from falls. -It provided a definition of what was considered a fall. -Fall risk assessments occur during pre-admission, upon admission, 30 days post admission, every 6 months or quarterly if required by state regulations, upon change of condition, and after each fall. -The fall risk assessment is part of the resident's record. -Interventions were to be established and documented on the service plan.	D 270		

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D 270	Continued From page 11 -Team members were to receive notice of updated assignments based on the service plan. -Conduct a review of the fall incident as soon as practical after the resident is stable and the outcome of this review was to identify measures to prevent future falls and injury. The care plan/service plan was to be updated with new interventions appropriate for the resident's cognitive level and relative to the conditions involving the fall. -A new intervention must be developed for each fall, or a determination made that current interventions were appropriate using root cause analysis to identify potential areas that may have led to the fall. -Notify direct care team members of the fall and changes made to the care plan/service plan interventions as applicable. -The resident was to be placed on the 24-hour report and inform the Executive Director or designee so they could review. -Team members would be trained on the fall management program and policies upon hire and annually. -When a resident has more than one fall in any rolling 30-day period, the resident, family and/or responsible party should have a meeting with the Director of Health and Wellness (DHW) or designee to discuss and implement the Negotiated Risk Agreement, if appropriate. -Falls were to be monitored as a quality indicator. Review of Resident #2's current FL2 dated 06/01/23 revealed: -Diagnoses included abnormalities of gait and mobility, myasthenia gravis, bladder dysfunction, neuromuscular dysfunction of bladder, fracture of left fibula, and generalized muscle weakness. -The resident was documented as constantly disoriented.	D 270		

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D 270	Continued From page 12 -The resident was documented as semi-ambulatory requiring a wheelchair -The resident required assistance with bathing and dressing. -The resident was documented as having an indwelling urinary catheter. Review of the Resident Register for Resident #2 revealed: -The resident was admitted to the facility on 05/08/23 from her own residence. -The resident was forgetful and needed reminders. -The resident used a hearing aid. -The resident used a motorized scooter for ambulation. Review of Resident #2's care plan dated 06/01/23 revealed: -The resident was ambulatory with the aid of a wheelchair due to muscle weakness. -The resident had limited upper extremity strength. -The resident had a urinary foley catheter. -The resident required a one person assist for toileting to clean and empty the urinary catheter. -The resident required extensive assistance with bathing. -The resident was independent with ambulation and transferring. -The resident could transfer herself from the bed to her wheelchair and could transfer herself from the wheelchair to the commode. Review of Resident #2's Service Description dated 8/30/23 revealed: -The resident had short-term memory loss. -The resident required stand-by assist for showers. -The resident used an electric scooter.	D 270		

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-The resident was independent in mobility.
-The resident required stand-by assist with transfers.
-The resident was observed transferring successfully without assistance but was recommended to have stand-by assist for showering.
-The resident took medications that could decrease coordination, cause drowsiness, lethargy and other side effects that could increase fall risk.

a. Review of Resident #2's Accident/Injury (A/I) report dated 09/16/23 at 8:00pm revealed:
-The resident was found on the floor in front of her bed.
-The resident stated that her electric wheelchair ran out of control and knocked her down as she was transferring from the bed to the wheelchair.
-The resident's catheter hose was wrapped around the wheelchair controller causing it to get stuck in forward and pulled the resident's catheter out.

Review of Resident #2's handwritten progress notes dated 09/16/23 revealed:
-There was an entry at 8:00pm that the resident was found on the floor in front of her bed.
-Resident said her electric wheelchair ran out of control and then knocked her down as she was trying to transfer from her bed.
-The resident's catheter hose was wrapped around the wheelchair controller and was stuck in forward.
-The electric wheelchair was against a table, still hung up with the wheels moving in place.
-The incident pulled the resident's catheter out.
-The resident had no visible injuries and said she was ok.
-The resident said she did not hit her head and

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did not want to go to the emergency department (ED).
-The home health (HH) agency was notified that the resident's catheter needed to be replaced and was waiting for a call back from the registered nurse (RN).
-The primary care provider (PCP) was notified, and a message was left for the responsible party (RP).
-Vital signs were blood pressure (BP) 130/70, pulse 68, respirations 18, temperature 98.0 and will keep check on the resident.
-There was an entry at 8:45pm that the HH RN called back and said she would come first thing in the morning to replace the resident's catheter.

Review of Resident #2's handwritten progress notes dated 09/17/23 revealed:
-There was an entry at 11:15am that the HH RN came to see the resident and replaced her catheter.
-There was an entry at 10:30pm that resident stated she has been fine today with no issues or concerns as a result of the fall last night, will continue to monitor.
-There were no fall risk interventions documented for Resident #2.

b. Review of Resident #2's A/I report dated 09/30/23 at 12:15am revealed:
-The resident was in her room.
-The resident was observed sitting on the floor in front of her wheelchair and recliner.
-The resident stated she slid while transferring from her recliner to her wheelchair.
- The type of fall was documented as found on the floor unwitnessed.
-The PCP was notified via fax at 2:06am.
-Resident #2's RP was notified via text at 12:36am.

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-Vital signs were documented, BP 105/57, pulse 82, and respirations 21.

Review of Resident #2's handwritten progress notes dated 09/30/23 at 12:15am revealed:
-The resident was in her room
-The resident had an unwitnessed fall.
-The resident was observed sitting on the floor in front of her wheelchair and recliner.
-The resident stated she slid while transferring from her recliner to her wheelchair.
-The resident had no bruising, bleeding, or skin tears at this time.
-The resident had no complaints of pain at this time.
-The PCP and the RP were notified.
-Vital signs were BP 105/57, pulse 82, and respirations 21.

Review of Resident #2's handwritten progress notes dated 10/01/23 revealed:
-There were no handwritten progress notes for the day shift on 10/01/23.
-There was an entry at 11:00pm that the resident voiced no complaints from the previous fall noted above.
-The resident was reminded to page for staff to come and assist her due to recent falls.

c. Review of Resident #2's A/I report dated 10/04/23 at 7:30pm revealed:
-The resident was found in her room.
-The resident had an unwitnessed fall.
-The resident was found sitting on the floor in her room in front of her recliner, the resident stated that she slid while transferring from her wheelchair to her recliner.
-Vital signs were BP 118/60, pulse 84, and respirations were 20.
-The PCP was notified via fax at 11:48pm.

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-A voice mail was left for the RP at 7:41pm.

Review of Resident #2's handwritten progress notes dated 10/04/23 revealed:
-There was an entry at 7:30pm, the resident had an unwitnessed fall.
-The resident was observed sitting on the floor in front of her wheelchair and recliner.
-The resident stated she slid while transferring from her wheelchair to her recliner.
-The resident had no bleeding, bruising, or skin tears at this time.
-The resident had no complaints of pain at this time.
-The residents PCP and RP were notified.
-Vital signs were documented as BP 118/60, pulse 84, and respirations were 20.

Review of Resident #2's record revealed there were no handwritten progress notes for 10/05/23.

Review of Resident #2's record revealed there were no handwritten progress notes for 10/06/23.

Review of Resident #2's PCP visit notes dated 10/05/23 revealed:
-Chief complaint: fall while transferring.
-The resident had a fall while transferring from her recliner to her power chair this week.
-This is the third or fourth fall she's had while transferring over the previous several weeks.
-The resident was agreeable to physical therapy (PT) and occupational therapy (OT) referral.

Review of Resident #2's handwritten progress notes dated 10/07/23 with no time noted revealed, the resident voiced no complaints from previous fall noted above and is coming to meals.

d. Review of Resident #2's handwritten progress

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notes dated 11/11/23 revealed:
-There was an entry at 11:57am that the resident was observed sitting in her bathroom by her toilet on her bottom.
-The resident stated she did not hit her head.
-The resident had no visible injuries at this time.
-Resident #2's RP was notified at 12:05pm.
-Resident #2's PCP was faxed at 12:17pm.
-There were no other entries on 11/11/23.

Review of Resident #2's handwritten progress notes dated 11/12/23 revealed:
-There was an entry at 10:00pm that the resident voiced no complaints from recent fall.
-There were no other entries on he 11/12/23.

Request for an A/I report was not provided for the documented fall on 11/11/23.

Interview with Resident #2 on 11/30/23 at 9:06am revealed:
-She was not quite sure how long she had been at the facility.
-She had an indwelling catheter for a long time and took care of her own catheter care.
-The home health nurse came out monthly and changed her catheter.
-The facility staff were available when she needed them, but she was independent and took care of herself.
-She used an electric wheelchair.
-She denied having any falls.

Interview with a personal care aide (PCA) on 11/30/23 at 2:46pm revealed:
-There was no set time to monitor the residents, but they were all monitored frequently.
-If a resident had a fall, the PCAs were notified at shift change and the medication aide (MA) may ask them to check on the resident more

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D 270	Continued From page 18 frequently. -This would involve more frequent checks on the resident and she would remind them to use their call pendant for assistance. -Resident #2 was very independent and had to be reminded to call for assistance. -She knew Resident #2 had some falls but was not sure how many or how long ago. Interview with the MA on 11/30/23 at 2:20pm revealed: -After a resident fell, the MA assessed them for injuries. -The resident would be sent to the Emergency Department if they hit their head, had visible injuries or complained of pain. -If a resident fell frequently, sometimes a chair or bed alarm would be ordered or a halo for their bed, and they would be sure to keep the resident's door open to their room. -It was up to the nurse,Director of Health and Wellness (DHW) to determine if a resident required increased monitoring. -The nurse could order every 1-hour monitoring, if every one-hour monitoring was ordered, there was a form that the PCAs signed off that they checked the resident every hour. -She thought Resident #2 received PT/OT for a while after her falls. Interview with the Resident Care Coordinator (RCC) on 11/30/23 at 2:55pm revealed: -The residents were to be checked every two hours by the PCAs and/or MAs. -If a resident fell, the MAs were to chart on the resident's progress notes each shift for 72 hours. -The MAs notified the nurse of every resident fall. -Any increased monitoring of the residents would be at the discrepancy of the nurse (DHW) and the nurse would be responsible for ordering	D 270		

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increased supervision.
-The nurse could order every 1-hour monitoring, if every one-hour monitoring was ordered, there was a form that the PCAs signed off that they checked the resident every hour.
-She was unsure of any interventions put in place for Resident #2 after her falls.
-Any fall interventions for Resident #2 were determined by the nurse or PCP.

Interview with the Director of Health and Wellness (DHW) on 11/30/23 at 4:53pm revealed:
-She was a Registered Nurse.
-She had been employed with the facility since 08/01/2023.
-The fall risk assessments were done on admission only if deemed a fall risk such as using an assistive device or history of falls and repeated in 30 days, then repeated in 6 months or a year.
-Fall risk assessments could be repeated if the resident had a change in condition or a fall.
-Examples of interventions for falls were chair alarms, bed alarms, PT, OT, reminder signs to use pendant to call for help, discuss with family possibility of hiring a sitter.
-There was no increased monitoring for residents in the Assisted Living side because they had call pendants.
-She was not aware of the one-hour monitoring sheets.
-The MAs documented on the residents' handwritten progress note each day for 3 days after a fall.
-This documentation included asking the resident if they had pain or changes since their fall.
-She was not familiar with the facility's fall policy dated 06/2022 as far as implementing interventions after each fall.
-She did not reassess Resident #2 for fall risk

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after each fall.
-She had not performed a root cause analysis for Resident #2's falls.
-She had observed Resident #2 transfer successfuly without assistance previously but was not sure how long ago.
-Resident #2 received PT and OT in October 2023.
-Resident #2's care plan/service plan was not updated after each fall to reflect new interventions.
-She did not realize she was responsible for implementing interventions after each residents' falls and to update the residents' care plans to reflect the interventions.
-She had not implemented any fall prevention interventions for Resident #2.

Interview with the Administrator on 11/30/23 at 6:00pm revealed:
-Fall interventions were ordered by hospice, PCP, or the nurse (DHW).
-The residents were monitored based on their needs, there was no set frequency of monitoring.
-PT and OT were ordered for Resident #2 in October 2023 but was not aware of any additional fall prevention interventions implemented.
-She was notified of falls in the daily stand-up meeting.
-Falls were discussed in Quality Assurance and Quality Improvement Meetings.
-The facility nurse (DHW) and RCC were responsible for implementing interventions for residents after a fall.
-The nurse (DHW) was responsible for notifying the MAs of the interventions implemented.
-The MAs were responsible for notifying the PCAs of the interventions implemented.
-Fall Assessments were done quarterly by the DHW.

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D 270	Continued From page 21 -The DHW was responsible for ordering increased monitoring if needed after a resident fell. -She expected the fall policy to be followed.	D 270		