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	HAL036015	A. BUILDING: _____ B. WING _____	01/05/2024

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BROOKDALE ROBINWOOD	1750 ROBINWOOD ROAD GASTONIA, NC 28054

(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 Gaston County Department of Social Services completed an annual survey from 01/03/24 - 01/05/24.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews the facility failed to provide supervision for 1 of 5 sampled residents related to a resident sustaining 10 unwitnessed falls in two months (Resident #2). The findings are: Review of Resident #2's current FL2 dated 05/23/23 revealed: -Diagnoses included increased ammonia level, intraparenchymal hemorrhage of the brain (a condition when blood collects between the skull and the surface of the brain), obstructive sleep apnea (is a condition when intermittent air flow blockage during sleep), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and cirrhosis of the liver (a chronic liver damage leading to scaring of the liver and liver failure). -She was intermittently disorientated.	D 270		

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-She was semi-ambulatory.
-Her level of care was Assisted Living.

Review of Resident #2's Resident Register revealed an admission date of 03/01/23.

Review of Resident #2's hospital documentation dated 01/03/24 revealed:
-Resident #2 presented to the Emergency Department (ED) for altered mental status.
-Resident #2 frequently fell and had a possible fall on 01/02/24
-Resident #2's computerized tomography (CT) scan revealed a large left-sided subdural hemorrhage (a condition when blood collects between the skull and the surface of the brain).
- Resident #2 underwent emergency surgery, with burr holes (holes made in the skull to relieve pressure on the brain from blood compressing the brain tissue).
-Resident #2 was intubated (a tube placed in the airway) due to emergency surgery and respiratory failure.
-Resident #2 was critically ill and required admission to the Intensive Care Unit.

Review of Resident #2's care plan dated 03/01/23 revealed:
-She required limited assistance with bathing.
-She was independent with eating, toileting, ambulation with an assistive device, dressing, grooming and transfers.

Review of the Facility's Fall Management Policy dated October 2023 revealed:
-Residents who sustain a fall should have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury.
-Resident falls were to be noted into the

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resident's record and entered into the facility's BAIRS (the facility's computer documentation program) system.
-A post fall evaluation is completed after a resident fall, individualized interventions are considered, and the evaluation is a part of the resident record.
-When a fall occurs documentation of the resident's fall/injuries, resident's response, and interventions taken in the facility's Point Click Care (PCC, computer documentation system) progress notes.
-The Service Plan (care plan) is reviewed for potential fall interventions and updated as necessary.
-The fall was to be reviewed in the next stand-up meeting.
-The fall was to be discussed at the next collaborative care review (CCR) meeting.

Review of the facility's Post Fall Evaluation Form revealed:
-There was a section for the Post Fall Evaluation-Initial information which included information about the fall.
-There were care plan interventions available for use to reduce the risk of falls located in the Post fall Evaluation form, section 2.
-An environmental intervention was for clutter to be removed from resident's environment to verify safe walkways.
-A compliance with safety intervention was a recommendation of a sitter and increased frequency of monitoring such as with rounding and life enrichment engagements.
-There were 40 available interventions to choose from.

a. Review of Resident #2's progress notes dated 11/04/23 revealed:

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-A medication aide (MA) documented the resident was found sitting on the floor.
-Resident #2 stated she fell asleep in the recliner and tipped forward and hit her head.
-EMS was called and Resident #2 refused transportation to the hospital for treatment/assessment.

Review of Resident #2's Incident Accident Report revealed dated 11/04/23 revealed:
-A witnessed fall at 4:00pm documented as Resident #2 fell asleep in her recliner, tipped forward hitting her head.
-The Emergency Medical Services (EMS) was called.
-Resident #2 refused transport to the hospital.

Review of Resident #2's Post Fall Evaluation Form dated revealed the was no section 2 completed on the form completed dated 11/04/23.

Review of Resident #2's care plan dated 03/01/23 revealed there was no updated implementation of interventions documented.

Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

b. Review of Resident #2's progress notes dated 11/06/23 revealed:
-A MA documented Resident #2 fell asleep on her recliner and fell forward hitting the front of her head.
-Resident #2 sustained a knot on the right side of her forehead and a scratch on the right side of her forehead and face.
-The EMS was called, and Resident #2 refused transportation to the hospital for treatment/assessment.

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D 270	Continued From page 4 Review of Resident #2's Incident Accident Report revealed there was no report completed for 11/06/23. Review of Resident #2's Post Fall Evaluation Form revealed there was no section 2 completed on the form dated 11/06/23. Review of Resident #2's care plan dated 03/01/23 revealed there was no updated intervention for 11/06/23. Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24. c. Review of Resident #2's progress notes dated 11/14/23 revealed: -The Resident Care Coordinator (RCC) documented Resident #2 fell asleep while eating and fell forward. -Resident #2 stated that she hit her head. -EMS was called and Resident #2 refused transport to the hospital for treatment/assessment. Review of Resident #2's Incident Accident Report revealed there was no report completed for 11/14/23. Review of Resident #2's Post Fall Evaluation Form revealed there was no section 2 completed on the form dated 11/14/23. Review of Resident #2's care plan dated 03/01/23 revealed there was an updated intervention to increase rounds and physical therapy for 11/06/23.	D 270		

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Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

d. Review of Resident #2's progress notes dated 11/25/23 revealed:
-Resident #2 was walking down the hall, lost her balance/footing and fell in the bistro.
-There were no injuries noted.

Review of Resident #2's Incident Accident Report dated 11/25/23 revealed Resident #2 sustained a fall in the hallway with no apparent injury noted.

Review of Resident #2's Post Fall Evaluation Form revealed there was no form completed for a fall dated 11/25/23.

Review of Resident #2's care plan dated 03/01/23 revealed there was no updated intervention for 11/25/23.

Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

e. Review of Resident #2's progress notes dated 12/07/23 revealed:
-A MA documented Resident #2 fell in her room and hit her face and head.
-EMS was called and Resident #2 was transported to the hospital for evaluation.

Review of Resident #2's Incident Accident Report dated 12/07/23 revealed:
-Resident #2 fell in her room and hit her face and head.
-EMS was called and Resident #2 was transported to the hospital for evaluation.

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Review of Resident #2's Post Fall Evaluation Form revealed there was no form completed for a fall dated 12/07/23.

Review of Resident #2's care plan dated 03/01/23 revealed an updated intervention to pick up after her dog and clutter to prevent falls.

Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

f. Review of Resident #2's progress notes dated 12/26/23 revealed:
-The Health and Wellness Director (HWD) documented Resident #2 sustained a fall in her bedroom hallway at 8:15am
-The HWD documented Resident #2 fell in the hallway at 11:30am and complained of hitting her head.
-The HWD documented that the fall at 11:30am Resident #2 there were "physical signs" of a head injury.
-The HWD documented after the first all, the EMS was notified and Resident #2 refused to go to the ED.
-The HWD documented that the fall at 8:15am Resident #2 sustained a nickel sized skin tear on her right lower leg on the outer part.

Review of Resident #2's Incident Accident Report dated 12/16/23 revealed;
-The first fall at 8:15am, Resident #2 fell in the hallway of her room.
-The second fall of the day at 11:30am, Resident #2 fell in the hall.
-Both falls were unwitnessed.
-Resident #2 sustained a skin tear to her right lower leg, bilateral hips and buttocks.
-There was an injury, and no outside treatment

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was administered.

Review of Resident #2's Post Fall Evaluation Form revealed there was no form completed for 2 falls dated 12/16/23.

Review of Resident #2's care plan dated 03/01/23 revealed an updated intervention plan dated 12/16/23 for Resident #2 to use the grab bar in the bathroom while physical therapy was working with Resident #2.

Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

g. Review of Resident #2's progress notes dated 12/17/23 revealed:
-A MA documented Resident #2 was found on the floor in her room.
-Resident #2 stated she lost her balance.

Review of Resident #2's Incident Accident Report dated 12/17/23 revealed:
-At 1:00am, Resident #2 sustained an unwitnessed fall.
-For the body part involved there was a check mark placed beside bilateral knees.
-There was no apparent injury or harm and there was no outside treatment was administered.
-Resident #2 stated she was going to the restroom, lost her balance and went down onto her knees.

Review of Resident #2's Post Fall Evaluation Form revealed there was no form completed for the fall dated 12/17/23 at 1:00am.

Review of Resident #2's care plan dated 03/01/23 revealed an updated intervention on 12/17/23,

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Resident #2 was educated to always use her assistive devices.

Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

h. Review of Resident #2's progress notes dated 12/17/23 revealed:
-At 10:46, MA documented, Resident #2 fell four times in less than 24 hours.
-Resident #2 stated her walker dumped her over and she stated she was dizzy.

Review of Resident #2's Incident Accident Report dated 12/17/23 revealed:
-At 10:15am, Resident #2 sustained an unwitnessed fall at her bedside.
-For the body part involved there was a check mark placed beside her bilateral hip and buttocks.
-EMS was called and Resident #2 was transported to the hospital for treatment/assessment.
-The MA documented this was Resident #2's 4 fall in less than 24 hours.
-Resident #2 stated her walker dumped her over and complained she was dizzy.

Review of Resident #2's Post Fall Evaluation Form revealed an updated intervention on 12/17/23, Resident #2 was educated to always use her assistive devices.

Review of Resident #2's care plan dated 03/01/23 revealed an updated intervention on 12/17/23, Resident #2 was educated to always use her assistive devices.

Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on

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D 270	Continued From page 9 01/05/24. Review of Resident #2 hospitalization records dated 12/17/23 to 12/19/23 revealed: -Resident #2 presented to the hospital for evaluation of chronic dizziness, recurrent falls, chronic in nature and difficulty with ambulation. -The Neurologist documented a very faint area of subdural collection (a serious condition where blood collects between the skull and the surface of the brain) noted on the left side of the brain which appeared to be chronic which could be related to a fall in the past from the MRI of the brain completed on 12/18/23. -Resident #2 was a follow-up appointment with the Neurologist on 01/02/24 at 8:45am. Telephone interview with Resident #2's family member on 01/04/24 at 11:25am revealed the Neurology appointment for 01/02/24 was rescheduled due to transportation issues with the family. i. Review of Resident #2's progress notes dated 01/01/24 revealed A personal care aide (PCA) documented Resident #2 fell at her bedside after losing her footing. Review of Resident #2's Incident Accident Report revealed there was no report completed for a fall on 01/01/24. Review of Resident #2's Post Fall Evaluation Form revealed there was no form completed for a fall on 01/01/24. Review of Resident #2's care plan dated 03/01/23 revealed there were no updated interventions implemented on 01/01/24.	D 270		

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Review of a Facility's frequent rounding sheet revealed the facility did not provide one by exit on 01/05/24.

Interview with a MA on 01/04/24 at 10:55am revealed:
-After a fall if she was there, she was responsible for completing an Incident/Accident Report which included what happened, any injuries, who was notified and if the resident was sent out, which she completed about 5 on Resident #2.
-After a fall, Resident #2's record was placed in the hot box area to remind the MAs to document vital signs and a note was to be completed in the progress notes, as well as to monitor Resident #2 every shift.
-The MAs were responsible for completing the I/A Report and putting it in the HWD's box.
-The HWD was responsible for the Post-Fall Report which was the interventions.
-The staff would be informed about the post fall interventions in the morning stand up.
-The post fall intervention she was told to use on Resident #2 were to remind Resident #2 to ask for help, use her walker, keep her room free of clutter, and to continue monitor Resident #2.
-When she continued to monitor Resident #2, she would check on Resident #2 and just make sure she had not fallen.
-Staff checked on residents every 2 hours which was the policy.
-She checked on Resident #2 during her medication pass and when she was walking down the hall.
-She was not instructed to check on Resident #2 any more frequently than every 2 hours even after falls.
-There was no increased supervision on Resident #2 or a way to document increased rounding.
-The only documentation was in the progress

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notes and that was per shift or with an incident or accident.

Interview with a Home Health (HH) Licensed Practical Nurse (LPN) on 01/03/24 at 10:20am revealed:
-Resident #2 received weekly visits by HH.
-On 01/03/24, she was sending Resident #2 to the hospital for further evaluation because Resident #2 displayed a cognitive decline and dozing off at breakfast.

Interview with a HH Registered Nurse (RN) on 01/04/24 at 10:30am revealed:
-Resident #2 had a change in condition about 4 months ago where Resident #2 dozed off throughout the day.
-Resident #2 would doze off in the middle of a sentence.
-She was concerned about falls many times when she saw Resident #2 during her visits because of Resident #2's cluttered room and dozing off in mid-sentence.
-After every visit she told staff to increase monitoring with Resident #2 especially after a head injury.
-She educated the staff to increase monitoring after a witnessed/unwitnessed fall, with or without a head injury, and look for a change in Resident #2's mental status such as increased dozing off, confusion, and if the staff were unable to get Resident #2 to respond after she dozes off easily.
-The staff were educated to call 911 or her primary care physician (PCP).

Interview with a MA on 01/04/24 at 11:00am revealed:
-Resident #2 fell a lot and there were a lot of head injuries, about 8 head injuries where Resident #2 refused to go to the emergency room

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D 270	Continued From page 12 (ER) 5 out of the 8 times, for further evaluation. -The falls were discussed in the morning stand up and instructions from the HWD were to monitor Resident #2 to see if Resident #2 falls again because all her falls were unwitnessed. -She would document in Resident #2's progress notes and falls or concerns about Resident #2. -There were no instructions to monitor Resident #2 for changes in mental status, increased dozing off, confusion or increased pain, confusion, or any changes out of the normal with Resident #2, after a fall, fall with injury, or back from the hospital. Interview with the HWD on 01/04/24 at 11:15am revealed: -Our policy for rounding on the residents was every 2 hours. -When a fall occurred the MA was responsible for completing an Incident/Accident report which included the date and time of the fall, if the fall was witnessed or not, description of what happened, injuries, notifications to PCP, EMS and if the resident went to the ED for further evaluation. -The MA placed the Incident/Accident report in her box and she and the RCC entered the information into the computer program section one which was the Post Fall Initial report. -She was also responsible for completing section 2 with the interventions used after every fall which made up the Post Fall report. -She was then responsible for adding the interventions to the resident's care plan. -The interventions she used for Resident #2 were to use the call bell and ask for help, keep room clutter free to help prevent falls and to call for staff if feeling dizzy. -There was an intervention to increase the frequency of monitoring by increased rounding that she could have used to monitor Resident	D 270		

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#2's cognitive status after falls, especially after head injuries, but she did not use it, because she did not think to increase supervision to every 15 or 30 minutes, every hour or even one on one supervision.
-There was no increased monitoring document for the staff to use when they completed and type of increased monitoring more than the required 2 hours because the facility did not use rounding sheets.

Telephone interview with Resident #2 family member on 01/04/24 at 11:25am revealed:
-Resident #2 went into surgery on 01/03/24 after arriving at the hospital to repair a brain bleed.
-She was aware Resident #2 fell on 01/01/24 and she was told by the MA that Resident #2 did not have any injuries.
-Resident #2 fell about 10 times in the past 2 months.
-Resident #2 refused a lot of help and tried to maintain as much independence as possible.
-There were no care plan meetings to discuss interventions placed to help decrease the number of falls.
-She was aware of the falls and there were several falls when Resident #2 hit her head.
-She was aware that all Resident #2 falls were unwitnessed and none of the staff recommended were increased supervision to check for mental status changes.

Interview with Resident #2's PCP on 01/04/24 at 2:02pm revealed:
-Starting seeing Resident #2 as a new patient in August 2023.
-Resident #2 fell a lot, about 5 times in the past 2 months with injuries.
-Resident #2 sustained about 3 head injuries with the falls and with Resident #2 not asking for help

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or letting staff know if she fell there could have been other falls.
-She expected there to be increased supervision because it was unknown just how many times Resident #2 fell because all of the falls were unwitnessed, and if she hit her head there was no way to tell unless the increased supervision included monitoring Resident #2 for changes in her mental status such as increased dozing off and the difficulty waking her up, slurred speech, and confusion.
-Increased supervision could lead to a decrease in the amount of falls.
-Resident #2 was at serious risk of a fall because of the increased clutter in her room, increased sleepiness, and dizziness, therefore increased the risk of a fall leading to an increased risk of serious injuries including a head injury which could result in a head injury leading to bleeding on the brain resulting in death.

Interview with the Administrator on 01/04/24 at 2:00pm revealed:
-The MAs were responsible for completing the Incident/Accident form after every fall and give it to the HWD for processing.
-The HWD was responsible for completing the Incident/Accident form in the computer which included the Post Fall report containing interventions put in place after every fall.
-The Post Fall report contained interventions used after every fall.
-One of the interventions was to increase monitoring/rounding which could be used to monitor for signs and symptoms of a head injury, such as confusion, and mental status changes.
-Resident #2 refused to to to the ER after falls even falls with head injuries.
-She was aware that Resident #2 fell a lot because of clutter in her room, increased

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D 270	Continued From page 15 sleepiness and not calling for assistance. -The normal rounding on residents was every 2 hour the staff were required to check in on residents. -She was not aware Resident #2 did not have increased monitoring after falls to decrease the amount of falls and to check for changes in mental status incase there were issues after a head injury. -She was not aware of Resident #2's fall on 01/01/24 until 01/03/24 when the HH Nurse informed her about Resident #2's mental status changes. _____ The facility failed to ensure supervision of resident #2 who sustained 10 unwitnessed falls in two months and 5 of the 10 falls included hitting her head resulting in Resident #2 being hospitalized with a a large left-sided subdural hemorrhage, underwent emergency surgery with burr holes made in the skull to relieve pressure on the brain from blood compressing the brain tissue, and intubated because of respiratory failure and placed in the Intensive Care Unit. The failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2024.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 271		

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D 271	Continued From page 16 Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 5 sampled residents (Resident #2) who sustained a fall and developed mental status changes. The findings are: Review of Resident #2's current FL2 dated 05/23/23 revealed: -Diagnoses included increased ammonia level, intraparenchymal hemorrhage of the brain (a condition when blood collects between the skull and the surface of the brain), obstructive sleep apnea (is a condition when intermittent air flow blockage during sleep), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and cirrhosis of the liver (a chronic liver damage leading to scarring of the liver and liver failure). -She was intermittently disorientated. -She was semi-ambulatory. -Her level of care was Assisted Living.	D 271		

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D 271	Continued From page 17 Review of Resident #2's Resident Register revealed an admission date of 03/01/23. Review of Resident #2's hospital documentation dated 01/03/24 revealed: -Resident #2 presented to the Emergency Department (ED) for altered mental status. -Resident #2 frequently fell and had a possible fall on 01/02/24 -Resident #2's computerized tomography (CT) scan revealed a large left-sided subdural hemorrhage (a condition when blood collects between the skull and the surface of the brain). - Resident #2 underwent emergency surgery, with burr holes (holes made in the skull to relieve pressure on the brain from blood compressing the brain tissue). -Resident #2 was intubated (a tube placed in the airway) due to emergency surgery and respiratory failure. -Resident #2 was critically ill and required admission to the Intensive Care Unit. Review of the Facility's Head Injury Policy dated September 1998 revealed: -After a resident sustains a head injury and displays altered responsiveness or a significant change from prior level/prior observation, call 911. -If no apparent injury or minor bruise, notify the resident's PCP or Home Health provider. -Continue to monitor the resident for 72 hours and if the condition changes to require emergency response, call 911. Review of Resident #2's Incident Accident Report revealed there was no report completed for a fall on 01/01/24.	D 271		

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Review of Resident #2's progress notes dated 01/01/24 at 9:01pm revealed a personal care aide (PCA) documented Resident #2 fell at her bedside after losing her footing.

Review of Resident #2's progress note dated 01/02/24 revealed at 1:17pm, a medication aide MA documented Resident #2 was confused, nodding off every minute or so and would respond sometimes after many times of calling Resident #2's name.

Review of Resident #2's progress note dated 01/03/24 revealed a MA document Resident #2 was sent out to the Emergency Room (ER) due to Resident #2 nodding out, confused and hallucinating.

Interview with a MA on 01/04/24 at 10:55am revealed:
-Resident #2 falls a lot and was nodding off frequently even in mid-sentence.
-Resident #2 was sent out to the hospital before for the nodding off and was sent back stating nothing was wrong.
-On 01/01/24, there was documentation Resident #2 fell but there were no injuries reported.
-On 01/02/24, after lunch, Resident #2 was confused and she documented it.
-She did not document anything more about the confusion because Resident #2 was confused before and sent out to the hospital and sent back and the hospital told us there was nothing wrong.
-On 01/03/24, Resident #2 was sent to the ER and did not know.

Telephone interview with Home Health Licensed Practical Nurse (LPN) on 01/05/24 at 3:00pm revealed:
-On 01/03/24 at 10:00am she arrived at the

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facility and found Resident #2 in the dining room very confused, and talking non-sense.
-Resident #2 displayed bruising to both of her cheeks on her face and her whole face was swollen more than usual.
-She asked the staff if Resident #2 fell recently and was told no.
-Resident #2 was not acting like usual self, confused, dozing off more than usual, like ever second and could not stay awake.
-She tried 5 times by calling out Resident #2's name and shaking Resident #2 shoulders before Resident #2 would respond.
-Resident #2 was having hallucinations and she told Resident #2 and the staff Resident #2 needed to go to the ER.
-After she convinced Resident #2 to go to the ER 911 was called.

Interview with the HWD in 01/04/24 at 4:32pm revealed:
-On 01/01/24, the MA notified her in the evening that Resident #2 fell and there were no injuries.
-Staff were to monitor Resident #2 to see if she was acting normally, as they went by Resident #2's room or during the medication pass.
-Staff were not trained to look for signs and symptoms of a head bleed like headache, confusion, lethargy, pain in the head area, difficulty speaking, and slurred speech.
-On 01/02/24, Resident #2 was confused as documented by the MA in the progress notes.
-She was not aware there was no Incident/Accident report completed when Resident #2 fell on 01/01/24.
-When Resident #2 displayed confusion, increased dozing off and hallucinations after a fall then 911 should have been called.
-She was not aware 911 was not called on 01/02/24 when Resident #2 started acting

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D 271	Continued From page 20 confused. Interview with the Administrator on 01/04/24 at 5:30pm revealed: -She was not aware of Resident #2's fall on 01/01/24. -There should have been an Incident and Accident report completed and monitoring of Resident #2 for 72 hours for signs of confusion or acting differently than normal and then notifying 911. -911 was to be called when Resident #2 fell and no injuries were noted but later developed confusion, not able to wake up easily after calling her name and hallucinating. -She was not aware 911 was not called on 01/02/24 when Resident #2 was confused, hallucinating and unable to stay awake or wake up easily. _____ The facility failed to immediately respond after Resident #2 displayed confusion, nodding off often and would respond sometimes after many times of calling Resident #2's name within 24 hours after an unwitnessed fall resulting in Resident #2 being hospitalized with a a large left-sided subdural hemorrhage, underwent emergency surgery with burr holes made in the skull to relieve pressure on the brain from blood compressing the brain tissue, intubated because of respiratory failure and placed in the Intensive Care Unit. The failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/24 for this violation. CORRECTION DATE FOR THE TYPE A1	D 271		

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D 271	Continued From page 21 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2024.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (Resident #2) related to a missed pulmonologist appointment and not taking a medication prescribed to improve brain function. The findings are: Review of Resident #2's current FL2 dated 05/23/23 revealed diagnoses included increased ammonia level, intraparenchymal hemorrhage of the brain (a condition when blood collects between the skull and the surface of the brain), obstructive sleep apnea (is a condition when intermittent air flow blockage during sleep), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and cirrhosis of the liver (a chronic liver damage leading to scarring of the liver and liver failure). Review of Resident #2's Resident Register revealed an admission date of 03/01/23. Review of Resident #2's hospital documentation	D 273		

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dated 01/03/24 revealed:
-Resident #2 presented to the Emergency Department (ED) for altered mental status.
-Resident #2 frequently fell and had a possible fall on 01/02/24
-Resident #2's computerized tomography (CT) scan revealed a large left-sided subdural hemorrhage (a condition when blood collects between the skull and the surface of the brain).
- Resident #2 underwent emergency surgery, with burr holes (holes made in the skull to relieve pressure on the brain from blood compressing the brain tissue).
-Resident #2 was intubated (a tube placed in the airway) due to emergency surgery and respiratory failure.
-Resident #2 was critically ill and required admission to the Intensive Care Unit.

Review of Resident #2's care plan dated 03/01/23 revealed:
-She required limited assistance with bathing.
-She was independent with eating, toileting, ambulation with an assistive device, dressing, grooming and transfers.

a. Observation of Resident #2's bedroom on 01/03/24 at 11:08am revealed there was a continuous positive airway pressure (CPAP, a machine that used mild air pressure to keep breathing airways open during sleep) machine on Resident #2's bedside table.

Review of Resident #2's primary care physician's (PCP) assessment and plan progress note dated 10/12/23 revealed a referral to pulmonology for further evaluation and management of sleep apnea.

Review of a physician's order sheet dated

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D 273	Continued From page 23 10/12/23 revealed an order to refer to pulmonology. Review of Resident #2's Fax/Physician/Healthcare Provider Order Sheet dated 11/01/23 revealed: -There was a request from the facility for an order for Resident #2 to use the CPAP machine. -There was an order dated 11/02/23 for Resident #2 to use the CPAP machine at bedtime and remove upon wakening in the morning. Telephone interview with Resident #2's Pulmonology Nurse Practioner (NP) on 01/05/24 at 9:00am and 12:25pm revealed: -On 07/05/23, Resident #2 was first seen as a new patient. -On 07/21/23, Resident #2 received a sleep study. -On 08/16/23, Resident #2, who was accompanied by family, was seen in the office for the results of the sleep study and diagnosed with moderate obstructive sleep apnea. -On 08/16/23, the sleep study revealed that during sleep, Resident #2 stopped breathing on an average of 15 times per hour and Resident #2's oxygen saturation levels was less than 90%, 18% of the time. -She wanted Resident #2 to keep her oxygen saturation above 90% all of the time. -On 08/16/23, Resident #2 was ordered a CPAP machine with settings and the order was faxed over to the Durable Medical Equipment (DME) company. -On 08/16/23, Resident #2 and family was instructed to return to the office in 30 to 90 days for a required insurance compliance follow-up an a physician's order sheet containing the follow up order was sent with Resident #2. -Resident #2 did not return to the off for the	D 273		

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required insurance compliance follow-up.
-There were no records related to a re-scheduling of the appointments or any appointments made after 08/16/23.
-If Resident #2 came back for her required follow-up appointment, she would have adjusted the settings based on Resident #2 complaints and compliance of the CPAP at the time.
-Since Resident #2 did not return for the required follow-up appointment, Resident #2 insurance stopped paying for the CPAP machine and Resident #2 was to return the machine to the DME company.
-Resident #2's history of atrial fibrillation and now a diagnoses of obstructive sleep apnea, put her at a severe risk of having a heart attack, stroke and congestive heart failure (CHF) which could lead to death.
-Resident #2's CHF and hypertension (HTN), Resident #2's oxygen saturation dropping below 90% at night, failure to wear the CPAP was a severe risk factor for Resident #2 to have a CHF exacerbation, heart attack or stroke which could lead to death.

Telephone interview with Resident #2's family member on 01/05/24 at 11:25am revealed:
-In August 2023, Resident #2 received a CPAP machine for her obstructive sleep apnea.
-Resident #2 refused to wear the CPAP machine most of the time.
-She was not aware of the follow-up appointment 30 to 90 days after the August 2023 appointment.
-She was not aware if the facility took Resident #2 for the 30 to 90 day follow-up appointment.

Interview with Resident #2's PCP on 01/04/24 at 12:02pm revealed:
-On 10/12/23, she saw Resident #2 at the facility for a routine visit.

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-Resident #2 used a CPAP machine that was prescribed by a pulmonologist.
-There were no orders for the CPAP machine to put on at night and off in the morning, so she wrote an order for that and a referral to follow-up with pulmonary for further evaluation and treatment of Resident #2's sleep apnea.
-She was not aware Resident #2 did not see the pulmonologist during the 30 to 90 days that were required and when she ordered the referral.
-There was no communication from the facility related to the order for the referral to the pulmonologist.

Interview with the Health and Wellness Director (HWD) on 01/05/24 at 10:03am revealed:
-Resident #2 was seen at the pulmonologist office on 08/16/23.
-Resident #2 was taken by her family to the visit on 08/16/23.
-Third shift MAs prepared the physician visit packet which contained Resident #2's physician order sheet which was filled out by the physician containing all new orders including follow-up appointments.
-When Resident #2 returned from the appointment, the MA on duty was responsible for obtaining the physician visit packet from the family winch contained the orders for the follow-up appointment.
-The MA was responsible for making a copy of the follow-up visit order and giving it to transportation to put on their calendar.
-There was no packet returned with Resident #2 that she was aware of.
-She did not contact the family and ask about the packet and she did not call the pulmonologist's office to request notes or to see if there were any orders written.
-On 10/12/23, Resident #2 saw the facility's PCP

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at the facility and an order was written to use the CPAP machine during the night and take off in the morning.
-She did not review the PCP's progress note which had the referral to the pulmonologist for further evaluation and management of Resident #2's sleep apnea.
-The PCP progress notes were faxed to the facility later that afternoon once seen by the PCP and she was not educated to review the PCP's progress notes.
-She thought all of the orders were written on the physician order sheet and since she did not review the physician's progress note which had the pulmonology referral on it in the section under "assessment and plans" the order was missed.
-If she reviewed the physician's progress note she would have called the physician about the pulmonary referral.
-She did not call Resident #2's PCP or the pulmonologist's office even after Resident #2's family was asking questions about the programming of Resident #2's CPAP machine.

Interview with the Administrator on 01/05/24 at 11:45am revealed:
-Resident #2's PCP's was the facility's contracted PCP and would have been given a physician's order sheet for any new orders.
-The PCP's progress note that were faxed over later that day also could contain orders and the HWD was responsible for reviewing the PCP's progress notes and the PCP order sheet for implementation of those orders and also responsible for calling the physician to follow up on orders needing clarification or with any questions.
-She was not aware the orders for a follow -up appointment with the pulmonologist 30 to 90 days after being seen on 08/16/23 or the pulmonology

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referral made by Resident #2's PCP on 10/18/23.

b. Review of an e-scribed physician's order dated 11/16/23 revealed:
-On 11/16/23, there was a faxed request for pre-authorization for the order for Xifaxan (a medication used to treat or prevent complications of liver disease such as hepatic encephalopathy) 550mg two times a day.
-On 1130/23, there was a faxed authorization from the facility for the order for Xifaxan 550mg two times a day.

Telephone interview with the facility's contracted pharmacy on 01/04/24 at 8:50am revealed:
-On 11/16/23, a e-scribed order was received for Xifaxan 550mg, two times a day for Resident #2.
-On 11/16/23, a fax was sent to the physician's office and to the pharmacy requesting pre-authorization for the Xifaxan.
-On 11/30/23, Resident #2's insurance company sent the pharmacy an authorization for the Xifaxan.
-On 12/04/23, another escript for Xifaxan was received from the provider.
-The medication was never dispensed because the family/Resident #2 refused to pay the co-pay.
-The facility was responsible for calling the pharmacy to inquire about the Xifaxan.

Review of Resident #2's November 2023 electronic Medication Administration Record (eMAR) revealed.
-There was an entry dated 11/16/23 for Rifaximin (Xifaxan) 550mg two times a day
-Resident #2's Xifaxan 550mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 11/16/23 at 7:00pm and 11/17/23 to 11/30/23 at 7:00am and 7:00pm.

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D 273	Continued From page 28 Review of Resident #2's progress notes revealed Resident #7's Xifaxan was not administered on 11/16/23 to 11/19/23, 11/23/23 to 11/30/23 due to medication on order and 11/20/23 to 11/22/23 due to the medication requiring pre-authorization. Review of Resident #2's progress notes dated 11/17/23 at 1:10pm revealed: -A MA documented Resident #2 was falling asleep or nodding out every few minutes. -The MA also documented Resident #2 nodded out at breakfast into her plate of food several times during breakfast and lunch on 11/17/23. Review of Resident #2's progress notes dated 11/28/23 at 9:36pm revealed Resident #2 was very sleepy tonight and was woken up several time by staff and her peers while eating dinner. Review of Resident #2's December 2023 electronic eMAR revealed. -There was an entry dated 11/16/23 for Rifaximin (Xifaxan) 550mg two times a day -Resident #2's Xifaxan 550mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 12/01/23 to 12/31/23 at 7:00am and 7:00pm. Review of Resident #2's progress notes revealed Resident #7's Xifaxan was not administered on 12/01/23 due to waiting on medication to be discontinued (d/c' ed), 12/02/23 to 12/05/23, 12/06/23, 12/14/23, 12/17/23, due to waiting on prior authorization, 12/04/23, 12/07/23 to 12/13/23, 12/15/23 to 12/16/23, 12/20/23 to 12/21/23, 12/23/23 to 12/31/23 due to waiting on family for approval of the cost of the medication, 12/22/23 due to waiting on medication, and 12/17/23 to 12/19/23, due to Resident being in	D 273		

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the hospital.

Review of Resident #2's progress notes dated 12/04/23 at 11:18am revealed a MA documented the pre-authorization was sent to the pharmacy on 11/20/23 and awaiting on the billing department from the pharmacy to call back and advise what the family will do.

Review of Resident #2's progress notes dated 12/06/23 at 9:16pm revealed Resident #2 was very lethargic, fell asleep at the table in the dining room and was woken up several times during the meal.

Review of Resident #2's progress notes dated 12/16/23 at 7:45am revealed a MA documented Resident #2 was nodding in and out every second for about a month.

Review of Resident #2's progress notes dated 12/16/23 at 9:28pm revealed:
-A MA documented Resident #2 was confused and hallucinating at times.
-Resident #2 stated that her dog was stuck in the sink and its head was stuck in a bucket.
-Resident #2 was falling asleep while trying to have a conversation with the staff.

Review of Resident #2's progress notes dated 12/17/23 at 10:46am revealed Resident #2 fell and was transported to the hospital.

Review of Resident #2's hospital discharge summary dated 12/19/23 revealed:
- Resident #2 presented to the Emergency Department (ED) on 12/17/23 with Resident #2 leaning to the right with ambulation due to weakness and chronic dizziness.
-Resident #2 was admitted on 12/17/23 with a

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problem list documented as; Atrial fibrillation, acute hepatic encephalopathy (HE), and elevated liver function tests.

Review of Resident #2's progress notes dated 12/17/23 at 10:46am revealed Resident #2 fell and was transported to the hospital.

Review of Resident #2's January 2024 electronic eMAR revealed.
-There was an entry dated 11/16/23 for Rifaximin (Xifaxan) 550mg two times a day
-Resident #2's Xifaxan 550mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 12/01/23 to 12/31/23 at 7:00am and 7:00pm.

Review of Resident #2's progress notes revealed Resident #7's Xifaxan was not administered on 01/01/24, 01/02/23 due to family refused to pay for medication and awaiting on a d/c order, 01/02/23 due to waiting on family to bring, and on 01/03/23 due to a billing issue.

Telephone interview with Resident #2's family member on 01/04/24 at 11:25am revealed:
-On 11/16/23, Resident #2's Hepatologist ordered Xifaxan 550mg two times a day.
-Near the end on November 2023, a MA informed her the medication required a pre-authorization and the pharmacy contacted the Hepatologist and got the pre-authorization.
-On 12/03/23, she told the facility staff that Resident #2 could not afford the Xifaxan because there was a co-pay of a little over $1000.00 a month.
-On 12/13/23 during a follow-up visit with Resident #2's Hepatologist, She told the physician that Resident #2 could not afford the Xifaxan and did not even start the medication.

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D 273	Continued From page 31 -on 12/13/23, the physician ordered new labs, changed the dosage on her medications to treat high ammonia levels and discontinued a medication that caused diarrhea to be worse. -She expected the facility to notify Resident #2 Hepatologist about waiting on the Xifaxan because of the pre-authorization and Resident #2 not being able to afford the Xifaxan. Telephone interview with a representative from Resident #2's Hepatologist's office on 01/04/24 at 3:25pm revealed: -Per the physician's notes dated 11/16/23, the Xifaxan was ordered to help with impaired brain function from Resident #2's liver disease. -Per the physician, the Xifaxan helped prevent hepatic encephalopathy (HE), a brain disorder that can occur due to severe liver disease that causes loss of brain function due to the liver not removing the toxins out of the body. -On 11/30/23, per the physician, he received a call from the facility stating the medication required a pre-authorization, and he checked and to the MA to re-run the prescription because it did not require one. -Per the physician's progress notes dated 12/13/23, he saw Resident #2 and her family in his office and he was informed by the family that Resident #2 could not afford the medication and Resident #2 never started the Xifaxan. -Per the physician, he was not aware Resident #2 did not start taking the medication at any point until 12/13/23. -Per the physician, he knew the Xifaxan was expensive so he told the MA on 11/30/23 to notify him if Resident #2 could not afford the medication and another treatment could be used. -Per the physician, symptoms of HE were increased confusion, fatigue, sleepiness and slurred speech.	D 273		

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-Per the physician, Resident #2 not getting the Xifaxan could seriously increase the risk of developing HE without other treatments.

Interview with the HWD on 01/05/24 at 10:03am revealed:
-On 11/16/23, there was an e-script from Resident #2's Hepatologist's office sent to the pharmacy for Xifaxan 550mg two times a day.
-Usually the pharmacy received the order and if there were no issuers then the pharmacy filled the medication and entered the order onto the eMAR.
-The Xifaxan required a pre-authorization and the facility was sent a fax regarding it.
-The MAs was responsible for receiving the faxes and contacting the physician.
-According to the fax in Resident #2's record, there was a fax sent to the facility on 11/16/23 requesting pre-authorization for the Xifaxan.
-According to Resident #2's record, there was a fax sent to the pharmacy on 11/30/23, to give prior authorization or d/c and to fax the facility if needed.
-She saw the fax dated 11/30/23 before but did not call the pharmacy or the physician herself to check to see what was going on with the Xifaxan.
-She did not complete any type of audit to check the orders on the eMAR with the medications on hand and the orders in the residents record because she was not trained on that part of the job and there were times she filled in for MAs who called out for the shift.

Interview with the Administrator on 01/05/24 at 11:45am revealed:
-The pharmacy was responsible for processing medications sent by the physician.
-The MAs were responsible for contacting the physician with any question or issues with the

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D 273	Continued From page 33 medications. -The HWD was responsible for monthly medication cart audits and pulling a 24 hour report every day which would contain medications not administered and follow up on the, which would include notifying the physician of medications not administered. -She was not aware Resident #2's physician was not notified about the Xifaxan was not administered or that the medication ws too expensive to get. _____ The facility failed to follow-up with Resident #2's pulmonologist for a required compliance appointment related to the use of a CPAP machine and failed to notify Resident #2's PCP and the Hepatologist of Resident #2 going 25 days without a medication used to prevent hepatic encephalopathy, due to severe liver disease, resulting in a 3 day hospitalization for hepatic encephalopathy and elevated liver enzymes. The failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 6, 2024.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and	D 286		

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D 286	Continued From page 34 non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime service consisted of non-disposable place settings for all residents. The Findings are: Observation during the noon meal service on 01/03/24 at 12:46pm revealed a utility cart in the kitchen with 5 styrofoam containers, containing the noon meal, ready to be delivered to residents. Observation on 01/04/24 at 6:00pm revealed staff pushed a utility cart with multiple styrofoam containers on it to residents' rooms. Observation on 01/05/24 at 8:46am of staff pushing a utility cart with multiple Styrofoam containers on it to residents' rooms. Interview with the Dietary Manager (DM) and the Cook on 01/03/24 at 12:46pm revealed: -Inside the styrofoam containers were lunches for residents who wanted to eat in their rooms. -All residents who choose to eat in their rooms got styrofoam containers and cups and plastic silverware. -It had always been that way since staff started working at the facility. -Interview with the Health and Wellness Director	D 286		

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D 286	Continued From page 35 (HWD) on 01/04/24 at 12:00pm revealed: -Some residents choose to eat in their rooms. -She did not know why residents who ate in their rooms got styrofoam containers and cups and plastic silverware. -She worked at the facility for the last 7 years and styrofoam containers had always been used. Interview with a Dietary Aide on 01/05/24 at 10:09am revealed she had worked at the facility for 2 years and any resident who ate in their room got styrofoam containers. Interview with the DM on 01/05/2024 at 10:11am revealed: -She assumed using the styrofoam containers was how it should have been served. -No one had given her any direction to do it any other way. Interview with the Administrator on 01/05/24 at 10:52am revealed: -All the communities had used styrofoam containers since the Covid-19 pandemic. -Before Covid-19 the facility used plates with dome covers, and real silverware, and cups with a plastic wrap to cover the glass. -She did not know why the use of styrofoam containers was still being used, it had always been that way. ,	D 286		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 298		

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D 298	Continued From page 36 (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure snacks were offered to all residents between meals. The findings are: Review of the facility's current weekly menu dated 12/31/2023 through 1/06/2024 revealed a mid-morning, mid-afternoon and mid-evening snack were listed on the menu. Observation of the kitchen food storage area on 01/03/24 at 12:54pm revealed there were boxes of fig bars, pudding, oatmeal cream pies, granola's and cheese crackers. Interviews with 5 residents during the initial tour on 01/03/24 from 9:15am to 10:30am revealed all of the five residents reported not receiving snacks three times a day. Interview with a resident in the dining room on 01/04/24 at 8:50am revealed she used to get snacks several months ago but not anymore.	D 298		

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D 298	Continued From page 37 Interview with a Medication Aide (MA) on 01/04/24 at 8:45am revealed: -Snacks were not given out to residents on a consistent basis. - In November 2023 the Health and Wellness Director (HWD) informed the staff snacks had to be offered to residents. -Snacks were offered for a few days after that meeting but not anymore. - When the census decreased the number of staff working decreased and there were only three staff to complete tasks. -If a resident asked for a snack, staff would give them one. Interview with a personal care aide (PCA) on 01/04/24 at 10:47am revealed: -She handed out the 2:00pm snack when showers were not given. -She was not aware that snacks were to be handed out at night or that it was a requirement. Interview with the HWD on 01/04/24 at 12:00am revealed: -Residents were to receive snacks three times a day at 10:00am, 2:00pm and 8:00pm. -Kitchen staff were to call over the walkie talkies that snacks were ready. -She routinely talked about handing out snacks with the staff. -She wanted to make sure residents were getting snacks. -She did not know if residents were getting their snacks. -She had not discussed this with the Dietary Manager (DM). -She saw snacks being offered at times. Interview with the DM and a dietary aide on 01/05/24 at 10:09am revealed:	D 298		

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D 298	Continued From page 38 -Snacks were to be distributed at 10:00am, 2:00pm and 6:00pm. -The snack cart was prepared by the kitchen staff and the PCA's were to take the snacks out to the residents. -In the last month no snacks had been distributed, prior to that snacks were offered approximately two times a week. -Kitchen Staff had the snack cart ready at 10:00 AM daily. Interview with the Administrator on 01/05/24 at 10:52am revealed: -The care staff were responsible for passing out snacks. -The kitchen staff prepared the snacks on the cart and the care staff were to go and get the cart. -It was not a staffing issue as managers could pass snacks as well. -No one had asked her about not receiving snacks.	D 298		