STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034112	A. BUILDING: _____ B. WING _____	C 04/25/2024

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HARMONY AT BROOKBERRY FARM	512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and complaint investigation survey from 04/23/24 to 04/25/24.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by:	D 254		

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Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#2 and #5) had a resident assessment completed annually.

The findings are:

1. Review of #2's current FL2 dated 04/09/24 revealed:
-Diagnoses included femur fracture displacement, hypertension, dementia, falls, insomnia, and protein calorie malnutrition.
-Resident #2 was ambulatory and needed personal care assistance with bathing and dressing.
-Resident #2 was incontinent of bowel and bladder.

Review of Resident #2's care plan dated 11/10/22 revealed:
-She had disruptive and socially inappropriate behaviors.
-She had no problems with ambulation and did not need an assistive device.
-She needed supervision with bathing.
-She was independent with all other activities of daily living (ADLs).

Review of Resident #2's record revealed there were no other care plans after 11/10/22 available for review.

Interview with a personal care aide (PCA) on 04/23/24 at 3:10pm revealed:
-Resident #2 was always confused and required frequent redirection.
-Resident #2 needed extensive to total assistance with her ADLs.

Based on observations, record review and staff

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interviews, Resident #2 was determined to be not interviewable.

Refer to interview with the Administrator on 04/25/24 at 2:55pm.

Refer to attempted telephone interview with the Health Care Coordinator (HCC) on 04/25/24 at 2:02pm.
2. Review of Resident #5's current FL2 dated 08/28/23 revealed:
-Diagnoses included candidiasis of skin and nail, post-polio syndrome, coronary artery disease, hypertension, hypothyroidism, stage 4 kidney disease, and dyslipidemia.
-Resident #5 was semi-ambulatory and needed personal care assistance with bathing.

Review of Resident #5's care plan dated 08/30/22 revealed:
-He was alert, oriented, had no memory deficits and was verbally aggressive.
-He was ambulatory with an assistive device (the device was not documented).
-He needed supervision with bathing and dressing and was independent with all other activities of daily living.

Review of Resident #5's record revealed there were no care plans after 08/30/22 available for review

Interview with Resident #5 on 04/24/25 at 3:40pm revealed:
-He did not need any assistance with eating, toileting, transferring, or dressing.
-He needed staff assistance to provide supervision during showers and help if he needed it.

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D 254	Continued From page 3 Interview with a nurse at Resident #5's primary care provider's (PCP) office on 04/25/24 at 10:30am revealed: -Resident #5's PCP signed a care plan for him on 11/22/22. -There had not been any other care plans received at the PCP's office or signed by the PCP since 11/22/22. -The PCP received and signed medication orders for Resident #5 in January 2024, but not a care plan. Refer to interview with the Administrator on 04/25/24 at 2:55pm. Refer to attempted telephone interview with the Health Care Coordinator (HCC) on 04/25/24 at 2:02pm. _____ Interview with the Administrator on 04/25/24 at 2:55pm revealed: -Resident care plan had been behind with being completed annually. -She sought extra assistance with getting all resident care plans up to date. -She thought all care plans were current for all residents, including Resident #5. -The RCC was responsible for assessing and interviewing residents, and for ensuring care plans were completed for each resident annually. Attempted telephone interview with the Health Care Coordinator (HCC) on 04/25/24 at 2:02pm was unsuccessful.	D 254		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 269		

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D 269	Continued From page 4 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: Based on observations, interviews, and record reviews, the facility to ensure 2 of 5 sampled residents (#3 and #6) received personal care assistance from staff including a resident who had oily hair and documentation of 2 showers in 22 days and a resident who requested staff to remove facial hairs (#3). The findings are: 1. Review of Resident #6's current FL2 dated 04/04/24 revealed: -Diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, depression, eczema, and sleep disorder. -Resident #6 needed personal care assistance with bathing and dressing. Review of Resident #6's Resident Register dated 04/04/23 revealed she needed assistance with bathing, dressing, hair, and grooming. Review of Resident #6's care plan dated 01/24/24 revealed: -Resident #6 was sometimes disoriented, forgetful, and needed reminders. -She needed supervision with bathing and did not require assistance with grooming and personal hygiene. Review of Resident #6's personal care logs revealed there was not a personal care log for	D 269		

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D 269	Continued From page 5 February 2024. Review of Resident #6's personal care log for March 2024 revealed: -Resident #6 was scheduled to receive a shower on third shift on Wednesdays and Saturdays. -There was documentation Resident #6 was assisted with a shower 8 times with extensive assistance between 03/08/24 and 03/31/24. -There was documentation Resident #6 was assisted with a shower on first shift 1 time and no documentation Resident #6 was assisted with a shower on second shift between 03/08/24 and 03/31/24. -There was documentation Resident #6 received assistance with shampoo/hair care 2 times between 03/08/24 and 03/31/24. -There was no documentation Resident #6 refused showers or hair care. Review of Resident #6's personal care log for April 2024 revealed: -Resident #6 was scheduled to receive a shower on third shift on Wednesdays and Saturdays. -There was documentation Resident #6 was assisted with a shower 2 times on third shift between 04/01/24 and 04/22/24; one shower was with extensive assistance and there was no documentation of the level of assistance received with the other shower. -There was no documentation on Resident #6 was assisted a shower on first or second shifts between 04/01/24 and 04/22/24. -There was documentation Resident #6 received assistance with shampoo/hair care 14 times between 04/01/24 and 04/23/24. -There was no documentation Resident #6 refused showers or hair care. Review of Resident #6's progress notes for	D 269		

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February, March, and April 2024 revealed there was no documentation Resident #6 refused a shower.

Observation of Resident #6 at various times during the day on 04/23/24 revealed Resident #6's hair was very oily.

Observation of Resident #6 on 04/24/24 at 8:55am am revealed Resident #6's hair was very oily.

Observation of Resident #6 on 04/24/24 at 1:38pm revealed Resident #6's hair was not oily.

Interview with a PCA on 04/24/24 at 9:13am revealed:
-Resident #6 was scheduled to be assisted with showers, including washing her hair, on third shift on Wednesdays and Saturdays of each week.
-Resident #6 was assisted with a shower and with washing her hair on non-shower days and shifts.
-Some PCAs told her that Resident #6 refused to take showers for them, but she did not have any trouble with getting her to take a shower and with washing her hair.
-She noticed yesterday, 04/23/24, that Resident #6's hair was very oily.
-She planned to give Resident #6 a shower today, 04/24/24, and wash her hair if third shift had not washed her hair on 04/23/24.

Second interview with the personal care aide (PCA) on 04/24/24 at 1:38pm revealed:
-She gave Resident #6 a shower and washed her hair.
-When she washed or combed a residents' hair, she documented on the residents' personal care log the event code: SH= shampoo/hair care.
-She documented SH on Resident #6's personal

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care log on 04/22/24, 04/23/24, and other dates in April because she combed Resident #6's hair.
-She would have documented the event code: S if she had assisted Resident #6 with a shower.

Interview with another PCA on 04/24/24 at 4:27pm revealed:
-She thought Resident #6 was scheduled for showers on first shift.
-She noticed Resident #6's hair was oily, but her hair was washed on her shower days.
-If Resident #6's responsible party wanted her hair washed each time it became oily, she did not mind providing the extra care.

Interview with the Administrator on 04/25/24 at 2:55pm revealed she expected PCAs to offer Resident #3 a shower and wash her hair on her scheduled shower days and on any other day or shift as needed.

Attempted telephone interview with Resident #3's responsible party on 04/25/24 at 10:18am was unsuccessful.

Attempted telephone interview with the Health Care Director (HCD) on 04/25/24 at 2:02pm was unsuccessful.

2. Review of Resident #3's FL2 dated 01/25/24 revealed:
-Diagnoses included major cognitive disorder due to dementia, heart disease, atrial fibrillation with pacemaker, hypertension, and hyperlipidemia.
-Resident #3 needed personal care assistance with bathing.

Observation of Resident #3 on 04/23/24 at 9:39am revealed:
-Resident #3 pointed to hair on her face.

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D 269	Continued From page 8 -She had peach fuzz on her top lip. -There were whisker-like hairs at the corner on each side of her mouth. Interview with Resident #3 on 04/23/24 at 9:39am revealed: -She had hair on her face that she wanted to get rid of. -She told facility staff and they told her they would get around to it, but they never did. -She would be so happy to get the hair off of her face. Interview with a personal care aide (PCA) on 04/24/24 at 9:00am revealed: -Resident #3 told her she wanted the hair on her face removed when she assisted her with a shower recently. -Resident #3 asked if the hair on her face could be waxed or shaved. -She told Resident #3 she would have to see what her family member said. -She had not talked to the family member yet. -She shaved male resident's faces, but she had not shaved a female resident's face before. Interview with another PCA on 04/24/24 at 4:14pm revealed: -Resident #3 said she needed the hair off her face. -The facility did not have anything to get the hair off Resident #3's face. -The PCA had not talked to her about Resident #3's request to have the hair removed from her face. Interview with a third PCA on 04/24/24 at 4:27pm revealed: -She shaved Resident #3 face a few times using a razor, but she did not remember the last time.	D 269		

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D 269	Continued From page 9 -She had not seen any hair on Resident #3's face lately and she had not requested for hair on her face to be shaved. -There were razors available to remove hair from residents' faces. Interview with a medication aide (MA) on 04/24/24 at 5:06pm revealed: -Residents who had facial hair were usually shaved when they were assisted with showers. -She had not noticed any hair on Resident #3's face and Resident #3 had not said anything to her about having her facial hair removed. -If she had known she would have cut Resident #3's facial hair upon her request. -There were razors available in the facility for facial hair removal. Interview with the Administrator on 04/25/24 at 2:55pm revealed she expected PCAs to assist Resident #3 with shaving her facial hairs if she requested it. Attempted telephone interview with Resident #3's responsible party on 04/25/24 at 9:19am was unsuccessful. Attempted telephone interview with the Health Care Director (HCD) on 04/25/24 at 2:02pm was unsuccessful.	D 269		
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.	D 270		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, record reviews and interviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #2, and #3) including a resident who had a history of falls which resulted in a fall with a fatal injury and death (#1), a resident who had eight falls in six months (#2), and a resident who eloped from the secured locked unit and was found having sexual relations with another resident (#3).

The findings are:

Review of the facility's undated policy titled Fall Prevention Program revealed:
-The goal of the Fall Prevention Program included the appropriate screening for, and assessment of, the resident so that an Individualized Service Plan (ISP) could be developed to reduce falls, prevent injuries, and ultimately improve the quality of life for the facility's residents.
-There were 10 screening factors that placed a resident in a High Risk Factor category which included unsafe behavior or the absence of safety awareness, chronic illness, acute illness, high risk medication use such as anti-hypertensive's, sensory impairment, pain, the use of restraints, decline in ability to transfer or complete activities of daily living (ADL), fatigue, and inappropriate use of assistive devices.
-The Resident Care Team should be trained and able to readily identify when a resident met any of the High Risk categories and the more risk factors a resident had, the more at risk they were

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for falls.
-Upon admission to the facility, every 6 months, and with significant changes in condition, the High Risk factor tool should be completed for each resident along with updating the ISP with the resident, care, manager, family, and responsible party, make referrals as needed, and communicate changes in the ISP to the care team.
-If a resident fell, staff should complete an incident report, post-fall assessment tool, review and update the High Risk factor screening tool if needed, and make any appropriate changes to the ISP.
-A list of individualized approaches of fall prevention measures should be kept within easy reach to be used as a resource tool by the Nursing team.
-There was a list of 36 suggested fall prevention interventions for the Nursing team to implement.

Review of the facility's undated policy titled Head Injuries revealed:
-If a resident had a fall or other incident with a suspected head injury, staff were to assess for visible signs of injury, obtain the resident's vital signs, ask the resident if they hit their head and where their pain was.
-Emergency Medical Services (EMS) should be called and the resident should not be moved if they verbalized that they hit their head, there was an apparent injury, there were signs of illness, or the resident lost consciousness.

1. Review of Resident #1's current FL2 dated 02/26/24 revealed:
-Diagnoses included hypertension, coronary artery disease, hypothyroidism, history of stroke, and mitral valve prolapse.
-She was semi-ambulatory and continent of both

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bowel and bladder.
-She was verbally able to make her needs known.
-She was ordered two medications to treat hypertension (carvedilol 6.25mg twice daily, and losartan potassium 25mg daily) along with an Aspirin (a non-steroidal anti-inflammatory medication that reduces the blood's clotting action) 81mg daily.

Review of Resident #1's Care Plan dated 02/08/24 revealed:
-Resident #1 was ambulatory with the use of an assisted device.
-She was oriented and had adequate memory.
-Her vision was adequate for daily activities.
-There were no performance codes to indicate the level of assistance needed with toileting, ambulation/locomotion, bathing, grooming/personal hygiene, or transfers.

Review of Resident #1's unsigned Individualized Service Plan (ISP) dated 03/06/24 revealed:
-Resident #1 had a history of occasional disorientation to person, place, time or situation that did not interfere with functioning in familiar surroundings but required some direction and reminding from others.
-Resident #1 had occasional difficulty remembering and using information and required some directions and reminding from others.
-Resident #1 was independent with toileting, transfers, and mobility/ambulation and used a walker.
-Resident #1 had a history of 1-2 falls in the previous 90 days with 1-2 predisposing diseases and medications.
-She was categorized as a moderate potential for falls; there were no personalized fall prevention interventions documented.
-Resident #1 required verbal

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reminders/prompts/cues for grooming and personal hygiene.

a. Review of Resident #1's incident/accident report dated 11/02/23 revealed:
-Resident #1 had an unwitnessed fall at 3:45pm in her room's kitchenette.
-Resident #1 had activated her call bell for assistance and a medication aide (MA) found Resident #1 on the floor.
-Resident #1 told the MA she had hit her head on her table and also hurt her hip during the fall.
-The MA contacted Emergency Medical Services (EMS) and Resident #1's power of attorney (POA).
-Resident #1's POA took her to the hospital.
-There were no documented fall prevention interventions implemented.

Telephone interview with Resident #1's Power of Attorney (POA) on 04/23/24 at 2:45pm revealed:
-Resident #1 had a history of falls.
-When Resident #1 had fallen on 11/02/23, she took Resident #1 to see her doctor.
-There was no fracture or injury as a result of Resident #1's fall on 11/02/23 and no new orders.

Interview with the Administrator on 04/23/24 at 3:30pm revealed:
-If a resident had fall prevention measures in place it would be documented in their care plan.
-The facility did not have any increased supervision sheets for staff to document on.
-If a resident had a fall, the MAs did "hot box" charting where they documented if that resident had any changes in condition during their shift for 72 hours following the fall.

b. Review of Resident #1's incident/accident report dated 12/27/23 revealed:

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-Resident #1 had an unwitnessed fall at 8:45am in her room.
-Resident #1 was found by staff on her bedroom floor.
-She had a laceration to the back of her head.
-Resident #1 told staff she had lost her balance and fell backwards, hitting her head on her table in the process.
-There were no documented vital signs or notifications to the primary care provider (PCP) or POA.
-There were no documented fall prevention interventions implemented.
-There were no hospital reports for review dated 12/27/23.

Review of Resident #1's PCP visit note dated 01/17/24 revealed:
-Resident #1's last staple was removed without issue but required local anesthesia because the area was still tender.
-Resident #1 likely had vascular dementia, though mild; symptoms had worsened briefly following her fall.
-The PCP had discussed at length during previous appointments the importance of fall risk factors such as consistent use of her walker, continued physical therapy (PT) which had been started in November 2023, and avoidance of polypharmacy.

Telephone interview with Resident #1's POA on 04/23/24 at 2:45pm revealed:
-Resident #1 had a fall on 12/27/23 that resulted in her being sent to the Emergency Room (ER).
-Resident #1 had to get four staples to the back of her head.

Telephone interview with a nurse from Resident #1's PCP's office on 04/24/24 at 10:30am

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revealed:
-Resident #1 was seen in the ER on 12/27/23 due to a fall, and had a follow up appointment with her PCP on 01/11/24 to have staples removed.
-Resident #1's PCP advised she continue with PT for strengthening.

Interview with a MA on 04/24/24 at 9:15am revealed:
-Resident #1 was independent with transfers and toileting and a stand-by assist with showers.
-She worked on 12/27/23 when Resident #1 fell and hit her head.
-The other MA had gone into Resident #1's room and found her on her bedroom floor.
-Resident #1 told her she fell backwards and hit her head on her table.
-Resident #1's head was bleeding, but she had no other signs of injury and she was alert and oriented.
-Resident #1 ended up with 4 staples to the back of her head.
-Resident #1 was placed on two-hour checks and the personal care aides (PCA) were responsible for documenting the checks.
-She did not know where the two-hour check sheets were so she was unable to provide them for review.
-Resident #1 also had a call light pendant to wear, but that was not an intervention specific to Resident #1 because all the residents were provided with a call pendant.
-Resident #1 used her call pendant at times but did not always have it on her or remember to use it when she fell.

Telephone interview with a second MA on 04/24/24 at 3:50pm revealed:
-She found Resident #1 lying on the floor in her room on 12/27/23.

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-Resident #1 had hit her head on something and had lot of bleeding from the back of her head.
-She called for help from other staff and got some towels to put under Resident #1's head.
-She checked Resident #1's vital signs and called Emergency Medical Services (EMS).
-Resident #1 was alert and oriented and denied other injuries.
-Resident #1 needed staples to close the wound to her head.
-Resident #1 had already been a high fall risk by the time she fell on 12/27/23, so she just encouraged her to not to use her rollator walker in her room because it threw off her balance; she encouraged her to use her smaller walker when ambulating in her room because it did not bump into things as much.
-She was not aware of any fall prevention measures in place for Resident #1.

c. Review of Resident #1's incident/accident report dated 02/27/24 revealed:
-Resident #1 had an unwitnessed fall at 1:45pm in the common area.
-Resident #1 was found by staff on the floor during an activity.
-There were no documented statements from Resident #1 regarding what happened to cause the fall, injuries, or notifications to the PCP or POA.
-There were no documented fall prevention interventions implemented.

Telephone interview with a nurse from Resident #1's PCP's office on 04/24/24 at 10:30am revealed:
-Staff reported Resident #1's fall on 02/27/24.
-The PCP advised that Resident #1 be evaluated in the ER due to her having complaints of hip pain.

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-She did not see any documentation of appointments or imaging following Resident #1's fall on 02/27/24.

Telephone interview with a MA on 04/24/24 at 11:40am revealed:
-She worked the shift Resident #1 fell on 02/27/24.
-Resident #1 told her she fell while trying to transfer into a chair at bingo.
-She did not witness Resident #1's fall.
-Resident #1 denied hitting her head or having any pain or injury as a result of the fall.
-Resident #1 was independent with her personal care but she was a fall risk due to her history of falls and she had an unsteady gait.
-Resident #1 had been working with PT but she needed reminders to use her walker.
-Resident #1 did have a couple of falls where she hit her head and had to be sent to the ER.
-The only fall prevention measure in place for Resident #1 was two-hour checks.
-The facility's protocol was to check on every resident every two hours.
-Staff did not document two-hour checks but both the PCAs and the MAs were responsible for doing two-hour checks on all of the residents.

d. Review of Resident #1's incident/accident report dated 03/04/24 revealed:
-Resident #1 had an unwitnessed fall at 10:00pm in her bathroom.
-Resident #1 was found by staff on her bathroom floor.
-There were no documented injuries from the fall.
-Resident #1 told staff she had lost her balance and fell.
-Vital signs were obtained and Resident #1 had no complaints of pain.
-Resident #1's PCP and POA were notified.

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D 270	Continued From page 18 -There were no documented fall prevention interventions implemented. Telephone interview with a MA on 04/24/24 at 3:40pm revealed: -She worked the shift when Resident #1 fell on 03/04/24. -Resident #1 had told her she had gotten dizzy and fallen, but did not report any injury or pain. -She had not been advised to implement a new fall prevention measure for Resident #1 after her fall. -She and the PCA had been doing two-hour checks on Resident #1 during the shift she fell, and the checks should be documented on a paper they had filled out. -Resident #1 did not have any fall prevention measures in place that she was aware of. -Resident #1 was independent with transfers and ambulation but she sometimes got a little confused in the evenings. -She had never seen the facility's fall policy or protocol. -Whenever a resident fell, she assessed them for pain or injury, checked their vital signs, and notified the doctor and family. e. Review of Resident #1's incident/accident report dated 03/24/24 revealed: -Resident #1 had an unwitnessed fall at 1:40am in her room. -Resident #1 told staff she slipped out of bed, then crawled to her resident room door to get help. -Resident #1 reported pain to her buttocks and lower back as a result of the fall. -The MA administered an as-needed pain medication. -Resident #1's POA was notified but there was no documented notification to her PCP.	D 270		

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D 270	Continued From page 19 Review of an electronic communication log dated 03/26/24 revealed: -A MA contacted the PCP office at 11:33am to report that Resident #1 fell on 03/24/24 and was complaining of hip and lower back pain. -The MA requested an order for an x-ray. -Resident #1's PCP advised that Resident #1 be evaluated in an office visit or urgent care prior to having imaging completed. -There was a note handwritten on the communication log that Resident #1's family would bring her to an appointment scheduled on 03/28/24 with the PCP. Review of Resident #1's PCP's visit note dated 03/28/24 revealed: -Resident #1 was being seen by the PCP due to complaints of hip and lower back pain due to a fall that occurred 4 days prior. -Resident #1 told the PCP she had fallen backwards and most of the force of the fall was on her gluteal area and lower back. -She had some muscle stiffness and soreness in the 2-3 days following the fall. -Resident #1 reported that she had been working with the PT at the facility she resided at but felt the quality of the sessions were hit or miss. -The PCP documented that it was his opinion that PT was a very important piece of Resident #1's health maintenance since she continued to have falls and deconditioning. -Resident #1's neurologist had recommended occupational therapy (OT) as well, so the PCP placed new orders for PT and OT. Telephone interview with Resident #1's PCP's nurse on 04/24/24 at 10:30am revealed: -Staff reported Resident #1's fall on 03/24/24. -The MA at the facility had requested x-ray	D 270		

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imaging on 03/26/24, but the PCP suggested Resident #1 be evaluated in urgent care instead.
-Resident #1 had an office visit with the PCP on 03/28/24 and imaging of her lumbar spine and bilateral hips was completed with no acute fractures visualized.
-Resident #1's PCP sent referrals to their health care system's internal PT and OT specialists on 03/29/24.
-There was a note from the therapy department that they were unable to reach Resident #1 by phone to schedule her appointments after multiple attempts, so the referrals were cancelled.

f. Review of Resident #1's incident/accident report dated 04/09/24 revealed:
-Resident #1 had an unwitnessed fall at 7:20pm in the elevator.
-Resident #1 told staff she had tried to sit on her rollator walker, but her legs did not move as quickly as her mind did, and she fell.
-She did not want to be sent to the hospital, so the on-call doctor and POA were made aware of the hospital refusal.
-There were no documented injuries from the fall.

Telephone interview with a nurse from Resident #1's PCP's office on 04/24/24 at 10:30am revealed:
-Staff reported Resident #1's fall on 04/09/24.
-Staff said that Resident #1 refused to go to the hospital so they were advised to monitor her for changes and follow up as needed.

Telephone interview with a MA on 04/24/24 at 3:50pm revealed:
-Resident #1 fell on 04/09/24 when she was assisting other residents in the dining room area.
-One of the other residents told her that Resident #1 had fallen.

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-She found Resident #1 laying on the floor.
-Resident #1 told her she had fallen onto her backside then laid down.
-She checked Resident #1's vital signs and Resident #1 denied pain or injury.
-She assisted Resident #1 back to her room.
-Resident #1 refused to have her call EMS.
-The on-call doctor told her to just continue monitoring Resident #1 for injury or pain.
-She had not implemented any new fall prevention measures for Resident #1 after the fall.
-She had never clearly understood if Resident #1 was supposed to be receiving two-hour checks or not.
-She had never seen a two-hour check sheet for Resident #1.
-The staff completed two-hour checks on residents if they were told to do so.
-She had never seen or been provided with the fall policy.

g. Review of Resident #1's incident/accident report dated 04/11/24 revealed:
-Resident #1 had an unwitnessed fall in her bathroom.
-The MA documented that she walked into Resident #1's room at 6:00am to give Resident #1 her morning medications and found Resident #1 laying on the bathroom floor undressed.
-Resident #1 was breathing but would not respond to the MA's attempt to wake her up.
-The MA called EMS.
-There were no vital signs documented.
-Resident #1's POA was notified.

Review of Resident #1's EMS report dated 04/11/24 revealed:
-Upon EMS arrival to the facility, Resident #1 was unresponsive and her skin was cold and pale.

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D 270	Continued From page 22 -Resident #1 was lying face down on her bathroom floor and was unresponsive and unconscious. -Resident #1's pupils were unequal and non-reactive to light. -Staff told EMS they entered Resident #1's room that morning at 6:30am and found her in that position, covered in feces and emesis so they cleaned her up then called 911. -Staff reported they had last seen Resident #1 around 10:30pm the previous evening, and at that time she was normal and had no complaints. -There was mottling noted on Resident #1's left arm which was underneath her on the floor. -Resident #1 was breathing adequately. -There was no obvious injury or bruising noted. -Resident #1 was transported to the hospital. Telephone interview with Resident #1's responsible party on 04/22/24 at 10:15am revealed: -She shared POA responsibilities with another family member. -On 04/11/24, she received a call from the MA at the facility that Resident #1 had fallen and the MA had to send her to the hospital because she was unresponsive, but breathing, when she was found. -Resident #1's other POA met Resident #1 in the ER. -She received a call from the other family member saying Resident #1's injury was very serious and the doctor had to intubate her. -One of the doctors at the hospital arranged a family meeting to notify Resident #1's family that Resident #1's brain had atrophied slightly due to age, so when she hit her head on the bathroom floor, the subsequent bleeding had pushed the brain aside and resulted in the crushing of her brain stem.	D 270		

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-Resident #1's injury was fatal according to the doctor at the hospital.
-Resident #1's family decided to remove the breathing tube, and Resident #1 passed away the following day, on 04/12/24.
-One of the staff at the facility told her that Resident #1 had not been checked on all night.
-Since Resident #1 was found undressed on the bathroom floor and her pajamas were still folded and underneath her pillow, she thought Resident #1 had fallen while doing her bedtime routine and was not found until the morning.
-Resident #1 was supposed to be on two-hour checks due to her history of falls.
-Since Resident #1's admission to the facility in November 2022, there had only been one care plan meeting, which she had initiated one year ago, to discuss fall prevention for Resident #1.
-She had requested the two-hour checks for Resident #1, along with having staff cue her more often to remind her to use her walker while ambulating and to wear and use her call light pendant necklace so she could call for help if needed.
-The facility staff told her they would increase supervision of Resident #1 to try to prevent her from falling.
-There was a lot of staff turnover at the facility so she did not think any of the staff who were involved in that care meeting were still employed at the facility.
-Resident #1 did not have dementia, but she had some confusion in the evenings at times.
-The Administrator told her that Resident #1 was not one of the residents the staff were supposed to complete two-hour checks for.

Telephone interview with Resident #1's POA on 04/23/24 at 2:45pm revealed:
-Resident #1 had multiple falls in the previous

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several months.
-The staff were supposed to check on Resident #1 every two hours around the clock.
-Resident #1 was supposed to use her walker but did not always use it when she was walking around her room.
-Resident #1 forgot to wear her call pendant sometimes.
-Resident #1 was a person of habits; she kept her pajamas under her pillow and her bedtime routine was to take off her clothes in her bathroom, rinse her clothes in the bathroom sink, then go to her bed and put on her pajamas.
-The morning of 04/11/24 when Resident #1 was found on the floor, she had two sets of pajamas folded under her pillow.
-Resident #1 had a friend who visited her every evening, and he told her that Resident #1 was still in her day clothes when he left her room at 10:00pm on 04/10/24.
-She thought that Resident #1 had fallen while getting ready for bed, then laid on the floor until morning when the MA found her.
-One of the personal care aides (PCAs) told her that all the staff were talking about how Resident #1 had not been checked on all night from 04/10/24 to 04/11/24.
-The hospital doctor told her that Resident #1 had a traumatic brain bleed that placed pressure on her brain and crushed her brainstem which placed her into a coma by the time she was brought into the ER.

Interview with a PCA on 04/24/24 at 9:30am revealed:
-Resident #1 was independent with toileting, ambulation, and transfers.
-Staff were supposed to check on Resident #1 every two hours because that was the standard expectation for staff to check on all residents

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every two hours.
-The staff did not document the two-hour checks and had never been asked to document them.
-Resident #1 was alert and oriented but she did not know if Resident #1 ever used her call pendant.
-Resident #1 had a history of falls but she was not aware of Resident #1 ever sustaining an injury from her falls.
-At shift change, the PCAs were expected to go room-to-room and "lay eyes" on all of the residents, even the residents who were independent.

Interview with a MA on 04/24/24 at 9:40am revealed:
-She was the MA on duty the night of 04/10/24 to the morning of 04/11/24.
-She went in to Resident #1's room around 6:00am to give Resident #1 her morning medications and found her laying on her bathroom floor.
-Resident #1 was laying on her stomach and there was no visible bleeding.
-Resident #1 was undressed and had feces on her along with emesis that appeared to be leaking from her mouth.
-She stayed with Resident #1 and called the MA on the first floor to come help her.
-She and the second MA tried to wake up Resident #1 but she did not respond, so she called 911.
-After calling 911 she left the second MA with Resident #1 and she went to pass some more medications.
-EMS arrived about 15 minutes after she called them.
-She had not checked Resident #1's vital signs because there were too many things in Resident #1's bathroom and she was cleaning Resident #1

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up.
-She had not seen Resident #1 at all during that shift prior to finding her at 6:00am.
-She had not done two-hour checks on Resident #1 because she did not know she was supposed to.
-She did not have a PCA working with her the night of 04/10/24 to the morning of 04/11/24.
-Resident #1's bed was still made up when she found her in the morning and it did not look like Resident #1 had ever gone to bed the night prior.
-Resident #1 was independent with toileting and transfers and was continent of bowel and bladder so she did not check on her overnight.
-She was not aware of Resident #1's fall history.

Interview with a second PCA on 04/24/24 at 1:35pm revealed:
-Resident #1 was independent with all of her activities of daily living (ADL) except for she needed the assistance of one staff for her showers.
-She worked the day before Resident #1 fell and Resident #1 seemed at her baseline.
-She was not working the night that Resident #1 fell.
-She was not aware of any fall prevention measures in place for Resident #1.
-She had never been told to do anything specific for Resident #1 regarding fall prevention.
-All of the residents were supposed to be checked on every two hours, and the PCAs documented their two-hour checks on a sheet of paper at the nurse's station.

Telephone interview with a third PCA on 04/24/24 at 2:30pm revealed:
-She worked the night shift of 04/10/24 but on a different floor, even though Resident #1's floor was her usual floor to work on.

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D 270	Continued From page 27 -Around 7:00am on 04/11/24, the MA who had worked on the first floor all night came back down from Resident #1's floor crying. -The MA told her the other MA had found Resident #1 undressed on her bathroom floor covered in feces and she was unresponsive. -After she learned that Resident #1 had passed away at the hospital, she talked to Resident #1's POA who told her that Resident #1's nightgown was still under her pillow, so they both thought Resident #1 had fallen while getting ready for bed on the evening of 04/10/24. -There was no PCA scheduled to work on the second or third floors the night shift of 04/10/24 to the morning 04/11/24. -The PCAs were supposed to do shift-to-shift checks at shift change and go into each resident's room and "lay eyes" on them, but if there was no PCA working night shift there was probably no shift checks completed to check on Resident #1 between second and third shifts at 11:00pm. -The PCAs were also supposed to check on all of the residents every two hours, but she did not think the MAs did two-hour checks. -She had never seen any paperwork to document two-hour checks on and she was never told by the supervisors to document two-hour checks. -She thought all of the staff were familiar that Resident #1 had experienced frequent falls and aware she needed to be checked on even though she was independent. -Resident #1 seemed to have a lot of falls due to not using her walker every time she got up to ambulate around her room. -Resident #1's POA told her that she had requested the staff check on Resident #1 every two hours; if the POA told the HCC that she wanted two-hour checks for Resident #1, it was his responsibility to relay that information to the	D 270		

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rest of the staff but he did not.

Telephone interview with Resident #1's physical therapist on 04/25/24 at 9:30am revealed:
-Resident #1 was a high fall risk due to her history of stroke and left-sided weakness and her history of falls.
-He had been seeing Resident #1 for PT services one day every week since November 2023, and his last visit with her had been on 04/08/24.
-One day, he did not remember the date, he went into Resident #1's room and found her on the floor.
-Resident #1 had been using her new large rollator walker which was great for hallways but too big for maneuvering around her room.
-When he found Resident #1 she was laying on the floor in her room with her head on her bathroom floor and the rollator walker was tangled up in her legs and the doorway.
-He educated her that the rollator walker was unsafe for her to use in her room and she should use her smaller walker in her room, but she preferred the rollator.
-He reported the fall to the staff and he also texted Resident #1's POA about replacing of her rollator walker but he never heard back from the POA about it.
-Resident #1 was independent with transfers but she struggled to navigate small spaces.

Interview with the HCC on 04/25/24 at 10:35am revealed:
-She was not aware of any staff training on falls that had been completed in the previous two months that she worked at the facility.
-The staff did not always check on residents that they viewed as being independent.
-When asked about completing two-hour checks on residents, one of the MAs told her she was not

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a PCA she was a MA, so she did not do two-hour rounds on the residents because that was the PCA's job.
-Resident #1 was independent with transfers and toileting.
-She was trying to educate the staff that the residents they cared for were in the assisted living unit of the facility rather than the independent living unit, and they all needed to be checked on.
-She was not aware of Resident #1 being on two-hour checks or not.
-She was not aware that Resident #1's family had requested staff to do two-hour checks on her.
-She had discussed Resident #1's frequent falls with her POA in the past because it seemed like Resident #1 had been more forgetful the last couple of weeks before she passed away.
-Resident #1 did not have any other symptoms, so she had not requested orders or an appointment to look further into the forgetfulness.
-The only fall prevention measure that she was aware of for Resident #1 was PT.
-The HCC was responsible for tracking falls and arranging any necessary staff education.

Telephone interview with the local hospital ER physician on 04/25/24 at 11:45am revealed:
-He had cared for Resident #1 in the hospital the morning of 04/11/24.
-During Resident #1's fall, her brain had moved in her skull causing torn veins, which resulted in bleeding called a subdural hematoma.
-Resident #1's brain bleed was acute and had been from the fall she had that night; it was not caused by any previous fall that she had.
-There was so much bleeding that it pushed her brain over to the side resulting in damage.
-Based on the age of the blood in Resident #1's skull, the fall had happened hours before she was seen in the ER.

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D 270	Continued From page 30 -It was always best to get to the hospital sooner rather than later with a brain bleed, but he did not know if it would have changed the outcome for Resident #1. Interview with the Administrator on 04/25/24 at 2:15pm revealed: -She was not aware Resident #1 had 7 falls between November 2023 and April 2024. -Resident #1 would be considered at high risk for falls with having 7 falls in the previous 6 months. -If she had been aware of Resident #1's falls she would have discussed the falls more in-depth with her POA and PCP. -She had never discussed fall prevention with Resident #1's family or PCP. -She was not aware Resident #1 had any increased forgetfulness in the weeks leading up to her death. -Resident #1 did not always use her walker while ambulating and it sometimes resulted in her falling. -She or the HCC would be responsible for sharing the fall policy with the staff. -She had never shared the fall policy with the staff. -The MAs were trained that if a resident fell, they were expected call the family and the doctor, complete an incident report, check vital signs, and add the resident to the "hot box" charting. -There was no expectation for the MAs to implement a new fall prevention intervention after each fall. -Since March 2024, with all falls, the in-house PT reviewed the fall situation for any fall prevention suggestions. -After Resident #1's fall on 04/09/24, the in-house PT suggested Resident #1 start PT services, but her PCP signed the order the day that Resident #1 passed away.	D 270		

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-She was not aware Resident #1 had been receiving PT services already.
-At the facility's daily stand-up meetings, falls that happened in the previous 24-hours were discussed.
-Resident #1 had not been on two-hour checks because she did not want to be checked on; there was no documentation of her declining two-hour checks.
-Resident #1 was alert and oriented and able to call for staff to help her if she needed it, so staff were not told to check on her every two hours.
-She was not aware Resident #1's family had requested that staff check on her every two hours.
-There were no fall prevention measures in place for Resident #1 other than having a call pendant to wear.
-The night Resident #1 fell between 04/10/24 and 04/11/24, there was one MA working on the floor and no PCAs which was common for night shift.
-The MA was responsible for checking on residents that night, but she did not expect her to check on Resident #1 because she was independent.

Attempted telephone interview with the second MA working the night of 04/10/24 to 04/11/24 on 04/24/24 at 3:36pm was unsuccessful.

2. Review of Resident #2's current FL2 dated 04/09/24 revealed:
-Diagnoses included dementia, hypertension, fall, femur fracture displacement, protein calorie malnutrition, and insomnia.
-She was ambulatory.
-She was constantly disoriented.
-She was incontinent of bowel and bladder.

Review of Resident #2's Individualized Service

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Plan (ISP) dated 03/20/24 revealed:
-Resident #2 resided in a locked unit due to serious cognitive impairment and may not be able to recognize danger; required supervision and oversight for safety.
-Behaviors were documented as disruptive, aggressive or socially inappropriate.
-Resident #2 also experienced hallucinations and delusions, made unsafe decisions and had poor judgment.
-It was indicated Resident #2 was a high potential risk for falls and interventions should be personalized.
-There were no documented fall interventions to minimize or prevent falls on Resident #2's ISP.

Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 03/21/24 revealed Resident #2 needed a walker for ambulation and needed frequent reminders to use it due to her confusion and behaviors.

Observations of Resident #2 on 04/24/24 at 1:35pm revealed:
-Resident #2 was bruised on the right side of her face and her lip was swollen and scabbed.

Observation of Resident #2 on 04/24/24 at 3:10pm revealed:
-Resident #2's gait was unsteady and staff were heard frequently reminding Resident #2 to get her walker.
-She was observed yelling and cursing at staff and visitors.

Review of Resident #2's incident/accident report dated 01/17/24 at 8:45pm revealed:
-Resident #2 was found in her room on the floor by medication aide (MA).
-Resident #2 was assessed for injury by the

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Hospice nurse.
-There were no documented interventions to prevent fall reoccurrence.

Review of the progress notes for Resident #2 dated 01/17/24 revealed Resident #2 was found on the floor by the MA and complaining of back pain.

Review of Resident #2's incident/accident report dated 03/20/24 at 9:00pm revealed:
-Resident #2 was found lying on the floor.
-Resident #2's range of motion was checked.
-Respiration rate and temperature were checked.
-Resident #2's family and Hospice were notified.
-There was no follow up documented on the form.
-There were no documented interventions to prevent fall reoccurrence.
-The incident report was reviewed by the Health Care Director (HCD).

Review of the chart notes for Resident #2 revealed there was no documentation regarding the fall on 03/20/24.

Review of Resident #2's incident/accident report dated 04/11/24 at 8:30am revealed:
-A MA was walking past Resident #2's room and heard her talking loud.
-The MA went into the room and found Resident #2 on the floor between the bed and the closet.
-Resident #2 had bleeding from an old spot on the back of her head.
-Resident #2 complained of neck and back pain.
-Vital signs were documented as blood pressure 144/84, pulse 82, respiration 18, temperature 97.3.
-Resident #2 was sent to the emergency department.
-Resident #2 returned to the facility with staples in

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the back of her head.
-Hospice would provide service.
-There were no documented interventions to prevent fall reoccurrence.

Review of the progress notes for Resident #2 revealed:
-Resident #2 was found on the floor by the MA and sent out for bleeding from a gash on her scalp.
-Hospice was called for follow-up.
-The note included "will continue to monitor".

Review of Resident #2's incident/accident report dated 04/21/24 at 6:30am revealed:
-Resident #2 was found on the floor in her room.
-Resident #2 had a swollen right eye and there was blood on her lip.
-Resident #2 refused to have her blood pressure, pulse and respirations checked.
-The MA assisted Resident #2 back to her wheelchair and brought her to the nurse's station so she could keep an eye on Resident #2.
-There were no documented interventions to prevent fall reoccurrence.

Review of Resident #2's physician's orders for April 2024 revealed there were no orders for interventions for fall prevention.

Interview with a personal care aide (PCA) on 04/23/24 at 3:10pm revealed:
-He worked with Resident #2 on the 3:00pm to 11:00pm shift.
-Resident #2 needed extensive assistance with her activities of daily living.
-Resident #2 did not use her call bell due to her level of cognition.
-She had to be reminded to use her walker; sometimes she walked right past the walker.

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-He tried to keep Resident #2 at the nurse's station so she could be watched.
-She got very angry sometimes and went to her room and locked the door; when that happened, he checked on her more frequently.
-He was unaware of the fall management policy.
-Management had not given him any instructions or interventions to put in place after a resident had a fall.

Interview with a second PCA on 04/24/24 at 9:00am revealed:
-She worked with Resident #2 on the 7:00am to 3:00pm shift.
-Resident #2 had a lot of falls.
-Resident #2 ambulated with a walker and had to be reminded to use it frequently.
-Resident #2 had poor balance and needed assistance for ambulation sometimes.
-Resident #2 also had behaviors and refused personal care.
-She checked on Resident #2 at least every two hours but document that she completed two hour checks.
-She was unaware of the fall management policy.
-Management had not given her any instructions or interventions to put in place after a resident had a fall.

Interview with a MA on 04/25/24 at 9:25am revealed:
-Resident #2 fell several times.
-She ambulated with a walker but forgot it frequently and needed redirection.
-She had behaviors and would get angry at the staff and curse them.
-When she was angry, she could not be redirected, and they sometimes had to leave her alone.
-Staff would try to keep Resident #2 at the nurse's

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station so she could be monitored.
-Sometimes it was difficult to watch her because there were only two staff on duty.
-They tried to communicate with each other and make sure someone was always out in the common areas to monitor the residents that were also in the common areas.
-She did not know about the fall policy.
-She did not know about new interventions in place for Resident #2 to prevent falls, but she knew what she did for the resident.
-There was not a document to log two hour checks at this time.

Interview with a Hospice nurse on 04/24/24 at 1:45pm revealed:
-She saw Resident #2 in the facility twice weekly.
-She got called when Resident #2 had a fall, and she went to the facility to assess the resident.
-The family did not want Resident #2 sent to the hospital unless necessary.
-Resident #2 had Lewy Body dementia and had frequent behaviors; she got agitated and yelled at the staff and refused care.
-She believed many of Resident #2's falls were due to her agitation.
-She tried to work with Resident #2's family on different interventions such as scheduling medications used for agitation, but the family did not agree.

Interview with Resident #2's family member on 04/24/24 at 9:14am revealed:
-Resident #2 had Lewy body dementia and her balance was getting worse.
-He was aware Resident #2 had frequent falls.
-He put cameras in Resident #2's room to try to get a better picture of why she was falling.
-Resident #2 often forgot to use her walker.
-Most staff were doing the best they could.

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D 270	Continued From page 37 -The staff had talked to him about using a different walker and scheduling as needed medications, but he did not agree with that. -He was unaware of any other interventions that were put in place to decrease Resident #2's falls. -He did not feel there was enough staff. Interview with the HCD on 04/23/24 at 2:30pm revealed: -Resident #2 had Lewy body dementia and had frequent falls. -Physical therapy was tried for Resident #2 but she did not follow instructions or refused to participate. -There was a discussion with Resident #2's family about her needing a higher level of care on 04/22/24. -The staff were to do at least two hour checks on the residents. Interview with the Health Care Coordinator (HCC) on 04/25/24 at 10:30am revealed: -She was hired as the HCC but was now doing scheduling. -She was aware Resident #2 had frequent falls. -There was a two-hour check sheet that was supposed to be completed by staff on the locked unit. -She tried to get started with training for things like the fall policy but management did not pursue it. Interview with Resident #2's primary care provider on 04/24/24 at 3:03pm revealed: -She stared at the facility in the middle of March and had not seen Resident #2 but could review her progress notes. -She reviewed Resident #2's record and saw she had Lewy body dementia which caused increased behaviors.	D 270		

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-Residents with Lewy body dementia also had poor safety awareness and no insight and thought they could do things they could not.
-She would expect to see residents with frequent falls discussed in meetings, trends identified, causative factors and increased monitoring.
-She was unaware of the facility's fall policy and did not know what the facility had in place to decrease Resident #2's falls.

Interview with the Administrator on 04/25/24 at 2:12pm revealed:
-There was a care plan meeting with Resident #2's family and the HCD on 04/22/24 to discuss level of care needs.
-She was aware Resident #2 had several falls.
-She stated staff kept Resident #2 at the nurse's station and someone was always with her.
-She expected staff in the locked unit to keep the residents exercised and stimulated.
-She also hired the Health Care Coordinator (HCC) to be stationed in the locked unit to have an extra set of eyes on the residents.

3. Review of Resident #3's current FL2 dated 01/25/24 revealed diagnoses included major cognitive disorder due to dementia, heart disease, atrial fibrillation with pacemaker, hypertension, and hyperlipidemia.

a. Review of Resident #3's Incident/Accident report dated 01/13/24 revealed:
-Resident #3 eloped from the facility on 01/13/24 and was found in the parking lot.
-Resident #3 was brought into the locked unit around 7:00pm by kitchen staff who stated they found her outside.
-The medication aide (MA) who was working in the locked unit on 01/13/24, was assisting with an emergency on the third floor of the facility.

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HARMONY AT BROOKBERRY FARM	512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106

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D 270	Continued From page 39 -When the MA returned to the locked unit around 7:05pm, she was informed by a personal care aide (PCA) that Resident #3 had gotten out of the locked unit. -The MA immediately went and observed Resident #3 and got a full set of vital signs. -The MA also checked for discoloration of Resident #3's limbs. -Resident #3's responsible party was notified, and a conference call was held with the Health Care Director (HCD) and the Administrator. Review of Resident #3's progress note dated 01/14/24 revealed: -Resident #3 was brought into the locked unit around 7:00pm by kitchen staff who stated they found her outside. -The medication aide (MA) who was working in the locked unit on 01/13/24, was assisting with an emergency on the third floor of the facility. -When the MA returned to the locked unit around 7:05pm, she was informed by a personal care aide (PCA) that Resident #3 had gotten out of the locked unit. (There was no documentation of how Resident #3 got out of the locked unit.) -The MA immediately went and observed Resident #3 and got a full set of vital signs. -The MA also checked for discoloration of Resident #3's limbs. -Resident #3's responsible party was notified, and a conference call was held with the HCD and the Administrator. -Resident #3 was placed on 1-hour checks and was doing well throughout the night with no complaints. Attempted interview on 03/23/24 at 3:30pm with the MA who documented the Incident/Accident Report and the Progress note dated 01/14/24 was unsuccessful.	D 270		

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D 270	Continued From page 40 Review of the forecast history through a national weather forecast company revealed the temperature on 01/13/24 was a high of 47 degrees Fahrenheit (F) and a low of 34 degrees F. Observation of the locked unit at various times on 04/23/24 through 04/25/24 revealed: -There was an entrance/exit door separating the locked unit from the rest of the first floor. -The entrance/exit door required a code to get in or out and only staff had the code. -There were 3 halls and there was a door at the end of each hall leading to a stairwell. -Beyond each door at the end of each hall was another door leading to the outside. -The outside door could be opened to exit, but not to enter. -There were also 2 doors in a common area that led to a fenced-in patio area. -There was a digital keypad and a large red alarm in place on each of the doors at the end of each hallway. -The door could only be opened by entering a code on the key pad and once the door was opened, the alarm sounded loudly. -There were different sounding devices on the patio area doors, and the doors had a magnetic lock on them. -Resident #3's room was 2 doors down from the left hall exit door. Observation of the back of the facility on 04/25/25 at 8:05am revealed: -There was one exit door from the locked unit at the back of the facility. -There was a side walk, if taken to the right, led to a large dumpster area which was enclosed with brick on the side where the locked unit exit door	D 270		

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was, and there was a large opening where staff could walk to access the dumpsters.
-The other side of the dumpster was fully enclosed and had doors.
-On the other side of the dumpster was a parking area and further down were parking spaces.
-There was a driveway that ran the length of the facility and a turn left from the back, right side or a turn right from the back, left side of the facility which led to a busy main street.
-On the other side of the drive way in the back of the facility were sparse trees.
-On the other side of the hill was a construction area and the top of an excavator (heavy equipment digging machinery) could be seen from the driveway.

Interview with a personal care aide (PCA) on 04/24/24 at 9:00am revealed:
-She was not working on the day that Resident #3 eloped from the facility.
-There was a different alarm in place when Resident #3 eloped, and the alarms were replaced after her elopement.
-The only way a resident could exit the locked unit to the outside of the facility was if a staff deactivated the old alarm and did not reset it.
-Staff checked on the residents every 2 hours, but they saw the residents more often because most of them wandered around the lock unit.

Interview with a second PCA on 04/24/27 at 9:13am revealed:
-She was not working on the day Resident #3 eloped from the facility.
-Staff checked on residents all the time in the locked unit when they were not performing their assigned PCA tasks.

Interview with a maintenance staff on 04/24/24 at

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D 270	Continued From page 42 10:01am revealed: -There was an exit door at the end of each of the 3 hallways in addition to the main entrance. -All the exit doors in the locked unit had alarms that were very loud, and the main entrance only had a keypad. -The current alarms had been put on the doors after Resident #3 eloped in January 2024. -He started working at the facility 5 days prior to Resident #3 eloping and was involved in replacing the old alarms. -The old alarms sounded, but they were not very loud. -There was a key pad, alarm, and a magnetic locking device on each door prior to the replacement of the alarms. -With the old alarms in place, staff still had to enter a code on the keypad to get out of the alarmed doors. -He did not know how Resident #3 could have gotten out of the facility through the locked and alarmed doors without entering a code. Interview with a medication aide (MA) on 04/25/24 at 9:40am revealed: -She did not work on the day Resident #3 eloped from the locked unit. -Staff were not told to do anything differently for Resident #3 or check on her more often after the day she eloped. -There were usually 2 staff working in the locked unit during her shift and it was sometimes hard to know where all the residents were all the time. Confidential interview with a staff on 04/25/24 at 1:16pm revealed: -On 01/13/24, a resident from the fourth floor (independent living) called the concierge desk and reported a "lady" had been standing outside in the cold for about 20 minutes.	D 270		

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D 270	Continued From page 43 -She did not know what the temperature was on 01/13/24, but it was between 7:30pm and 8:00pm, freezing cold and she could see her breaths in the air. -She observed Resident #3 outside in the back of the facility and attempted to find out who she was. -Resident #3 was wearing a t-shirt and pants and her skin was cold. -Resident #3 was confused and unable to answer questions. -She was taken to the locked unit and asked if she resided there. -Staff in the locked unit identified her and stated that they did not know she had been out of the locked unit. Second confidential interview with a staff on 04/25/24 at 1:40pm revealed: -She thought it must have been between 15 degrees F and 20 degrees F on 01/13/24. -On 01/13/24, a resident from the fourth floor (independent living) called the concierge desk and reported a "lady" had been standing outside near the bushes in the back of the facility. -She observed Resident #3 standing in the back of the facility near the bushes. -She did not know how long Resident #3 had been outside, but she was cold and shivering. -Resident #3 did not know where she was and when asked where she lived, Resident #3 pointed to the facility. -She did not have anything on her that identified her. -Resident #3 was taken to locked unit and staff did not know she was out of the locked unit or how she got out. -She did not know if care was provided to Resident #3 once returned to the locked unit or if staff received any type of training following the event.	D 270		

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D 270	Continued From page 44 Interview with Resident #3 on 04/25/24 at 1:35pm revealed she did not remember being outside of the facility alone. Interview with the Health Care Coordinator (HCC) on 04/25/24 at 10:30am revealed: -She worked at the facility for two months. -She was hired as the HCC but no longer worked fully in the capacity of HCC as she assisted with clinical duties as needed. -Residents in the locked unit were to be checked on at least every two hours and there was supposed to be documentation of the 2-hour checks. Interview with Resident #3's primary care provider (PCP) on 04/24/24 at 3:11pm revealed: -Resident #3's previous PCP no longer provided services to the facility effective 03/27/24 and she had been providing services to residents at the facility since then. -She reviewed the previous providers notes and she did not see any documentation regarding Resident #3 eloping. -The facility should have reported Resident #3's elopement to the provider because there may have been some type of intervention that the provider could have recommended. -She would have wanted to know how the resident got out, where she was found, the time she was last seen, if she had any acute changes in behavior, if the mental health provider was involved, and she would have wanted to check Resident #3's laboratory work. -She expected the facility to supervise Resident #3 more closely after her elopement. Interview with the Administrator on 04/25/24 at 2:24pm revealed:	D 270		

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D 270	Continued From page 45 -There was a little more supervision in the locked unit than on the assisted living unit of the facility. -Staff were to get residents in the locked unit up during the day and out of their rooms and provide activities to keep them engaged. Second interview with the Administrator on 04/25/24 at 2:55pm revealed: -On the evening of 01/13/24, Resident #3 eloped by exiting a stairwell door in the locked unit. -A staff had exited through the stairwell door to take the trash out and the door shut behind her. -The staff had to come back in through the kitchen door because the door she exited was locked from the outside. -When the staff came back into the locked unit, she forgot to turn the alarm back on. -One of the dietary staff was outside taking a smoke break and saw Resident #3 standing outside. -The dietary staff went back inside the facility to get help with assisting Resident #3 back into the facility. -She thought Resident #3 had been outside for 7 to 8 minutes at the most. -The weather was nice on 01/13/24 and it was not frigid cold. -She did not think the staff in the locked unit knew she was missing. -The staff in the locked unit made sure she was well, called her family and warmed her up. -Staff completed a body assessment, an incident/accident report was completed, and all the doors in the locked unit were checked. -Staff were told to "keep their eyeballs on her" at all times for about a week by making sure she was busy and accounted for. -There was no documentation of interventions or supervision provided for Resident #3 after her elopement.	D 270		

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D 270	Continued From page 46 -After Resident #3 eloped, all the doors were recoded and replaced with digital key pads and new door alarms were installed. Attempted telephone interview with Resident #3's responsible party on 04/25/24 at 9:19am was unsuccessful. Attempted telephone interview with the HCD on 04/25/24 at 2:02pm was unsuccessful. b. Review of Resident #3's Incident/Accident Report dated 02/16/24 revealed: -Resident #3 was involved in sexual contact with another resident on 02/16/24 at 4:45pm. -Between 4:40pm and 4:50pm the MA was getting all the residents to the dining room for dinner and she noticed 2 residents were not in the dining room. -The MA went to Resident #3's room with another MA and saw the two residents undressed. -One of the residents was on the bed and the other was standing and they were engaged in a sexual act. -The residents were startled when the MAs walked in and started to get dressed. Review of Resident #3's progress note dated 02/16/24 revealed: -Resident #3 was involved in sexual contact with another resident on 02/16/24 at 4:45pm. -Between 4:40pm and 4:50pm the MA was getting all the residents to the dining room for dinner and she noticed 2 residents were not in the dining room. -The MA went to Resident #3's room with another MA and saw the two residents undressed. -One of the residents was on the bed and the other was standing and they were engaged in a sexual act.	D 270		

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D 270	Continued From page 47 -The residents were startled when the MAs walked in and started to get dressed. -There was no documentation of interventions or supervision implemented. Attempted interview on 03/23/24 at 3:30pm with the MA who documented the Incident/Accident Report and the Progress note dated 01/14/24 was unsuccessful due to the MA no longer worked at the facility. Interview with a medication aide (MA) on 04/24/24 at 5:06pm revealed: -She was being trained by another MA when they walked into Resident #3's room and found her and a male resident sitting on the bed. -Both Resident #3 and the male resident were sitting on the bed with their pants down. -She did not observe any other details. -She and the other MA contacted the Administrator and Resident #3's responsible party. -Staff were told to check on Resident #3 every 30 minutes and to try to keep her and the male resident in the common area. -There was no documentation of increased checks for Resident #3. Interview with a MA on 04/25/24 at 9:40am revealed: -Staff were told to keep Resident #3 and the male resident apart after the incident on 02/16/24 , but there were no discussions of any interventions or increased checks implemented that she knew about. -There were usually 2 staff working in the locked unit during her shift and it was sometimes hard to know where all the residents were all the time. Interview with Resident #3 on 04/25/24 at 1:35pm	D 270		

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D 270	Continued From page 48 revealed she did not remember being in her room alone with a male resident. Interview with Resident #3's primary care provider (PCP) on 04/24/24 at 3:11pm revealed: -She reviewed the previous providers notes and she did not see any documentation regarding Resident #3 being sexually active with another resident. -She expected that the facility would have supervised Resident #3 more closely and possibly changed her room. Interview with the Administrator on 04/25/24 at 2:24pm revealed: -There was a little more supervision in the locked unit than on the assisted living unit of the facility. -Staff were to get residents in the locked unit up during the day and out of their rooms and provide activities to keep them engaged. Second interview with the Administrator on 04/25/24 at 2:55pm revealed: -She knew about the sexual activity between Resident #3 and another resident. -Staff notified Resident #3's family member who said that it had happened before at another facility. -Staff were not told to do anything differently for Resident #3 except to keep her active and encourage her to participate in group activities. -Resident #3 did not like to sit still for very long. Attempted telephone interview with Resident #3's responsible party on 04/25/24 at 9:19am was unsuccessful. Attempted telephone interview with the HCD on 04/25/24 at 2:02pm was unsuccessful.	D 270		

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D 270	Continued From page 49 The facility failed to ensure supervision for 3 of 5 sampled residents including one resident who had 7 falls in 6 months resulting in a scalp laceration requiring staples, back and hip pain, and a brain bleed which resulted in death (#1); a resident who had 8 falls in 6 months resulting in a scalp laceration requiring staples, back pain, and a swollen and bruised eye and lip (#2); and a resident who resided in the secured locked unit who eloped and was found outside of the facility in temperatures below 50 degrees, and the resident was found engaging in sexual activity with another resident. (#3). This failure resulted in serious physical harm and death which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 04/24/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 25, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 3 of 6 residents (#2, #3, and #6), who resided in the locked unit, related to provision of services by	D 273		

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a podiatrist.

The findings are:

1. Review of Resident #3's current FL2 dated 01/25/24 revealed:
-Diagnoses included major cognitive disorder due to dementia, heart disease, atrial fibrillation with pacemaker, hypertension, and hyperlipidemia.
-Resident #3 needed assistance with bathing.

Review of Resident #3's care plan dated 01/25/24 revealed:
-Resident #3 was sometimes disoriented, forgetful, and needed reminders.
-She required limited assistance with standby assistance for safety with bathing, standby.
-She required supervision and reminders with dressing.
-She required no assistance with grooming/personal hygiene.

Review of Resident #3's body/skin check sheets revealed:
-There was a body/skin check sheet dated 04/04/24 and 04/18/24 with documentation Resident #3's toenails needed to be cut badly.
-There were body/skin check sheets dated 04/08/24 and 04/11/24 with no documentation regarding Resident #3's toenails.

Observation of Resident #3 on 04/23/24 at 9:32am revealed:
-Resident #3 was in her bedroom and was barefoot.
-All of Resident #3's toenails were overgrown beyond the tip of her toes except for the second toe on the right foot.
-The toenails of the both big toes were at least one-half inch above the top of the toe; the left big

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(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 273	Continued From page 51 toe nail was curved to the left and the right big toe nail was curved to the right. Interview with Resident #3 on 04/23/24 at 9:33am revealed: -Her toenails hurt all the time with or without her shoes on. -"I want them off." -She did not know when her toenails were last clipped. Interview with a personal care aide (PCA) on 04/24/24 at 9:13am revealed: -She assisted Resident #3's with showers and noticed her toenails needed to be trimmed. -She documented Resident #3's toenails on her skin assessment sheets each time she assisted her with a shower, and she told the medication aide (MA) on duty. Interview with a PCA on 04/24/24 at 4:14pm revealed: -He assisted Resident #3 with showers. -When he assisted residents with showers, he assessed the resident's skin from head to toe and a completed a skin assessment form; looking at residents' toenails was a part of the residents' skin assessment. -Resident #3 needed her toenails trimmed. -He documented the resident needed her toenails trimmed on her skin assessment form, but he did not tell anyone because he felt like they already knew. -Resident #3 complained about her toenails needing to be trimmed and about her toes hurting when she had her shoes on. -Resident #3 was not the only resident who complained about their toenails. -He had not seen a podiatrist in the facility providing foot care to residents.	D 273		

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D 273	Continued From page 52 Attempted telephone interview with Resident #3's responsible party on 04/25/24 at 9:19am was unsuccessful. Attempted telephone interview with the Health Care Director (HWD) on 04/25/24 at 2:02pm was unsuccessful. Refer to interview with a personal care aide (PCA) on 04/24/24 at 9:00am. Refer to interview with a second PCA on 04/24/24 at 9:13am. Refer to interview with a medication aide (MA) on 04/24/24 at 5:06pm. Refer to interview with a MA on 04/25/24 at 9:40am. Refer to interview with the Health Care Coordinator (HCC) on 04/25/24 at 10:36am. Refer to the interview with a nurse at the facility's previously contracted podiatry provider's office on 04/25/24 at 11:14am. Refer to interview with the facility's primary care provider (PCP) on 04/24/24 at 3:40pm. Refer to interview with the Administrator on 04/23/24 at 3:34pm. Refer to interview with the Administrator on 04/25/24 at 2:55pm. Attempted telephone interview with the Health Care Director (HWD) on 04/25/24 at 2:02pm was unsuccessful.	D 273		

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D 273	Continued From page 53 2. Review of Resident #6's current FL2 dated 04/04/24 revealed: -Diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, depression, eczema, and sleep disorder. -Resident #6 needed personal care assistance with bathing and dressing. Review of Resident #6's care plan dated 01/24/24 revealed: -Resident #6 was sometimes disoriented, forgetful, and needed reminders. -She needed supervision with bathing and did not require assistance with grooming and personal hygiene. Review of Resident #6's body/skin check sheets revealed there was 1 body/skin check sheet available dated 04/12/24 and there was no documentation regarding Resident #6's toenails. Review of a request for treatment form for Resident #6 dated 04/21/24 revealed: -Resident #6's responsible party requested a routine checkup with a podiatrist as soon as possible. -The facility's PCP signed off on the request for treatment on 04/23/24. Review of Resident #6's orders revealed there was an order dated 04/23/24 for a podiatry consult for toenail trimming. Second observation of Resident #6 on 04/24/24 at 9:46am revealed: -Resident #6 was in her bedroom laying on her bed and did not have any shoes on. -All of Resident #3's toenails were overgrown about one-fourth of an inch beyond the top of her	D 273		

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D 273	Continued From page 54 toes. -The second and third toes on her right foot were thick. Interview with a personal care aide (PCA) on 04/24/24 at 9:00am revealed she assisted Resident #6 with showers, but she had not noticed Resident #6's toenails needed to be trimmed. Interview with a PCA on 04/24/24 at 9:13am revealed: -She assisted Resident #6 with showers and noticed her toenails needed to be trimmed. -She documented Resident #6's toenails needed to be trimmed with each shower/skin assessment on the skin assessment sheet and told the MA on duty. Interview with a PCA on 04/24/24 at 4:14pm revealed: -Resident #6 had long toenails, but she did not really complain about them. -He told the medication aide (MA) who worked during the shift when he assisted with showers that Resident #6's toenails needed to be trimmed. Attempted telephone interview with Resident #6's responsible party on 04/25/24 at 11:01am was unsuccessful. Attempted telephone interview with the Health Care Director (HWD) on 04/25/24 at 2:02pm was unsuccessful. Refer to interview with a personal care aide (PCA) on 04/24/24 at 9:00am. Refer to interview with a second PCA on 04/24/24 at 9:13am.	D 273		

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D 273	Continued From page 55 Refer to interview with a medication aide (MA) on 04/24/24 at 5:06pm. Refer to interview with a MA on 04/25/24 at 9:40am. Refer to interview with the Health Care Coordinator (HCC) on 04/25/24 at 10:36am. Refer to the interview with a nurse at facility's previously contracted podiatry provider's office on 04/25/24 at 11:14am. Refer to interview with the facility's primary care provider (PCP) on 04/24/24 at 3:40pm. Refer to interview with the Administrator on 04/23/24 at 3:34pm. Refer to interview with the Administrator on 04/25/24 at 2:55pm. Attempted telephone interview with the Health Care Director (HWD) on 04/25/24 at 2:02pm was unsuccessful. 3. Review of Resident #2's current FL-2 dated 04/09/04 revealed: -Diagnoses included hypertension, dementia, protein calorie malnutrition, insomnia, falls and femur fracture displacement. -She was constantly disoriented. Review of Resident #2's personal care log for March and April 2024 revealed she required extensive assistance with bathing. Observation of Resident #2 on 04/24/24 at 1:35pm revealed:	D 273		

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D 273	Continued From page 56	D 273		

-She was seated at the nurse's station with her walker.
-She ambulated without difficulty to her room.
-She had long, thick, yellowed, and jagged toenails to both feet.

Interview with a personal care aide (PCA) on 04/24/24 at 1:40pm revealed:
-Resident #2 needed extensive assistance with bathing.
-She often refused showers.
-She did notice Resident #2 had long toenails and she let the medication aide know.

Interview with a medication aide (MA) on 04/24/24 at 2:00pm revealed:
-She let the Health Care Director (HCD) know Resident #2 needed her toenails cut a while back.
-She did not think there was a podiatrist that came to the facility.

Attempted interview with the HCD on 04/25/24 at 2:05pm was unsuccessful.

Refer to interview with a PCA on 04/24/24 at 9:00am.

Refer to interview with a second PCA on 04/24/24 at 9:13am.

Refer to interview with a MA on 04/24/24 at 5:06pm.

Refer to interview with a MA on 04/25/24 at 9:40am.

Refer to interview with the Health Care Coordinator (HCC) on 04/25/24 at 10:36am.

Refer to the interview with a nurse at facility's

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D 273	Continued From page 57 previously contracted podiatry provider's office on 04/25/24 at 11:14am. Refer to interview with the facility's primary care provider (PCP) on 04/24/24 at 3:40pm. Refer to interview with the Administrator on 04/23/24 at 3:34pm. Refer to interview with the Administrator on 04/25/24 at 2:55pm. Attempted telephone interview with the Health Care Director (HWD) on 04/25/24 at 2:02pm was unsuccessful. _____ Interview with a PCA on 04/24/24 at 9:00am revealed: -If she noticed a resident with toenails that needed to be trimmed, she trimmed the resident's toenails if the resident was not diabetic. -If the resident was diabetic, she let the MA know the resident's toenails needed to be trimmed. Interview with a second PCA on 04/24/24 at 9:13am revealed: -She assisted residents with showers during her shift according to the resident's assigned shower days and shift. -When she assisted resident's with showers, she checked their toenails and if the resident's toenails needed to be trimmed, she documented the need on the resident's skin assessment sheets and told the MA on duty. -Skin assessments sheets should have been completed for each resident each time the resident was assisted with a shower. -She did not know if anyone reviewed the skin assessment sheets. -She cleaned residents' feet during showers, but	D 273		

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D 273	Continued From page 58 PCAs did not trim toenails. -She did not know the last time a podiatrist was in the facility to trim residents' toenails, but she thought it was more than 6 months ago. -All the residents in the locked unit needed to have their toenails trimmed. -None of the residents in the locked unit have gone out to see a podiatrist for foot care. -She had not seen the facility provider trim any of the residents' toenails. -She did not know who else to tell about the residents' toenails except for the MA. Interview with a medication aide (MA) on 04/24/24 at 5:06pm revealed: -None of the PCAs made her aware that any of the residents needed podiatry care. -None of the residents went out of the facility for podiatry care that she was aware of an there was not a podiatrist that provided care in the facility. Interview with a MA on 04/25/24 at 9:40am revealed: -Podiatry services last visited residents in the facility at the beginning of 2023. -Resident have told her their toes hurt. -All the residents in the locked unit needed foot care and she talked to the Health Care Director (HCD) about the residents needing podiatry care on various occasions with the last time being this week. Interview with the HCC on 04/25/24 at 10:36am revealed: -All the residents in the facility needed podiatry care. -She had not reached out to a provider regarding any of the residents needed podiatry care. -She did not know if any other staff contacted the residents' PCP for a referral for podiatry care.	D 273		

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D 273	Continued From page 59 -Podiatry services were discussed in leadership meetings, but she did not know how far along the facility was with securing podiatry services for the residents. Telephone interview with a nurse at facility's previously contracted podiatry provider's office on 04/25/24 at 11:14am revealed: -Their office last came to the facility to provide podiatry services on 02/09/23. -The facility was not able to get their paperwork together and the podiatry team would sit around waiting for hours and residents were not getting seen. -The podiatry office terminated services after the 02/09/23 visit. Interview with facility's primary care provider (PCP) on 04/24/24 at 3:40pm: -This facility did not have a contracted podiatrist. -Within the last 4 to 6 weeks, she gave the Administrator a list of providers who might be able to provide podiatry services to residents at the facility. -If there was a resident who needed their toenails trimmed or podiatry care, she expected for facility staff to contact her for a referral for a podiatry consultation. -She could trim toenails, but no facility staff had asked her to trim any of the residents' toenails. -She had only been asked for an order for podiatry once since she had been coming to the facility, 4 to 6 weeks. -She wrote an order for podiatry services for one resident in the locked unit on 04/23/24, but she could not remember the name of the resident. -Residents who did not receive podiatry care could experience long and painful toenails, hurt feet, and increased risks for falls.	D 273		

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D 273	Continued From page 60 Interview with the Administrator on 04/23/24 at 3:34pm revealed: -She was working on securing podiatry services for the facility. -Several of the providers she reached out to were not accepting new facilities to serve. -She had found a provider with podiatry services, but that provider wanted to provide primary care services in addition to podiatry services. -There had not been any podiatry services available at the facility since she started working at the facility in December 2023. -If a resident needed podiatry care, staff were to request a referral for podiatry from the resident's PCP. -Staff did not trim toenails, but the facility's contracted PCP was able to. Interview with the Administrator on 04/25/24 at 2:55pm revealed: -When PCAs assisted residents with showers or skin care, they were to assess the residents and report anything that needed attention by placing calling the facility PCP or by placing the resident on the PCP's list to be seen. -If a resident was seen by an outside PCP, MAs were to give the information to the HCD or the HCC to provide to the provider or get a referral. -The HCD and HCC were responsible for following up with referrals for podiatry. -She knew podiatry services were needed for residents in the facility, but the current PCP company for the facility did not provide podiatry services. _____ The facility failed to ensure residents who needed their toenails trimmed had access to a facility contracted podiatrist or were referred to a podiatrist for 3 of 5 sampled residents (#2, #3, and #6) which resulted in all 3 residents having	D 273		

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D 273	Continued From page 61 long toenails, and 2 of the residents experiencing painful toenails (#3 and #6) and placed all the residents at risk of experiencing long and painful toenails,and increased risks for falls. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/24/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 8, 2024.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) related to medication used to treat high blood pressure. The findings are: Review of Resident #2's current FL2 dated 04/09/24 revealed:	D 358		

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D 358	Continued From page 62	D 358		

-Diagnoses including high blood pressure, dementia, insomnia, fall, protein calorie malnutrition, and femur fracture displacement.
-There was an order for a clonidine patch (used for high blood pressure) 0.1mg weekly on Tuesday.

Review of Resident #2's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for clonidine patch 0.1mg weekly on Tuesday.
-Clonidine 0.1mg patch was documented as applied to the upper right back on 02/06/24, refused on 02/13/24, not recorded on 02/20/24, and applied to the upper left back on 02/27/24.

Review of Resident #2's March 2024 eMAR revealed:
-There was an entry for clonidine patch 0.1mg weekly on Tuesday.
-Clonidine 0.1mg patch was documented as refused on 03/05/24, applied to Resident #2's upper left back on 03/12/24, medication refilled on 03/19/24, and applied to Resident #2's chest on 03/26/24.

Review of Resident #2' April 2024 eMAR for 04/01/24 to 04/23/24 revealed:
-There was an entry for clonidine patch 0.1mg weekly on Tuesday.
-Clonidine 0.1mg patch was documented as unable to take on 04/02/24, applied to Resident #2's neck on 04/09/24, not recorded on 04/16/24, and refused on 04/23/24.

Review of an incident report dated 04/11/24 revealed a documented blood pressure of 144/84.

Observation of medications on hand for Resident

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D 358	Continued From page 63 #2 on 04/23/24 at 2:50pm revealed there were no clonidine 0.1mg patches available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 1:55pm revealed: -There was an entry for clonidine 0.1mg patch weekly for Resident #2 for her profile only. -The pharmacy had never sent clonidine patches for Resident #2 to the facility. -The clonidine patch was not one of the covered medications for Hospice so the facility had to get the medication from Hospice. Interview with a medication aide (MA) on 04/23/24 at 3:00pm revealed: -There were not any clonidine patches available for administration for Resident #2 on the medication cart. -She did not know how long the clonidine patch was not available. -She thought the facility pharmacy sent the clonidine patches. -The pharmacy told the facility that Hospice would have to provide the clonidine patches. -They were going back and forth between the facility pharmacy and Hospice about who would provide the patches. -She documented refused by accident; Resident #1 did not have any patches and she should have documented there were no patches available. -She had made the Health Care Director (HCD) aware that Resident #2 did not have any clonidine patches. Interview with the HCD on 04/23/24 at 2:15pm revealed he did not know anything about Resident #2 not having any clonidine patches.	D 358		

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HARMONY AT BROOKBERRY FARM	512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106

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D 358	Continued From page 64 Telephone interview with the Hospice registered nurse (RN) on 04/24/24 at 2:09pm revealed: -Hospice did not send medications to the facility for Resident #2. -The facility's pharmacy should provide all of Resident #2's medications, including the clonidine patch. -She was sure Resident #2 had previously had a clonidine patch on when she conducted her visits, but she did not know how long ago it was. Telephone interview with the Hospice Nurse Practitioner (NP) on 04/25/24 at 3:31pm revealed: -She saw Resident #2 every sixty days. -She was not aware Resident #2 did not have any clonidine patches. -She had a few higher blood pressures and should have the clonidine patch applied weekly. -She was not too concerned about the few higher blood pressures but was concerned that she did not have the clonidine patch available. -The facility's pharmacy should provide all of Resident #2's medications. -If Hospice did not cover a medication, it meant the pharmacy would bill the resident's traditional insurance. Interview with the Administrator on 04/25/24 at 2:12pm revealed: -She was not aware Resident #2 did not have any clonidine patches available for administration. -The HCD was responsible for making sure all residents had the medications they were ordered. -A nurse that worked for the pharmacy came to the facility quarterly and reviewed FL2's and checked the medication carts for medications on hand. -She was concerned that she had extra eyes on medication administration and there were still medications missing.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034112	A. BUILDING: _____ B. WING _____	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 65 Based on observations, record review, and interviews, it was determined that Resident #2 was not interviewable.	D 358		