Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED R HAL096031 B. WING 04/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 ROYALE AVENUE **GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI** GOLDSBORO, NC 27534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 000 Initial Comments D 000 The Adult Care Licensure Section conducted an annual and follow-up survey on April 23, 2024 and April 24, 2024. D 270 10A NCAC 13F .0901(b) Personal Care and The facility will 5/17/24 D 270 Supervision ensure that super vision 10A NCAC 13F .0901 Personal Care and is provided for Supervision (b) Staff shall provide supervision of residents in residents in accordance accordance with each resident's assessed needs, care plan and current symptoms. each residents assissed needs care plan & Cunend Symptoms. This Rule is not met as evidenced by: Specific interventions 5/17/24 TYPE A2 VIOLATION will be put in place Based on observations, interviews, and record reviews, the facility failed to provide supervision Hor residents with for 1 of 5 sampled residents (#2) with a history of a history of falls + multiple falls that resulted in serious injuries including a fractured nose and a closed head falls & injury to injury. The findings are: Review of the facility's fall policy upon entrance revealed: The facility Falls 5/10/24 -If a resident continued to have falls, staff would monitor the resident and situation to determine if Policy has been updated any lype of intervention was needed to keep the addressing specific protocols - IE - interventions resident safe, including meeting with family members and communication with the physician. -For a fall with no injury- the physician would be notified by phone and fax (with documentation in the medical record) if there is more than 1 fall in a 30-day period. specific needs. Division of Health Service Regulation ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Reviewed and Acknowledged 2024-05-21.2 0 2024

STATE FORM

ounes/admissrator

OXGF11

5/17/24

If continuation sheet 1 of 7

PRINTED: 05/03/2024 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R HAL096031 B. WING 04/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 ROYALE AVENUE **GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI** GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 270 | Continued From page 1 D 270 -For more than 2 falls in a month, staff would assess for further interventions and involve the physician for input. Review of Resident #2's current FL-2 dated 01/29/24 revealed: -Diagnoses included Alzheimer's dementia, hypertension, hypothyroidism, and seizure disorder. -She was constantly disoriented. QA program will Keep 5/17/24 up & trends for each resident 1 help -She was non-ambulatory. -She needed total care. a. Review of Resident #2's progress note dated 03/03/24 revealed: determine if interventions -She was found on the floor in the common area bathroom, hollering, with a knot on the left side of her forehead. -She was sent to the hospital via Emergency Specific interventions 4/24/2 Medical Services (EMS) transport. Review of Resident #2's incident and accident report dated 03/03/24 revealed: for resident #2. -She was found on the floor in the common area bathroom, hollering. O Observe resident -She was sent to the hospital via EMS transport. -She returned to the facility on 03/03/24 with no every 30 minutes. ② pesides will have new orders. Review of Resident #2's after visit summary 1:1 time & staff dated 03/03/24 revealed: menber as needed. -The reason for the visit was due to a fall. -The diagnoses were a fall and head injury. 3) Resident will be Review of Resident #2's record revealed there checked for was no documentation of an intervention put in incontinence every

place after her fall on 03/03/24.

04/24/24 at 11:05am revealed:

Interview with a medication aide (MA) on

2 hours.

@ Do now put resident

Division of Health Service Regulation

AND PLAN OF CORRECTION HALD96031 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 201DBSORO ASSISTED LIVING & ALZHEIMER'S CAI 201 ROYALE AVENUE GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI 201 ROYALE AVENUE GOLDSBORO, N. C 27534 SUMMARY STATEMENT OF DEFOCIENCES GOLDSBORO, N. C 27534 D270 Continued From page 2 She found Resident #2 in the common area between monoidal part of the Appropriate Defociences between the field and she sent her out to the hospital. Resident #2 in the rhead from the fall and she sent her out to the hospital. Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 12:00em. -There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00em. -There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00em. -There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00em. -There were no injuries or complaints of pain. Review of Resident #2's physician restraint order dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00em. -There were no injuries or complaints of pain. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seathet to keep resident safe which sitting in her wheelchair, linterview with a medication aide (MA) on 04/24/24 at 11:056m revealed Resident #2 had the seathet on her wheelchair to prevent her front failing. d. Roview of Resident #2's progress note dated 04/02/24 revealed:	1	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION					_
MALE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPOSITIONS PROVIDER OR SUSTED LIVING & ALZHEIMER'S CAI 201 ROYALE AVENUE GOLDSBORD ASSISTED LIVING & ALZHEIMER'S CAI 203 ROYALE AVENUE GOLDSBORD, NC 27534 PROVIDER'S PLAN OF CORRECTION PRETTY TAD PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORR		AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:							
ANAME OF PROVIDER OR SUPPLIER GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI O(49)ID PREFIX SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUPPLIER PROVIDER OF SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OF SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCY PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCY PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PROVIDER PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PROVIDER PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PROVIDER PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDE OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDE OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDE OR SUMMARY STATEMENT OR DEPICEMENT OR DEPI	1					A. BUILDING	G:		COM	PLETED	
ANAME OF PROVIDER OR SUPPLIER GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI O(49)ID PREFIX SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUPPLIER PROVIDER OF SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OF SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCIES PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCY PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICIENCY PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PROVIDER PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OF DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PROVIDER PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PROVIDER PREFIX PROVIDER OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDE OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDE OR SUMMARY STATEMENT OR DEPICEMENT OR PREFIX PROVIDE OR SUMMARY STATEMENT OR DEPICEMENT OR DEPI	l										
NAME OF PROVIDER OR SUPPLIER GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI GRAPH DEPTION (REACH PROPERTY STATEMENT OF REPRESENCE) FREFIX (REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER OR THE APPROPRIATE GRAPH DEPTION WITH THE REPORT OF THE APPROPRIATE D PROVIDER STAND OF CORRECTION (REACH CORRECTION WITH THE REPORT AT THE APPROPRIATE COMPLETE TAG D PROVIDER STAND OF CORRECTION (REACH CORRECTION WITH THE REPORT AT THE APPROPRIATE COMPLETE D PROVIDER STAND OF CORRECTION (REACH CORRECTION OF CORRECTION (REACH CORRECTION OF CORRECTION (REACH CORRECTION (RCACH CORRECTION (REACH CORRECTION (REACH CORRECTION (REACH COR				HAL096031	HAL096031		B. WING		1		
GOLDSBORO ASSISTED LIVING & ALZHEMER'S CA) O(M) 10 PREFIX O(M) 10 PREFIX CONTINUED SUMMARY STATEMENT OF DEPOSICIES (EACH DEFOISNOY MUST BE PRECEDED BY FILL REGULATORY OR LOS IDENTIFYING NOORMATION) D 270 Continued From page 2 - She found Resident #2 in the common area bathroom on 03/03/24, - Resident #2 hit her head from the fall and she sent her out to the hospital. - Resident #2 could not transfer on her own but she tried. D. Review of Resident #2's progress note dated 03/22/24 revealed: - Staff found her sitting on the floor at the front of her bed around 12:00am. - There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: - Staff found her sitting on the floor at the front of her bed around 12:00am. - Review of Resident #2's progress note dated 03/22/24 revealed: - Staff found her sitting on the floor at the front of her bed around 5:00am. - There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: - Staff found her sitting on the floor at the front of her bed around 5:00am There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: - Staff found her sitting on the floor at the front of her bed around 5:00am There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation aided the set of the found the fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place aft	I	111117							04	1/24/2024	
GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI PAID (SAMMARY STATUBARY OF DEPTRIENCIES (SAMMARY STATUBARY OF DEPTRIENCIES (SAMMARY STATUBARY OF DEPTRIENCIES (SAMMARY STATUBARY OF DEPTRIENCIES) (SAMMARY STATUBARY OF DEPTRIENCIES (SAMMARY STATUBARY OF DEPTRIENCIES) (SAMMARY STATUBARY OF DEPTRIENCIES (SAMMARY STATUBARY OF DEPTRIENCY) PREFEX (SAMMARY STATUBARY OF DEPTRIENCIES (SAMMARY STATUBARY OF DEPTRIENCY) D 270 Contlinued From page 2 -She found Resident #2 in the common area bathroom on 03/03/24. -Resident #2 in the head from the fall and she sent her out to the hospital. -Resident #2 could not transfer on her own but she Irled. D. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 12:00am. -There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 at 12:00am. -Review of Resident #2's progress note dated 03/22/24 at 12:00am. -Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. -Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. -There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. -There were no injuries or complaints of pain. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:105am revealed Resident #2's had the seat belt on her wheelchair to prevent her from falling. I Review of Resident #2's progress note that the found of the part of the program of the	ļ	NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE				
OCLIDBORO, NC 27534 OCHID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PLAN OF CORRECTION PREFIX TAG CONTINUED FROM THE PROPERTY OF THE APPROPRIATE PROPERTY OF THE APPROPRIATE PROPERTY OF THE APPROPRIATE DATE OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPR	l										
SUMMARY STATEMENT OF DESICIONIES (RACH DESICIONY MUST BE RECEDED BY PILL RECOULTORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 2 -She found Resident #2 in the common area bathroom on 03/03/24. -Resident #2 thin her head from the fall and she sent her out to the hospital. -Resident #2 could not transfer on her own but she tried. -I Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 12:00am. -Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. -Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 15:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 15:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed: Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat bet to her wheelchair to prevent her from falling. A Review of Resident #2's progress note that the form therefore the form the fall from the bed on one of the form the fall from the bed on 03/22/24 at 11:05am revealed Resident #2 had the seat bet to nher wheelchair to prevent her from falling.	ı										
PREFIX TAG MEDICENSOY MUST BE PRECEDED BY FULL TAG MEDIATORY OR USE DESTITYING INFORMATION) D 270 Continued From page 2 -She found Resident #2 in the common area bathroom on 03/03/24Resident #2 in the read from the fall and she sent her out to the hospitalResident #2 could not transfer on her own but she tried. D. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 12/00mmThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. C. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication side (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Breview of Resident #2's page the wheelchair for prevent her from falling.	r	(VALID	CLIMANA DV OTA	TELENIE AND THE	GOLDSBOK	KO, NC 2/5	34				
D 270 Continued From page 2 She found Resident #2 in the common area bathroom on 03/03/24. Resident #2 in the rhead from the fell and she sent her out to the hospital. Resident #2 in the rhead from the fell and she sent her out to the hospital. Resident #2 in the rhead from the fell and she sent her out to the hospital. Resident #2 in the rhead from the foll and she sent her out to the hospital. Resident #2 in the rhead from the foll and she sent her out to the hospital. Resident #2 sprogress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/27/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication side (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note dated of the program of the	PREFIX (FACH DEFICIENCY MUST BE DESCREED BY SAME						PROVIDER'S PLAN OF	CORRECTION		(VE)	
D 270 Continued From page 2 -She found Resident #2 in the common area bathroom on 03/03/24Resident #2 hit her head from the fall and she sent her out to the hospitalResident #2 could not transfer on her own but she tried. - B. Review of Resident #2's progress note dated 03/22/24 revealed: - Staff found her sitting on the floor at the front of her bed around 12:00 am There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00 am. - Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00 am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00 am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00 am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05 am revealed Resident #2 had the seat bot to her wheelchair to prevent her from falling. d. Beview of Resident #2's record revealed to prevent her from falling.		TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				(EACH CORRECTIVE ACTION SHOULD F		RE.		ε
D 270 Continued From page 2 She found Resident #2 in the common area bathroom on 03/03/24. Resident #2 hit her head from the fall and she sent her out to the hospital. Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. C. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchelir. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchelir to prevent her from falling. d. Review of Resident #2's progress that details and the seat belt on her wheelchelir to prevent her from falling. d. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's progress that details and the seat belt on her wheelchelir to prevent her from falling.					,	IAG			ATE	DATE	
She found Resident #2 in the common area bathroom on 03/03/24. Resident #2 this there head from the fall and she sent her out to the hospital. Resident #2 could not transfer on her own but she tried. 5. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. C. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 6:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 6:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 6:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 6:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 6:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 6:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note dated on the from falling.		D 070					DEFICIENC	·τ)			
sent her out to the hospital. Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress as the date of the province of the provi		D 270	-She found Resident #2 in the common area bathroom on 03/03/24, -Resident #2 hit her head from the fall and she sent her out to the hospital.			D 270	1 / /	1 4			_
sent her out to the hospital. Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress as the date of the province of the provi							to bed until si		i wa	-	
sent her out to the hospital. Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress as the date of the province of the provi							ready to so to	1 .			
sent her out to the hospital. Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress as the date of the province of the provi								40 10		i	
Resident #2 could not transfer on her own but she tried. b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. There were no injuries or complaints of pain. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress nate dated 03/27/24 revealed: Staff found her sitting on the floor at the front of her was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note dated 03/27/24 revealed: Staff found her sitting on the floor at the front of her was no documentation of an intervention put in place after her fall from the floor at the front of her was noted. A program of the floor at the front of her was noted. A program of the floor at the front of her was noted. A program of Resident #2's progress note dated on the floor at the front of her w							1 .				
b. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 12:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress attailed the date of the program							Sleep.				
b. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 12:00am. -There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. -There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's pregress attailed the seat belt on her wheelchair to prevent her from falling.		l l	-Resident #2 could not	ould not transfer on her own but							
-Staff found her sitting on the floor at the front of her bed around 12:00am. -There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. -Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. A program. A program. A program. A y manthly to ensure all finate transport of the front of the bed on 03/22/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling.			she tried.				Starly has	been		4/28/2	24
-Staff found her sitting on the floor at the front of her bed around 12:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatibelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress as to detail the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress as to detail the seat belt on her wheelchair to prevent her from falling.			03/22/24 revealed:				in-serviced	on			
There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. -There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review of Resident #2's pressure retailed to a season of the review		1									
Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress rate date of the province of t			her had around 19:00				in terrention	man.			
Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. -There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress and the table of the reverse of the table of the reverse and the table of the rev			-There were no injuries or complaints of pain.		1						
was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress sate dated and the seat belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress sate dated and the sate belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress sate dated the sate belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress sate dated the sate belt on her wheelchair to prevent her from falling.									-	5/17/2	4
was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress sate dated and the seat belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress sate dated and the sate belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress sate dated the sate belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress sate dated the sate belt on her wheelchair to prevent her from falling.			was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at				luc in sistem	1			
place after her fall from the bed on 03/22/24 at 12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00amThere were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress retained with a complex for a seatbelt of the seat belt on her wheelchair to prevent her from falling.							(NC 1000	0)			
12:00am. c. Review of Resident #2's progress note dated 03/22/24 revealed: -Staff found her sitting on the floor at the front of her bed around 5:00am. -There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's previous acts dated.							1 1 1 1 1 1	and a	Hed.		
O3/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress retails to the foot of the foot o			12:00am.				has been a	gny			
O3/22/24 revealed: Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress retails to the foot of the foot o			a Pavious of Devision (#0)		1		Estalt.				1
Staff found her sitting on the floor at the front of her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note detection. Service Completed of Sinter Completed of Tall Co			03/22/24 revealed:		d b		_			, ,	1
her bed around 5:00am. There were no injuries or complaints of pain. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note that the seat belt on the seat belt on her wheelchair to prevent her from falling.							0. 5000-71	ampl	e ted	5/15/24	1
was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress rate dated.			Staff found her sitting o	on the floor at the front of	of		Jeh- wood a				1
was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress rate dated.					1		- SICIS Nes	randi	_		1
was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress rate dated.					1			<	7		1
was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress rate details. Interview of Resident #2's progress rate details. A program. Observation incident i			was no documentation of an intervention put in place after her fall from the bed on 03/22/24 at		ut in		updated Fa	el Pol	ig		
Place after her fall from the bed on 03/22/24 at 5:00am. Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress rate dated.		,					updated inci	dut /	upon	t	
Review of Resident #2's physician restraint order dated 03/27/24 revealed an order for a seatbelt to keep resident safe while sitting in her wheelchair. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. A Review of Resident #2's progress note detail.											
Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. Administration will 5/17/24		1	5.00am.				QA program.	i			1
Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. Administration will 5/17/24			Review of Resident #2's physician and the				Observation)	interna	in Hi	~3m d.	
Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. Administration will 5/17/24 Manual of Resident #2's progress note details Administration will 5/17/24 Manual of Man		,	dated 03/27/24 revealed an order for a seatbelt to				0.000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Ì
Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress noted to the desired at the seat of th										,	1
04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note details.		,					administra+	w w	ll	5/17/24	
04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note details.		1	04/24/24 at 11:05am revealed Resident #2 had the seat belt on her wheelchair to prevent her				100	11-13/12	1 ann		1
the seat belt on her wheelchair to prevent her from falling. d. Review of Resident #2's progress note details		10					mon to with	pr ~ 8			1
d. Review of Resident #2's progress note dated		l ti) 16 10 - 0 1h 1	Ja	ensi-	M.	1
d. Review of Resident #2's progress note dated		fr				1	a x monthy	11 July 1			
d. Review of Resident #2's progress note dated			Ŭ				all trends.	t iss	ues.	•	
		d	l. Review of Resident #2 04/02/24 revealed:	's progress note dated					1		

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL096031 B. WING 04/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI 2201 ROYALE AVENUE GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 270 Continued From page 3 D 270 been addressed. -She was found face down on the floor with blood coming from her nose. administrata / RCC 5/17/24 -She was sent to the hospital via EMS transport. ill monitor staff Review of Resident #2's incident and accident report dated 04/02/24 revealed: -She was found on the floor face down with blood coming from her nose. -She was sent to the hospital via EMS transport. -She returned to the facility on 04/02/24 with a broken nose caused by the fall. carried out Facility Fall Policy 5/11/14 Review of Resident #2's after visit summary dated 04/02/24 revealed: updated. administrator -The reason for the visit was due to a fall. -The diagnoses were a fall and closed fracture of the nasal bone. will monitor to Review of Resident #2's record revealed there ensure solicy is was no documentation of an intervention put in place after her fall on 04/02/24. e. Review of Resident #2's progress note dated 04/09/24 revealed: Administrator and -She was found on her bedroom floor wrapped in -There were no injuries or complaints of pain. reports weekly to Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall on 04/09/24. eventions ar f. Review of Resident #2's progress note dated 04/15/24 revealed: -She was found by staff lying on the floor at her

-She complained of pain in her shoulder and arm.

-She was sent to the hospital via EMS transport.

-She stated she was "hurting very bad."

PRINTED: 05/03/2024

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING:_ COMPLETED R HAL096031 B. WING 04/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 ROYALE AVENUE **GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI** GOLDSBORO, NC 27534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 270 Continued From page 4 D 270 Review of Resident #2's incident and accident report dated 04/15/24 revealed: -Staff found her lying on her left side on the floor at her bedside. -Her shoulder and arm were very painful to move or touch. -She was sent to the hospital via EMS transport. -She returned to the facility on 04/15/24 with a bruised shoulder and no new orders. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall on 04/15/24. g. Review of Resident #2's progress notes dated 04/21/24 revealed: -She was found in her room lying on the floor at her bedside. -She had an open cut area on her right eye with swelling and bleeding. -She was sent to the hospital via EMS transport. Review of Resident #2's incident and accident report dated 04/21/24 revealed: -Staff found her lying on her right side on the floor at her bedside. -She had a cut open area on her right eyebrow. -She was sent to the hospital via EMS transport. -She returned to the facility on 04/21/24 with a bruise on her right eye and no new orders. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall on 04/21/24. Interview with a personal care aide (PCA) on 04/24/24 at 11:13am revealed: -She was aware Resident #2 had multiple falls, but she never witnessed any. -She was directed to keep the seat belt on the

OXGF11

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R HAL096031 B. WING 04/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 ROYALE AVENUE **GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAL** GOLDSBORO, NC 27534 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID Ю PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 270 Continued From page 5 D 270 resident's wheelchair locked and get help when she needed it for Resident #2. -She checked on Resident #2 every 2 hours. -She was never given any additional directives for Resident #2. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed: -Resident #2's bed was moved against the wall a few weeks ago because she rolled out of bed. -She was not sure of the date Resident #2's bed was moved against the wall. -Staff had not been given any directives to complete increase checks or any other specific directives to prevent Resident #2 from falling. Interview with the Resident Care Coordinator (RCC) on 04/24/24 at 8:54am revealed: -Staff were to monitor Resident #2 to ensure she did not fall out of her wheelchair. -The only things the facility came up with were to place a seat belt in her wheelchair and monitor Resident #2. -Monitoring meant to keep a close eye on Resident #2 and ensure she was positioned properly in her wheelchair and in bed, and to have her bed in the lowest position. -Staff were not told how often to monitor Resident #2 other than every 2-hour check. -After Resident #2 broke her nose on 04/02/24, there were no new interventions put into place, they were the same. -If the interventions were not working the facility had to do something different. -There was no reason nothing different was done for Resident #2 Interview with the Administrator on 04/24/24 at

12:24pm and 2:44pm revealed:

-If a resident was on the floor and it was not

OXGF11

PRINTED: 05/03/2024 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R HAL096031 B. WING 04/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 ROYALE AVENUE **GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI** GOLDSBORO, NC 27534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 270 Continued From page 6 D 270 witnessed by staff it was considered a fall. -The facility knew Resident #2 was a fall risk when she was admitted. -Staff kept an eye on Resident #2 and tried to keep her with them. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 04/24/24 at 10:02am was unsuccessful. Second attempted telephone interview with Resident #2's PCP on 04/24/24 at 4:06pm was unsuccessful. The facility failed to supervise Resident #2 which resulted in 7 falls in 7 weeks with 4 of the 7 falls requiring the resident to be seen and treated at the hospital, twice for head injuries, a bruised shoulder and a fractured nose. The facility's failure resulted in substantial risk for serious physical harm and constitutes a Type A2 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 A2 VIOLATION SHALL NOT EXCEED MAY 24. 2024.

Division of Health Service Regulation

JTATE FORM