STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on April 23, 2024 and April 24, 2024.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) with a history of multiple falls that resulted in serious injuries including a fractured nose and a closed head injury. The findings are: Review of the facility's fall policy upon entrance revealed: -If a resident continued to have falls, staff would monitor the resident and situation to determine if any type of intervention was needed to keep the 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.	D 270	The facility will ensure that supervision is provided for residents in accordance w each resident's assessed needs, care plan & current symptoms. Specific interventions will be put in place for residents with a history of falls & falls w injury to ensure supervision and safety. The facility Falls Policy has been updated addressing specific protocols - IE- interventions for resident based on specific needs.	5/17/24 5/17/24 5/10/24

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D 270	Continued From page 1 -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. -She was non-ambulatory. -She needed total care. a. Review of Resident #2's progress note dated 03/03/24 revealed: -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 Medical Services (EMS) transport. Review of Resident #2's incident and accident report dated 03/03/24 revealed: -She was found on the floor in the common area bathroom, hollering. -She was sent to the hospital via EMS transport. -She returned to the facility on 03/03/24 with no new orders. Review of Resident #2's after visit summary dated 03/03/24 revealed: -The reason for the visit was due to a fall. -The diagnoses were a fall and head injury. Review of Resident #2's record revealed there was no documentation of an intervention put in place after her fall on 03/03/24. Interview with a medication aide (MA) on 04/24/24 at 11:05am revealed:	D 270	QA program will keep up & trends for each resident & help determine if interventions are required. 5/17/24 Specific interventions have been put in place for resident #2. 4/24/24 ① Observe resident every 30 minutes. ② Resident will have 1:1 time & staff member as needed. ③ Residents will be checked for incontinence every 2 hours. ④ Do not put resident →	

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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 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 note dated 04/02/24 revealed:	D 270	to bed until she is ready to go to sleep. Staff has been in-serviced on interventions. 4/28/24 Fall Prevention (NC 106.8 Training) has been completed c staff. 5/17/24 In-Service completed c SIC's regarding - updated Fall Policy updated incident report QA program. Observation/interventions 5/15/24 Administrator will monitor QA program 2 x monthly to ensure all trends + issues regarding falls have 5/17/24 →	

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D 270	Continued From page 3 -She was found face down on the floor with blood coming from her nose. -She was sent to the hospital via EMS transport. 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. Review of Resident #2's after visit summary dated 04/02/24 revealed: -The reason for the visit was due to a fall. -The diagnoses were a fall and closed fracture of the nasal bone. Review of Resident #2's record revealed there 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: -She was found on her bedroom floor wrapped in a blanket. -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 on 04/09/24. f. Review of Resident #2's progress note dated 04/15/24 revealed: -She was found by staff lying on the floor at her bedside. -She complained of pain in her shoulder and arm. -She stated she was "hurting very bad." -She was sent to the hospital via EMS transport.	D 270	been addressed. Administrator / RCC will monitor staff / residents to ensure interventions are carried out. Facility Fall Policy updated. Administrator will monitor to ensure policy is followed. Administrator and RCC monitor incident reports weekly to determine if any interventions are necessary.	5/17/24 5/17/24

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D 270	Continued From page 4 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	D 270		

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D 270	Continued From page 5 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	D 270		

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D 270	Continued From page 6 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.	D 270		