STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021008	A. BUILDING: _____ B. WING _____	R 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

(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	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 review, the facility failed to notify physician for 1 (#3) of 5 sampled residents regarding one resident frequently sliding out of wheelchair on to the floor: The findings are: Review of Resident #3's current FL-2 dated 2/12/15 revealed: -Diagnoses included dementia, transient cerebral ischemia, syncope 2 collapse, atrial fibrillation, hyperlipidemia, hematuria, diverticulosis of colon, gastroesophageal reflux disease (GERD) and anxiety. Review of Resident #3's Resident Register revealed an admission date of 11/14/12. Review of Resident #3's current Care Plan dated 2/12/15 revealed no documentation of resident frequently sliding out of wheelchair on to the floor. Review of the Care Notes for Resident #3 revealed: -On 12/23/14 (7-11 p.m.) slipped down into his chair and wouldn't sit up. -On 12/29/14 (7-3), "[Resident] continues to slide	D 273		

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D 273	Continued From page 1 out of wheelchair onto the floor. He is not falling. Just slip out. Staff checked on him every hour to try to keep him off the floor." -On 1/7/15 (3-11), Resident sliding out of the chair. -On 1/19/15 at 2:30 p.m. Resident slipped out of his chair onto the floor. No injury Observation on 3/10/15 between 3:00 p.m.-3:30 p.m. in the dayroom revealed: -Resident #3 sat slumped in his wheelchair with his head on top of the wheelchair's backrest, elbows resting on the wheelchair's armrest and feet in shoes on the floor. -Staff repositioned Resident #3 in his wheelchair at 3:30 p.m. Observation on 3/11/15 at 3:30 p.m. in the dayroom revealed: -Resident #3 sat slumped in his wheelchair with his head on top of the wheelchair's backrest, elbows resting on the wheelchair's armrest, and feet in shoes on the floor. -Staff repositioned Resident #3 in his wheelchair at 3:30 p.m. Observation on 3/12/15 at 11:30 a.m. and 3:30 p.m. in the dayroom revealed: -Resident #3 sat slumped in his wheelchair with his head on top of the wheelchair's backrest, elbows resting on the wheelchair's armrest and legs crossed. -Staff repositioned Resident #3 in his wheelchair at 11:30 a.m. and 3:30 p.m. Based on record review and observations of Resident #3 on 3/10/15 at 3:10 p.m. and 3/12/15 at 11:30 p.m. revealed, he was determined not to be interviewable.	D 273		

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D 273	Continued From page 2 Telephone interview with Resident #3's family member on 3/12/15 at 9:49 a.m. revealed: -She was aware Resident #3 sat slumped in his wheelchair and slid to the floor occasionally. -Staff notified her when resident slid out of his wheelchair on to the floor. -She did not know, if Resident #3's physician had been notified about resident sitting slumped in his wheelchair and occasionally sliding on the floor. -Resident #3's physician should have been made aware. Confidential interviews with 5 of 5 personal care aides revealed: -They were aware Resident #3 sat slumped in his wheelchair. -They were instructed by the RCC to reposition resident, if they observed him sitting in the wheelchair slumped. -No time frame was given on how often staff should monitor Resident #3 in his wheelchair. -They stated Resident #3 sat slumped in his wheelchair because he was used to sitting in his recliner in his bedroom with a family member. Confidential interviews with 3 of 3 medication aides revealed: -They had not notified Resident #3's physician about resident sliding out of his wheelchair on to the floor. -They gave no reasons why Resident #3's physician had not been notified. Interview with the Resident Care Coordinator (RCC) on 3/12/15 at 11:00 a.m. revealed: -RCC was aware Resident #3 sat slumped in his wheelchair. -Resident #3 slides out of his wheelchair on to the floor at least 2 times per week.	D 273		

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D 273	Continued From page 3 -It had been 6 months or more since Resident #3 started sitting slumped in his wheel chair and sliding out of his wheelchair onto the floor. -RCC did not know why Resident #3 started sitting slumped in his wheelchair or sliding out of the wheelchair. -Resident #3 had no injuries from sliding out of his wheelchair onto the floor. -No incident reports had been written regarding Resident #3's sliding out of wheelchair on to the floor. -The staff had been instructed to check on Resident #3 frequently and to reposition him in the wheelchair, if needed. -RCC did not tell them how often to monitor Resident #3 in his wheelchair. -RCC had notified the Administrator about Resident #3 sitting slumped in his wheelchair and sliding out of his wheelchair onto the floor. - RCC had not notified Resident #3's physician about resident sitting slumped in his wheelchair or sliding out of his wheelchair on the floor, prior to the survey. -RCC stated, "I never thought of notifying Resident #3's physician about resident sitting slumped in his wheelchair or sliding out of his wheelchair on the floor. -Supervisors were responsible for notifying the residents' physician of any changes in residents' condition on the day the changes occur. -On 3/12/15 at 11:00 a.m., RCC contacted Resident #3's physician office about resident sliding out of his chair. -RCC was waiting on a call back from Resident #3's physician's nurse. Interview with the Administrator on 3/12/15 at 11:30 a.m. revealed: -She was aware Resident #3 sat slumped in his wheelchair and occasionally slid out of his	D 273		

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D 273	Continued From page 4 wheelchair on to the floor. -"I do not know, if Resident #3's physician was made aware." -Resident Care Coordinator (RCC) was responsible for giving staff instructions on when to notify the physician. Attempted to reach Resident #3's physician, but he was unavailable by phone. _____ Plan of Protection dated 3/12/15 revealed: -Effective 3/12/15, a chair alarm will be attached to Resident #3's wheelchair. -Physical Therapy (PT) evaulation was completed on 3/18/15. -Retraining with staff on reporting of changes in residents' conditions will begin 3/12/15 and will be completed 3/20/15. -Restraining with staff on referral and follow-ups for changes in residents' conditions will begin 3/12/25 and be completed 3/20/15. -The inservice will be done by the Administrator. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2015.	D 273		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	{D912}		

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{D912}	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews and record review, the facility failed to notify physician for 1(#3) of 5 sampled residents regarding one resident frequently sliding out of wheelchair on to the floor. [Refer to Tag D 912 10 A NCAC 13F .0902(b) (Type B Violation)].	{D912}		