STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on July 7-10, 2015.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls in the dining room, hallways and resident rooms and bathrooms did not have stains, and holes and missing tile, the exhaust vent in the ceiling was not dusty, the doors in the dining room, residents' rooms, hallway and living room did not have stains, the window frames in the dining room and hallway did not have scraped paint, the baseboards and floors in the dining room, resident rooms, resident bathrooms and hallways did not have built-up dirt and grime and the woodened hand rails in the dining room were polished. The findings are: Observation of the dining room on 7/7/15 at 11:36 a.m. revealed: -Two of four walls had scrapes of white paint. -One of four walls had chipped white paint. -One of two back doors had scraped paint and rust on the bottom of the door on the metal plate. -The other back door had scraped paint. -The plastic wire protector located on the the wall	D 074		

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D 074	Continued From page 1	D 074		

near the exit door in the front of the kitchen had brown rust.
-The ¾ of the front and back of the metal frame around the two windows which faced the hallway and the dining room had scraped paint.
-Four woodened handrails on the walls were dusty and needed to be polished.

Observation of the hallway between the nurse's station and the dining room on 7/7/15 at 11:51 a.m. revealed:
-Two of three woodened baseboards located in a small space between the dining room wall and the ice machine were scraped.
-The baseboards and floor had built-up dirt and grime by the ice machine.

Observation of the exit door across from room #4 on 7/7/15 at 11:53 a.m. revealed:
-The bottom of the door and the bottom of the window frame next do the door had scraped paint.
-The bottom of the exit door had built-up dirt.
-The corner of the floor in front of the exit door had built-up black dirt and grime.
-The bottom of room #4's woodened door was scraped.
-The floor inside room #4 had brown dried stains under the chair and throughout the room. Multiple rust spots were on the floor under the bed near the entrance door. All four baseboards around the room had brown stains.
-The tiled floor inside the private bathroom in room #4 had greater than 15 tiles stained brown.
-Tile was missing from the wall between the wall and the floor located under the sink.

Interview with housekeeper on 7/7/15 at 12:20 p.m. revealed:
-The hall and other rooms were waxed three

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D 074	Continued From page 2 weeks ago. -The walls are cleaned weekly and as needed. -The baseboards are cleaned monthly and as needed. Observation of room #5 on 7/7/15 at 12:20 p.m. revealed: -A hole in the wall by the sink where a missing towel bar holder was located. -The floor throughout the room had brown wax build up. Observation of the wall in the living room on 7/7/15 at 12:41 p.m. revealed 3 of 4 walls had scraped paint. Interview with a Personal Care Aide (PCA) on 7/8/15 at 7:24 a.m., second PCA on 7/9/15 at 3:51 p.m. and a third PCA on 7/9/15 at 4:26 p.m. revealed the residents or family had not complained about the cleanliness of the facility. Telephone interview with a family member on 7/8/15 at 2:30 p.m. revealed: -The family member came to the facility to visit a resident every 1 and 1/2 to two months. -Most of the time the family member come to the facility, it is clean. -Other times the floor is not swept. Confidential staff interview revealed: -The chipped paint on the bottom of the door and window seals had been chipped for at least 1 ½ years. -If anything needed to be repaired, the Housekeeping Supervisor was made aware. Observation of residents' rooms and bathrooms during the initial tour on 7/7/15 between 11:30 A.M. and 12:45 P.M. revealed:	D 074		

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D 074	Continued From page 3 - Bathroom floor in room 16 has brown and yellow area around base of commode. - The floor in the bathroom sticks to your shoes bottoms. - The floor in room 16 has several areas of cream colored discoloration. - The largest area been approximately three feet long by one foot wide. - Bathroom floor in room 10 was sticks to the bottom of your shoes. - Exit door between rooms 12 and 13 had several areas on door and frame where the paint has come off. - Room 12 in bathroom has two metal strips with sharp edges approximately 18 inches in width on the wall opposite the commode. - In the bathroom of room 13, there are several holes ranging in size of approximately half inch to three quarter inch on wall on right of commode. - Room 14, wall above commode with tape over square hole approximately five inches in width and length. - There are also several nail holes in the wall above room 14's commode. - Bathroom floor in room 15 sticks to the bottom of your shoes. - Fourteen of the sixteen rooms had multiple areas of cream colored discoloration on their floors. Observation of residents' common bathroom during initial tour on 7/7/15 between 11:30 A.M. and 12:45 P.M. revealed: - The first shower stall in the residents' common bath has a tile missing next to the installed seat. - Exhaust vent in ceiling covered with large amount of dust. - In the third shower stall there are two tiles missing from the left lower back wall.	D 074		

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D 074	Continued From page 4 - There is one tile that is out of place behind the right lower back wall with another tile that is broken below and to the left of it. Interview with Maintenance on 7/9/15 at 2:20 P.M. revealed: - That he only comes to the facility once per week on Thursdays. - Only comes to facility other than Thursdays if there is an emergency call from facility. - "The floors are in bad shape." - There is a gentleman that has been working with the Administrator to get floors clean. - Any major repairs such as painting has to be done through the corporate office. Interview with Housekeeping Manager on 7/9/15 at 3:50 P.M. revealed: - He has been working with the Administrator to get facility floors cleaned. - A couple of the bedroom floors and part of the hallway have been stripped and cleaned, then refinished. - Anticipate that it will take about a month to strip, clean and refinish the rest of the facility's floors. Interview with Memory Care Coordinator (MCC) on 7/9/15 at 5:25 P.M. revealed: - For the last month they have been waxing the floors. - Facility put order into corporate for the walls to be repaired. - Corporate tells facility that they are "working on it". - Facility changed maintenance person and maybe that is why the repairs to the walls kind of got pushed to the side. - Floors, walls and baseboards should be cleaned every day.	D 074		

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D 074	Continued From page 5 - Resident, family or staff have not complained about the cleanliness of the facility. - " Every so often the Administrator will say that the floors need waxing". Interview with Administrator on 7/9/15 at 6:18 P.M. revealed: - "I would like a five star facility." - Facility only has maintenance person one day per week on Thursdays. - The maintenance company services the whole eastern region. - She was hoping to get maintenance for at least three days per week. - Started stripping, cleaning and waxing floors around the 15th or 20th of June 2015. - It should take around one month to complete work on the floors. - The floors are normally stripped and waxed yearly. - Facility will be getting new floors but do not know when. - The entire facility was painted two years ago. - Until facility lost their maintenance person around four months ago, the walls were painted more frequently.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility	D 076		

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D 076	Continued From page 6 failed to assure the furniture in the dining room, nurse's station, residents' rooms and living room were cleaned and in good repair including two serving tables in the dining room, a leather cushioned chair in the living room, chester drawers and night stands in the resident rooms and a rubber rolling wheel on a hospital bed in a resident's room. The findings are: Observation of the dining room on 7/8/15 at 8:00 a.m. revealed: -One of two serving tables in the dining room on 7/8/15 at 8:00 a.m. revealed the plastic laminate had peeled from two areas of the table. -Three of four of the metal legs on the other table had multiple rust spots. Observation of the chester drawer and the night stand in room #4 on 7/7/15 at 11:53 a.m. revealed the corners of the chester drawers had scraped wood. Observation of room #5 on 7/7/15 at 12:11 p.m. revealed one of four wheels of the hospital bed next to the window had pieces of rubber from the wheel shedding. Interview with housekeeper on 7/7/15 at 12:20 p.m. revealed she dusted the furniture daily in the residents' rooms. Observation of room #5 on 7/7/15 at 12:20 p.m. revealed the edges of the woodened night stand including the drawers were scraped. Observation of a leather seated chair located in the living room by the piano on 7/7/15 at 12:41 p.m. revealed there was a small rip in the seat of	D 076		

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D 076	Continued From page 7 the chair. Interview with a Personal Care Aide (PCA) on 7/8/15 at 7:24 a.m., second PCA on 7/9/15 at 3:51 p.m. and a third PCA on 7/9/15 at 4:26 p.m. revealed the residents or family had not complained about the furniture at the facility. Confidential interview with staff revealed: -The facility had not had new furniture within the past couple of years. -There was no complaints about the current furniture. -The missing knobs on some of the dressers, the plaster covering on the dining room tables, and all the rest of the furniture had been like that for at least 1 ½ years. -If anything needed to be repaired, the Housekeeping Supervisor was made aware. Observation of residents' rooms during the initial tour on 7/7/15 between 11:30 A.M. and 12:45 P.M. revealed: - In room 3 dresser drawer with missing pull handle. - In room 6 dresser drawer with missing pull handle. - The box spring under the mattress in room 6 had the plastic edge guard hanging. - In room 12 bedside table is missing its pull knob. - At nursing station the corner of the back counter had approximately two feet of the laminate torn off from the counter. - A drawer on the right side of the back counter at the nursing station was broken and hanging out of the slot. - Three areas on the counter at the front of the nursing station had laminate torn off. - The cushion was falling out in the bottom of a	D 076		

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D 076	Continued From page 8 rocking chair in room 6. Interview with Maintenance on 7/9/15 at 2:20 P.M. revealed: - That he only comes to the facility once per week on Thursdays. - Only comes to facility other than Thursdays if there is an emergency call from facility. - The Administrator would know about the repair and replacement of the furniture. Interview with Housekeeping Manager on 7/9/15 at 3:50 P.M. revealed: - When furniture are broken we either they are either repaired or replaced. - Will replace staples to box spring corner edging in room 6. - Chair in room 6 is from resident's home and it will be removed and resident's family called to pick up. - Do not know how often mattresses are replaced. - Mattresses are checked and if there are holes or rips the mattress is replaced. - Residents will let me know if something is wrong with furniture or facility and I will try to fix or make Administrator aware of what is wrong. Interview with Memory Care Coordinator (MCC) on 7/9/15 at 5:25 P.M. revealed: - When there are damaged furniture they are either repaired or replaced if they cannot be repaired. - Resident, family or staff have not complained about furniture been broken or the cleanliness of the facility. Interview with Administrator on 7/9/15 at 6:18 P.M. revealed: - Facility only has maintenance person one day	D 076		

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D 076	Continued From page 9 per week on Thursdays. - The maintenance company services the whole eastern region. - She was hoping to get maintenance for at least three days per week. - Family is aware that the bottom of chair in room 6 is broken. - Will remove chair from room 6 and call family concerning broken chair. - She inspects mattresses weekly and if there are any wear and tear they are replaced. - All the mattresses in facility are less than one year old. - Broken or worn furniture are either repaired or replaced.	D 076		
D 092	10A NCAC 13F .0306(b)(7) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (7) individual clean towel, wash cloth and towel bar in the bedroom or an adjoining bathroom; and This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure residents had a towel bar in the room or adjoing bathroom. The findings are: Observation of residents' rooms and bathrooms during the initial tour on 7/7/15 between 11:30 A.M. and 12:45 P.M. revealed:	D 092		

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D 092	Continued From page 10 - No towel bars in rooms 3, 5, 6,7,8,11,12 and 13. - Of the eight rooms that were missing towel bars, three had sharp remnants protruding from the wall where the towel bars should have been. Interview with Housekeeping on 7/9/15 at 8:13 A.M. revealed: - She had never seen any towels on the towel bars. - Some of the rooms do not have any towel bars. - She would be responsible for making sure that there were clean towels on the towel bars in the rooms or bathrooms. Interview with Housekeeping Manager on 7/9/15 at 3:50 P.M. revealed that the towel bars that are broken will be replaced. Interview with Maintenance on 7/9/15 at 2:20 P.M. revealed: - That he only comes to the facility once per week on Thursdays. - Only comes to facility other than Thursdays if there is an emergency call from facility. - Facility has the "heavy duty" towel bars on order. - The towel bars should be in before Thursday of next week. - If towel bars arrive before Thursday, I will install them when I come to facility. Interview with Memory Care Coordinator (MCC) on 7/9/15 at 5:25 P.M. revealed: -She was aware that a towel bar needed to be placed in each room or bathroom. -She did not know when the towel bars would be replaced in each room or bathroom. -If furniture was broken, it would be replaced.	D 092		

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D 092	Continued From page 11 Interview with Administrator on 7/9/15 at 6:18 P.M. revealed: - Facility only has maintenance person one day per week on Thursdays. - The maintenance company services the whole eastern region. - She was hoping to get maintenance for at least three days per week. - Facility just ordered around 12 towel bars. - Towel bars were ordered July 1, 2015 and approved by corporate on July 6, 2015. - Once the towel bars are delivered, maintenance will install in rooms and bathrooms.	D 092		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and 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: TYPE A1 VIOLATION Based on observation, interview and record review, the facility failed to provide personal care with transferring of a resident was in accordance with the residents care plan resulting in a fractured left femur for 1 of 5 sampled residents (#3). The findings are:	D 269		

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D 269	Continued From page 12 Review of Resident #3's current FL-2 dated 4/7/15 revealed: -The resident's diagnoses included dementia/Alzheimer's, Parkinson's disease, subdural hematoma, and seizure disorder. -The resident was constantly disoriented and ambulatory with a wheelchair. -The resident was receiving hospice services. -There were no orders related to transferring or supervision. Review of Resident #3's prior FL-2 dated 4/14/14 revealed no orders related to transferring or supervision. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 7/8/10. Review of Resident #3's current "Resident Service Plan" dated 12/9/14 revealed: - The resident was sometimes disoriented. -The resident was ambulatory with aide or devices. -The resident had limited strength with the upper extremities. -The resident was on fall precautions. -The resident was fully dependent with transferring to and from bed and to and from chair. -There was no documentation of the number of staff needed to transfer the resident. Review of Resident #3's prior "Resident Service Plan" dated 11/11/14 revealed: -The resident was sometimes disoriented. -The resident was ambulatory with aide or devices. -The resident had limited strength with the upper extremities.	D 269		

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D 269	Continued From page 13 -The resident was fully dependent with transferring to and from bed and to and from chair. -There was no documentation of the number of staff needed to transfer the resident. Review of Resident #3's Licensed Health Professional Support (LHPS) task revealed: -Four quarterly LHPS reviews from 1/13/15-6/11/15 revealed the resident was heavy care, required two staff when transferring, and required a hoyer lift. -Review of the LHPS review dated 11/2/14 revealed the resident required a one person assist when transferring. The resident continued to stand without difficulty of pivoting. Review of Resident #3's Hospice clinical notes included: -An entry dated 10/1/14 revealed the resident was non ambulatory and required a two person assist for transferring between bed and wheelchair. The resident needed total assistance for all activities of daily living. -An entry dated 10/6/14 revealed the resident is non-ambulatory, needs 1-2 person ' s assistance for transferring between bed and wheelchair. The resident is weaker and is unable to hold the body up while providing personal care. -An entry dated 10/22/14 revealed the resident was non-ambulatory, the resident spends most of the time in the wheelchair and the resident needs 1-2 person's assistance for transferring between bed and wheelchair. -An entry dated 11/25/14 revealed the resident is non-ambulatory, the resident was unable to stand up and pivot, needs two person assistance for transferring between bed and wheelchair. The resident's diagnoses included Arthropathy and osteoarthritis.	D 269		

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D 269	Continued From page 14 -An entry dated 12/3/14 included the resident was non-ambulatory and required 2 persons assist when transferring. Interview with the Hospice nurse on 7/10/15 at 10:35 a.m. revealed: -Resident #3 was admitted to hospice on 2/21/14. Upon admission to hospice, staff stated the resident required a two person assist when transferring. -The resident had always required a two person assist when transferring. -She documented a clinical note on 12/3/14 which revealed Resident #3 needed a 2 person assist when transferring. Telephone interview with Resident #3's Hospice Aide on 7/9/15 at 7:19 p.m. revealed: -She comes to the facility on Monday, Wednesday and Fridays to provide personal care to the resident. -She had been providing personal care to the resident for the past two years. -Resident #2 had always required a two person assist when transferring for the past two years since the resident had started hospice. -The Hospice aide had always gotten another staff at the facility to help her transfer the resident. Review of Resident #3's incident report dated 12/4/14 revealed: -On 12/4/14 at 10:45 p.m., the resident was being put to bed. In the process of pivoting from wheelchair to bedside, the resident slid down to the floor. -The resident was not alone. -The resident was alert and oriented, -The resident had a deformity and refused to let staff take vital signs.	D 269		

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D 269	Continued From page 15 -The resident's primary care physician was notified at 10:50 p.m. and responsible party was notified at 10:54 p.m. -The resident was taken to the hospital by the Emergency Medical Services (EMS) to the local hospital at 11:20 p.m. Review of a progress note for Resident #3 dated 12/4/14 at 10:45 p.m. by a Medication Aide (MA) (who no longer worked at the facility) revealed: -While the resident was being put to bed, the resident was being pivoted from wheelchair to the bed and went down to the floor. -The resident's left leg was at an odd angle. -The MA placed a call to hospice, the resident's responsible party and called 911 to transport resident to the hospital. -The resident was transported to the hospital at 11:20 p.m. Review of Resident #3's Hospice clinical note dated 12/5/14 at 1:13 a.m. revealed: -The Hospice nurse assessed the resident at the hospital. -The MA on duty revealed the resident had fallen to the floor while 2 Nursing Assistance (NA's) were transferring the resident to the bed. -The resident had a left femur fracture and UTI's. -The resident's left leg was turned inward. The patient moans when being repositioned by hospital staff. -The resident will be evaluated on 12/5/14 by an Ortho-surgeon to determine if the resident is a candidate for surgery. Interview with the Hospice nurse on 7/8/15 at 3:00 p.m. revealed: -When Resident #3 broke the left femur December 2014, staff reported while staff was transferring Resident #3, the resident slid to the	D 269		

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D 269	Continued From page 16 floor. -The resident's left leg was "tilted inside." Review of Resident #3's hospital discharge summary dated 12/10/15 revealed: -The resident was admitted to the hospital on 12/5/14 and discharged on 12/10/14. -The resident's admitting diagnoses revealed a left femur fracture. -The final diagnoses revealed left femur fracture status post (s/p) repair. -The resident was brought to the emergency department for left hip pain after a fall. -The "nursing home" staff reported the patient's left leg "turned inwards" after the fall. -"The patient is very confused and unable to provide history due to dementia." -The resident had surgical repair on the left femur while at the hospital. -Follow-up with [named Orthopedic] in 14 days to have the staples removed. -The discharge medication list included Ceftin 500 milligrams twice daily for three doses (used to treat UTI's.) Review of Resident #3's Physicians Progress Notes dated entry 12/23/14 at 4:35 p.m. by the Orthopedics Nurse Practitioner revealed: -"Status postop open reduction and internal fixation (ORIF) subtrochanteric femoral fracture." -The resident had the surgery on 12/8/14. -"Left hip and lateral left thigh with surgical incision sites with three staples removed at today's visit without difficulty." -Steri-strips were applied. -"Laceration sites are healing well without any signs of infections. " -The subtrochanteric and intertrochanteric left hip fractures are in stable position. -"Clean the surgical incisions daily with [named]	D 269		

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soap and warm water." Keep the areas clean and dry.
-Notify the provider if the incisions have any signs of infection. Non-weight bearing to the left lower extremities. "Follow-up in two weeks or sooner if there are any problems or concerns.

A progress note for Resident #3 dated 12/10/14 (no time) revealed:
-The resident complained of pain in the thigh at 10:00 p.m.
-The resident received Oxycodone as needed (used to help control pain.) At 11:00 p.m., the Oxycodone helped to relieve the pain.

Review of Resident #3's orders revealed:
-The resident had an order dated 12/10/14 for Oxycodone 5/325 milligrams (mg) tablet take one tablet by mouth as needed every six hours.
-There was a subsequent order dated 12/12/14 for Oxycodone 5/325 mg take one tablet by mouth every four hours for pain.

Review of Resident #3's orders revealed:
-An order dated 1/8/15 for a geri chair due to the resident's recent leg fracture.
-An order dated 1/26/15 for a hoyer lift to be used for transferring the resident.

Interview with a PCA on 7/9/15 at 3:51 p.m. revealed:
-She had always transferred Resident #2 using a two person assist.
-She was working at the facility on 12/4/14 (3-11) when Resident #3 slid from the bed.
-She did not know the time of the injury.
-She did not witness the slide, because she was working with another resident on the other end of the hall.
-On 12/4/14, there were three PCAs and one

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D 269	Continued From page 18 Medication Aide (MA) working at the facility second shift when the resident had slid on the floor. After she finished with her assigned resident, within 5 minutes she had gone to check on Resident #3. Resident #3 was sitting on the floor in front of the resident's bed, leaning on the right side with the right arm touching the floor and with the left leg under the bed. Both of the resident's feet were under the bed. The resident's face was towards window. The resident laid on the bed and complained of the left leg bothering the resident. The MA on duty advised the staff on duty not to move the resident. Emergency Medical Services was at the facility within 10 minutes to take the resident to the hospital. -The PCA who was working with Resident #3 during the time of the injury no longer works at the facility. -Before the fall, Resident #3 could stand up long enough for staff to pull up the resident's clothes. -Resident #3 had not had any more falls before or after the injury on 12/4/14. Interview with second PCA on 7/9/15 at 4:26 p.m. revealed: -She worked at the facility on 12/4/14 (3-11). -She did not witness Resident #3 fall on 12/4/14. She was not assigned to Resident #3 on her shift and does not know the time the injury occurred. -Toward the end of her shift (3-11), she was making rounds to check on the residents she was assigned to before she had gotten off work. -Resident #3's door was opened. She passed by Resident #3's room and saw Resident #3 on the floor. The PCA assigned to Resident #3 was the only PCA in the room with the resident. The PCA assigned to Resident #3 told her she was trying to transfer the resident from the wheelchair to the bed. She told the PCA assigned to the resident,	D 269		

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the resident required two person assist when transferring.
-When she saw Resident #3 after the fall, the resident was leaning against the resident ' s bed. One of the residents' legs were on the side of the bed. The resident did not scream or holler after the fall. The MA, who worked on second shift on 12/4/14, told staff to take the resident's vitals and to not move the resident. EMS was called by the MA.
-The PCA assigned to Resident #3 no longer works at the facility.
-Resident #3 was and had always been a 2 person assist with transferring.
-She had always used a two person assist when transferring the resident from bed to chair.
-Currently, staff use a hoyer lift to transfer Resident #3 to the bed and chair, because the resident is "none weight bearing."
-Resident #3 had not had any more falls before or after the injury on 12/4/14.

Interview with the Resident Care Manager on 7/9/15 at 9:36 a.m. revealed:
-She worked at the facility on 12/4/14 as the Manager on duty.
-She did not witness Resident #3 fall from the bed on 12/4/14.
-The PCA was trying to "pivot the resident" to the bed. The aide lost balance and helped the resident to the floor.
-Resident #3 was a one person assist when the resident had slid to the floor on 12/4/14.
-The MA who wrote the progress note on 12/4/14 no longer works at the facility.

Telephone interview with Resident #3's Responsible Party on 7/8/15 at 2:30 p.m. revealed:
-Either the first of the year (2015) or the end of

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last year (referring to 12/4/14 incident) the resident fell and broke a hip.
-The Responsible Party was told the resident's legs "give way" and a staff member was transferring the resident.
-Staff was not keeping the resident close while transferring.
-Since the resident had been at the facility, the resident had always required a two person assist to transfer.

Interview with a MA on 7/9/15 at 5:10 p.m. revealed Resident #3 had been a two person assist when transferring for at least the past 9 months.

Interview with the Memory Care Manager on 7/9/15 at 5:54 p.m. revealed:
-She received a call on 12/4/14 from the MA who worked second shift close to the end of the shift. She could not remember the time. The MA reported the PCA assigned to Resident #3 was transferring the resident from the wheelchair to the bed. The PCA assigned to the resident had to let the resident slide to the floor. The MA did not like the position of the resident's leg and had called EMS. The resident refused to have vital signs taken. The Memory Care Manager called the hospice nurse.
-Before Resident #3 fell 12/4/14, the resident required 1 to 2 person assist.
-Before Resident #3's leg was twisted on 12/4/14, the resident was diagnosed with osteoarthritis and could stand.
-If staff think they could transfer a resident using a one person assist versus two person assist, they can use a one person assist.
-The PCA and MA assigned to Resident #3 second shift on 12/4/14, no longer works at the facility. The PCA assigned to Resident #3 on

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D 269	Continued From page 21 12/4/14 (3-11) always transferred the resident using one person assist, because she had the strength to transfer the resident. -Currently, within the past three months, she expected staff to transfer Resident #3 using a two person assist. The resident is none weight bearing. When transferring the resident, one staff should guide the hoyer lift while the other staff is assisting the resident. -Staff used the LHPS review to determine a resident's assistance with transferring. -She did not know if the facility had a written policy with transferring. Interview with the Administrator on 7/9/15 at 6:21 p.m. revealed: -The number of staff needed to transfer a resident is not documented on "Resident Service Plan." The assistance is determined by the LHPS nurse. -Resident #3 had a fall on 12/4/14. -The MA on duty called her late one night and told her the PCA assigned to Resident #3 was transferring the resident from the wheelchair to the bed. The resident's bottom did not grip to the bed. The resident slid to the floor. The resident did not have any bruises. She could not remember the time of the call. -The Administrator told the MA to call 911 and call hospice. -After Resident #3 had fallen, the MA assessed the resident to make sure the resident was not in danger. -EMS arrived at the facility and transported Resident #3 to the hospital. Resident #3's primary care physician and Responsible Party were notified. -Before Resident #3 had the fall on 12/4/14, the resident required a one person assist when transferring.	D 269		

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D 269	Continued From page 22 -Currently, the resident require a two person assist when transferring. -The LHPS nurse determined the number of staff needed to transfer a resident. -Hospice should communicate with the Memory Care Manager about the number of staff needed to transfer a resident, so the Memory Care Manager could communicate to staff. -If the Hospice nurse had given a recommendation and the LHPS nurse had a different recommendation in reference to the number of staff needed to transfer a resident, staff should always take the recommendation with the larger number of staff needed to transfer the resident. -The Hospice aide comes to the facility three times weekly to assist the resident. Interview with a third PCA on 7/9/15 at 9:16 a.m. revealed: -She worked with Resident #3 weekly on first shift (7-3). -Three months ago (referring to 4/26/15) Resident #3 slid from the bed. -The PCA had given the resident a bed bath. -She dressed Resident #3 and sat the resident on the side of the bed. The resident started sliding down the bed. -The PCA caught the resident, slid the resident to the floor with the residents' legs straight in front and sat the resident on the floor. -The hospice nurse came to the facility and did an assessment on the resident. -The resident was not hurt and did not go to the hospital. -Resident #3 had always required a two staff person assist when transferring, even before the fall December 2014. -Currently, staff used a hoyer lift and two staff to transfer the resident.	D 269		

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D 269	Continued From page 23 Review of Resident #3's progress note entry dated 4/26/15 (7-3) by a MA revealed: -The hospice nurse came to assess the resident. -The resident did not have any injuries. -The resident was in bed relaxing at the end of the shift. Interview with a PCA on 7/8/15 at 10:21 a.m. revealed: -Between March 2015 and May 2015, Resident #3 had a fall. -The resident did not need to go to the hospital nor did the resident have injuries. Interview with the Hospice nurse on 7/8/15 at 3:00 p.m. revealed: -Resident #3 had only had a slide from the bed, since 12/4/14. -She could not remember the date of the slide. -The resident did not have any injuries. Interview with the Administrator on 7/9/15 at 6:21 p.m. revealed: -Within the past couple of months (referring to 4/26/15), a PCA was assisting Resident #3 with personal care. Resident #3 started sliding down the bed. The assigned PCA caught the resident and slid the resident appropriately to the floor. Resident #3 did not have any injuries from the slide. -The Hospice nurse was called and came to evaluate the resident. -She could not remember the time of the slide. Interview with a MA on 7/9/15 at 5:10 p.m. revealed she had only known Resident #3 to have a fall on 12/4/14. Interview with a PCA on 7/9/15 at 10:35 a.m.	D 269		

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D 269	Continued From page 24 revealed she worked with Resident #3 daily and the resident always required a two person assist with transferring. Observation of Resident #3 revealed: -On 7/7/15 at 11:30 a.m., the resident was sitting in the hallway in a wheelchair. -On 7/8/15 at 8:00 a.m., the resident was eating breakfast in the dining room. -On 7/9/15 at 12:01 p.m., the resident was sitting in the resident ' s room in a wheelchair. -On 7/10/15 at 11:30 a.m., the resident was sitting in the hallway in the resident ' s wheelchair. An attempted interview with Resident #3 on 7/9/15 at 12:01 p.m. revealed: -The resident had fallen down and broken the hip. -The resident did not say when the injury occurred or which hip had been broken. -The resident could no longer be interviewed, because of the residents ' diagnoses. Based on observation, interview and record review, Resident #3 was not interviewable. Interview with the Memory Care Coordinator on 7/9/15 at 7:10 p.m. revealed: -The Hospice nurse had never made a recommendation about the number of staff needed to transfer Resident #3. -If the Hospice nurse and LHPS nurse both had different recommendations about transferring a resident, she would call the Administrator for guidance. Interview with the Memory Care Manager on 7/10/15 at 12:07 p.m. revealed: -She does not review the hospice notes by the Hospice nurse, because sometimes she cannot read the handwriting. She does not contact the	D 269		

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D 269	Continued From page 25 nurse to see what was written. -Before the Hospice nurse leave the facility after assessing the resident, the nurse gives her some recommendations or writes an order. Interview with the Administrator on 7/10/15 at 12:08 p.m. revealed: -The Memory Care Manager should review the hospice notes when the Hospice nurse comes to visit the resident. -She was not aware the Memory Care Manager was not reviewing the nurse visit notes. Interview with the Hospice nurse on 7/8/15 at 3:00 p.m. revealed: -A hoyer lift was ordered for Resident #3 on 1/26/15. -Currently, Resident #3 is wheelchair bound. -Before Resident #3's fall (December 2014), the resident could pivot with staff's assistance. Telephone interview with Resident #3's Nurse Practitioner on 7/9/15 at 2:10 p.m. revealed: -Resident #3 had a fall December 2014, which broke the left femur. -The Nurse Practitioner did not have a current concern with the resident ' s care. -Currently the resident was being seen by hospice. -"Refer to hospice for the care needed when transferring the resident, because she did not know." On 7/10/15, the facility submitted a Plan of Protection which revealed: -Immediately, the facility in coordination with the Licensed Help Professional Support (LHPS) nurse will identify residents that require a two person assist with transfers by placing a "helping hands" picture inside the resident ' s closet, which	D 269		

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D 269	Continued From page 26 will indicate a two person assist. -The employees will be trained new identifying procedures for transfers. -All hospice notes and LHPS recommendations will be reviewed by the care managers and monitored by the Administration for coordination of care at least monthly. -Any conflicting recommendations from disciplines will be referred to the primary care physician for further instructions. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 8, 2015	D 269		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents were free of neglect related to a resident sliding or falling from a bed. The findings are: Based on observation, interview and record review, the facility failed to provide personal care with transferring of a resident was in accordance with the residents care plan resulting in a fractured left femur for 1 of 5 sampled residents (#3). [Refer to Tag D 269 10A NCAC 13F .0901(a) (Type A1 Violation)]	D914		