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D 000	Initial Comments The Adult Licensure Section and the New Hanover County Department of Social Services conducted a complaint investigation on 7/21/15 - 7/23/15. Telephone exit with the facility on 7/27/15. The New Hanover Department of Social Services initiated the complaint investigation on 7/10/15.	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 A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 7 residents (Residents # 4 and Resident #5) sampled with multiple falls, including falls with injuries requiring visits to the emergency room. The findings are: 1. Review of Resident #5's chart revealed: - A current FL2 dated 04/16/15. - An admission date of 04/29/14. - Diagnoses included abnormality of gait, anxiety state, memory loss, hypertension and esophageal reflux. - Resident #5 was semi-ambulatory.	D 270		

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D 270	Continued From page 1 Continued review of Resident #5's chart revealed: - Fall assessments were completed 04/29/14, 07/08/14, 10/02/14, 10/18/14, 02/03/15, 05/18/15 and 06/03/15. - Nursing note documentation of a fall on 03/05/15 that required a visit to the local emergency room. New orders included following protocol for skin tears/abrasions. No fall assessment was completed. - Nursing note documentation on 04/23/15 that Resident #5 slid off his bed. The prescribing practitioner was notified and no new orders were received. No fall assessment was completed. - Review of physician's order dated 04/27/15 revealed an order for physical therapy (PT) to evaluate and treat for gait strengthening and ataxia. - PT began on 04/29/15. - A fall assessment completed 05/18/15 for the fall on 04/29/15. - Nursing note documentation dated 05/21/15 described a fall with no injuries. The prescribing practitioner was notified and no new orders were received. No fall assessment was completed. - Nursing note documentation dated 06/03/15 which described Resident #5 fell in the bathroom and received no injury. The prescribing practitioner was notified and no new orders were received. A fall assessment was completed. - PT documentation, in the nursing notes, dated 06/19/15 revealed probable discontinuation of PT next week. - Nursing note documentation of a fall on 06/22/15, when Resident #5 was found on the floor of his bathroom, that required a visit to the local emergency room and resulted in a C6 fracture. - Review of death certificate dated 06/27/15 revealed the cause of death was senile	D 270		

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degeneration of the brain. Contributing factors were listed as pneumonia and dysphagia.

Review of documentation on the facility's "Fall Assessment Tool" revealed:
- On 04/29/14, Resident #5 scored 7.
- On 07/08/14, Resident #5 scored 15.
- On 10/02/14, the resident scored 12.
- Resident #5 scored 15 on the 10/18/14 assessment.
- On 02/03/15, the resident scored 15.
- The resident scored 18 on the assessment dated 05/18/15.
- Resident #5 scored 18 on the assessment dated 06/03/15 (indicates the resident was at least 80 years old, had intermittent confusion, was independent and incontinent, had a history of multiple falls, loss of balance while standing, use of a walker, and had decrease of muscular coordination).

Review of the 30 minute check documentation revealed Resident #5 had been checked every 30 minutes, except for 03/05/15 from 12:00 am to 2:00 am when he was in the local emergency room.

Interview on 07/22/15 at 10:05 am with a Nursing Assistant (NA) revealed:
- Resident #5 "was a very independent man".
- He had an alarm that would sound when he stood from his wheel chair or from his bed.
- He would often disconnect the alarm so it wouldn't sound every time he stood up.
- Resident #5 was observed every 30 minutes for safety.
- He was "constantly" encouraged to ask for help instead of attempting to walk to or go to the restroom on his own.

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D 270	Continued From page 3 Interview on 07/22/15 at 10:15 am with a NA/Medication Aide (MA) revealed: - Resident #5 was "very independent" and preferred to do things himself. - He would not ring for assistance very often. - Staff reminded him to call for assistance when he needed it, rather than try to do things by himself. - Resident #5 received safety checks every 30 minutes. Interview on 07/22/15 at 10:25 am with NA/MA revealed: - The staff encouraged Resident #5 to ask for assistance "all the time". - He was "independent" and inclined to attempt to do things for himself. - Resident #5 did not ask for help very often. - He had a chair alarm that was checked by staff during the safety checks, every 30 minutes. Interview on 07/23/15 at 1:50 pm with the area Director revealed: - Fall assessments are completed on each resident every 90 days or after each fall. - She knew when to complete a fall assessment based on the incident reports she received from staff on duty when a fall would occur. - She was unable to locate the fall assessments from the falls occurring 03/05/15, 04/23/15 and 05/21/15. - Resident #5 was on 30 minute checks, had an alarm and was receiving PT. - Residnet #5 had been placed on a two hour toileting schedule in an attempt to reduce him going to the bath room and not requesting assistance. - The facility had discussed with Resident #5 and his family about moving him to a more visible room, a room on the main hallway, so that more	D 270		

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D 270	Continued From page 4 employees would walk past the room and keep an eye on Resident #5. - Resident #5 did want to change rooms. Interview on 07/23/15 at 3:55 pm with the Director of Services revealed: - The area Directors conduct the fall assessments upon admission to the unit, every 90 days and after each fall. - Resident #5 was placed on 30 minute checks because of his status as a "falling star". - Resident #5 had a chair alarm that he would turn occasionally turn off. -Resident #5 would sometimes go to the bath room by himself, despite the encouragement from staff to call for assistance. - He was a "very independent" person. - The facility had offered to Resident #5 the opportunity to change rooms, to have a room on a more heavily traveled main hallway. - Resident #5 and his family did not want him to change rooms. Interview on 07/23/15 at 4:20 pm with the Administrator revealed: - The area Directors conduct fall assessments upon admissions, every 90 days and after each fall. - Incident reports are completed after each fall and notify an area Director that an assessment is due. - Resident #5 was a very independent person by nature. - His family was very involved in his care. - He knew he should call for help, but he preferred to at least go to the bath room by himself. Refer to interview with the Area Director of the Magnolia Hall on 7/23/15 at 3:50pm.	D 270		

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D 270	Continued From page 5 Refer to the interview with the facility Administrator on 7/23/15 at 4:20pm. 2. Review of Resident #4's FL-2 dated 9/11/14 revealed diagnoses which included senile dementia, anxiety state, urinary incontinence and peripheral neuropathy. Review of Resident #4's Resident Register revealed an admission date of 01/15/09. Review of facility's "Nurses Notes" revealed the following documentation: - On 5/29/15 at 1:45pm, "resident [Resident #4] found on the floor near husband's bed. Small skin tear to the [left] knee noted " . - [Standing orders] implemented to apply bacitracin and band aid. - "Resident continues to have increased confusion as well as weakness and leaning forward and to the side". Review of a facility's physician communication note faxed on 5/29/15 revealed: - Resident [#4] found on floor near her husband's bed. Small skin tear noted to [left] knee. - Standing orders implemented to apply bacitracin and band aid. Review of a facility's Incident Report dated 5/30/15 (9:30am) revealed: - Resident #4 sustained a fall from or around chair or wheelchair. - Resident #4 was lying on the floor in the hallway, wheelchair on top of her. - The resident had a bump on her head, was sent out to the local emergency room (ER) for	D 270		

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evaluation.
- The facility's plan of treatment was to monitor the resident closely.

Review of local emergency room (ER) "Emergency Department Encounter" report dated 5/30/15 revealed:
- Resident #4 chief complaint was head injury with unknown level of consciousness (LOC).
- Per EMS [emergency medical service], patient was found down at the [facility] by medical staff. Unknown LOC, unknown time down.
- Patient has a hematoma on her forehead.
- Patient has a history of dementia. Patient is lethargic at triage.
- CT (computed tomography) of brain without contrast done on 5/30/15 revealed no evidence of fracture, but soft tissue hematoma associated with right forehead. No evidence of hemorrhage, mass, midline shift or focal infarct.
- Resident was discharged back to facility.

Review of facility's "Nurses Notes" revealed the following documentation:
- On 5/30/15, "resident [#4] was lying on the floor in the hallway, wheelchair on top of her, bump on her head (fore). Resident sent to ER for evaluation".
- On 5/31/15 at 9:15am, "bruising around [right] eye with swelling, bruised forehead with swelling, corner of left nostril with small bruise. All affected areas [due to] fall.

Review of a facility's Incident Report dated 6/4/15 8:45am revealed:
- Resident #4 sustained a fall from or around chair or wheelchair.
- Staff heard resident holler and when they looked in the direction of the noise, staff saw resident face down on the floor.

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D 270	Continued From page 7 - The resident was sent to the ER for evaluation. The resident remained on the floor until EMS arrived to transport. Review of local ER "Emergency Department Encounter" report dated 6/4/15 revealed: - The resident's chief complaint was multiple falls, patient from [facility] with multiple falls this week, was seen 3 times for the same. Patient has multiple bruises in multiple stages of healing all over. - She was seen on Saturday for a fall out of her wheelchair. She has significant bruising of her forehead. - Today she fell out of her wheelchair once again. For some reason the nursing home [leaves] her alone in her wheelchair where she is not strong enough to hold herself up. - [Family member] is very upset by this. Patient is nonverbal and unable to give any history. - CT of head without contrast on 6/4/15 revealed right frontal extracranial soft tissue swelling without underlying fracture. No demonstrated bleed, mass or acute cortical infarct. - Cervical spine CT on 6/4/15 findings: There is a fracture involving the anterior ring of C1. Findings suggest a subacute to chronic C1 fracture. - She is not a surgical candidate. We will discharge home with strict instructions and fall prevention instructions. - Final impression: urinary tract infection, fall, minor head injury and C1 fracture. Review of local ER "Emergency Department Encounter" report dated 6/5/15 revealed: - Resident #4's chief complaint was multiple falls and was seen yesterday in this ED, diagnosed with subacute C1 fracture, facility sent	D 270		

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back for pain control.
- It was reported that the patient was very aggressive and hostile. Patient sleeping.
- Resident was admitted to hospital on 6/5/15.
- Hospital course: encephalopathy with history of dementia. Patient with recent diagnosis of urinary tract infection, with pain from fracture, both likely contributing. Reports of combativeness not so; in fact today unable to arouse. CT head without acute pathology; frontal and occipital hematomas of scalp. Over the last 48 hours she has continued to deteriorate is now unresponsive, proceeding with hospice care.
- Final impression included subacute C1 fracture, urinary tract infection and metabolic encephalopathy (global brain dysfunction that is caused by organ failure).
- An inpatient consult to hospice was ordered on 6/8/15.
- Patient has continued to decline, is obtunded and moaning in pain.
- Met with [family member] to discuss hospice services, in the hospice care center. A bed was offered and [the family member] has accepted it.
- Case discussed with hospice clinical liaison. Patient said to be actively dying.
- Patient with multiple contusions to head, face and extremities, very lethargic, responds to pain, but not opening eyes or following commands.
- Limbs with wounds from falls in various stages of healing.

Review of Resident #4's death certificate revealed the resident expired on 6/11/15 and the cause of death was metabolic encephalopathy.

Review of facility's "Nurses Notes" revealed the following documentation:
- On 6/4/15, shortly after resident [#4] returned to the unit from breakfast, she fell forward and out

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of her wheelchair, bleeding from nose.
- [Resident} sent to ER for evaluation.
- On 6/4/15 at 10:00pm, the resident returned from the ER. Resident has a cervical spine fracture. Resident has on a cervical collar, it is not to be removed unless health care provider states it. Resident is to be in recliner or bed.
- On 6/5/15 at 9:35am, resident is in severe pain due to fall yesterday. Resident continually trying to pull off cervical collar and hollering "help me, help me. Called MD [physician] office, obtained order to send to ER. Resident transported to [local hospital] via EMS at 10:25am.
- On 6/6/15, resident is out of facility. Admitted to hospital due to fall.
- On 6/8/15, spoke with [Resident #4's family member] for update on resident. [Family member] expressed that resident had declined greatly and was now at the hospice care center.
- On 6/9/15 at 2:20pm, called hospice care center to check on status of resident, spoke with her nurse. She stated resident may not make it through the night. Resident's nurse stated she was sent to us with a broken neck.

Review of documentation on the facility's "Fall Assessment Tool" revealed:
- On 3/23/15, Resident #4 scored 19 (Indicates a fall risk due to resident was at least 80 years old, confused at all times, incontinent, had fallen 1 or 2 times before, wore glasses, confined to chair, loss of balance while standing/ wide base of support, and was receiving psychotropic medications)
- On 6/01/15 the resident scored 19 (indicates a fall risk with no changes).

Interview with a 1st shift nursing assistant (NA) on 7/22/15 at 2:05pm revealed:

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- She had worked at the facility for 9 months and was working (1st shift) when Resident #4 fell the 3rd time on 6/4/15.
- She walked around the corner (on the hallway) and the resident was on the floor in the hallway and her wheelchair was turned over beside her.
- The resident was alert but had a cut on her head and was bleeding.
- The resident was transported to the ER and that was the last time the NA saw her.
- All residents who are fall risks have a small butterfly placed on the outside of bedroom door and these residents are checked every 30 minutes to make sure they are safe and assistance given if needed (example assist to bathroom).
- Resident #4 was on 30 minute checks.

Interview with another 1st shift NA on 7/22/15 at 2:00pm revealed:
- On 6/4/15, Resident #4 was in her wheelchair after breakfast, reached for something and fell.
- The NA did not witness the fall but was told about the fall by another staff member.
- The NA saw the resident the next day and her face was black and blue.

Interview with a family member on 7/23/15 at 10:40am revealed:
- Resident #4's 1st ER visit was on 5/30/15. The facility called the family member and reported the resident fell in the hallway and her wheelchair was found on top of her.
- The facility did not report the fall had been witness by staff.
- The resident had a "lump" on her forehead, but no serious injuries.
- On 6/4/15, the facility reported to the family

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member the resident had fallen out of her wheelchair (did not know if the fall was witnessed).
- The resident was transported to the local ER and the resident's face was completely black and blue. The resident's knees and right arm was black and blue.
- The family member did not know the resident's diagnosis.
- The resident was taken back to the ER on 6/5/15 (on a Sunday) and admitted for care.
- The family member became upset a few days later when the hospital physician inform her the resident was actively dying and was placed on hospice care.
- The resident had a "horrendous fall " and passed away on 6/11/15.
- Even though the physician did not tell me why the resident was dying, looking at her injuries, " I attributed her death to the falls.
- Before the falls occurred, the resident ambulated without assistance in her wheelchair by scooting forward. The resident had no previous falls from the wheelchair.
- The family member's only concerns regarding the residents care was the recent falls.
- The facility never discussed any plans to prevent or decrease the resident's falls.
- The family member did ask the facility to be mindful of the resident when she was in the wheelchair (watch her closer) after 1st ER visit.
- The family member was concerned the resident fell on 6/4/15 and was 10 days later she was gone.

Interview with the facility's area director (Magnolia Hall) on 7/23/15 at 2:15pm revealed:
- Resident #4's 1st fall occurred on 5/27/15 when the resident was found on the bedroom floor beside her spouse's bed. The resident only

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had minor skin tear and was not transported to the local ER.
- To prevent falls, the staff continued 30 minute checks and the resident was to be assisted in recliner if awake or assisted to bed.
- The Area Director did not know if the staff was doing these fall prevention interventions.
- On 5/30/15, a 2nd fall occurred when the resident fell out of wheelchair just after breakfast (The resident ate breakfast between 8:00am and 8:30am).
- After the 2nd fall occurred on 5/30/15, the staff was instructed to always assist the resident in the recliner (with lower extremities elevated) at the nurse's station after meals so she would be visible to staff and area director.
- The 3rd fall on 6/4/15 occurred in the hallway on Magnolia Hall after breakfast at 8:45am.
- The resident was not in the recliner at the nurse's station, but ambulating in the hallway.
- The staff should have assisted the resident in the recliner right after she finished eating breakfast.
- The resident was evaluated at the local ER and diagnosed with a fracture of C1 (spinal fracture).
- The resident was discharged back to the facility with cervical collar on neck and complaining of pain.
- The resident was transported back to the ER on 6/5/15 (3rd shift) due to pain and repeatedly pulling cervical collar off.
- The facility was informed by a family member (a few days later) the resident was transferred to the hospital hospice center and died about 3 days later.
- After the 3rd fall, the resident's face was a mess, all bruised up on both sides. The resident had abrasions from previous falls and swelling to forehead.

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THE COMMONS AT BRIGHTMORE	2320 FORTY-FIRST STREET WILMINGTON, NC 28403

(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 270	Continued From page 13 - The facility had placed residents on 1 to 1 supervision at times to prevent falls/injuries until other interventions were in place, but Resident #4 was not placed on 1 to 1 supervision. Interview with the facility's Director of Services (RN) on 7/23/15 at 4:00pm revealed: - Resident #4 had been assessed as a high fall risk before falls. - The resident remained on 30 minute checks and the staff was placing her in the recliner near the nurse's station after meals. - The resident was "having a decline" after diagnosed with a UTI and we were trying to determine what was going on. Interview with the facility's Administrator on 7/23/15 at 4:20pm revealed: - Resident #4 had 3 falls (5/29/15, 5/30/15 and 6/4/15). - The staff tried to watch her close but she could move her wheel chair. - She was going to do what she wanted to do. - When the resident was transported to the hospital after the falls, the hospital needed to keep her to find out what was wrong with her because the resident's change occurred over 2 weeks. Interview with the nurse at Resident #4's primary physician's office on 7/23/14 at 3:35pm revealed: - The facility contacted the resident's physician on 5/29/15, 5/30/15 and 6/4/15 and reported resident #4's falls at the facility. - After the fall on 6/4/15, the facility's area director (Magnolia Hall) reported the facility was not able to provide care to the resident due to the resident was combative and was removing the cervical collar. - The area director requested an order to send	D 270		

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D 270	Continued From page 14 the resident to the ER for evaluation. - The physician was aware the resident had a history of combativeness at the facility, but there was no documentation of fall prevention orders in the resident's record. Refer to interview with the Area Director of the Magnolia Hall on 7/23/15 at 3:50pm. Refer to the interview with the facility Administrator on 7/23/15 at 4:20pm. _____ Interview with the Area Director (Magnolia Hall) on 7/23/15 at 3:50pm revealed: - According to the facility's fall policy, a fall assessment was completed on admission for all residents. - Subsequent fall assessments were completed evert 90 days. - If a resident scored 10 points or more, was a fall risk. - A "falling star" was placed at the resident's door and the resident was placed on 30 minute supervisory checks by the nursing staff. - A list of all residents who were fall risks was placed at each unit's nursing station. Interview with the facility's Administrator on 7/23/15 at 4:20pm revealed: - If a resident was assessed to be a fall risk (score 10 or more points on the facility's fall assessment) a falling star was placed at the resident's door. - The nursing staff was to do 30 minute safety checks (look in the resident's room to assure the resident was safe, provide or assist with any care that was needed).	D 270		

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D 270	Continued From page 15 - If a resident had repeated falls, the facility provided skid-proof socks, 2 hour bathroom schedule, and a mat alarm. - The staff will try to determine what happened, why it happened and prevention of re-occurrence of fall. _____ According to the facility's Plan of Protection dated 7/23/15, the facility will institute 1:1 supervision for falls with injury when the resident returns to the facility. The interventions to avoid future falls will be individualized to the needs of the resident. The 1:1 will continue until the physician has evaluated the level of care for the resident and interventions established. The facility Administrator will initiate and monitor all 1:1 interventions.	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record review, observation and interview, the failed to assure medication, Zoloft (used to treat depression and anxiety) was administered as ordered by the prescribing practitioner for 1 of 7 residents (Resident #3).	D 358		

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D 358	Continued From page 16 The findings are: Review of the Resident #3's current FL2 dated 01/02/15 revealed diagnoses included Alzheimer's dementia, hypertension, esophageal reflux, hypothyroidism, glaucoma, and macular degeneration of retina. Review of Resident #3's Resident Register revealed an admission date of 04/21/15. Review of an original physician's order dated 02/29/15 revealed an order for Zoloft 25 mg to be administered daily for 7 days, then 50 mg daily thereafter. Review of the February 2015 Medication Administration Record (MAR) revealed: - A handwritten entry for Zoloft 25mg to be administered daily for 7 days, then Zoloft 50 mg to be administered daily. - Zoloft 25 mg was initialed as administered daily for 7 days 02/10/15 - 02/16/15. - Zoloft 50 mg was initialed as administered for 1 dose on 02/17/15. - The handwritten entry was crossed out and highlighted with a yellow marker. - No additional doses were initialed as administered. Review of the March, April, May, June and July 2015 MARS revealed no entries for the administration of Zoloft. Observation on 07/22/15 at 4 pm of medication available for Resident #3 revealed: - Zoloft 50 mg filled 06/08/15 with a quantity of 30. - The medication label had a handwritten, facility generated sticker indicating the "opened date of	D 358		

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D 358	Continued From page 17 06/20/15". - Eleven tablets remained. Interview on 07/22/15 with a pharmacy representative revealed: - The initial order for Zoloft 25mg to be administered daily for 7 days was filled on 02/09/15, with a quantity of 7. - The pharmacy filled Zoloft 50 mg with a quantity of 30 on 03/28/15 and on 06/08/15, with a quantity of 30. - No other scripts were filled for Zoloft for Resident #3. - Neither the Zoloft 25 mg nor the Zoloft 50 mg had ever been printed on the MARs for Resident #5. - She was unable to locate a discontinuation for the order. Interview on 07/22/15 at 4:15 pm with a Medication Aide (MA) revealed: - She usually worked the 3 pm - 11 pm shift on the unit where Resident #3 lived. - She did not recall administering Zoloft 50 to Resident #3. - She was unable to locate the Zoloft 50 mg entry for administration on the July MAR. Interview on 07/23/15 at 7:40 am with a MA revealed: - She usually worked the 11 pm - 7 am shift on the unit where Resident #3 lived. - She did not recall administering Zoloft 50 mg to Resident #3. Interview on 07/23/15 at 9:32 am with a MA revealed: - She usually worked the 7 am - 3 pm shift on the unit where Resident #3 lived. - She could not recall what medication was	D 358		

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D 358	Continued From page 18	D 358		

ordered or administered for Resident #3 without the MAR being available for her to review (interview was conducted via telephone).
- She was unaware that 11 tablets of Zoloft 50 mg was available for Resident #3.

Interview on 07/23/15 at 7:45 am with the Special Care Unit Director revealed:
- The February 2015 MAR handwritten entry for Zoloft was marked out and yellowed out indicating that the order was discontinued.
- Usually the employee who discontinued an entry on the MAR would put their initials, but this entry was not initialed.
- The order must have been overlooked when the March MAR was verified.
- She was the staff person who initially verified each MAR, by comparing the newly printed MAR to the existing MAR.
- The MARs were then double checked by two additional MAs.
- She conducted cart audits periodically, by comparing the medication available for administration to the current MARs.
- She did not keep documentation of the cart audits and could not recall the last time an audit was conducted, "it's been a while".

Interview 07/23/15 at 8:158 am with the prescribing practitioner revealed:
- She was unable to recall specifically what medications were ordered for Resident #3, without the resident record available for review.
- If she ordered a medication, it was her expectation that the facility administer the medication as ordered.

The order for Zoloft 50 mg daily was discontinued by the prescribing practitioner on 07/23/15.

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D912	Continued From page 19	D912		
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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations based on their assessed needs and current symtoms (Residents # 4 and 5). The findings are: Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 7 residents (Residents # 4 and Resident #5) sampled with multiple falls, including falls with injuries requiring visits to the emergency room. [Refer to tag 0270 - 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]	D912		