STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 October 20, 21, 22 and 23, 2015.	D 000	Responses to cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in this statement of Deficiencies of Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with state law.	
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 observation, record review and interview, the facility failed to assure supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 7 sampled residents who received injuries due to falls (Residents #6, #7). The findings are: 1. Review of Resident #6's FL-2 dated 6/2/15 revealed: -The resident resided in the Special Care Unit (SCU). - Diagnoses included Alzheimer's dementia, hypertension. - The resident was constantly disoriented, was a wanderer, ambulatory, and needed assistance with bathing and dressing. Review of Resident #6's current FL-2 dated 9/04/15 revealed:	D 270	10A NCAC 13F .0901(b) Personal Care and Supervision. (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. RECEIVED NOV 05 2015 ADULT CARE LICENSURE SECTION RALEIGH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Mize, Director of Operations — TITLE: Director of Operations — (X6) DATE: 11/25/15

11/25/15

Reviewed & Accepted 12/3/15 [illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 1 - Diagnoses included Alzheimer's dementia, s/p ACDF C4-5 (status post, anterior cervical discectomy and fusion surgery in the neck area of the spine), acute, new, and hypertension. - The resident required extensive assistance with ambulation, transfers, toileting, eating, dressing and bathing. Review of Resident #6's Resident Register dated 3/12/15 revealed: - The resident was admitted to the facility on 3/12/15. - The resident had significant memory loss, must be directed, and needed orientation to time and place. - Resident #6 was transferred to a local hospice house on 10/02/15. Review of Resident #6's Initial Resident Assessment Plan dated 3/17/15 revealed: the resident had "no problems with ambulation/locomotion, was "sometimes disoriented", was "forgetful - needed reminders", was "independent" for mobility. Review of Resident #6's Quarterly Review (care plan update) dated 4/08/15 revealed: "no (assessed) changes". Review of Resident #6's Quarterly Review (care plan update) dated 7/08/1515 revealed: "difficulty eating" and "unsteady gait". Review of Resident #6's Care Notes revealed: - On 6/14/15 the resident was complaining of neck pain and was hard to arouse, physician notified and resident was sent to the local hospital's Emergency Department for evaluation, was treated and released and had a follow-up with primary care physician (PCP) within 3 days.	D 270	Every resident will receive a Falls Assessment using the Fall Risk Assessment Tool at move in and after a fall. Any resident identified as a high falls risk by Falls Management Team will be placed on 72 hour monitoring to include increased supervision, ED and Care Manager to determine any immediate interventions required based on circumstances of fall. Documentation for period of 72 hours after fall, vitals initially and every shift x 72 hours or additional as necessary, assessment of possible risk/contribution factors for falls to include lighting, clutter, furniture placement, location, height of toilet seat, FSBS if diabetic, utilization of assisted device, recent medication changes. If resident has 2 falls within 4 week period an order for PT Evaluation or other treatment/interventions to include 72 hour Hot Box Charting for follow up and monitoring. Each morning, Monday thru Friday, ED and/or Care Managers will review shift change report to review notes from previous shift and weekend to address any concerns including falls. ED and/or Care Manager will initial shift change report and review Incident reports daily, to ensure compliance and follow up with family, physicians, and compliance with Falls Management Policy.	10/23/15 ongoing 10/23/15 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 2 - On 8/22/15 at 8:30 am the resident was found on the floor (location not given) on her right side, refused to have vital signs taken,was transported to the local hospital ER for evaluation and was returned at 11:45 am, PCP and family contacted. - On 8/31/15 (date does not match with Accident/Incident Report of 9/01/15) at 10:20 am the resident was observed on the floor on her left side, sent to the local hospital ER for an unwittnessed fall, PCP and family notified. - On 9/04/15 (no time given) the resident returned from a regional medical center. Review of Accident/Incident Reports for Resident #6 revealed: - On 8/22/15 at 8:00 am, the resident was discovered in room 401 (resident's room) on the floor laying on her right side and was transported to a local hospital by EMS for treatment for bruising; body area(s) bruised not documented. - Power of Attorney (POA) and Primary Care Physician (PCP) physician notified. - On 9/01/15 at 10:05 am, the resident was observed laying on the floor in a bedroom (room not documented) on her left side and was transported to a local hospital by EMS for treatment of skin tear on forehead and swelling. - The POA and PCP were notified. Review of treatment records from 3/01/15 to 10/21/15 from a local hospital for Resident #6 revealed: - On 8/22/15 at 8:22 am Resident #6 was admitted to the emergency department for a fall injury to right elbow and complaint of all-over pain. - Admission narrative revealed: "Staff states that the pt. was found laying on the floor and that she had been seen earlier in the living room". - The resident was treated, released, and	D 270	To ensure ongoing compliance; Staff will receive formal training on Fall Prevention Awareness at least once per quarter and at hire of new associate. All staff is reminded of fall prevention techniques during monthly staff meetings. The Falls Management Team will review incident reports at a minimum on monthly basis and will consist of ED, Care Manager, Med Tech/SIC, Aide/Floor Staff and any other discipline as determined by ED. Team will review all resident falls from past month using Incident Reports and charts for trends. All residents that are considered high falls risk have name on yellow paper posted by resident room door to aid staff in knowing who is considered high fall risk.	11/4/15 ongoing 11/5/15 Quarterly thereafter 11/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 3 returned to the facility. - On 9/01/15 at 10:51 am Resident #6 was admitted to the emergency department for a fall injury of cervical spine. - EMS report revealed: This was an unwitnessed fall with an unknown cause for the fall, the patient was found on the floor on her left side with staff stating only visible injury was a hematoma to her forehead; staff got the patient off of the floor and placed her on her bed. - The patient was immobilized and had a hematoma to her left forehead. - After assessment, the Emergency Department Physician notes revealed the resident needed to be transferred to a medical center for treatment. - Resident #6 was transferred from the local hospital to the accepting regional medical center by helicopter. Review of medical records fro Resident #6 from 9/01-04/15 from the regional medical center revealed: - On 9/01/15 Resident #6 was air-lifted to the medical center from a local hospital and was emergency admitted to the Neurology trauma unit. - Trauma notes revealed patient found "down" at (the facility), unwitnessed fall, uncertain duration of time "down", unclear LOC (level of conciousness); acute management of significant spine injury. - Surgical consult for Resident #6 revealed C4-5 concerns with a possible epdiural hematoma behind the fractures, definite cord compression. -Due to cervical fractures and risk of quadriplegia, and worse prognosis without surgery, family elected to go ahead with surgery to stabilize the spine. -Strict spine precautions, to surgery tonight (9/01/15) for fusion of cervical vertebrae.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27216

(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 4 - Resident #6 was discharged on 9/04/15 from the regional medical center to the facility Memory Care Unit with hospice support. Review of Resident #6's PCP's office notes revealed: - On 6/02/15 the resident was seen for complaint of neck pain, referred to physical therapy. - On 6/14/15 the resident was sent to the local hospital per request of family for complaint of resident not steady, leaning, and difficulty to arouse. - On 6/18/15 the resident was seen for follow-up. - On 8/22/15 received a call from the facility reporting Resident #6 having a fall and being sent to the hospital. - On 8/25/15 the resident was seen for follow-up. - On 8/25/15 facility requested a urinalysis for the resident. - On 9/01/15 received voicemail from the facility reporting Resident #6 having a fall and being sent to the hospital. - On 9/06/15 received voicemail from the facility the resident was back at the facility; resident placed with hospice services. - On 9/08/15 resident complaining of pain, order for Oxycodone 5 mg as needed (prn). - On 9/10/15 dementia advancing, continue supportive care, Oxycodone changed to 5 mg twice a day (bid); from fall at facility and surgery at (a regional medical center) resident having increasing pain. - On 9/28/15 received call from hospice reporting resident was not swallowing medications or eating, spitting out Oxycodone, order for liquid morphine 0.25 ml. every 2 hours prn for pain and Ativan 0.5 mg every 4 hours prn for agitation. - On 10/01/15 visit for Resident #6's declining health, not eating, not taking medications, discontinued oral medications, changed Ativan to	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 5 gel. - On 10/02/15 call from hospice, more decline, moving resident from facility to (a local hospice house). Interview on 10/21/15 at 8:20 am with a SCU Staff revealed: - "Resident #6 fell and broke her neck in a fall last month (September, not sure of date)". - The resident had problems with her neck and head before the fall. - "The resident wandered and was always walking around (the SCU)." - (Resident #6) was found in another resident's room and "it looked like she was seated in a chair, maybe dropped off to sleep, and fell out of the chair". - The time was around 10:00 am and all SCU staff were in a stand-up meeting at the nurse's station. - We heard a weak "thump sound" and ran to look. - The PCA saw the resident lying on the floor in front of a chair. - A nurse was there as she had found the resident on the floor. - EMS was called; "we did not know the extent of Resident #6's injuries until she went to the hospital." - The resident stayed at the hospital about 1 week and returned to (SCU) wearing a neck brace. -Resident #6 was placed with hospice and she died a couple of weeks later. - Her diagnosis was that she had broken her neck. - If a resident was a falls risk, staff were verbally told in stand-up meetings. - The PCA did not know if Resident #6 was considered a fall risk as the PCA was not told she	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 6 was. -For falls supervision, staff would watch the residents closely by trying to keep them all together. - The facility had a fall policy about what to do after a fall, but not sure about one for fall prevention. - They might use "gripper socks" on the residents. - All SCU staff were in the meeting at the front desk, so no one was in the hallways when the resident fell. - There were no changes in supervision after Resident #6's 8/22/15 fall. Confidential interview with a 2nd SCU Staff revealed: - Resident #6 liked to walk the halls, sit at the end of the front hall on the couch, or in another resident's room, she was constantly walking around. - On 9/1/15 the resident wandered into room #405. - The MA was not sure what happened when Resident #6 fell on 9/1/15, staff was out helping other residents. - Falls risk residents are checked every hour and toileted every 2 hours. - After the fall on 8/22/15, Resident #6 had a 3 day, every 30 minutes checks. - "If (Resident #6 was wandering, she would wander back." - Confidential interview with a 3rd SCU staff revealed: - In August, Resident 6 was having "issues" with her neck. - The resident walked in and out of other resident's rooms. - After the 8/22/15 fall she was put on 72 hour checks every 30 minutes, after that residents	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 7 would be monitored routinely every 2 hours. - "Each time a resident had a fall, the same would be done; it was our routine". - The staff was not sure if the facility had a falls prevention policy. - When Resident #6 fell on 9/01/15, we were finishing a staff stand-up meeting; meetings were held around 9:45 am to around 10:00 am. - The meetings were for all SCU staff and were held up front at the nurse's station. - MAs would conduct the meetings with managers present; the meetings could last 15, 20, or 30 minutes depending on what was going on. - During the meeting, staff tried to have all residents in the TV/living room area. - Some residents stayed in their rooms, some walked around. Observation on 10/21/15 at 9:50 am of the SCU staff meeting revealed: - SCU staff were standing around the front of the nurses' station facing the wall behind the desk area, a MA and a manager were conducting the meeting on the other side of the desk facing the staff and behind them, the TV/living room area. - Most of the residents were seated in the TV/living room area and 2 residents were slowly walking back and forth between tables. Confidential interview with a 4th and 5th SCU staff revealed: - After Resident #6's fall in August, she was put on 72 hr. every 30 minute checks; after that she was back on routine every 2 hours checks. -The same was done for every resident who had a fall. - For falls prevention, staff was told by the Special Care Coordinator (SCC) to keep a check on residents, but was not told a specific time. - On 9/01/15, when staff were coming to the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 8 morning meeting, Resident #6 was sitting in her room in a chair. - The resident was found in another resident's room on her right side on the floor. - The LHPS (Licensed Health Professional Support) nurse was there to see another resident, heard the resident fall, and went to check on her. - All SCU staff, at least 1 assisted living staff, and managers attend the morning meetings. - Staff stands at the nurse's station facing the wall. - The majority of the residents were in the living room, some wandering around, some in their rooms asleep. -The managers could see the resident's wandering. -When Resident #6 fell, the meeting was coming to an end; no one saw her fall. Confidential interview with a 6th SCU Staff revealed: -There had been several residents that had fallen in the past 6 months, 2 residents tripped over their feet while walking and had no injuries, a resident fell, had a fractured hip last month, and was in a rehabilitation facility. - Usually there were 1 staff in the dining room area, and 1 in each hall (2). - During a staff meeting, all staff are up front at the desk. - Staff could turn around to check on residents. - Residents in their rooms would get checked on after the meeting. - We kept the falls risk residents seated up front (TV/living room area) and they had staff assistance while ambulatory. Confidential interview with a 7th SCU staff revealed: - An incident happened while we were in a	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 9 stand-up meeting about 2-3 months ago, not sure of date. - Resident #6, who was no longer at the facility had a fall. -The resident walked into another resident's room that was vacant and sat in the chair. - Five minutes into the meeting we heard a fall and went to check. Resident #6 was lying on the floor on her left side; it looked like she was moving from the chair to the bed. - Resident #6 stated "help me get up off the floor, and complained of neck pain". - She was sent to the hospital and came back with a neck brace, had broken 2 vertebrae; and was placed with Hospice due to having dementia. - Later she was placed with (local hospice house) and passed away. - During the stand-up meetings, all SCU staff stood around the (front) desk, no staff were in the halls. -The meetings lasted up to 30 minutes. - Residents could be in their rooms, no staff checked as the residents were usually asleep. - For falls prevention, residents were checked every 15 or 30 minutes, 1 hour after a fall and hospital visit; staff kept the residents close by and toileted them regularly. Confidential interview with an 8th SCU staff revealed: - Resident #6 fell on 1st shift on 9/01/15 and broke her neck in 2 places and Resident #7 fell the next day and fractured his hip. -Resident #6 always kept her head down, but could raise it. -She fell in the hallway at the end of the hall and was sent to the hospital. -When she came back, she wore a neck brace and a cervical collar. - The resident was ordered pureed food and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 10 nectar thickened liquids, but would not eat anything. - The resident would talk, saying she was not hungry and she would not drink much. - After 1 week, she was "shutting down", her blood pressure was 90/45 when this staff checked it (did not remember the date or time), she had stopped consuming anything. - The resident was sent to (a local hospice house) and died 2 days after leaving the facility. - This staff had not been told Resident #6 was a falls risk. - This staff was not aware of a facility falls prevention policy, but staff tried to keep residents out of their rooms and together with staff. Confidential interview with a 9th SCU staff revealed: - Resident #6 fell on 1st shift on 9/01/15, (could not remember the time) and no one saw her fall. - She was starting to lose her balance when ambulating, but continued to walk on her own. -She would wander off down the hallway. -Staff would try to keep the resident in sight. - The resident fell in another resident's room, but this staff did not know the details. - Her health declined after the fall and she stopped eating. - There was no facility policy for falls prevention, and staff received instructions from the SCC. - For falls prevention staff would see that shoe laces were tied if the resident walked and try to keep residents in sight. Interview on 10/23/15 at 11:30 am with the LHPS nurse revealed: - The nurse started seeing Resident #6 on 4/02/15 and did an initial assessment, no tasks had been ordered at that time. - On 6/02/15, the nurse was informed physicial	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 11 therapy (PT) had been ordered and was working with the resident. - On 9/01/15 there was no visit scheduled with the resident due to no tasks ordered (PT was no longer a task); the nurse was in the facility to see other residents. - On 9/01/15 the nurse was walking down the 300 hall to see the scheduled resident when she saw Resident #6 lying on her right side on the floor in another resident's room which was the furtherest away from the nurse's station. - No staff were in the resident rooms or in the hallway. - The nurse did not know how long the resident had been lying on the floor. - The resident was making no sounds, but was grimmacing. - The nurse asked if she was ok and then took the resident's vital signs and yelled for staff to call 911. Resident #6 was on the floor and needed help. - The resident was in major distress and became agitated. - The nurse tried to calm the resident while waiting for the staff to arrive. Interview on 10/22/15 at 10:50 am with Resident #6's POA revealed: - The resident started leaning her head to the right around Mother's Day (5/10/15). - Physical therapy was provided and her physician changed some of her medications, but we could not determine the reason for the change. - Leaning her head caused vision changes, especially when she walked. - The resident liked to walk around the SCU alot. - On 8/22/15 the POA was called at 8:15 am by the facility saying the resident had an unwittnessed fall and received bruises; she went	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 12 to the hospital, was seen and released. - The resident had been released by the time the POA got to the hospital. - On 9/01/15, the POA was called (do not remember the time) and was told the resident had fallen on the floor in another resident's room and was sent to a local hospital. - The POA went to the hospital and saw that the resident had a big knot on the left side of her head and wore a cervical collar. - The ER physician told the POA they did not see this type of injury often, the resident had a severe neck injury affecting the C3, C4, C5 and C6 (cervical vertebrae) were almost severed and she needed to be transported to a regional medical center immediately. - Resident #6 was flown by helicopter to a regional medical center and admitted to the emergency trauma area. - The POA was called by the trauma physician and stated "the resident needed to have emergency surgery. - The surgeon told the POA the resident would die if he did not do the emergency surgery, but also could die during the surgery. - The neck surgery was done through the front of the neck instead of the back due to her age and condition, but would be able to stabilize her head and keep her alive. - The POA wanted the resident to be placed in a local hospice house, but placement could only happen if the resident was within 7 days of dying so the resident was sent back to the facility to recover with hospice care. - The head injury looked severe; the bruised spot sunk in after a few days; we were not sure what happened (to her)." - Resident #6 "did not come back from it, she was in a steady decline, which came rapidly." - The fall led to a condition that caused her death;	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 because of the condition, she could not eat, or eventually, swallow. - "Family went very often to see the resident and were not sure what staff did to supervise the resident after the previous fall; I often wondered about that." - Staff never discussed supervision for Resident #6 with the POA. - After her fall on 8/22/15, the POA did not receive any communication from the facility about supervision for falls prevention or changes in staff supervision. - "They should have watched her more closely as she was a falls risk." - The resident was taken to a local hospice house on 10/02/15 and died on 10/04/15. Interview on 10/23/15 at 12:45 pm with Resident #6's PCP revealed: - "The resident had advanced dementia and spasms of the neck for a long time and was prone to falls". - On 6/02/15 the PCP talked with the SCU staff about Resident #6 being "prone to falls, the resident needed to have staff hold hands or have a walker in front of her". - On 6/18/15 the PCP talked again with staff about the resident being prone to falls. - Physical therapy was ordered to help with the resident's balance. - "Resident #6's vision was not good and it was hard for her to see from the side due to her neck condition. - Staff needed to keep the resident in front of them and always needed someone around watching her. - If staff was not around, they would not see the resident fall; it was needed to have someone free to keep a check on the residents."	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 14 Interview on 10/22/15 at 5:45 pm with the Special Care Coordinator (SCC) revealed: - After Resident #6 fell on 8/22/15 she was supervised by having falls risk monitoring of 30 minute checks if she was not out in the front (TV/living room area), toileting was every 2 hours, and staff made rounds no greater than 1 hour. - After a fall, residents would have staff checks every 30 minutes for 72 hours. After 72 hours, the resident would be evaluated and go back to the falls risk monitoring. - On 9/01/15 Resident #6 was found on the floor at the foot of the bed at 10:15 am in another resident's room. - She walked a lot and often walked into other residents' rooms. - She was found by the LHPS nurse who was going to see another resident. - The staff stand-up meetings happened every day at 9:45 am and lasted 10 to 15 minutes. - All SCU staff attend and stand facing the managers and medication aides. - The majority of the residents were seated in the living area, with maybe 2-3 residents in their rooms at that time. - No staff were on the hallways. - The facility did not have a falls prevention policy, but had a falls program. Interview on 10/22/15 at 7:00 pm with the Special Care Unit Coordinator revealed: - For Resident #6, physical therapy worked with her, we contacted the physician frequently regarding her condition, we did not have a chance to implement alarms. - After Resident #6's fall (on 9/01/15) she was referred to hospice, had fall mat, hospital bed; after discharge from hospital, bed alarm not an option at that point, as we did everything for her, she continued to stay on 30 minute checks.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 15 Review of the facility falls prevention policy revealed: - "Employee Safety Responsibilities" handout which included the following: - "FALLS: When any individual falls, (resident, employee, or visitor) no one should help him/her get up until a nurse or, in the alternative, an EMT (from a 911 call), has assessed for injuries." - Attached forms included: 1. Fall Prevention document - 3 steps: observations of the resident, surroundings, and interactions with staff and other residents. 2. Falls Inservice form - steps to take after an unwitnessed fall (no signatures) 3. Falls Among the Elderly form with signatures and dated 7/22/15, factors contributing to falls, gait belt use. 4. Physical Therapy inservice on the use of gait belts, fall prevention, dated 8/5/15; no outline of program content. Refer to Interview on 10/22/15 at 7:00 pm with the Special Care Unit Cordinator. Refer to Interview on 10/22/15 at 7:00 pm with the Senior Care Manager. Refer to Interview on 10/22/15 at 7:00 pm with the Director of Operations. Refer to Interview on 10/22/15 at 7:00 pm with the Administrator. --- 2. Review of Resident #7's current FL-2 dated 6/9/15 revealed: Review of Resident #7's current FL-2 dated 6/9/15 revealed: -Resident #7' orientation status was listed as	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 16 constantly disoriented. -Resident #7 needed assistance with bathing, dressing, and was incontinent of bowel and bladder. -Resident #7's ambulatory status was listed as semi-ambulatory with the use of a walker. -Diagnoses included Alzheimer's,dementia, weakness, hypokalemia, osteoarthritis, pancreatitis, and depression. Review of Resident #7's current FL-2 dated 6/9/15 revealed medications included: -Medications included Tylenol 500mg one by mouth every 12 hours. -Aspirin 81mg one by mouth daily. -Paroxetine 40mg one by mouth daily. (Used to treat depression.) -Neurontin 100mg one by mouth daily. (Used to treat convulsions and nerve pain.) -Quetiapine 12.5mg one every AM, and one at bedtime. (Used to treat psychosis.) -Acidophilus capsule one by mouth daily. -Lisinopril 5mg by mouth at bedtime. (Used to help prevent heart attacks and lower blood pressure.) -Melatonin 1mg at bedtime. (Used to treat insomnia.) -Potassium Chloride 10 MEQ by mouth daily. -Lorazepam 0.5mg daily as need for anxiety. Review of Resident #7's resident register revealed Resident #7 was admitted on 2/14/13. Review of the facility's Admit/Discharge Report revealed Resident #7 was discharged from the facility on 10/05/15. Review of Resident #7's hospital records revealed Resident #7 was discharged to a skilled nursing facilty/rehabilitation center on 10/5/15.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 17 Review of Resident #7's care plan dated 6/4/15 revealed: -Resident #7's mental health and social history was documented as a wanderer. -Resident #7's ambulation status was documented as ambulatory with and aide or device, limited range of motion, and limited strength. -Resident #7's bowel and bladder status was documented as incontinent. -Resident #7's orientation status was documented as forgetful and constantly disoriented. -Resident #7's vision and hearing status was documented as adequate for daily activities. -Resident #7's activity of daily living status was documented as requiring extensive assistance (3 personal care aides) with bathing, dressing, and hygiene after toileting. -Resident #7's mobility status was documented as needing limited assistance. -"The resident ambulates throughout facility with walker or wheelchair and has a very unsteady gait." -"The resident is able to propel himself through the facility while in his wheelchair." -"The resident is able to transfer to and from chairs with assistance from staff for safety." Review of Resident #7's care notes revealed: -There were no care notes provided for the month of July. -There were 8 documented falls from 8/6/15 through 9/29/15. -8/6/15 (no time documented) "Resident #7 fell in the bathroom, range of motion was done, vital signs were taken." -8/26/15 at 9AM "Resident #7 was observed losing his balance in common area falling to the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 18 floor landing on his bottom. No injuries present at this time. No other reports at this time. Will continue to monitor." -8/26/15 at 6:55PM "Resident #7 became very aggressive towards staff, hitting, scratching, punching, and kicking staff members. Requested UA& culture check. Resident was also given PRN Ativan." -8/28/15 (no time documented) "Resident #7 was complaining of pain in both knees, and not being able to walk.Waiting on order for x-ray and UA/culture." -8/28/15 (no time documented) "Resident #7 had no complaint of pain or discomfort. Got the UA/culture sent off and sending a clarification on X-rays." -8/31/15 "The urine specimen that was sent off was unlabeled so the lab could not use it. Staff was trying to collect another one." -9/3/15(no time listed) "Upon arrival was told by 3rd shift supervisor in charge that resident must have scooted on his bottom from bathroom to bed." -9/4/15 "Resident #7 was returned from hospital at 6:50AM. No new orders." -9/4/15 10:20AM "Resident #7 was observed on the floor on right side. He was sent out via EMS to hospital." Review of Resident #7's accident and incident reports revealed; -There were only 3 reports provided (9/4/15, 9/22/15, and 9/29/15.) -On 9/4/15 at 1:40AM Resident #7 was found on the floor of his bedroom on his left side. -Resident #7 presented with a laceration to his left temple and pressure was applied to stop bleeding. -On 9/4/15 at 1:50AM Resident #7 was sent out of facility to the local emergency room.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 19 -Resident #7 was alert before he was taken out of facility. -Resident #7 was not seen by the primary care physician. -The facility staff spoke directly with Resident #7's primary care physician at 2AM. -The POA was notified at 2:05AM. Review of facility's documentation of emergency room records dated 9/4/15 revealed: -3AM Resident #7 was seen after "patient fell out of bed and hit head." -7:30AM discharge instructions included a diagnosis of a closed head injury, trauma, and a skin tear. -"Follow up with your primary care physician as soon as possible." Review of Resident #7's hospital radiology report signed and dated 3:58 AM 9/4/15 revealed: -The reason for the head CAT scan was a fall out of bed and head trauma. -No evidence of acute intracranial abnormality. Review of facility's documentation of emergency room records dated 9/4/15 revealed: -9:20AM Resident #7 was seen after he "tripped". -"Lacerations from an earlier fall were noted above left eye." -3:40PM discharge instructions include a diagnosis of 2nd fall today. Review of Resident #7's hospital radiology report signed and dated 10:07AM 9/4/15 revealed: -The reason for the 2 view chest x-ray was hypoxia (deprivation of oxygen) and falling. -There were bilateral degenerative changes with chronic rotator cuff tears. Further review of Resident #7's care notes	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 20 revealed: -9/11/15 (2nd) "Resident #7 was observed sitting on dining room floor. Resident has no new bruises or skin tears." -9/22/15 7:40AM "Resident #7 is being sent to hospital via EMS. He was found sitting in the floor in front of his bed." -9/22/15 (3rd) "Resident #7 was sent to ER at (about 2:10AM) because he was observed sitting in his room on the floor." Review of Resident #7's incident and accident report dated 9/22/15 revealed: -On 9/22/15 at 7:30AM Resident #7 was found to be lying on his back on floor in front of bed. -On 9/22/15 at 7:40AM Resident #7 was sent out of facility to the local emergency room. -Resident #7 was alert and no apparent injuries were noted before he was taken out of facility. -Resident #7 was not seen by the primary care physician. -A message was left on the primary care physician's office answering machine at 7:50AM. -The POA was notified at 7:45AM. Review of Resident #7's emergency room physician record dated 9/22/15 revealed at 8:38AM Resident #7 was seen because of a fall while getting into bed resulting in a right shoulder injury and a rib fracture. Review of Resident #7's hospital radiology report at 9:09AM on 9/22/15 revealed: -The reason for the exam was post fall and pain with passive range of motion. -"There was severe arthritis of the right shoulder with evidence consistent with chronic complete rotator cuff tear. There is osteopenia. There is suggestion of joint effusion. There is a displaced fracture of the right 9th rib which may be acute. There is an old healed fracture of the right 4th rib.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 21 The impression was a possible fracture of the right 9th rib. There were severe arthritic changes of the right shoulder." Review of Resident #7's hospital radiology report at 9:52AM on 9/22/15 revealed: -The reason for additional views was a rib fracture was seen on the shoulder x-ray. -There was a fracture of the right 9th rib. There was an old fracture of the left 5th rib. Further review of Resident #7's care notes revealed: -9/23/2015) 2nd (no time given) "Resident #7 continues to be monitored. He continues to stand and walk. When trying to assist him he becomes aggressive and combative. 30 minute checks still being implemented." Review of Resident #7's emergency room physician report dated 9/23/15 revealed: -2:26AM Resident #7 was seen after resident was found on the floor of his facility. -Around 6AM Resident #7 was discharged with a diagnosis of a contusion of the occipital scalp (Head injury) and instructions to follow up with his primary care physician in 2-3 days. Review of Resident #7's hospital CAT scan report signed and dated 4:26AM on 9/23/15 revealed no acute intracranial injury. Further review of Resident #7's care notes revealed: -9/26/15 "Resident #7 up today combative and in some pain. PRN Tylenol given at 8AM." -9/28/15 2:30PM "Resident #7 has been in his room in bed with complaints of pain. Has eaten meals in room. And transfers with assistance." -9/29/15 8:55PM "Resident #7 sent to ER. Found on floor lying on back. Resident complaint of back	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 22 pain. Was sent to ER." -9/30/15 "Resident has been out at hospital with right hip fracture." -10/2/15 was the last entry in the care notes "out of facility in hospital." Review of Resident #7's local Emergency room physician report dated 9/29/15 revealed: -"The patient was unable to ambulate. The staff at facility reported to EMS they don't have enough staff to watch patient so they left him in a wheelchair. Unwitnessed fall. Found on ground. EMS called." -"X-ray showed closed right femoral neck fracture, plan to operate tomorrow. Admit to the hospital." Review of Resident #7's CAT scan of the abdomen and pelvis dated 9/29/15 revealed: -There was an acute impacted right femoral neck fracture. The right hip remained located. Review of Resident #7's orthopedic consultation report signed and dated 9/30/15 at 1:23PM revealed: -"The patient is an 88-year old patient who slipped out of a wheelchair apparently. He is unable to give a history and is quite confused. He had an obvious deformity to the leg and was brought to the ER where he was found to have a displaced femoral neck fracture." -"He cannot cooperate with the exam and cannot answer questions." -"A recommendation for a right hip hemiarthroplasty later today." Review of Resident #7's primary care physician's discharge summary signed and dated 10/5/15 revealed: -The diagnoses at the time of discharge included	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 23 hypertension, dementia, anxiety and agitation, anemia secondary to blood loss, and a fall with impacted right hip fracture, status post right hip hemiarthroplasty. -During the hospital stay Resident #7 had episodes of anxiety and agitation and needed intravenous anti-psychotics. He was also seen by palliative care. The patient also received physical therapy. The patient overall appeared stable at the time of discharge. He was discharged in stable condition and advised to undergo further physical therapy and was sent to rehab. -An addendum revealed Resident #7 was held over the weekend because of a fever. Confidential staff interview revealed: -Resident #7's room was the last room on the left on the opposite end from the front desk in the unit. -Most of the falls were on 2nd and 3rd shift. -Resident #7 would fall sometimes in the bathroom after tripping on his own feet. -It took at least 2 staff and sometimes 3-4 staff to take care of Resident #7. -"Resident #7 used to not want to get out of bed because he was sore, we would use the walker to get him up into his wheelchair." -"We have bed/chair alarms; he might have had one, but not for very long, right before he was discharged." -Staff member could not recall exactly how many times Resident #7 had fallen in the past 2-3 months. A 2nd confidential staff interview revealed: -"He stop letting me help him and got really combative around mid-July early August." (cannot recall exact date) -"We would be trying to change him and he would kick staff during incontinent care."	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 24 -"It took at least 3 staff to toilet him." -"Resident #7 used to walk with a limp but he could walk on his own." -Resident #7 started using a walker and holding onto the side rails in the halls. -Sometimes Resident #7 would not remember where his glasses were and they would be in his room. -Resident #7's room was all the way on the end of the hallway. -Staff had not seen a mat on the floor by his bed or known of bed/chair alarms being used. -Anytime a resident fell and came back from the hospital they were put on 30 minute checks x 3 days. -"It had always been that way and we would document the falls and behaviors." -Staff member could not recall exactly how many times Resident #7 had fallen in the past 2-3 months. -Most falls occurred as a result of Resident #7 trying to get to the bathroom on his own. A 3rd confidential staff interview revealed: -"I started noticing Resident #7 declining (physically/mentally) in July after a fall. He was very stubborn and independent. He fell so many times I can't recall the exact number." -"We would check on him and 5 minutes later he would fall." -"He became so combative even with the physical therapist that they signed off on him." -Resident #7 was taken off Gabapentin and he had Lorazepam ordered for anxiety as needed. -"By August after falls Resident #7 seemed to decline and it seemed like he decided he was not going to walk anymore." -Staff had not seen a bed/chair alarm or mat used for Resident #7. -"All of us suggested Resident #7 be moved	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2768 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 25 closer to the front desk of the unit. We were told by the Special Care Unit Coordinator (SCC) there was no room available. If Resident #7 had been moved closer to the front desk in the unit I believe it would have kept him ambulatory longer. I don't think it would have helped after August." -Staff could not recall exactly but estimated Resident #7 fell 5 times since July 2015. -"We were told Resident #7 fractured his right hip after this last fall and they would have to replace the ball in his right hip and he would have to go to rehab." -It was standard procedure to do 30 minute checks x 3 days after a fall. -Staff could not recall the details of 9/22/15 but knew Resident #7 fell 2 times within a 24 hour period. A 4th confidential staff interview revealed: -Resident #7 was very aggressive with staff and other residents. -"Mid-August Resident #7's behaviors and health really started declining all at once." -"Resident #7 wanted to be independent and was always asking to be taken to the bathroom. Then he would have episodes of trying to do everything for himself. We had a hard time with him." -There were no alarms or mats for Resident #7. -It took on average 2-3 staff to assist Resident #7 with activities of daily living. -"There were at least 4 falls since July 2015 and I'm sure there were more. We do 30 minute checks after a fall x 3 days." -"I think if Resident#7 had been moved closer to the front desk in the unit he wouldn't have fallen so much. We could have kept a closer eye on him. We could have done more than 30 minute checks just because staff would have been walking past his room." -"Several of us staff suggested to the Special	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 26 Care Unit Coordinator (SCC) for Resident #7 to be moved closer to the unit's front desk about a month before Resident #7 left the facility. We were told they would try to see what could happen." -"Resident #7 had just been put to bed the night he fell and broke his hip. Several staff had just put his night clothes on and other staff were trying to get him medicine for anxiety. We think he tried to get up to the bathroom. After an unwitnessed fall we call EMS. 2 days after this fall we were told he broke his hip." -"Alarms, mat, and gripper socks would have helped. Sitters were never mentioned. I think Resident #7 would have benefited from a higher level of care." 3rd shift staff interview unsucessful. Interview with the Special Care Unit Coordinator (SCC) on 10/22/15 at 6PM revealed: -Resident #7 had Lorazepam as needed for anxiety. -"Resident #7 had started declining physically and mentally by the end of August. He was very challenging because he could be very physically combative with staff but not residents. When he was admitted to the facility he could still walk. Then he started having to use a walker or wheelchair. He could pivot out of his wheelchair to toilet to get to another chair." -"He came in with a hunched over back and limited range of motion in his right arm." -The SCC believed there were 3-5 falls during August-September 2015. The family refused a bed alarm, and mat in September 2015. -A sitter had not been addressed through the facility or with the family. -The SCC was aware that even though a family refuses to pay out of pocket for devices that the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 27 responsibility ultimately fell on the facility. -Staff were looking into moving Resident #7 closer to the front desk of the unit per other staff's requests but the SCC had not considered the fact that moving Resident #7 might have enabled staff to check on Resident #7 more often than every 30 minutes as she felt like her staff were already doing that. -The facility staffed 10:1 ratio of residents to staff on 1st shift and 8:1 on 2nd and 3rd shift. On average there were 4 staff on 3rd shift. She was aware that sometimes it took 3 staff to assist Resident #7 with his activities of daily living. -The SCC believed Resident #7's Primary Care Physician (PCP) was aware of all falls. The staff from the facility would fax requests for orders as necessary. -"I think we were able to meet Resident #7's needs. It was never discussed with the Administrator or doctor about the need for a higher level of care." Family Interview on 10/22/15 at 10:51 revealed: -"I noticed a decline physically and mentally in Resident #7 in late July-early August. I did not say anything about it at the time, but I did share my concerns with the staff (cannot recall exact names) at facility about him not being able to use the walker anymore" -"Late July-early August he began to fall a lot; he was taken to the ER 4 times. These times were at night. I believe he couldn't understand that he had incontinent briefs on and he was still trying to get up to use the bathroom." -Resident #7 had chronic shoulder issues. He could feed himself but if you tried to do passive range of motion it was painful for him. -"Somewhere around September 10th or 11th I met with the Special Care Unit Manager (SCC) and I told her I was concerned about Resident #7	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 28 being so far from the front desk in the unit. The SCC said she had just been discussing that issue and was working on getting Resident #7 a room closer to the front desk, but the other family member would have to agree to change rooms first." -"Sometime in early September Resident #7's primary care physician made referral for a psych evaluation. The SCC was going on vacation and I told her to hold off on that appointment until she got back from vacation. It was my impression she had already scheduled the appointment. Resident #7 fell and was discharged from the facility before he got that appointment." -"There was another incident (cannot recall exact date) where Resident #7 was trying to sit in the dining room chair; he just missed the chair. Then he fell on the 23rd of September. I think the facility called our family every time." -"I don't recall any conversations about bringing in a sitter or adding more staff. I think that would have helped at night. I can't recall how many staff the facility has at night. The only thing I recall regarding early September is one of the staff (couldn't recall name) asked if I were leaving after my visit to the facility and would I bring Resident #7 down to the living room because they didn't want to leave him alone in his room." -"The SCC did mention bed/chair alarms and a mat to go on the floor by Resident #7' s bed. I refused the alarms because of the cost. I refused the mat because I was afraid he would slip in his sock feet." -"At some point I inquired about using bedrails to the SCC but was told they were not used at facility." -"Our family received 8-10 calls from the facility at the end of July-early August. He always fell at night and was found on the floor when staff were making rounds."	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 29 -"I do not recall ever being told that Resident #7 had broken rib. Another call from the facility said Resident #7 had hit his head and I did see some old bruising." -"I was informed Resident #7 had fallen on 9/29/15 at 10PM and was in the ER. A surgeon called me on 9/30/15 and told me Resident #7 would require surgery." -"Resident #7 can't move his arms above his head. If you explain things you are going to do to him first; he will come around. The physical therapist at the facility had signed off on him due to his cognition. After his last fall and surgery he had to go to a skilled nursing facility. They are really monitoring him there." -"I do feel like the facility let the family know when Resident #7 fell. I knew it was just a matter of time before he really got hurt. He was just an accident waiting to happen. He was no longer safe to use the walker. I think he would have benefited from being moved closer to the front desk in the unit. He probably could have benefited from a sitter at night. They still used the walker when trying to transfer him to the wheelchair. The SCC said she had seen him coming down the hall before with the walker." Interview with Resident #7's Primary Care Physician (PCP) on 10/22/15 at 4:55PM revealed: -He had been Resident #7's primary care physician x 2 years. -The PCP had noted in his chart on 9/2/15 "An improvement in behaviors, very unsteady on his feet, high risk for falls, currently on Paxil and Seroquel." -He had ordered a psychiatric evaluation to help manage antipsychotic medications for Resident #7 on 9/9/15. -The PCP was not aware that Resident #7 had sustained a laceration to his head, had a broken	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 30	D 270		

rib or got a CAT scan.
-The only fall he was aware of for Resident #7 was his last fall at the facility and the call was generated from the orthopedic surgeon late September 2015 from the local hospital.
-Resident #7's medications had been adjusted in the hospital after the fall because Resident #7 couldn't sleep.
-Resident #7 was discharged to a skilled nursing facility for rehabilitation after his surgery.
-"I think a bed alarm and mat would have helped."
-The PCP was not aware Resident #7's room was located all the way down the hall opposite from the unit's front desk. The PCP believed Resident #7 could have benefited from being closer to the front desk of the unit.
-"It sounds to me like they need better supervision at the facility."

Interview with the Administrator on 10/22/15 at 7:30 pm revealed:
"The majority of Resident #7's falls happened within a months' time."
-"We did not have an opportunity to go through the above mentioned processes with Resident #7 before he fell and broke his hip. He was hospitalized, had surgery, and discharged from the hospital to a rehabilitation facility."

Refer to Interview on 10/22/15 at 7:00 pm with the Special Care Unit Cordinator.

Refer to Interview on 10/22/15 at 7:00 pm with the Senior Care Manager.

Refer to Interview on 10/22/15 at 7:00 pm with the Director of Operations.

Refer to Interview on 10/22/15 at 7:00 pm with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2768 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 31 the Administrator. Interview with facility management (Director of Operations, Senior Care Manager, Administrator, and Special Care Unit Coordinator) were concurrently conducted on 10/22/15 at 7:00PM Interview on 10/22/15 at 7:00 pm with the Special Care Unit Cordinator The current monitoring system for residents who are are a fall include: Stand-up meetings with all staff to discuss current and newly identified residents who were fall risks. -A roster of residents were kept on the medication cart with additional notes.(shift to shift report). 30 minute checks on the residents, engaging residents in activities, and keeping them in the common room areas so staff could watch the residents. -Standard procedure after a fall was 30 minute checks x 3 days. -"The assessments come from me(Special Care Unit Coordinator), quarterly reviews, direct visualization of the residents, PT/OT recommendations and from the doctors." -"After a fall we go by our protocols, contact the doctor, contact the family, take vital signs, and implement 30 minute checks." -An unwitnessed fall was always a send out to the ER. When a resident came back from the ER, 30 minute checks were implemented x 3 days, vital signs were taken x 3 days on all shifts, and if the resident had not returned to baseline, the doctor was notified. Interview on 10/22/15 at 7:00 pm with the Senior Care Manager revealed: -"The facility keeps doing the same thing if a resident keeps falling." -The staff had conversations with the Power of	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 32 Attorney, and doctor to address a higher level of care. -"If we can not meet their (the residents') needs, we try to have conversations with the family; sometimes families resist discharge." Interview on 10/22/15 at 7:00 pm with the Director of Operations revealed: -The facility implemented 30 minute checks after each fall. -The facility could use bed and chair alarms for falls risk residents and daily visualizations of residents, physical therapy, occupational therapy, and recommendations from resident's physicians. -"We offered bed alarms and a mat which the family refused as they would have to pay for it out of pocket." - "We will pay for alarms and mats and all kinds of things families cannot pay for out of pocket." -"If we have a resident who we feel we can not meet their needs; we start to have a conversation with the family about a possible discharge." Interview on 10/22/15 at 7:00 pm with the Administrator revealed: -The monitoring system for resident's at risk for falls are: discussion at stand -up meetings, a roster of falls risks residents are kept on the medication carts, 30 minute checks on the residents, engaging residents in acitivities, and keeping them in the common room areas so staff can watch the residents. -The facility could use bed and chair alarms for falls risk residents and daily visualizations of residents, physical therapy, occupational therapy, and recommendations from resident's physicians. -After a resident had an unwittnessed fall, was sent to the hospital, and returns, 30 minute checks went done for 72 hours on all shifts which included checking vital signs.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 33 -For residents who continue to fall, "If they keep falling, we do the same thing". -"If we can not meet their (the residents') needs, we try to have conversations with the family; sometimes families resist discharge." _____ The Director of Operations provided a Plan of Protection for residents effective 10/23/15. "Effective immediately, any resident identified a high fall risk by the falls management team will be immediately placed on a 72 hour monitoring until alternative interventions can be implemented. Senior care managers will review/train new falls management plan with care manager and ED on 10/23/15. Senior care manager will train Med/Techs on 1st and 2nd shift on 10/23/15. Care managers will train all med techs on Falls Management Plan on 3rd shift on 10/23/15. This will continue daily until all med techs are trained. New Falls Management Plan will be implemented and monitored by management to include review of fall incidents. Fall Risk worksheet will be completed on all residents, 72 hour follow up after fall, monthly fall management team meetings to include review recommendations and follow through. Communication log will be reviewed by care manager and or ED, initialed with follow up on any concerns noted." CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2015.	D 270		
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	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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
D912	Continued From page 34 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 supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 7 sampled residents who received injuries due to falls (Residents #6, #7). [Refer to Tag D 0270, 10A NCAC 13F .0901(b), (Type A1 Violation)].	D912	G.S. 131D-21 (2) 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. Resident Rights training with a focus on resident right to receive the proper care based on needs and care plan was completed with all staff on 11/4. Ombudsman has been contacted to set date for Resident Rights Training.	11/4/15 ongoing quarterly thereafter