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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on December 13 and 14, 2016 with an exit conference via telephone on December 15, 2016.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (Residents #1 and #5) with frequent falls in accordance with the residents' assessed needs and current symptoms. The findings are: Review of the facility's Fall Management Program revealed: -The Fall Management Program did not include any information related to supervision of residents with falls. -An incident report was to be completed for all falls and the responsible party and physician notified. -The Executive Director (ED) was required to review all incident reports for content, accuracy and completeness.	D 270		

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-The ED and/or Care Manager should determine any immediate interventions required, based on circumstances of fall.
-Staff was to complete a "72 Hour Follow Up" to investigate possible circumstances and risk factors, and document vital signs and observations for 72 hours after the fall.
-If a resident had two falls within a 4-week period, the physician was to be contacted to request an order for "PT evaluation or other treatment/interventions".
-The resident (record) was to be placed on "Hot Box/Alert Charting" for 72 hours for follow up and monitoring.
-The health care team was to review incident reports on a monthly basis to look for trends and to ensure completion of required forms and documentation.

A. Review of Resident #1's current hospital-generated FL-2 dated 06/20/16 revealed:
-Diagnoses included dementia, osteoarthritis, and pneumonia.
-The resident was intermittently disoriented, semi-ambulatory, and had bruising on her legs.

Review of Resident #1's Resident Register revealed an admission date of 01/19/16.

Observation on 12/13/16 and 12/14/16 of Resident #1's room location revealed:
-The facility layout was in the shape of an "H" with a long center hallway and a shorter hallway on each end.
-The administrative offices, activity room, beauty shop, and dining room were located in the center of the long center hallway.
-Resident #1's private room was the next to last room at the end of one of the shorter hallways.
-There was a star posted by the resident's name

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D 270	Continued From page 2 plate by the door. Review of Resident #1's Resident Notes and Accident/Injury Reports since admission revealed: -Resident #1 experienced 13 unwitnessed falls from 04/10/16 through 12/08/16. -The physician was notified of the falls and staff implemented various interventions in an effort to decrease the falls. -The resident was alone in her room when each of the 13 falls occurred. -Six falls occurred during the night shift, four falls during the evening shift, and 3 falls during the day shift. -Documented fall injuries included a fractured toe, "hitting her head", skin tears, bruises, lacerations, abrasions, and swelling. -There was no documentation staff increased supervision of the resident in response to the resident's falls. Continued review of the Resident Notes and Accident/Injury Reports revealed: -On 04/10/16 at 6:00 am, the resident was found "sitting in floor between bed and chair" and reported to staff she tripped. The resident sustained swelling to the right ankle and a skin tear to the right arm. There was no documentation staff increased supervision of the resident in response to her fall. -On 04/13/16 at 4:05 am, the resident rang the call light. Staff "went in to find" the resident "sitting in the floor at the foot of her bed". The resident reported she lost her balance and fell. The resident sustained bruising to her left hip/lower back area. Documentation on 04/13/16 revealed the resident had "difficulty walking on right ankle, foot is bruised and has mod. swelling". Documentation on 04/14/16 revealed	D 270		

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the resident had a right toe fracture. There was no documentation staff increased supervision of the resident in response to her fall.
-On 04/13/16 at 5:00 pm, the resident was found "sitting on the floor by her bed and night stand" and reported she fell off the bed while trying to answer the phone. There were no documented injuries. There was no documentation staff increased supervision of the resident in response to her fall.
-On 04/30/16 at 3:00 am, the resident was found "lying in the floor between the bed and recliner" and reported she lost her balance, sat down on a waste basket, then fell onto the floor. The resident complained of pain in the "left hip area". There was no documentation staff increased supervision of the resident in response to her fall.
-On 05/01/16 at 3:30 am, staff found the resident "sitting in the floor beside the bed". The resident reported she fell off the bed while trying to get up to use the bathroom. The resident sustained a skin tear to the right leg. There was no documentation staff increased supervision of the resident in response to her fall.
-Documentation on 06/20/16 revealed the resident "needs help with ADLs (Activities of Daily Living); she is weak and unsteady".
-On 07/15/16 at 7:00 am, staff found the resident "sitting in the floor beside the tub". The resident reported she fell against the bathtub. The resident sustained a skin tear to the right elbow, bruised right middle finger, and an abrasion to the back. There was no documentation staff increased supervision of the resident in response to her fall.
-On 08/26/16 at 8:00 pm, the resident "rang out" and was found "sitting on the floor between bed and recliner". The resident reported she "just lost her balance". There were no documented injuries. There was no documentation staff

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increased supervision of the resident in response to her fall.
-On 09/06/16 at 3:45 am, the resident "pushed call button" and found the resident "laying on bed on top of cover". The resident reported she fell out of bed and complained of pain on the "right side of upper leg and on top". Staff "found a bruise that appeared old". There was no documentation staff increased supervision of the resident in response to her fall.
-On 09/06/16 at 3:50 am, the resident "rang again" and was found "laying on the floor on her bottom in front of the bedside toilet". The resident reported she got her feet twisted and did not complain of pain "except on the left hip from where she was sitting". There was no documentation staff increased supervision of the resident in response to her fall.
-On 09/28/16 at 7:40 am, the resident's family member called the facility and reported to staff the resident was in the floor. Staff found the resident sitting on the floor "leaned up against the bed". There were no documented injuries. There was no documentation staff increased supervision of the resident in response to her fall.
On 09/29/16, the resident complained of leg pain and requested staff send her to the local Emergency Room (ER) to be "checked out".
-Documentation on 10/01/16 at 2:00 pm revealed the resident was "needing more assistance than usual dressing and not doing very much walking due to pain".
-On 10/06/16 at 8:40 pm, the resident was found sitting on the floor beside her bed and reported she slid off the side of the bed. There were no documented injuries. There was no documentation staff increased supervision of the resident in response to her fall.
-On 11/04/16 at 9:30 pm, the resident was found sitting on the floor in the middle of her room and

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reported to staff she lost her balance. The resident sustained a laceration, bruising, and swelling to the left knee and was sent to the ER for evaluation. There was no documentation staff increased supervision of the resident in response to her fall.
-On 12/08/16 at 11:00 am, the resident was found "laying on the floor on her back" and "hitting her head on bedside table". The resident reported she lost her balance transferring from the bed to the wheelchair. The resident sustained a skin tear on her right hand and was sent to the ER via ambulance. There was no documentation staff increased supervision of the resident in response to her fall.

Review of the "72 Hour Follow Up" reports for Resident #1 revealed:
-A follow up report was completed after each of the resident's falls.
-Each form included a section for each shift to document assessment of resident injury, difficulty walking, soreness, behavior changes, and requests for over-the-counter pain reliever for a period of 3 days.
-Each form included a section to be completed immediately following the resident's fall to assess contributing environmental factors, resident vital signs, and a section of blank lines with instructions to "Document steps taken to correct".
-The 'steps to correct' section for all the forms was blank except on two occasions when the steps to correct were "slow down" on 04/13/16 and to "use walker" on 09/28/16.

Review of hospital Emergency Room (ER) records dated 07/15/16 for Resident #1 revealed:
-Resident #1 was evaluated for a fall and back pain.
-The resident reported she lost her balance

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because she was not using her walker and had right arm pain, back pain, and "pain in her right hip but (was) able to bear weight".
-The resident had a "moderate size abrasion" and mild tenderness to the back, a skin tear and tenderness to touch and range of motion to the right arm and wrist, and mild pain with range of motion to the right hip.
-The resident had multiple x-rays, including right elbow, right hip, lumbar spine, and right wrist.
-X-ray results included "severe osteopenia" and degenerative changes, but no acute fractures.
-The resident returned to the facility.

Review of hospital ER records dated 09/29/16 for Resident #1 revealed:
-Resident #1 was evaluated for a right hip injury "from a fall 3 days ago".
-The resident reported pain "mid shaft of right femur/hip". No obvious deformity noted.
-The resident had multiple x-rays, including lumbar spine, pelvis and lateral left hip, and right femur.
-X-ray results included osteopenia and degenerative changes, but no acute fractures.
-The resident was given a prescription for a narcotic pain reliever and returned to the facility.

Review of hospital ER records dated 11/04/16 for Resident #1 revealed:
-Resident #1 was evaluated for a fall and left knee and right lower leg pain and skin tear.
-Multiple x-rays were obtained, including left knee, right lower leg, and Computerized Tomography (CT) Scan of the head.
-X-ray results included osteopenia, osteoarthritis, and degenerative changes, but no acute fractures.
-The resident was discharged back to the facility.

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Review of hospital ER records dated 12/08/16 for Resident #1 revealed:
-Resident #1 was evaluated for a fall and "hit head" and complained of pain in the right wrist and left hip.
-The resident had a "skin avulsion" to the right hand with "loss of epidermal tissue" and mild tenderness to touch of the left hip.
-Multiple x-rays were obtained, including pelvis and left hip, right hand, and CT scan of the head.
-X-ray results included osteopenia and degenerative changes, but no acute fractures.
-The resident was discharged back to the facility.

Review of Resident #1's record revealed:
-The current care plan, completed on 01/28/16 and signed by the physician on 02/02/16, indicated the resident required limited assistance for transfers and for ambulation from room to room.
-The care plan section entitled, "Risk Management Provisions - Safety Measures To Implement" was blank.
-There was no documentation of updates or change of condition noted to the care plan.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluations revealed:
-An LHPS evaluation was completed on 01/26/16 with no LHPS tasks identified and no recommended changes to care.
-An LHPS evaluation was completed on 04/08/16 with identified LHPS tasks of transfers, clean dressing changes, and physical and occupational therapy.
-The 04/08/16 LHPS evaluation included the following: "Resident is doing well. No concerns or problems. Staff monitors resident for falls due to recent falls. Home health is performing dressing

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changes to LLE (left lower extremity). PT/OT (Physical therapy/Occupational therapy) will evaluate resident. Resident manages her own wc (wheelchair) with staff assistance with transfers. Continue plan of care. No changes recommended". "Fall Risk" was included under the section entitled LHPS Personal Care Task Provided.
-An LHPS evaluation was completed on 07/15/16 with an identified LHPS task of transfers and included the following: "Resident is doing well today. No concerns or problems. Resident manages her own wc with staff assistance with transfers. Staff monitors resident for falls due to recent fall. She is going to MD (Medical Doctor) to get checked out today. Continue plan of care, no changes recommended. "Fall Risk" was included under the section entitled LHPS Personal Care Task Provided.
-There was no documentation of further LHPS quarterly assessments completed.

Review of PT and OT start-of-care and end-of-care dates provided by the facility revealed:
-The resident received OT from 03/28/16 to 05/05/16 and was evaluated by OT on 08/15/16.
-The resident received PT from 03/24/16 to 05/19/16; again from 07/25/16 to 09/07/16; and again from 10/06/16 to 10/22/16.

Interview on 12/14/16 at 10:20 am with Resident #1 revealed:
-Staff "don't come in here unless I call them".
-She did not like to call for staff assistance because she liked to "do it herself".
-She had one leg that was shorter than the other, requiring her to wear a special shoe.
-She often "forgot" to put on her shoe when she got up, which caused her to fall.

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D 270	Continued From page 9 -Staff did not check on her at regular intervals, but "only come if I call". -She would "probably" allow staff to assist her to the bathroom if they came to her room at regular intervals and asked her if she needed to go. Telephone interview on 12/14/16 at 6:25 am with the night shift Medication Aide (MA) revealed: -She routinely woke Resident #1 up every two hours throughout the night to go to the bathroom and stated, "with her, I have to because if I don't she'll get up by herself and fall". -The MA started waking the resident every two hours "after her last fall about 2 weeks ago" because she noticed most of the resident's falls were when she was trying to go to the bathroom at night. -She instructed the resident on several occasions to ring the bell for help, but she was "very independent" and did not want to call for help. -The MA had not been given any instructions from management regarding increased supervision for Resident #1. Telephone interview on 12/14/16 at 6:33 am with the night shift Personal Care Aide (PCA) revealed: -Resident #1 would not call for help to use the bathroom, so staff "generally check on her". -"We try not to wake her up too much, but if she's up and around, we ask her" if she needs to go to the bathroom. -The PCA was not the person routinely assigned to Resident #1's hall, but she helped out during the MA's breaks or as needed. Interviews on 12/13/16 at 11:30 am and 2:55 pm with a day shift MA revealed: -Staff routinely checked on all residents every two hours or every time they passed by the door.	D 270		

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D 270	Continued From page 10 -Resident #1 was on the "same standard" for checks as all the other residents. -Staff "just keep reminding her to use her walker and check on her 'ever so often'". -When asked how much "ever so often was", the MA stated, "probably every two hours like the others. We like to leave the door open so we can look in on her." Interview on 12/13/16 at 3:45 pm with an evening shift PCA revealed: -Staff checked on Resident #1 "a little more" because she "falls more often. Well, not more often, but when she falls lately, it's worse." -The PCA clarified the falls were getting worse, meaning she was having more injuries. -There was currently no defined schedule for increased supervision of Resident #1. Interview on 12/13/16 at 4:08 pm with a second evening shift PCA revealed: -Resident #1 did not ring her bell "until after she falls". -The PCA did not know why the resident had excessive falls and stated, "She just doesn't push that bell for help sometimes". -There was currently no defined schedule for increased supervision of Resident #1. Interview on 12/13/16 at 4:32 pm with the Resident Care Manager (RCM) revealed: -Resident #1 was not on any set routine for increased checks. -The physician had reviewed the resident's medications and therapy had rearranged her room to see if it would help. -"We can't prevent all falls." Interviews on 12/14/16 at 8:53 am and 11:45 am with the Executive Director (ED) revealed:	D 270		

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D 270	Continued From page 11 -The star posted by residents' names on their name plate meant that resident was a fall risk. -The star was an internal identifier and not part of the Fall Management Policy. -Staff did "extra checks" on Resident #1 when she fell, depending on her reason for falling or whether or not it was from a standing position, etc. -The resident had been seen by therapy on several occasions due to her falls and other interventions, such as rearranging of her furniture, had been implemented. -The ED offered "a couple of months ago" to move the resident closer to the front of the facility, but the resident and the Power of Attorney (POA) declined. -The ED informed the resident and POA if the resident's falls continue, they would not have a choice. -The ED wanted to move the resident closer so she would be seen faster or a little more often and stated, "on the front hall, her room would be passed by more frequently". -Resident #1 "rarely" used the call bell. Telephone interview on 12/13/16 at 3:11 pm with Resident #1's POA revealed: -The resident fell several years ago and broke her hip and femur; as a result, she had a "short leg". -The resident had a special shoe with a "build-up", but she often got out of bed and tried to ambulate without putting on the shoe, which caused her to fall. -"Staff say they can't know if she needs anything unless she rings" but she has some dementia and doesn't ring the bell for assistance. -The resident reported to the POA that when she rings the bell, it takes a long time for staff to respond; however, the POA did not know whether or not the resident's perception of time was	D 270		

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accurate because she was confused.
-The POA instructed the resident if she could not wait for staff assistance, to void in her incontinent brief rather than get out of bed unassisted.
-The POA visited every day for approximately 15 minutes to an hour.
-During her visits, she had not witnessed staff "come just to check on her-maybe to give her a pill".
-The POA stated she was satisfied with the care being provided by the facility and thought they were doing what was necessary to try to keep the resident safe, but stated she thought it would help to check her more often and offer assistance to the bathroom.

Telephone interview on 12/14/16 at 9:37 am with the Nurse Practitioner (NP) revealed:
-She began working at the facility in October 2016 and would not necessarily have any information regarding falls occurring prior to that time.
-Resident #1 had recurrent urinary tract infections and mild cognitive impairment.
-The resident had a prior hip fracture and repair; as a result, she had lifts in her left shoe because her leg was more than 2 inches shorter than the right.
-She believed most of the resident's falls were because she forgot her walker and shoe when she got up to walk.
-The facility staff did a good job trying to minimize the resident's falls by rearranging the furniture in the room and getting her evaluated by the physician and PT/OT.
-The resident liked to keep her door closed.
-More frequent supervisory checks would reduce the resident's falls "in theory", but would "not prevent them altogether".
-"I definitely see value" in moving the resident to a "more trafficked area of the facility".

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D 270	Continued From page 13 -Given the resident's number of previous falls and risk factors, she was "obviously" at risk for serious injury. Refer to interview on 12/13/16 at 3:40 pm with a second day-shift MA. Refer to telephone interview on 12/14/16 at 6:25 am with a night shift MA. Refer to interview on 12/13/16 at 3:45 pm with an evening shift PCA. Refer to interview on 12/13/16 at 4:08 pm with a second evening shift PCA. Refer to interview on 12/13/16 at 4:32 pm with the RCM. Refer to interviews on 12/14/16 at 8:53 am and 11:45 am with the ED. B. Review of Resident #5's current hospital generated FL-2 dated 6/28/16 revealed: -Diagnoses of hypertension, congestive heart failure, dementia, chronic back pain. -Resident #5 was assessed as needing limited assistance with toileting, bathing, dressing, and grooming/personal hygiene, ambulation/locomotion, and transferring. Review of Resident #5's Resident Register revealed an admission date of 7/09/15. Observation of Resident #5's room location on 12/13/16 and 12/14/16 revealed: -The facility layout was in the shape of an "H" with a long center hallway and a shorter hallway on each end. -The administrative offices, activity room, beauty	D 270		

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shop, and dining room were located in the center of the long center hallway.
-Resident #5's private room was about halfway of the center hallway on 100 hall.
-There was a star posted by the resident's name plate by the door.

Review of the facility's Accident Reports and Care notes for Resident #5 revealed:
-Resident #5 experienced 4 unwitnessed falls occurring on day and night shift since May 2016.
-Resident #5 had unwitnessed falls documented on 5/17/16, 8/01/16, 10/22/16, and 11/03/16.
-On 5/17/16 at 9:25 am staff found the resident sitting on the bathroom floor. Resident stated she was going from the toilet to the wheelchair and slipped causing her to fall. No injuries noted.
-The physician and the residents family were notified of the fall.
-There was no documentation staff increased supervision of the resident in response to the resident fall.
-Staff continued to monitor the resident over the next 72 hours (6:00 am, 2:00 pm, 10:00 pm) and no issues related to the fall noted.
-Resident #5 was visited by Physical Therapy on 5/25/16 for evaluation due to recent fall and seen by the physician on 6/13/16. Physical therapy discharged on 6/06/16 due to goals met.
-On 8/01/16 at 10:20 pm staff found resident sitting on the floor at the front of the bed. Resident was trying to get in bed but did not have her wheelchair locked.
-Designated area on accident report to report injury was blank.
-The physician and the residents family were notified of the fall.
-Care notes reported no injuries due to fall.
-There was no documentation staff increased supervision of the resident in response to the

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resident fall.
-Staff continued to monitor the resident over the next 72 hours (6:00 am, 2:00 pm, 10:00 pm) and no issues related to the fall were noted.
-Resident #5 was seen by the physician on 8/16/16.
-Resident #5 fell on 9/22/16 at 3:50 pm and fall was not noted in the facility accident reports.
-Resident #5 "fell out of her wheelchair and hit her head on the floor. Bleeding was noted on left upper side of head near temple. Resident was incoherent for a while. Tried to obtain vital signs Resident not cooperating. Resident started talking and became very combative. Resident transported to a local hospital for evaluation".
-Resident #5 returned from the hospital on 9/22/16 at 10:00 pm with no new orders.
-Scheduled to follow up with Primary Care for elevated blood pressure.
-It was noted that the resident had left shoulder pain and bruise to her left eye resulting from 9/22/16 fall.
-Resident was seen by her Primary Care Physician on 10/04/16 to follow up after fall. No new orders at that time.
-There was no documentation staff increased supervision of the resident in response to the resident fall.
-Staff continued to monitor the resident over the next 72 hours (staff documenting on resident every 7-8 hours during the 72 hours time frame). The resident complained of soreness from fall over the next 48 hours after fall. No other complaints or issues related to fall were documented.
-On 10/22/16 at 3:15 pm staff found the resident sitting in the floor between her chair and the wheelchair. Resident stated she slid out of her chair trying to clean the floor.
-Blood Pressure (BP) was low 86/60, and heart

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rate was 78. The physician was notified and the evening dose of BP medication was held. There were no injuries noted.
-Staff also notified the family of the fall.
-There was no documentation staff increased supervision of the resident in response to the resident fall.
-Staff continued to monitor the resident over the next 72 hours (6:00 am, 2:00 pm, 10:00 pm) and no issues related to the fall were noted.
-On 11/03/16 at 8:30 pm staff found the resident sitting on the floor in front of the refrigerator.
-Resident stated she was getting out of the wheelchair to fix her bed and lost her balance and sat down on the floor.
-The physician and the residents family were notified of the fall.
-Designated area on accident report to report injury was blank. Care notes reported no injuries due to fall.
-There was no documentation staff increased supervision of the resident in response to the resident fall.
-Staff continued to monitor the resident over the next 72 hours (6:00 am, 2:00 pm, 10:00 pm) and no issues related to the fall were noted.
-Seen by the physician on 11/08/16.
-There was no documentation staff increased supervision of the resident after each of the falls.

Review of Resident #5's current care plan dated 6/28/16 revealed:
-The current care plan, completed on 6/28/16 and signed by the physician on 6/28/16, indicated the resident could ambulate in wheelchair to/from destination without staff assist. However, the care plan section titled "Risk Management" and "Safety Measures to Implement" staff have documented the resident just completed Physical Therapy to help improve transfer safety.

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D 270	Continued From page 17 -There was no documentation of updates or change of condition noted to the care plan. Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 7/15/16 revealed: -An LHPS evaluation was completed on 07/15/16 with an identified LHPS task of transfers and included the following: "Resident is doing well today. No concerns or problems. Staff assist the resident with wheelchair transfers. She manages her own wheelchair from place to place. Staff reports no concerns or problems". No changes to care recommended. -There was no documentation of further LHPS quarterly assessments completed. Based on observation, record review and interviews with staff, it was determined Resident #5 was not interviewable. Interview on 12/14/16 at 3:30 pm with Resident #5's Alternate Power of Attorney revealed: -Resident #5 had lived at the facility for many years. -The facility had notified her when the resident fell and if the resident required going to the hospital. -She tried to visit about once a month. -She had visited and pushed the call bell and felt the staff responded quickly. She felt they take good care of the resident. -She is unaware if any new precautions had been taken to prevent future falls. Refer to interview on 12/13/16 at 3:40 pm with a second day-shift Medication Aide (MA). Refer to telephone interview on 12/14/16 at 6:25 am with a night shift Medication Aide (MA).	D 270		

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D 270	Continued From page 18 Refer to interview on 12/13/16 at 3:45 pm with an evening shift Personal Care Aide (PCA). Refer to interview on 12/13/16 at 4:08 pm with a second evening shift Personal Care Aide (PCA). Refer to interview on 12/13/16 at 4:32 pm with the Resident Care Manager (RCM). Refer to interviews on 12/14/16 at 8:53 am and 11:45 am with the Executive Director (ED). _____ Interview on 12/13/16 at 3:40 pm with a second day shift MA revealed: -A star placed by the resident's name plate on the door meant the resident was at risk for falls. -If a resident had a star on the door, it meant staff were supposed to "just watch them more". -The MA stated "more" meant every two hours. -When asked if that was the standard for all residents, the MA stated, "Well, actually, we look at all our people every 30-40 minutes whether they have a star or not". Telephone interview on 12/14/16 at 6:25 am with a night shift MA revealed: -The star by a resident's door meant the resident was a fall risk. -If a resident had a star, staff had to check on that resident a little more often, "probably about every hour, just look in". -There was no set standard for frequency of checks. Interview on 12/13/16 at 3:45 pm with an evening shift PCA revealed: -The PCA initially stated the star by a resident's door meant the resident had a "Do Not Resuscitate" order. -The PCA looked at a few doors on the hall, then	D 270		

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returned and stated the star meant the resident was at risk for falls.
-If a resident had a star, that meant staff was to "watch them typically closer", meaning "if we see them walking down the hall with someone not a fall risk, we would watch the fall risk person closer to make sure they don't fall".
-Staff routinely made rounds on all residents every two hours and certain ones every hour.
-Residents who were checked every hour were those who had heavy incontinent episodes, were sick, or had frequent falls.
-There was no set standard for frequency of resident checks; even if staff check on a resident every hour, it was not a required standard, just "our routine".

Interview on 12/13/16 at 4:08 pm with a second evening shift PCA revealed:
-A star by a resident's door meant there was a "fall hazard".
-If a resident had a star by their door, staff were supposed to make sure walkers were in their hands when they came out of the room and keep an extra watch on them.
-Keeping an "extra watch" meant staff would walk around and take a look in their rooms "a little more often if it looked like they've been staggering around or not feeling well", but staff "tend to watch out for fall hazard folks even if they're acting right".
-There was no standard frequency for resident checks; staff just "try to look in as they are going up and down the hall".
-Today, the PCA had "about 28 residents" on her assignment and was responsible for completing 6 baths, which took an average of 20-30 minutes each.
-When the PCA was off the hall giving baths, the other PCA working answered her call bells.

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D 270	Continued From page 20 -The MA was also on the hall for a "couple hours at a time passing meds". Interview on 12/13/16 at 4:32 pm with the RCM revealed: -A star on a resident's door meant the resident was a fall risk. -If a resident had a star on their door, staff were "just supposed to lay eyes on them more often". -Staff made rounds on incontinent residents every two hours, but were up and down the hall "all the time" and would "just look in the room" to make sure they "haven't had an accident". Interviews on 12/14/16 at 8:53 am and 11:45 am with the ED revealed: -The star posted by residents' names by their door meant that resident was a fall risk. -The star was an internal identifier and not part of the Fall Management Policy. -Staff were supposed to "have eyes" on the residents with stars "no less than every hour", but there was no set schedule or documentation of increased supervision of the resident because it was "just protocol". -There was currently no system in place to ensure staff were following an hourly protocol, "just trust". _____ The facility failed to provide supervision for 2 of 2 sampled residents (Residents #1 and #5) with frequent falls in accordance with the residents' assessed needs and current symptoms. Resident #1 experienced 13 unwitnessed falls with resulting injuries including a fractured toe, "hitting her head", skin tears, bruises, lacerations, abrasions, and swelling. Resident #5 experienced 5 unwitnessed falls with resulting injuries including bruising, "hit her head" and	D 270		

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D 270	Continued From page 21 "incoherent for a while". The failure of the facility to provide supervision in accordance with residents' assessed needs and current symptoms resulted in injury of two residents as well as substantial risk of serious injury or death of residents and constitutes a Type A2 Violation. _____ On 12/14/16, the ED submitted a Plan of Protection as follows: -The Administrator and RCM will review all residents to identify if any require increased supervision. -Identified fall risk residents will be assessed by the primary care physician for therapy needs. -All staff will receive inservice training on observing and reporting changes in resident conditions. -A tracking form will be put in place to document increased supervision and all staff will be trained on documentation of increased supervision. -Administrator or designee will check documentation daily for 30 days and randomly thereafter. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 14, 2017.	D 270		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30	D 280		

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D 280	Continued From page 22 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an on-site review and evaluation of 4 of 5 sampled residents (Residents #1, #2, #4, and #5) was completed quarterly and included a physical assessment, evaluation of the residents' care being provided, or needed recommendations for changes in the care of the resident. The findings are: A. Review of Resident #1's current hospital-generated FL-2 dated 06/20/16 revealed: -Diagnoses included dementia, osteoarthritis, and pneumonia. -The resident was semi-ambulatory and intermittently disoriented. Review of Resident #1's record revealed the current care plan, completed on 01/28/16 and	D 280		

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D 280	Continued From page 23 signed by the physician on 02/02/16, indicated the resident required limited assistance for transfers. Review of Resident #1's Resident Notes and Accident/Injury Reports since admission revealed: -Resident #1 experienced 13 unwitnessed falls from 04/10/16 through 12/08/16. -Documented fall injuries included a fractured toe, "hitting her head", skin tears, bruises, lacerations, abrasions, and swelling. Review of Physical Therapy (PT) and Occupational Therapy (OT) start-of-care and end-of-care dates provided by the facility revealed: -The resident received OT from 03/28/16 to 05/05/16 and was evaluated by OT on 08/15/16. -The resident received PT from 03/24/16 to 05/19/16; again from 07/25/16 to 09/07/16; and again from 10/06/16 to 10/22/16. Review of Resident #1's Licensed Health Professional Support (LHPS) evaluations revealed: -An "LHPS Initial Evaluation and Quarterly Review" form was completed on 01/26/16, but no LHPS tasks were identified on the form. -The LHPS task of "Transferring semi-ambulatory residents" was not identified and therefore did not include a physical assessment or recommendations to the current plan of care. -An LHPS evaluation was completed on 04/08/16 with identified LHPS tasks of transfers, clean dressing changes, and physical and occupational therapy. -The 04/08/16 LHPS evaluation did not include a physical assessment of the resident's abilities or limitations regarding transfers, a physical assessment of the resident's wounds, an	D 280		

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evaluation of the resident's response to wound care being provided or physical and occupational therapy, or recommendations for changes to the resident's plan of care.
-An LHPS evaluation was completed on 07/15/16 with an identified LHPS task of transfers.
-The 07/15/16 evaluation did not include a physical assessment of the resident's abilities or limitations regarding transfers, response to the care being provided by staff, or recommendations for changes to the resident's plan of care.
-There was no documentation of an LHPS evaluation within 30 days of the start of physical therapy on 07/25/16.
-There was no documentation of an LHPS evaluation within 30 days of the start of physical therapy on 10/06/16.
-There was no documentation of further LHPS quarterly assessments related to the resident's transfers.

Interview on 12/14/16 at 10:20 am with Resident #1 revealed:
-She had one leg that was shorter than the other, requiring her to wear a special shoe.
-She often "forgot" to put on her shoe when she got up, which caused her to fall.
-She would "probably" allow staff to assist her to the bathroom if they came to her room at regular intervals and asked her if she needed to go.

Refer to interview on 12/13/16 at 1:50 pm with the Resident Care Manager.

Refer to interview on 12/14/16 at 11:45 am with the Executive Director.

B. Review of Resident #2's current FL2 dated 6/24/16 revealed:
-Diagnoses included dementia, chronic kidney

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D 280	Continued From page 25 disease, osteoarthritis, and congestive heart failure. -Resident #2 was constantly disoriented. -Resident #2 was non-ambulatory and required a wheelchair. -Resident #2 required personal care assistance with bathing, dressing, total care and feeding. -A physician's order for a border patch applied to the inner thighs and changed 3 times weekly. Review of Resident #2's record revealed the current care plan, completed on 6/23/16 and signed by the physician on 6/24/16, indicated the resident required assistance for transfers, a dressing change 3 times weekly. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluations revealed: -An "LHPS Initial Evaluation and Quarterly Review" form was completed on 4/08/16, with a "wheelchair" transfer task identified on the form. -The 4/08/16 evaluation documented the resident "manages her own wheelchair with staff assistance". No changes were recommended. -An LHPS evaluation was completed on 7/15/16 with identified LHPS tasks of wheelchair transfers and chopped meats for feeding techniques. -The 07/15/16 evaluation did not include a physical assessment of the resident's abilities or limitations regarding transfers or response to the care being provided by staff, and recommended no changes to the current plan of care. -The 7/15/16 evaluation did not include a dressing change 3 times weekly. -There was no documentation of further LHPS quarterly assessments related to the resident's transfers, dressing changes, or feeding techniques.	D 280		

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	HAL030008	A. BUILDING: _____ B. WING _____	12/15/2016

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D 280	Continued From page 26 Based on observation, record review and interviews with staff, it was determined Resident #2 was not interviewable. Refer to interview on 12/13/16 at 1:50 pm with the Resident Care Manager. Refer to interview on 12/14/16 at 11:45 am with the Executive Director. C. Review of Resident #5's current hospital generated FL-2 dated 6/28/16 revealed: -Diagnoses included hypertension, congestive heart failure, dementia, and chronic back pain. -Documentation the resident was intermittently disoriented and non-ambulatory with wheelchair. Review of Resident #5' s Resident Register revealed an admission date of 07/09/15. Review of Resident #5's record revealed the current care plan, completed on 6/28/16 and signed by the physician on 6/28/16, indicated the resident could ambulate in wheelchair to/from destination without staff assist. Review of the facility's Accident Reports and Care notes for Resident #5 revealed: -The resident had experienced 5 unwitnessed falls from 5/17/16 through 11/3/16. -Documented fall injuries included hitting her head and bruising of the left eye from the fall on 9/22/16. Review of Physical Therapy (PT) start-of-care and end-of-care dates provided by the facility, indicated the resident was seen by PT on 5/25/16 for evaluation due to recent fall and discharged on 6/6/16 due to goals met. Review of Resident #5's Licensed Health	D 280		

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D 280	Continued From page 27 Professional Support (LHPS) evaluation on 7/15/16 revealed: -The identified LHPS tasks were transfers. There were no changes to care recommended. -The 7/15/16 LHPS evaluation included the following: "Resident is doing well today. No concerns or problems. Staff assist resident with wheelchair transfers. She manages her own wheelchair from place to place. Staff reports no concerns or problems". -There was no documentation of an LHPS evaluation within 30 days of the start of physical therapy on 5/25/16. -There was no documentation of further LHPS quarterly assessments completed. Based on observation, record review and interviews with staff, it was determined Resident #5 was not interviewable. Refer to interview on 12/13/16 at 1:50 pm with the Resident Care Manager. Refer to interview on 12/14/16 at 11:45 am with the Executive Director. D. Review of Resident #4's current hospital FL-2 dated 11/14/16 revealed: -Diagnoses included arthritis, body mass index less than 19 in adult, chronic back pain, chronic hypoxemic respiratory failure, chronic obstructive pulmonary disease, essential hypertension, macular degeneration, osteoarthritis, and physical deconditioning. -The resident was alert and oriented and semi-ambulatory. -The resident required personal care assistance with bathing and dressing. -A physicians order for oxygen 3 liters as needed.	D 280		

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D 280	Continued From page 28 Review of Resident #4's Resident Register revealed an admission date of 8/23/16. Review of Resident #4's current care plan completed on 9/26/16 and signed by the physician on 9/26/16 revealed: -The "resident needs some staff assistance with ambulation due to oxygen use. Staff keeps pathways clear and retrieves equipment for resident". -The Care Plan section titled "Risk Management" and "Safety Measures to Implement" was blank. The "resident is dependent on oxygen at 2 liters. Staff monitors oxygen and changes tanks as needed". Review of Resident #4's Licensed Health Professional Support (LHPS) evaluations revealed no LHPS was completed since admission. Refer to interview on 12/13/16 at 1:50 pm with the Resident Care Manager. Refer to interview on 12/14/16 at 11:45 am with the Executive Director. _____ Interview on 12/13/16 at 1:50 pm with the Resident Care Manager revealed: -The facility had not had a nurse for the past "2 or more months" to complete the quarterly LHPS evaluations, but "the residents had been being seen by their physicians, home health and physical therapy as necessary and if ordered, so (the residents') needs had been met, just not the paperwork". -"Corporate was to send a nurse 6 months ago, but none had been sent yet." -She was aware LHPS were to be done quarterly. -She was not aware who was responsible to	D 280		

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D 280	Continued From page 29 assure LHPS were done quarterly. Interview on 12/14/16 at 11:45 am with the Executive Director revealed: -The quarterly LHPS evaluations had not been done since July as they did not have a nurse to complete them, for the nurse was out on maternity leave and then did not return to work at this facility. -She was aware the LHPS evaluations were to be done quarterly by a nurse. -She would contact "Corporate again to follow-up on their plan".	D 280		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on interviews, record reviews, and observations the facility failed to assure that snacks were offered or made available to all residents between each meal, for a total of three snacks per day. The findings are: Review of the facility's 7-day week-at-glance menu posted in the kitchen revealed snacks were listed three times daily; once after the breakfast meal, once after the lunch meal; and once after	D 298		

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D 298	Continued From page 30 the evening meal. Observation on 12/13/16 from 9:00 am to 5:00 pm revealed: -The facility had a census of 53 residents residing in the building. -No snacks were observed served or offered to the residents between meals. -No snacks were observed out in the open and available to residents. Interviews on 12/13/16 at 10:10 am and 12/14/16 at 9:45 am with the Cook revealed: -She had worked as the first shift facility cook for 4 years. -The Dietary Manager (DM) no longer worked at the facility and had been gone for 3 weeks. -The Personal Care Aides (PCA) were to come to the kitchen for the snack cart that was prepared by the kitchen staff at bedtime only. -The residents "used to get snacks 3 times a day- in the morning, afternoon and bedtime, but it had stopped about January 2016. She was not sure who ordered, or why, the snack service changed. -"No one asked her to prepare a snack cart during the daytime." -She "had not prepared a snack cart during the daytime in a very long time". -Snacks were listed on the menu to be served. -"If a resident asked for something to eat, it would be given to them." Interview on 12/13/16 at 4:40 pm with the Executive Director revealed: -There was currently no DM for the past 3-4 weeks. -Snacks were served to the residents by cart at bedtime. -Snacks were available at all times if a resident asked for one.	D 298		

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D 298	Continued From page 31 -There were not snacks out in the open and available for residents. Confidential interviews with 13 residents on 12/13/16 revealed: -Snacks were served at bedtime only. -Snacks were "brought to our rooms by cart only at bedtime". -"If I ask, I am sure they would give me something." -"There is a vending machine if I want anything." -The interviewed residents were not aware they could ask for a snack when they wanted one. -Three residents stated they ate snacks between meals, but they provided the snacks themselves. -One resident stated they would not eat a snack even if it was served. Interview on 12/14/16 at 10:00 am with a Medication Aide revealed: -The snack cart was prepared by the kitchen and served to the residents 2 times per day (morning and bedtime) by the PCAs. Observation on 12/14/16 at 10:10 am revealed a PCA serving snacks to the resident rooms by a cart containing 2 types of juices, packs of cookies, and packs of crackers. Interview on 12/14/16 at 10:10 am with the PCA serving snacks revealed: -She had worked at the facility 3 years. -Snacks were served from a cart prepared by the kitchen staff. -Snacks were served in the morning and evening. Interview on 12/14/16 on 10:15 am with a resident's sitter revealed: -She had been coming to the facility almost daily for 3 years.	D 298		

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D 298	Continued From page 32 -She had never seen snacks served during the daytime.	D 298		
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 observations, interviews, and record reviews, the facility failed to provide care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding supervision of residents. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (Residents #1 and #5) with frequent falls in accordance with the residents' assessed needs and current symptoms. [Refer to tag D270, 10A NCAC 13F .0901(b) (Type A2 Violation).]	D912		