Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041050	A. BUILDING: _____ B. WING _____	R 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF GREENSBORO	1208 NEW GARDEN ROAD GREENSBORO, NC 27410

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 01/04/17 and 01/05/17.	{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, who required assistance with ambulation and was identified as a high fall risk, and Resident #8, who had multiple falls with injury) in accordance with the residents' assessed needs and current symptoms. The findings are: A. Review of Resident #1's current FL-2 dated 12/08/16 revealed: -Diagnoses included Parkinson's disease, osteoporosis, encephalopathy and altered mental status. -Resident #1 had a history of falls with various injuries including hip fracture, traumatic hemopneumothorax, multiple rib fractures, multiple lacerations and was documented as "high risk for falls". -Resident #1 required extensive assistance with	D 270		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Michael Wilson MICHAEL WILSON | Executive Director | 2-15-17

Reviewed and excepted by Diana Spalding RN 2/20/17

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D 270	Continued From page 1 ambulating. Review of the Resident #1's Resident Register revealed an admission date of 06/11/16. Review of Resident #1's Progress Notes and Accident/Injury Reports since admission revealed: -Resident #1 experienced 11 unwitnessed falls from 07/13/16 to 01/04/17 with 8 of the 11 falls occurring within the past 45 days. -Resident #1 was alone in his room or private bathroom when each of the falls occurred. -Five falls occurred during the night shift, five falls during the evening shift, and one fall during the day shift. -Documented fall injuries included a fractured rib, hitting his head, skin tears, abrasions, lacerations, and bruises. -Staff notified the physician and family after each fall and implemented various interventions in an effort to decrease the falls. -There was no documentation staff increased supervision of the resident in response to the resident's falls. Continued review of the Progress Notes and Accident/Injury Reports revealed: -On 07/13/16 at 8:45 pm, Resident #1 was "found" on the floor. Documented injuries included a skin tear to the left elbow, small cut to the right wrist, skin tear to left lower leg and bruising. The resident was sent to the local Emergency Room (ER) for evaluation. There was no documentation staff increased supervision of the resident in response to his fall. -On 08/05/16, the physician ordered a "wheelchair evaluation". -On 08/26/16 at 10:00 pm, Resident #1 requested assistance by pressing his pendent and was	D 270		

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D 270	Continued From page 2 "found" sitting upright on the bedroom floor. There were no documented injuries. There was no documentation staff increased supervision of the resident in response to his fall. -On 10/08/16 at 10:10 pm, Resident #1 was "found" on the floor in bedroom. Documented injuries included abrasions to both knees, swelling of the left knee and complaints of pain. An x-ray of the left knee was negative for acute fracture. There was no documentation staff increased supervision of the resident in response to his fall. -On 11/13/16 at "around 11:30 pm Resident #1 was "found" on the floor. Documented injuries included a "small cut" and bruising to the left elbow and a scrape and bruising to the left rib area with complaints of pain. X-rays revealed a left rib fracture. There was no documentation staff increased supervision of the resident in response to his fall. -On 11/23/16 at 10:00 am, Resident #1 was "found" on the floor. Documented injuries included complaints of left hip and arm pain, hitting his head on a motorized wheelchair, abrasion to the left knee, and bruising to left "arm/elbow"area and scattered to all extremities".The resident was sent to the local ER for evaluation. There was no documentation staff increased supervision of the resident in response to his fall. -On 11/29/16 at 6:10 pm, Resident #1 was "found" on his bedroom floor. Documented injuries included 3 skin tears to the right leg. There was no documentation staff increased supervision of the resident in response to his fall. -On 12/02/16 at 8:09 pm, Resident #1 was "found" on the bedroom floor. Documented injury was a skin tear to the left leg. There was no documentation staff increased supervision of the resident in response to his fall.	D 270		

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D 270	Continued From page 3 -On 12/04/16 at 12:00 am, Resident #1 was "found" on the floor beside the bed. Documented injury was a skin tear to the right arm. There was no documentation staff increased supervision of the resident in response to his fall. -On 12/09/16 at 1:30 am, Resident #1 was "found" on the floor beside the bed. Documented injury was a skin tear to the left knee. There was no documentation staff increased supervision of the resident in response to his fall. -On 12/27/16 at 5:15 am, Resident #1 was "found" sitting on the bathroom floor beside the toilet. Documented injury was a "small bruise to left shoulder". There was no documentation staff increased supervision of the resident in response to his fall. -On 01/04/17 at 6:15 am, Resident #1 was "found" on the floor beside the bed and reported he hit his head. The resident was transferred to the local hospital ER for evaluation. There was no documentation staff increased supervision of the resident in response to his fall. Review of radiological studies and hospital evaluations for Resident #1 revealed: -Emergency Room (ER) evaluation on 07/13/16 revealed skin tears to the left elbow. -An x-ray of the sacrum/coccyx on 08/02/16 was negative for acute fracture. -An x-ray of the left knee on 10/08/16 was negative for acute fracture or dislocation. -X-rays of the right and left ribs on 11/14/16 revealed a minimally displaced acute fracture of the lateral sixth rib. -An ER evaluation on 11/23/16 revealed bruising on upper and lower extremities, superficial laceration of left knee and "several small skin tears on all extremities". -Computerized Tomography (CT) of the head and cervical spine on 11/23/16 was negative for acute	D 270		

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D 270	Continued From page 4 abnormalities. -X-rays of the left shoulder, elbow, and wrist on 11/23/16 showed no acute abnormalities. -CT of the head on 12/05/16 was negative for fracture. -An ER evaluation on 01/04/17 with diagnoses of fall, minor closed head trauma, and multiple abrasions. -A CT of the head and cervical spine on 01/04/17 revealed a right temporal scalp contusion without underlying fracture. Review of Resident #1's admission Service Plan (Care Plan) dated 06/11/16 revealed: -Resident #1 required the physical assistance of one person to assist with mobility and with transferring. -The resident required assistance to the bathroom "at least 4x per shift". -One fall risk intervention to remind the resident to rise and change positions slowly. Review of updates to the Service Plan on 12/03/16, 12/09/16, and 12/10/16 revealed: -There was no change in the physical assistance required with transferring. -There was no change to the frequency or level of assistance required to the bathroom. -The "Mobility" section of the Service Plan included the following entry on 12/09/16: "I have recently returned from the hospital 12/09/16 and have lost a lot of strength. I need total assistance with my mobility needs at this time." -The "Fall Risk" section of the Service Plan included the following entry on 12/03/16: "I have been having increased leaning and falls. Assist me with all ADL (Activities of Daily Living) care and services. Check on me frequently when I am in my room for safety. At least 5x per shift."	D 270		

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D 270	Continued From page 5 Interview on 01/04/17 at 3:15 pm with a Medication Aide (MA) revealed: -The Personal Care Aides (PCAs) routinely made rounds every two hours. -Resident #1 was a "very severe fall risk because he tries to get up on his own and falls", so staff "keep an eye on him". -"Keeping an eye" on the resident meant staff left his door open and looked into his room as they passed by the door. -There was no specified time frames for checking on Resident #1. -"We make sure his walker and wheelchair is put away from him so he has to call for assistance to use them". -The bedside commode was kept near his bed because he "usually "transferred himself to the BSC (bedside commode) independently, but the resident's recliner, walker, and wheelchair were "kept out of reach" so he would call for assistance before trying to use them. -Resident #1 routinely used his pendant to call for staff assistance after a fall, "but usually not beforehand". Interview on 01/05/17 at 11:22 am with a second MA revealed: -Staff routinely made rounds on all residents every 2 hours on all shifts. -Staff were "doing more frequent checks" on Resident #1 because they were all aware of his falls. -"More frequent checks" meant staff "look in" the resident's room as they walk past. -There was no specified schedule for monitoring Resident #1, staff "just watch closely". Interview on 01/05/17 at 11:40 am with a Personal Care Aide (PCA) revealed: -There was no "standard" for how often residents	D 270		

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D 270	Continued From page 6 were checked; she made rounds "as often as I possibly can unless they're a fall risk, then I check them a little bit more". -If a resident was a fall risk, staff "just look in" as they were going up and down the hall. -There was no specified schedule for monitoring Resident #1. Interview on 01/05/17 with a second PCA revealed: -The standard frequency for rounds was every two hours; however, independent residents were checked less frequently (beginning, middle, and end of shift). -There was no set schedule for monitoring residents. -If a resident needed specific supervision or toileting schedules, that information would be available to the PCA through the computerized documentation system accessible to all staff. -Staff members were able to pull up any resident's Service Plan to know what care was to be provided for that individual resident. -Resident #1's Service Plan required staff to assist with toileting 4 times per shift. Interview on 01/05/17 at 12:30 pm with Resident #1's hospice nurse revealed: -She was aware of the resident's falls and at one time, the resident was falling "every day or every other day-we lost count at one point". -The resident's frequent falls were due to a decline in his Parkinson's disease and cognition. -Resident #1 did not fully understand at times, but at other times "chose" to try to ambulate independently because he "forgets he can't walk by himself". -She instructed staff not to store the resident's wheelchair and walker where he could reach them to discourage him from using them	D 270		

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D 270	Continued From page 7 independently. -If staff made frequent, scheduled visits to the resident's room and asked him if he needed anything or offered to assist him to the bathroom, she felt "it would have an impact on the number of falls" the resident was currently experiencing. Telephone interview on 01/05/17 at 3:17 pm with the Assisted Living Coordinator (ALC) revealed: -The facility's standard frequency of rounds for all residents was every two hours. -Resident #1 had a "very, very shuffling gait" and he required physical assistance and verbal cueing while being assisted to ambulate. -Some of the resident's falls were due to noncompliance because he "won't ring" for assistance when he wants to get up. -She was not aware staff were instructed by the hospice nurse to keep the resident's walker and wheelchair out of his reach and believed it would be safer for the resident for those items to be kept close by for him to use. -She made updates to the resident's Service Plan as they were needed and increased staff checks of Resident #1 in December 2016 from four times per shift to five times per shift. -There was no specified schedule for frequency of monitoring Resident #1. -There was no system in place for monitoring to ensure staff provided increased supervision of Resident #1. -Resident #1's falls "may" be reduced if staff made frequent, scheduled visits to the resident's room and asked him if he needed anything or offered to assist him to the bathroom. Interviews on 01/04/17 at 4:30 pm and 01/05/17 at 12:15 pm and 3:09 pm with the Executive Director (ED) revealed: -The facility implemented a new Falls	D 270		

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D 270	Continued From page 8 Management Program at the end of December 2016, but prior to that time, the facility did not have a specific Falls Management Program in place. -The facility management team had a "stand-up" meeting every day during which issues from the previous day, including resident falls, were discussed. -The physician and the resident's family was notified after every fall. -There had been "a lot" of communication with the physician and the resident's family regarding Resident #1's falls. Interview on 01/04/17 at 11:37 am with Resident #1's Power of Attorney (POA) revealed: -The number of Resident #1's falls was "concerning". -The resident was "stubborn" and sometimes he called for help and sometimes he did not call due to "stubbornness". -"I do think they (staff) could be watching him more closely". -He visited the resident every evening for varied lengths of time. -When he was visiting with the resident for a "couple of hours", sometimes no staff entered the room during that time and sometimes the MA came into the room to administer medications. -If staff made more frequent visits to the resident's room and offered assistance, it would "definitely" help with the resident's falls, because the resident's main complaint was that when he had to go to the bathroom, he was not able to wait. Attempted interview on 01/05/17 at 3:49 pm with Resident #1's physician was unsuccessful and no return call was received prior to exit from the facility.	D 270		

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D 270	Continued From page 9 Attempted interview on 01/05/17 at 4:30 pm with Resident #1 was unsuccessful. B. Review of Resident #8's current FL-2 dated 07/08/16 revealed diagnoses included cerebral vascular disease, hypertension, bipolar, cataracts, and cardiovascular disease. Review of the Resident #8's Resident Register revealed an admission date of 06/30/16. Review of Resident #8's Accident/Injury Reports since admission revealed: -Resident #8 experienced 14 unwitnessed falls from 09/07/16 to 01/05/17. -Five falls occurred during the first shift, six falls during the evening shift, and two fall during the day shift. -Documented fall injuries included 3 head injuries, skin tears, abrasions, lacerations, and bruises. -Staff notified the physician and family after each fall. -Interventions documented included, a wheelchair to go to back and forth to meals in, and a physical and occupational therapy consult with treatment dated 11/29/16. -There was no documentation staff increased supervision of the resident in response to the resident's falls. -On 10/11/16 at 6:36 pm, Resident #8 was "found walking in his room with a skin tear to the back of head". Documented injuries included a skin tear to the back of his head. The resident was sent to the local Emergency Room (ER) for evaluation. After an evaluation in the ER, a laceration to the back of his head was found and repaired with staples. There was no documentation staff increased supervision of the resident in response to his fall.	D 270		

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D 270	Continued From page 10 -On 11/14/16 at 9:45 am, Resident #8 was "found on his bedroom floor". There were no documented injuries. There was no documentation staff increased supervision of the resident in response to his fall. -On 11/23/16 at 12:30 pm, Resident #8 was "found" on the floor in bedroom after "losing his balance". There were no documented injuries. There was no documentation staff increased supervision of the resident in response to his fall. -On 11/25/16 at 4:05 pm Resident #8 was "found sitting upright in front of his bedroom door". There were no documented injuries. There was no documentation staff increased supervision of the resident in response to his fall. -On 11/29/16 at 7:40 am, Resident #8 was "found on his knees in front of his bedroom closet". There were no documented injuries but his walker was lying next to the resident, broken. There was no documentation staff increased supervision of the resident in response to his fall. -On 12/09/16 at 6:36 pm, Resident #8 was "found on knees in his bathroom by a family member". Documented injury was a head injury. Resident #8 was sent to ER for evaluation. ER summary noted a diagnosis for "head injury". There was no other information available. There was no documentation staff increased supervision of the resident in response to his fall. -On 12/12/16 at 8:30 am, Resident #8 was "found on his bathroom floor". Documented injury was a head injury. Resident #8 was sent to ER for evaluation. ER summary noted a diagnosis for "head injury". There was no other information available. There was no documentation staff increased supervision of the resident in response to his fall. -On 12/15/16 at 1:21 pm, an interdisciplinary meeting was held and documentation that a family member replaced Resident #8's walker	D 270		

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D 270	Continued From page 11 and safety checks were to be "increased". There was no documentation staff increased supervision or "safety checks" of the resident in response to his fall. -On 12/29/16 at 1:25 am, Resident #8 was "found on the floor in front of his recliner after falling out of bed". There were no documented injuries. There was no documentation staff increased supervision of the resident in response to his fall. -On 01/01/17 at 1:25 am, Resident #8 was "found on his bathroom floor". Documented injuries was a laceration to the right knee, and a knot to the back of the shoulder. There was no documentation staff increased supervision of the resident in response to his fall. -On 01/04/17 at time unknown, Resident #8 was "found on the floor in front of his bathroom". There were no documented injuries. There was no documentation staff increased supervision of the resident in response to his fall. Review of Resident #8's Progress Notes revealed: -Staff notified the physician and family after each fall and implemented various interventions in an effort to decrease his falls. -There was no documentation staff increased supervision of the resident in response to the resident's falls. Review of Resident #8's admission Service Plan (Care Plan) dated 07/07/16 revealed: -The document was signed by a physician on 07/13/16. -"I am independent with mobility, transferring, dressing, bathroom, bathing, and dining". -There was no updates to the Service Plan for staff to increase supervision of the resident. Review of Resident #8's Licensed Health	D 270		

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D 270	Continued From page 12 Professional Support (LHPS) dated 07/15/16 revealed Resident #8 had no LHPS tasks documented. Interview on 01/05/17 at 11:30 am with a Personal Care Aide (PCA) revealed: -Staff members were able to access any resident's Service Plan to know what care was to be provided for that individual resident. -There was no set schedule for monitoring residents. -Every resident gets checked on every 2 hours. -Resident #8 had been declining and the staff had to assist him with ambulation and to the bathroom because of his falls. -Resident #8 was one that when he (Resident #8) rings his alarm, "you have to rush" to check on him because he may already be on the floor. -In our stand-up meetings we were told about all residents that had fallen and all of those residents get "extra rounds" and Resident #8 was one that got those "extra rounds". -"Extra rounds" meant that resident "gets looked in on every time I go by his door". -Resident #8 did not have a task to check off for "extra rounds". Interview on 01/05/17 at 11:45 am with a second PCA revealed: -Resident #8 "won't sit still and has to be moving all the time". -"Resident #8 gets frequent checks every 30 minutes", per the Assisted Living Coordinator (ALC) because he has had 2 head injuries lately. -He was to accompany Resident #8 to breakfast and lunch because his equilibrium was off and loses his balance a lot. -He feels that Resident #8 is "just tired" and the resident's health has declined for several months now.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041050	A. BUILDING: _____ B. WING _____	R 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 13 -He made the lead PCA and ALC aware of concerns. -Staff members were able to access any resident's Service Plan to know what care was to be provided for that individual resident. -Resident #8's had the tasks of transfers, assist with dressing and bathing if needed, nothing about increased supervision documented. Interview on 01/05/17 at 12:00 pm with Resident #8 revealed: -He liked to keep busy and did a lot for himself. -A PCA helps him to the dining room for meals on occasion. -He has been falling a lot lately, states "I am tired" (just doesn't have the energy). -He has fallen and hit his head and required staples but unsure why he fell. Interview on 01/05/17 at 3:00 pm with a third PCA revealed: -Resident #8 was "very independent minded" but required assistance with ambulation because he was "off balance" when he tried to ambulate with his walker alone. -The PCAs were able to access the Service Plan for each resident to see the tasks to be completed for each resident. -The stand-up meeting was a way for the PCA's to learn about falls and residents that require anything new. Telephone interview on 01/05/17 at 3:45 pm with the Assisted Living Coordinator (ALC) revealed: -The frequency of rounds was every 2 hours. -Resident #8 had issues with balance and several fall had resulted from it. -Resident #8 is "very independent" and like to do things himself. -Resident #8 got safety checks more than the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 14 every 2 hours because of his recent falls. "Every time staff goes by his room they are to check on him". Interviews on 01/04/17 at 4:30 pm and 01/05/17 at 12:15 pm and 3:09 pm with the Executive Director (ED) revealed: -The facility implemented a new Falls Management Program at the end of December 2016, but prior to that time, the facility did not have a specific Falls Management Program in place. -The facility management team had a "stand-up" meeting every day during which issues from the previous day, including resident falls, were discussed. -The physician and the resident's family was notified after every fall. Attempted interview on 01/05/17 at 4:00 pm with Resident #8's physician was unsuccessful and no return call was received prior to exit from the facility. The facility failed to provide supervision for 2 of 2 sampled residents in accordance with their assessed needs and current symptoms. Resident #1 required assistance with ambulation and was identified as a high fall risk. The resident experienced 11 unwitnessed falls with resulting injuries including a fractured rib, hitting his head, skin tears, abrasions, lacerations, and bruises, with no documentation of increased supervision in response to the falls. Resident #8 experienced 14 unwitnessed falls with resulting injuries including 3 head injuries, skin tears, lacerations, abrasions and bruises with no documentation of increased supervision in response to the falls. The failure of the facility to provide supervision in accordance with residents'	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 15 assessed needs and current symptoms resulted multiple injuries of two residents and substantial risk of serious injury or death of residents and constitutes a Type A2 Violation. On 01/05/17, the Executive Director submitted a Plan of Protection as follows: -Facility staff would begin an immediate audit to identify any residents that may need increased supervision. -Any residents identified will have supervision provided based on assessed needs. -All staff will be inserviced regarding supervision expectations prior to their next scheduled shift. -The leadership team will conduct 2-3 meetings weekly to ensure ongoing compliance. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2017.	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 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 with multiple falls.	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 16 The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (Residents #1, who required assistance with ambulation and was identified as a high fall risk, and Resident #8, who had multiple falls with injury) in accordance with the residents' assessed needs and current symptoms. [Refer to tag 270, 10A NCAC 13F .0901(b) (Type A2 Violation).]	{D912}		

Sunrise Senior Living, Inc.
Plan of Correction Template

Name of Community: Brighton Gardens of Greensboro
Address: 1208 New Garden Road, Greensboro, NC 27410
License number: HAL-041-050
Inspection date(s): January 3, 2017
Name and Title of Sunrise Representative Signing the Plan of Correction:
Michael Wilson, Executive Director
Signature of Sunrise Representative: Michael Wilson
Date of Submission: February 15, 2017

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 1 F .0901(b) Personal Care and Supervision Staff shall provide supervision of resident in accordance with each resident's assessed need.	02/04/17	**A. With respect to the specific resident/situation cited:** Resident Care Director completed a chart audit on Resident #1, met with the interdisciplinary team; and individualized falls management interventions on the service plan were enhanced and updated, including incorporating follow-up as necessary. Resident Care Director completed a chart audit on Resident #8, met with the interdisciplinary team; and individualized falls management interventions on the service plan were enhanced and updated, including incorporating follow-up as necessary.
	01/08/17	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** For current residents, audits of their medical records and interdisciplinary meetings were conducted by the Resident Care Director, the Assisted Living Coordinator and the Reminiscence Coordinator; and residents that have the potential for needing increased supervision were identified. This resident information was discussed with the Wellness Team and designated Care Managers, and incorporated into their service plans as appropriate.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		C. With respect to what systemic measures have been put into place to address the stated concern:
	01/17/17	As another means to identify residents who may require follow up or enhanced interventions or supervision, the Assisted Living Coordinator, Reminiscence Coordinator, Resident Care Director, or Designee will review interventions during change of condition discussions as a result of resident requests, and during care plan reviews.
	01/17/17	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
131D-21 Declaration of Resident's Rights Every resident shall have the rights to 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.	02/04/17	**A. With respect to the specific resident/situation cited:** Resident Care Director completed a chart audit on Resident #1, met with the interdisciplinary team; and individualized falls management interventions on the service plan were enhanced and updated, including incorporating follow-up as necessary. Resident Care Director completed a chart audit on Resident #8, met with the interdisciplinary team; and individualized falls management interventions on the service plan were enhanced and updated, including incorporating follow-up as necessary.
	01/08/17	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** For current residents, audits of their medical records and interdisciplinary meetings were conducted by the Resident Care Director, the Assisted Living Coordinator and the Reminiscence Coordinator; and residents that have the potential for needing increased supervision were identified. This resident information was discussed with the Wellness Team and designated Care Managers, and incorporated into their service plans as appropriate.
	01/17/17	**C. With respect to what systemic measures have been put into place to address the stated concern:** As another means to identify residents who may require follow up or enhanced interventions or supervision, the Assisted Living Coordinator, Reminiscence Coordinator, Resident Care Director, or Designee will review interventions during change of condition discussions as a result of resident requests, and during care plan reviews.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		D. With respect to how the plan of correction will be monitored:
	01/17/17	The Executive Director is responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

Reviewed and excepted by Diana Spalding RN 2/20/17