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
	HAL035024	A. BUILDING: _____ B. WING _____	C 02/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 and Franklin County Department of Social Services conducted an annual survey and complaint investigation from 1/30/18-2/02/18, and 2/05/18. The complaint investigations were initiated by Franklin County Department of Social Services on 11/08/17, 11/22/17, 12/07/17, 12/21/17, 12/22/17 and 1/3/18.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide adequate for 5 of 10 residents in the Special Care Unit (SCU) with histories of frequent falls (#2, #3, #10, #11 and #12) which resulted in serious injuries including a femur fracture (#2) and a subdural hematoma (#10), and other injuries including bruises and skin tears (#3, #10 and #12). The findings are: 1. Review of Resident #2's FL2 dated 9/29/17 revealed: -Diagnoses included dementia, anemia, vitamin B deficiency and anxiety. -The resident was intermittently disoriented.	D 270		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lenora Jenery — TITLE: Executive Director — (X6) DATE: 3/27/18

Reviewed + Accepted 4/2/18
B Rainey for K Miller

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D 270	Continued From page 1 -Resident #2 was ambulatory. -The resident was continent of bladder and bowel. -She had limitations with vision and hearing, and required assistance with putting on glasses and hearing aides. Review of Resident #2's Resident Register revealed an admission date of 6/5/15. Review of Resident #2's assessment and care plan dated 3/6/17 revealed: -The resident needed assistance with toileting and bathing. -She required reminders for wearing her glasses and hearing aides. Interview with Resident #2's family member on 2/1/18 at 5:00pm revealed: -Overall, the family member was pleased with the care at the facility; the family only had problems at the end of her time there. -His concern was with the falls, because there was no story that would make sense for the injury she had with the hip. -The physician at the emergency room told the family that the X-rays showed a violent persistent type of break, but the facility had no idea what had happened. -The family member called the facility later, but never heard back from anyone. -Some of the falls in November 2017 had stories that made sense with her injuries, but the last fall, on 12/22/17, did not. -He was told by the facility staff there were no cameras to tell exactly what happened. -He did not feel that she got a lot of individual care and supervision. Review of hospital records for Resident #2 dated	D 270		

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D 270	Continued From page 2 11/12/17 revealed: -The resident was treated at the hospital after an unwitnessed fall in the facility. -She was treated for a skin tear to the lateral right forearm with many bruises along the arm, and a small laceration to the right parietal scalp. -She had no cervical fractures Review of facility Incident/Accident Reports for Resident #2 revealed no report for the fall that occurred on 11/12/17. Review of a facility Incident/Accident Report for Resident #2 dated 11/24/17 revealed: -The resident visited another resident's room, lost her balance and fell to the floor. -Staff applied pressure to a cut on the resident's right forehead. -The resident was sent to the emergency room (ER). Review of hospital records for Resident #2 dated 11/24/17 revealed: -The resident reported that someone hit her while walking and reported facial pain. -She was treated for facial lacerations; injuries were documented as a gaping, bleeding 4.5cm laceration to the left inferior orbital rim down to the skull; a jagged, gaping 7.0cm laceration superior to the left eyebrow down to the skull; bruising around the left eye; traumatic hematoma of the head; multiple scattered ecchymosis of the upper and lower extremities; a few abrasions to the tips of her fingers with jagged nails bilaterally; and a possible 3rd right rib fracture. Review on a facility Incident/Accident Report for Resident #2 dated 11/29/17 revealed: -The resident was found lying on her left side against the table.	D 270		

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-No injuries were documented.

Review of hospital records for Resident #2 dated 11/29/17 revealed:
-Resident #2 was seen at 8:00pm to be evaluated post fall for an unwitnessed fall from her wheelchair.
-She presented with a large hematoma on her forehead.

Review of a facility Incident/Accident Report for Resident #2 dated 12/22/17 revealed Resident #2 was sent to the ER after being examined by the Primary Care Provider (PCP).

Review of hospital records for Resident #2 dated 12/22/17 revealed:
-On 12/22/17, Resident #2 was brought in to the hospital for non-traumatic hip pain with unknown cause. The right hip was externally rotated and shortened; she was diagnosed with a comminuted intratrochanteric fracture of the right femur with proximal migration of distal fracture fragment and resultant virus deformity; there was no evidence of dislocation or hip fracture.
-Resident #2 had surgery to repair the fractures on 12/23/17 and was stable postoperatively. At 9:00pm on 12/23/17, the resident died. The cause of death was documented as hip fracture, failure to thrive and dementia.

Review of Resident #2's facility progress notes revealed:
-From approximately 12/1/17 to 12/18/17, Resident #2 had symptoms of respiratory issue, cough, weakness and diarrhea; she was treated with antibiotic therapy and OTC (over-the-counter) medications for the flu. The resident was in bed and refusing most meals.
-On 12/21/17, the resident ambulated to the

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nursing station and sat down on the floor; she was put in a wheelchair, returned to her room and put in bed.
-On 12/22/17, Resident #2's Primary Care Provider (PCP) documented that her right leg was rotated outward and referred her to the hospital.
-The Personal Care Aides (PCA) documented providing personal care, incontinent care and supervision to Resident #2 on 12/21/17, 12/22/17 and 12/23/17 while hospital record documented that the resident was admitted to the hospital 12/22/17 and died on 12/23/17.

Interview with Resident #2's PCP/Nurse Practitioner (NP) on 2/1/18 at 9:15am revealed:
-She was treating Resident #2 in the facility.
-Resident #2 had been referred to hospice after discussions with the family on 12/19/17.
-The resident had some falls, then got the flu and never really got back to herself.
-The NP had seen her the morning of 12/22/17 and she was sitting comfortably on the couch in the day room, with a pillow at her side.
-The PCAs were helping her get dressed (on the morning of 12/22/17) and said she was moaning. When the NP examined Resident #2 lying flat, she could see that the leg was shortened and externally rotated. Resident #2's pain was related to that hip.
-The NP knew that an incident did not happen between 1:00pm and 2:00pm, because the NP was with the resident during that time. Although she was treating Resident #2 for the flu this day (12/22/17), staff reported that she was having leg pain; the NP was not made aware of leg pain until the morning that she saw her on 12/22/17.

Interview with the Resident Care Director (RCD) on 2/1/18 at 3:00pm revealed:
-Resident #2 had flu symptoms for about a week

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prior to the hip injury.
-She had been very weak and in bed mostly.
-It was reported to her the evening before Resident #2 was sent to the hospital, the resident had walked down the hall and sat down at the nurse's station. The next morning, she was on the couch in the main room and seemed to be doing better.
- The NP was concerned with the leg looking dislocated and sent the resident to get it checked at the hospital. She had not heard anything about a fall involving Resident #2 that day or the evening before.
-The PCAs and Medication Aides (MA) reported all falls to her, and she reported them to the PCP and family.
-She believed Resident #2 was on 15 minute checks because of previous falls.
-She monitored the 24 hour log for PCA documentation.

Interview with a MA on 2/2/18 at 4:15pm revealed:
-She remembered Resident #2 had flu symptoms for about a week before she was sent to the hospital for her leg.
-Resident #2 was in her bed mostly, refusing meals, and had diarrhea.
-On the night of 12/21/17, around 7:00pm, she saw Resident #2 coming down the hall walking; the MA greeted her and was happy to see her up.
-Resident #2 looked okay, did not appear to be in pain, and just looked weak and tired.
-The MA was on the way to provide care for another resident on the hall. Other PCAs were at the nurse's station and saw Resident #2. When she returned from the other resident, Resident #2 was in a wheelchair at the nurse station.
-The other PCAs said she sat down in the floor at the station, and they took her back to her room

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D 270	Continued From page 6 and put her to bed. Attempted interview with a PCA involved in Resident #2's care on 12/21/17 at 1:50pm was unsuccessful. Interview with the Administrator on 2/2/16 at 11:15am revealed: -The Administrator was aware of the number of falls with serious injuries in the past few months. -There was not a set criteria for sending a resident out with emergency medical services (EMS). Typically, the supervisor made the decision or communicated with the RCD who made the decision. -The RCD notified the PCP or decided if it was something she did not need to proceed with; the RCD would decide which direction that would go in. -When a resident returned from the hospital, the facility followed the PCP orders. -The facility had a weekly falls meeting with the Administrator, the RCD, Physical Therapist, and Activity Director to address falls; they wanted to create interventions to decrease falls and looked for trends in falls. -Typically, the resident was put on 15 or 30 minute checks after a fall. -The Administrator believed Resident #2 was on 15 minute checks. -All staff monitored residents when they were in their rooms, and the Administrator walked past frequently. -The staff completed a 24 hour log regarding resident care and the RCD monitored that log. -He was aware that those logs were not in the resident records and some were not available. Refer to interview with a Personal Care Aide (PCA) on 1/31/18 at 3:40pm.	D 270		

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D 270	Continued From page 7 Refer to interview with a Medication Aide (MA) on 2/5/18 at 4:50pm. Refer to interview with the Resident Care Director (RCD) on 2/1/18 at 11:10am and 2/5/18 at 12:00pm. Refer to interview with the Administrator on 2/2/18 at 11:01am. Refer to review of the facility's policy and procedure for "Fall Management Program" dated September 2015. Refer to review of the facility's policy and procedure for "Alert Charting Protocols" dated August 2015. Refer to review of the facility's undated Alert Charting Log (Hot Box) instructions. 2. Review of Resident #12's F-2 dated 2/21/17 revealed: -Diagnoses included generalized weakness, hypertension, insomnia, type 2 diabetes, anxiety disorder, difficulty walking, and Alzheimer's dementia. -Resident #12 was intermittently disoriented. -The resident was ambulatory. -The resident was continent of bladder and bowel. -The resident exhibited inappropriate behaviors of wandering and being verbally abusive, injurious to others, and injurious to property. Review of Resident #12's assessment and care plan dated 9/12/17 revealed: -The resident needed assistance with bathing and	D 270		

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dressing.
-The resident was seeing a mental health provider for behavioral issues.

Review of Resident #12's facility Progress Notes revealed:
-On 9/26/17, the resident was found on the bathroom floor after an unwitnessed fall
-On 9/27/17, resident had an unwitnessed fall in her bedroom.
-On 9/29/17, resident's family noted bruising on her wrists and questioned facility staff regarding cause of bruising.
-On 10/1/17, the resident had an unwitnessed fall.
-On 10/30/17, the resident eloped unwitnessed, left the building and fell in the parking lot of the facility; the resident was sent to the hospital and treated for facial trauma, nasal laceration and fracture.

Interview with Resident #12's family member revealed:
-The family member was in the facility often.
-She was concerned with the multiple falls.
-She knew that Resident #12 was difficult and combative.
-She had been told by staff that Resident #12 had disarmed the security system and gotten outside on 10/30/17; she did not believe Resident #12 had the capacity or strength to disarm the door unwitnessed with no one hearing her as it was early in the morning.
-She was told the resident fell going up the hill going towards the highway, and then told later that someone saw her fall in the parking lot where she hurt her face.
-In September 2017, she was concerned with the bruises on her arms, she took photos of the bruises; both arms had bruising from the wrists almost to the elbows. A staff at the facility had

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called her the day before and said that her relative was having behaviors, resisting care and throwing things. She did not believe the bruising was related to her fall as the facility reported.
-She was concerned with supervision as most of the time the staff would be at the nurse's station visiting or in the Resident Care Director's (RCD) office.
-Another family member visited the facility on 12/11/17 and a PCA was assisting Resident #12 in eating but then walked away. Resident #12 fell asleep and the family member pushed her in the wheelchair back to her room.
-When resident #12 was transferred to bed she screamed in pain, and the family member requested that she be sent to the hospital.
-At the hospital, they were told she had fractured ribs and a punctured lung; the hospital physician told the family that he did not believe the rib fractures were from an old fall.
-The family member had not been notified of any recent falls.
-Resident #12 was put into hospice care when discharged from the hospital and died 12/26/17.

Interview with a Medication Aide (MA) on 2/1/17 at 2:15pm revealed:
-The resident had many behaviors and refused care.
-The MA could usually calm her and get her to cooperate.

Interview with a second MA on 2/5/17 at 12:15pm revealed:
-She did provide care for Resident #12.
-The morning of the elopement she was already in the facility counting medications early, and no door alarm went off.
-The resident had been walking the halls not long prior to being found.

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D 270	Continued From page 10 -The MA knew nothing about bruising on her arms, and said it could have happened when she was fighting, because she was a fighter. -When Resident #12 would become combative they would try to talk her down, give her PRN meds for agitation. -Resident #12 would walk a lot in the facility and was very fast. Confidential interview wtiha staff revealed: -"Residents with dementia were like young children that needed someone to keep an eye on them at all times." -Residents had decreased awareness of what was around them and some had behaviors. -The facility needed more staff to supervise the residents. -Some of the staff at the facility would disappear for long periods. -The staff would take longer to complete tasks, take extended breaks and not do what they were supposed to do. -The staff were supposed to supervise the resident, but they were not always doing that. -The MAs were too busy on the medication cart to chase down where staff were all the time. Interview with the RCD on 2/1/17 at 5:15pm revealed: -She did not recall family asking about arm bruising, but the record notes indicate this happened. -Resident #12 had violent behaviors, she may have bumped arm or hit on something. -The resident had multiple falls during this time. -The PCA who did the documentation regarding bruising no longer worked at the facility. Refer to interview with a Personal Care Aide (PCA) on 1/31/18 at 3:40pm.	D 270		

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Refer to interview with a Medication Aide (MA) on 2/5/18 at 4:50pm.

Refer to interview with the Resident Care Director (RCD) on 2/1/18 at 11:10am and 2/5/18 at 12:00pm.

Refer to interview with the Administrator on 2/2/18 at 11:01am.

Refer to review of the facility's policy and procedure for "Fall Management Program" dated September 2015.

Refer to review of the facility's policy and procedure for "Alert Charting Protocols" dated August 2015.

Refer to review of the facility's undated Alert Charting Log (Hot Box) instructions.

3. Review of the current FL-2 dated 12/13/17 for Resident #10 revealed:
- Diagnoses included dementia, metabolic encephalopathy, cerebral infarction, hypertension, hypothyroid, seizure disorder, and hypokalemia.
- The resident was constantly disoriented.
- The resident's level of care was documented as memory care.

Review of the Resident Register for Resident #10 revealed:
- The admission date was 12/16/17.
- The resident was listed with significant memory loss and must be redirected.
- The resident needed assistance with dressing, bathing, toileting, and grooming.

Review of the Resident Services - Level of Care

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D 270	Continued From page 12 Services Program Review dated 12/7/17 for Resident #10 revealed: - The resident walked/wheeled self with minimal assistance, needed verbal cues and/or reminders, and transferred with minimal assistance. - The resident needed physical assistance with bathing and grooming and dressing. - Continuous supervision was needed with continence management. - Physical assistance was needed with meals, may participate but may be unsteady or need adaptive equipment; wanders during meals and resists eating. - The resident had an orientation and behavior level of moderate confusion and might have some unpredictable behaviors or require moderate emotional support. - The resident wandered inside of the facility but did not leave the building; was confused and easily redirected. Review of the Individual Care Plan for Resident #10 dated 12/15/17 revealed: - The resident was independent with ambulation and transferring. - The facility staff was to promote safety and minimize risks from falls daily. - The resident consistently needed one person assistance with dressing, bathing, toileting, grooming, eating and transfers. - The resident was oriented to person, did not wander, used glasses and a hearing aide. Review of the Fall Review dated 12/16/17 upon admission for Resident #10 revealed: - The resident had a memory/cognitive impairment and poor safety awareness. - The resident had a balance impairment. - The resident was taking antidepressants and	D 270		

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(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
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anti-hypertension/vasodilators medications.
- The resident ambulated with assistance.
- The resident ambulated with left sided weakness, had left eye blindness, was hard of hearing and used a hearing aide.

Observations on 1/30/18 from 12:29 p.m. until 1:29 p.m. revealed:
- Resident #10's bedroom was at the end of the left side hall and was the last bedroom on the right side before the exit door.
- The resident returned from lunch to her room.
- Resident #10's recliner was next to her roommate's recliner facing the TV.
- The call bell was on the wall, behind and above Resident #10's recliner.
- There was an end table with a lamp next to Resident #10's recliner and in front of the call bell.
- The string to the call bell hung down approximately one foot away from Resident #10's recliner, behind the lamp on the end table.
- At 1:02 p.m. and 1:24 p.m., Resident #10 was sitting in the recliner in the bedroom with the TV on.
- From 12:35 p.m. until 1:29 p.m. no staff went down to check Resident #10 in her bedroom.

Observation on 1/31/18 at 11:54 a.m. in the hall way outside Resident #10's bedroom revealed:
- Voices were heard in the bedroom assisting the two residents inside to get ready to go to the dining room.
- A PCA went into the bedroom.
- Resident #10's roommate came out of the room in a wheelchair pushed by a second PCA.
- Resident #10 came out of the bedroom with a third PCA assisting her to the dining room in a wheelchair.

Interview on 1/31/18 at 12:00 p.m. with a PCA

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revealed:
- Usually one PCA got Resident #10 and her roommate ready for meals.
- Today staff were helping each other get residents to the dining room.
- There had not been any instructions to have two PCAs when Resident #10 was in the bedroom with her roommate.
- Residents were to be checked every 2 hours but she tried to watch residents more often.

Observations on 2/1/18 at 5:00 p.m. revealed:
- Resident #10's roommate was heard from the hallway yelling "Hello, hello" from his bedroom.
- Resident #10 was sitting in her recliner next to her roommate.
- The call bell string had been tied loosely to the base of the lamp within reach of Resident #10.
- Resident #10 was saying "help me, I'm scared" and repeatedly banging a quad-cane on the floor.
- The roommate announced, "She needs to go to a nursing home where someone can keep an eye on her."

Interview with a second PCA on 2/2/18 at 4:40 p.m. revealed:
- She thought PCAs were supposed to check all residents every two hours.
- The PCAs checked on Resident #10 and her roommate more often because if the PCAs did not check on them, the PCAs would find Resident #10 or her roommate on the floor.
-"One of them might fall today and the other tomorrow (the roommate and Resident #10)."

Review of facility Progress Notes for Resident #10 revealed on 12/16/17 at 2:20 a.m., Resident #10 was found on the floor beside the bed "without bruising". The resident was placed on 15 minute checks.

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D 270	Continued From page 15 Review of Accident/Incident Reports for Resident #10 revealed: - On 12/16/17 at 2:20 a.m., the resident was found on the floor by the bedside. - No injuries at this time. Evaluation/treatment rendered in facility. Review of facility Progress Notes for Resident #10 revealed: - On 12/17/17 at 3:25 a.m., the resident was found on the floor by the bedside; had some scratches on her back and no other injuries were noted. The resident was trying to get out of the bed. - The resident remained on 15 minute checks. Review of Accident/Incident Reports for Resident #10 revealed on 12/17/17 at 3:25 a.m., the resident was found on the floor on 15 minute checks. No injuries. Review of Progress Notes for Resident #10 revealed the resident was on 15 minute checks after the falls dated 12/16/17 and 12/17/17. Review of facility Progress Notes for Resident #10 revealed on 12/22/17 the resident was seen by the Primary Care Physician (PCP) group. Orders were received for physical therapy and a medication review was completed. Review of physical therapy (PT)/occupational therapy (OT) notes for Resident #10 revealed: -There was documentation of an order to evaluate and treat dated 12/22/17 for PT/OT for a recent fall. - On 12/27/17 a treatment diagnosis was muscle weakness (generalized) and other signs and symptoms involving musculoskelatal system.	D 270		

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- The medical diagnosis was repeated falls.
- Goals were to improve non-assisted ambulation without assistive device and to be safe and independent with bed mobility and to complete safe transfers with modified independence to reduce fall risk.

Interview on 2/2/18 at 4:10 p.m. with the PT office receptionist revealed the PT provider was not available for interview but the resident continued to receive therapy from PT/OT.

Review of facility Progress Notes for Resident #10 revealed:
- On 1/13/18 at 8:5__.m (unable to be read), resident was found on the floor by the bedside.
- No visible injuries and no complaints of pain.

Review of Accident/Incident Reports for Resident #10 revealed on 1/12/18 at 11:05 p.m., the resident was found on the floor by the bedside. No visible injuries at this time.

Review of facility Progress Notes for Resident #10 revealed on 1/30/18 at 6:50 a.m. the resident was found on the floor after trying to help her roommate; no apparent bruises or signs of discomfort.

Review of Accident/Incident Reports for Resident #10 revealed:
-On 1/30/18 at 1:45 a.m. Unwitnessed fall. The resident was found on the floor.
-The resident was trying to help her roommate and bumped her head.

Review of facility Progress Notes for Resident #10 revealed:
- On 1/31/18 at 2:31 p.m. the "Resident was off balance today." The PCP was notified.

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D 270	Continued From page 17 - On 1/31/18 at 3:40 p.m. the resident had an unwitnessed fall. No injuries. Will continue to monitor. PCP notified. Review of Accident/Incident Reports for Resident #10 revealed: - On 1/31/18 at 10:30 a.m. Unwitnessed fall. The resident was found lying on the floor in her bedroom. "No injury." The resident was transported to the hospital by emergency medical service (EMS). - On 1/31/18 at 6:00 p.m. The resident was found on the floor. Unwitnessed fall. No injuries were documented. The resident was transported to the hospital by EMS on 1/31/18 at 6:05 p.m. Resident #10 returned to the community on the same day with no new orders. Review of the hospital record for Resident #10 dated 1/31/18 revealed: - The resident went to a local emergency room on 1/31/18 after a fall in the facility. - There was documentation in the hospital report the reason for the visit was a fall. - Diagnoses included subdural hematoma and a cut on the top/back of the resident's head. - Lab testing, urine and blood were completed and a CT Scan (computed tomography) of the head and spine were completed. Interview with a fifth PCA on 2/1/18 at 5:27 p.m. revealed: -She was working the evening when Resident #10 fell, she thought it was 1/30/18 or 1/31/18. -She went to the resident's bedroom to take the resident to the dining room for supper and the PCA did not know what had happened. -She found the resident on the floor between the recliners and the bathroom door. -She thought Resident #10 might have gotten	D 270		

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D 270	Continued From page 18 tangled up in something like the wheelchair. Interview on 2/1/18 at 3:31 p.m. with the Resident Care Director (RCD) revealed: - Resident #10 fell in a dark room one of the times on 1/31/18 with a PCA in the bedroom. - The resident was a one person assist with activities of daily living. - The aide was assisting the resident's roommate. - The resident hit her head on the floor and the cut was bleeding. - She went to the emergency room. - The resident sustained a subdural hematoma of the brain. - She was on 30 minute checks when she returned from the hospital with a subdural hematoma. - This was the usual frequency of checks after a fall for residents but resident checks might be more frequent as necessary. - The PCAs knew what to do for each resident based on the shift reports and what was listed on the assignment sheet. - She was not clear if the resident had a fall mat or if other interventions were implemented for the resident since the falls had occurred. - The resident was on the list to see the PCP. - The PCP group came to the facility two times per week. - There had been antidepressant medications added recently per family request. - There was not any increased supervision implemented when medications were changed. - Supervisors were to check the resident when notified by PCA of a fall and they would complete Progress Notes, Accident/Incident Report, notify the PCP and responsible person. Interview on 2/1/18 at 5:05 p.m. with a sixth PCA revealed:	D 270		

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D 270	Continued From page 19 - The PCA had been trained as an aide and had been at the facility working 3 - 4 months. - He knew what to provide for each resident upon shift change as the supervisor made rounds with the aides and told them what had happened with each resident and for instance how the resident was to be checked. - When Resident #10 fell on 1/31/18 in the early evening, the PCA was preparing Resident #10 and her roommate in their bedroom for dinner. - There was usually only one staff in the room with the two residents. - He had his back to Resident #10 as he was transferring the roommate from the bed to the wheelchair when he heard Resident #10 and looked over his shoulder and out of the corner of his eye, he saw Resident #10 getting up from the chair and fall. - The resident was calling her roommate's name as she got up from the chair and then began to lose her balance and fell backward onto the floor. - He went right to Resident #10 while calling for help and found her head to be bleeding, she was conscious, had no bruises or obvious other injuries. - She recognized the PCA and called him by name. - The resident was made comfortable and the MA checked the resident. - The resident was transported to the emergency room. Review of the Progress Notes for Resident #10 revealed there was no documentation of the supervision checks for Resident #10 after unwitnessed falls dated 1/13/18, 1/30/18, and 1/31/18. Review of Progress Notes for Resident #10 dated 2/1/18 after return to the facility from a hospital	D 270		

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D 270	Continued From page 20 emergency room visit for the second fall on 1/31/18 at 1:00 a.m. revealed: -Resident #10 was diagnosed with subdural hematoma, continue current medications, leave cut on head without ointment, check for vomiting, increased confusion, excessive sleepiness, or difficulty arousing or any new concerns. - Resident #10 was on 30 minute checks throughout the day and afternoon. - Another Progress Note at 5:00 a.m. documented continued 30 minute checks. - Another Progress Note at 3:05 p.m. documented the resident was a little sore but okay, continue to monitor. Review of Progress Notes dated 2/2/18 revealed Resident #10 was continued on 30 minute checks, and had no complaints of pain and was seen by the physician's assistant (PA). Review of Progress Notes dated 2/3/18 for Resident #10 revealed: - At 5:32 a.m., the resident was found on the floor during 30 minute check rounds with a bruise on the left arm with redness. No other injuries. - The resident's back was hurting her and she lost her balance. - Resident #10 was sent to the local hospital emergency room. - When the resident returned to the facility she would be on 15 minute checks. - At 2:45 p.m., resident returned from hospital due to a fall. She complained of left leg pain, as needed pain relief administered. - On 2/3/18 at 11:00 p.m. the resident continued to stand alone and constantly had to be reminded to sit and wait for assistance. - Resident #10 was to be checked every 15 minutes.	D 270		

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D 270	Continued From page 21 Review of the hospital record for Resident #10 dated 2/3/18 revealed: - The visit to the emergency room was for a fall in the facility. - There was a repeat CT Scan completed and there was some improvement in the subdural hematoma from the scan completed on 1/31/18. - No other injuries were documented. - The resident was discharged back to the facility. Review of Progress Notes dated 2/4/18 for Resident #10 revealed: - At 6:20 a.m. the third shift, the resident was still on 15 minute checks. - At 10:45 p.m. the resident fell on 2/3/18 at 5:32 a.m. Complains of pain in her leg. - Resident continues on 15 minute checks. - Resident encouraged to not to try to ambulate alone. Review of a Progress Notes dated 2/5/18 for Resident #10 revealed: - At 5:00 a.m., the resident was on one to one sitter care by the facility at this time. - Continued every 15 minute checks. No complaints of pain. - At 3:50 p.m., the resident received an x-ray to her hip, but was not able to be in the supine position for the x-ray; the x-ray was eventually completed. - The resident was in excruciating pain and was transported to the emergency room for evaluation. Interview on 2/1/18 at 12:03 p.m. with a third PCA revealed: - Resident #10 could get agitated and very concerned for her roommate. - She often tried to get out of the bed to help her roommate when he was being assisted in the	D 270		

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bedroom or the bathroom.
- Usually one PCA was assigned to the two residents in a bedroom.
- She would have been on 30 minute checks after a fall as noted on the assignment sheet.
- The resident and her roommate usually stayed in their bedroom and did not go to the day room area where they could be watched.

Interview on 2/1/18 at 12:30 p.m. with a fourth PCA revealed:
- She had taken care of Resident #10 on the day shift.
- Resident #10 required assistance to get a bath, toilet and get to the dining room.
- Resident #10 could get out of the bed by herself but needed assistance.
- She had a few falls recently and was on more frequent checks, every 30 minutes depending on if she had a fall.
- Resident #10 was not on increased frequency of checks because of a fall at this time.
- After any fall, residents were on 30 minute checks.
- They would be documented on the assignment sheet.
- There was no system in place to watch residents such as one care staff being posted at any given spot that was not easily visible to other staff or far away from the main sitting area.
- The resident usually stayed in her bedroom and did not go to the day room area.
- PCAs tried to be on the halls or day room or in resident rooms.
- If a PCA needed a break, the PCA would notify another staff member and/or the supervisor to cover.
- The PCAs did rounds with the previous shift to know how each resident had been the previous shift.

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D 270	Continued From page 23 - She did not know why the resident fell. Telephone interview on 2/4/18 at 11:20 p.m. with a Supervisor/Medication Aide (MA) revealed: - The PCAs helped Resident #10 with her bath on scheduled days. - The resident required a one person assist with ambulating, toileting, transfers, bathing, and grooming. - The resident had a few unwitnessed falls when first admitted in December 2017 without injuries. - One time the resident was trying to get her covers off of her and her back became scratched with no other injuries. - The resident was on 15 minute checks after the falls. - Then the resident fell on 1/30/18 and had another unwitnessed fall on 2/3/18 and was found in her room on the floor about 12 midnight. - The resident tried to get out of the bed but got tangled up in the bed sheets and she had them wrapped around her legs when found. - The resident did not always use the call bell. - There were no injuries. - The resident wore non-slip socks. - There was no fall mat on the floor and no chair alarms in use. - She expected care staff to check on residents after falls every 30 minutes. - Resident #10 had not been on 15 minute checks. - On admission back from the hospital after a fall, the resident automatically went into the "hot box" documentation form for every two hour checks depending on what happened to them. - There was one person in the room with them when they were being assisted for activities of daily living. - When the roommate was being assisted by a PCA in the bedroom, usually a one person assist,	D 270		

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D 270	Continued From page 24 Resident #10 would try to get up from her chair or the bed to help him. - When the PCA came on shift, she found out Resident #10 fell on 1/31/18 two times. - On the evening on 1/31/18 shift change revealed there was one PCA in the bedroom assisting the roommate and Resident #10. - There was no information provided related to any change in the number of PCAs when in the room with Resident #10 and her roommate nor any change in the frequency of resident checks. Interview on 2/4/18 at 11:27 p.m. with a seventh PCA revealed: - Resident #10 had weakness on the left side due to a stroke. - She usually walked with a walker since she had a stroke. - The resident required assistance with a walker because of the weakness. - The resident was assisted with bathing at about 5:30 a.m. and put back to bed in the mornings before breakfast. - The resident was a one person assist. Interview on 2/5/18 at 12:38 a.m. with an eighth PCA revealed: - She was the 1:1 sitter for Resident #10 since she had fallen and went to the hospital on 2/3/18. - The 1:1 sitters were from the facility and the family would eventually decide on a sitter situation. - The PCA was keeping every 15 minute documentation on a resident check form. - Documentation of the 15 minute checks started on 2/01/18 at 12:00 a.m. and was documented except for when the resident was at the hospital on 2/3/18 from 12:00 a.m. - 9:30 a.m. - The sitters for each shift stayed with the resident constantly to care for her and to assist with	D 270		

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D 270	Continued From page 25 transfers and ambulation to ensure no further falls. Interview on 2/5/18 at 3:05 p.m. with a MA revealed: - Resident #10 would try to get up from the chair or bed when staff were helping her roommate. - Recently she had falls and had an injury. - The resident had been losing her balance recently and the Physican Assistant (PA) was aware and had reviewed her medications. - The resident had been on 30 minute checks since falls at the end of January 2018 and again a couple of days ago. Interview on 2/2/18 at 9:15 a.m. with the PA for Resident #10 revealed: - Residents would fall and she could not think of anything to prevent resident falls. - Resident #10 had three falls lately, and a fall the night before. - There were no signs of the hematoma worsening after the second fall, so the second fall probably did not make it worse since they sent her home. - There were no staples in her scalp wound. They used a bonding agent on the laceration. - She was walking and talking, and had no other problems this morning. - When the resident came into the facility, she was independent with walking. - She had previously used a walker before admission. - Perhaps a chair/bed alarm or they could push the two beds together in Resident #10's bedroom for both she and her roommate to be closer and to dissuade getting out of bed to check on the other one. - If they pushed the beds together, the resident's visual deficit might make it difficult to get out of	D 270		

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the bed on that side.
- It would be up to the facility and their policy as to how often to check on residents.
- She thought every 2 hours checks, at least, when they were down at the end of the hall in their rooms alone rather than in the main day room area.
- One to one staff coverage would be difficult to achieve in this setting.
- She had been aware of the falls for Resident #10 and had looked at medications.
- An antidepressant had been added upon family request and had a recent decrease in the dose of the medication, Zoloft (antidepressant used to treat depression, panic attacks and irritability) per family request.

Interview on 2/2/18 at 11:37 a.m. with the Executive Director (ED) revealed:
- He was aware of the number of falls with serious injury in the past two months in the facility.
- There were weekly fall meetings that reviewed overall trends for falls, especially for residents with behaviors and frequent falls, and looked for possible interventions.
- The Administrator, RCD, Activity Director and Rehabilitation Director attended the weekly fall meetings.
- Interventions included keeping residents up near the nurse's station and in day rooms.
- This would not be 24 hours a day but staff made every two hour rounds routinely and anyone having had a fall would be on more frequent checks such as every 30 minutes or every 15 minutes.
- The room for Resident #10 and her roommate were reviewed to ensure the environment as necessary to decrease falls.
- The resident and her roommate would not be

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D 270	Continued From page 27 moving to a room closer to the nurse station and the day room without the family approving. They would not break them up. - Care staff were to respond accordingly to witnessed and unwitnessed falls, complete checks and forms, and notify supervisors. - Supervisors were able to decide about whether to send a resident to the hospital if the RCD was not in the facility. They would have the ability to call the RCD if it was questionable about whether to send a resident out. - When residents returned from the hospital, the supervisor and/or RCD were to review the hospital records for orders and the resident's condition. - A follow-up visit to the PCP would be scheduled. - The RCD would institute interventions. Telephone interview on 2/2/18 at 4:13 p.m. with Resident #10's family member revealed: - The resident had been admitted to the facility since December 2017. - They were pleased with the care at the facility over all. - The family member knew of the recent falls and the facility had checked the resident for a urinary tract infection which was negative. - The family member thought there would be more attention paid to check on the resident to prevent the falls. - The PA was very helpful to work out the medication changes due to the possibility of the resident being weaker or dizzy from the medications. Telephone interview on 2/5/18 at 5:03 p.m. with a second family member revealed the family member was not able to discuss concerns for Resident #10 because the family member was with the resident in the hospital at that time.	D 270		

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D 270	Continued From page 28 Based on observation, interviews and record reviews, Resident #10 was not interviewable. Refer to interview with a Personal Care Aide (PCA) on 1/31/18 at 3:40 p.m. Refer to interview with a Medication Aide (MA) on 2/5/18 at 4:50pm. Refer to interview with the Resident Care Director (RCD) on 2/1/18 at 11:10 a.m. and 2/5/18 at 12:00 p.m.. Refer to interview with the Administrator on 2/2/18 at 11:01 a.m.. Refer to review of the facility's policy and procedure for "Fall Management Program" dated September 2015. Refer to review of the facility's policy and procedure for "Alert Charting Protocols" dated August 2015. Refer to review of the facility's undated Alert Charting Log (Hot Box) instructions. 4. Review of Resident #11's current FL-2 dated 12/13/17 revealed: -Diagnoses included Dementia, Urinary Tract Infection, Dysphagia, Urinary Retention, Anemia, Hyperlipidemia and Myasthenia Gravis. -Resident #11 was constantly disoriented and semi-ambulatory. -Resident #11 wore glasses and was hard of hearing. -Resident #11 was continent of bowel and bladder; and needed assistance with bathing and dressing.	D 270		

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D 270	Continued From page 29 Review of Resident #11's current care plan dated 2/2/18 revealed: -Resident #11's move-in date was on 12/15/17. -Resident #11 was ambulatory with a wheelchair. -Resident #11 required one staff person to assist with toileting, transfers and ambulation. -The assessment was signed and dated 1/16/18 by the Resident Care Director (RCD). -The care plan was signed and dated 2/2/18 by the Primary Care Provider (PCP). Review of an undated fall intervention sheet for Resident #11 revealed: -Resident #11's fall risk interventions included general safety measures: assuring the resident's room was clutter free, adequate lighting, bedding was not gathered around the bed, a clear path from the bed to the chair and/or bathroom and that the resident was wearing appropriate footwear. -Individualized interventions for Resident #11 included Geri (protective) sleeves, physical therapy, scoop mattress and a wheelchair. Observation on 1/30/18 at 12:28pm revealed Resident #11's bed had a concave or "scoop" mattress in place and a wheeled walker at the foot of the bed. Observations on 1/30/18 from 12:29pm until 1:29pm revealed: -Resident #11's room was at the end of the hall and was the last room on the right side before the exit door. -Resident #11 returned to his room from the lunch meal in a wheelchair being pushed by a Personal Care Aide (PCA). -The PCA assisted Resident #11 to the bathroom and then to his recliner in his room.	D 270		

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D 270	Continued From page 30 -Resident #11's recliner was next to the window and his roommate's (a family member) recliner was next to Resident #11's recliner facing the TV. -The call bell was on the wall, behind and above his roommate's recliner. -There was an end table with a lamp next to his roommate's recliner and in front of the call bell. -The string to the call bell hung down approximately one foot away from his roommate's recliner behind the lamp on the end table. -There was no call bell within reach of Resident #11's recliner. -At 1:02pm and 1:24pm, Resident #11 and the roommate were sitting in their recliners in their room with the TV on. -From 12:35pm until 1:29pm no staff member went down to check Resident #11 in his room. Interview with a PCA on 2/1/18 at 3:08pm revealed Resident #11 had frequent falls because "he was one of them that was going to do what he wants to do, he's stubborn." A second interview with the same PCA on 2/2/18 at 4:40pm revealed: -Resident #11 was confused and his mind kept telling him he could do things he was not able to do like trying to get up on his own. -She would tell Resident #11 to use the call bell for staff to come and help him, but he would not use the call bell. -She thought PCAs were supposed to check all residents every two hours. -The PCAs checked on Resident #11 more often because if the PCAs did not check on him, they would find him on the floor. -"One of them might fall today and the other tomorrow (Resident #11 and his roommate)." Observations on 2/1/18 at 5:00pm revealed:	D 270		

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D 270	Continued From page 31 -Resident #11 was sitting in his recliner in his room and the roommate was sitting in her recliner next to him. -Resident #11 had a long sleeve sweatshirt on with visible bruises to both of his hands and wrists. No protective sleeves were on either arm. Interview with Resident #11 on 2/1/18 at 5:00pm revealed: -He was "happy someone heard me" because he was "on the edge, waiting for the Lord to take" him. -He felt great, but just wanted to die, there was no point in living because there was nothing to do and he had lived long enough. -He did not remember having any falls and did not know where the bruises came from on his hands and wrists. Observation on 2/2/18 at 8:50am revealed Resident #11 was in his wheelchair and had protective sleeves on both forearms. Interview with a second PCA on 2/1/18 at 5:13pm revealed: -Resident #11 would not stay up front in the common areas and the living room. -Resident #11 had two falls from his bed that she could remember. -Resident #11 had a tendency to lay at the edge of his bed and rolled off the bed. -She would make sure Resident #11 was closer to the wall when she assisted him to bed so the resident was not near the edge. -She could not think of any other interventions in place to help prevent Resident #11 from falling. Interview with a third PCA on 2/1/18 at 5:24pm revealed: -Resident #11 had not had any falls on his shift,	D 270		

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but he knew Resident #11 had had falls on other shifts.
-Resident #11 would have been able to say what happened if he had fallen.
-When he was working, he checked on Resident #11 "a lot", but could not say specifically how often he checked Resident #11.

Observations on 2/1/18 at 5:27pm revealed:
-Two PCAs assisted Resident #11 from his recliner to standing with a wheeled walker.
-Resident #11 left his room ambulating unaccompanied with the wheeled walker.

Review of a progress note and an incident report dated 12/20/17 for Resident #11 revealed:
-On 12/20/17 at 10:25pm, staff documented Resident #11 was sent to the emergency room (ER) due to a severe skin tear on his right arm. The aide went into the resident's room to assist with daily activities and found resident lying on the floor in front of his recliner.
-On 12/20/17 at 9:30pm, the incident report noted that Resident #11 was found on the floor and was sent to ER for a skin tear.

Review of ER discharge instructions for Resident #11 dated 12/20/17 revealed Resident #11 was evaluated in the ER for a fall and a skin tear on the upper right arm.

Interview with a Medication Aide (MA) on 2/5/18 at 4:50pm revealed:
-She had written the progress note dated 12/20/17 at 10:25pm for Resident #11.
-She could not remember any details about the fall other than what she wrote in the progress note.

Review of a progress note and an incident report

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D 270	Continued From page 33 dated 12/23/17 for Resident #11 revealed: -On 12/23/17 at 2:55pm, staff documented Resident #11 slipped out of his wheelchair in the dining room causing a skin tear to his left upper arm. -On 12/23/17 at 1:00pm, the incident report noted that Resident #11 slipped out of his wheelchair resulting in a skin tear. Interview with a second MA on 2/5/18 at 3:05pm revealed: -Resident #11 had paper thin skin. -On 12/23/17, Resident #11 "just slid out of his chair in the dining room" and got a skin tear. Review of a progress note and an incident report dated 12/25/17 for Resident #11 revealed: -On 12/25/17 at 7:00pm, staff documented Resident #11 was found on the floor on his buttocks. The resident stated he was trying to help his roommate get back in the chair. Resident #11 was very agitated and had no injuries. -On 12/25/17 at 6:15pm, the incident report noted that Resident #11 was found on the floor on his buttocks. Interview with the second MA on 2/5/18 at 3:05pm revealed on 12/29/17, Resident #11 fell and messed up his arm with another skin tear. -Resident #11 had Home Health following him for the skin tears and sleeve protectors to prevent skin tears. Review of an incident report dated 1/4/18 for Resident #11 revealed on 1/4/18 at 4:06am, staff documented Resident #11 had an unwitnessed fall and the resident stated he fell out of bed. The Administrator documented the resident had no injury and no outcomes.	D 270		

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D 270	Continued From page 34 Review of progress notes and an incident report dated 1/11/17 for Resident #11 revealed: -On 1/11/18 at 5:30am, staff documented Resident #11 was found on the floor. The resident stated he rolled over and fell out of the bed. Resident #11 had a skin tear on the back of his upper right leg and the back of his left arm above his elbow. -On 1/11/18 at 10:00pm, staff documented Resident #11 had an unwitnessed fall in his room at approximately 5:30pm with no complaints of pain or visible injuries. -On 1/11/18 at 5:30pm, the incident report noted that Resident #11 was found on the floor in front of his bedroom door. Staff encouraged resident to ask for assistance before trying to ambulate on his own. Review of a progress note dated 1/14/17 for Resident #11 revealed on 1/14/18 at 9:30pm, staff documented Resident #11 was taken to the hospital by a family member for left arm swelling and returned with no new orders. Review of ER discharge instructions for Resident #11 dated 1/14/18 revealed Resident #11 was evaluated in the ER for a skin tear on the upper arm, hemorrhage inside the eye and joint swelling. Interview with the second MA on 2/5/18 at 3:05pm revealed on 1/14/18, Resident #11's family member took him to the hospital because she was concerned the wrap on his arm was too tight. Review of a progress note and an incident report dated 1/18/17 for Resident #11 revealed: -On 1/18/18 at 3:10pm, staff documented Resident #11 had an unwitnessed fall and was found lying on his right side on his room floor with	D 270		

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D 270	Continued From page 35 a skin tear to his right thumb. -On 1/18/18 at 10:40am, the incident report noted that Resident #11 was found lying on his right side on the floor in his bedroom. The Administrator documented the resident had a scratch on his forehead. Interview with the second MA on 2/5/18 at 3:05pm revealed: -On 1/18/18, she had found Resident #11 on the floor in his room; he was not able to tell her what happened. -She had checked him for injuries by moving his arms and legs and asked him if he hurt anywhere. -Resident #11 did not have any injuries except the skin tear to his thumb on 1/18/18. -She could not think of any specific fall interventions for Resident #11, "no more then what we been doing just trying to monitor them (Resident #11 and his roommate)." Review of a progress note and an incident report dated 1/30/17 for Resident #11 revealed: -On 1/30/18 at 6:55am, staff documented Resident #11 was found on the floor in his room with no injuries and reported he was trying to help his roommate. -On 1/30/18 at 2:45am, the incident report noted that Resident #11 stated he was trying to help his roommate get situated in the bed. The Administrator documented the resident had no injury and no outcomes. Interview with a fourth PCA on 2/5/18 at 4:40pm revealed: -She had found Resident #11 after he fell, but she did not remember the date. -She heard him yelling from the hall. -Resident #11 was trying to help his roommate	D 270		

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and tripped over the wheelchair.
-She did not know what interventions were put in place to help prevent falls for Resident #11.

Interview with a third MA on 2/2/18 at 4:00pm revealed:
-Resident #11 had a lot of falls.
-Staff tried to keep Resident #11 up front in the common areas, but Resident #11 would propel his wheelchair back down to his room.
-Otherwise staff tried to check Resident #11 "every 30 minutes, might be every 15 minutes."

Upon request on 2/1/18, 2/2/18 and 2/5/18 documentation of 15 and 30 minute checks from 12/20/17 through 2/5/18, for Resident #11 were not available for review.

Interview with the RCD on 2/5/18 at 12:00pm and 5:26pm revealed:
-Resident #11 was able to stand and tried to get up on his own.
-Resident #11 needed staff to assist him with transfers, toileting and getting into bed.
-Fall prevention measures for Resident #11 included a scoop mattress, in-house physical therapy and protective arm sleeves.
-She was not aware of Resident #11 having two falls documented on 1/11/18.

Interview with Resident #11's PCP on 2/2/18 at 9:16am revealed:
-Resident #11 had a diagnosis of myasthenia gravis which caused chronic muscle weakness and therefore put the resident at high risk for falls; "If anyone had a reason to fall, it would be [name of Resident #11]."
-Resident #11 had a lot of falls when he first came to the facility (12/15/17), because he would forget he could not stand and try to anyway.

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D 270	Continued From page 37 -Resident #11 also rolled out of his bed reaching for Resident #10. -"We could not keep (Resident #11) from falling unless we tied him down." -She could not think of any interventions that would keep Resident #11 from falling, not even a chair alarm because his room was at the end of the hall and by the time staff would hear the alarm and get down there it would have been too late. -Resident #11 and his roommate would have been the only residents in need of more frequent checks at the facility. -It was not her area of expertise to know how often staff should perform safety checks on residents. -The facility staff was very good about notifying her whenever a resident fell. -She had had detailed discussions with staff during her weekly visits to the facility about possible fall prevention interventions such as chair alarms, scoop mattresses and pool noodles under bed sheets. -She also worked with Hospice staff with implementing some the interventions such as the scoop mattress for Resident #11. Interview with the Administrator on 2/2/18 at 11:01am revealed: -He was aware of the frequent falls Resident #11 had since admission to facility in December 2017. -He had discussed possible fall interventions and room configurations with Resident #11's Power of Attorney (POA), but had not come to any conclusions. -Resident #11 worried about his roommate and had falls trying to help her. -Some of the interventions put in place for Resident #11 included protective sleeves to prevent skin tears, working with rehabilitation staff	D 270		

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D 270	Continued From page 38 for safety awareness and getting a different type of mattress. -Staff were expected to "be more observant of (Resident #11) when the resident was in his room or in the community." -Being more observant meant "giving more attention" to Resident #11. -"We check residents as often as we can and as often as they need." -He was unable to provide specific time frames for safety checks on Resident #11. -He was not going to move Resident #11's room closer to the nurses station because that would not be fair to the residents who were in that room already and he was not going to separate Resident #11 from his roommate. Refer to interview with a Personal Care Aide (PCA) on 1/31/18 at 3:40pm. Refer to interview with a Medication Aide (MA) on 2/5/18 at 4:50pm. Refer to interview with the Resident Care Director (RCD) on 2/1/18 at 11:10am and 2/5/18 at 12:00pm. Refer to interview with the Administrator on 2/2/18 at 11:01am. Refer to review of the facility's policy and procedure for "Fall Management Program" dated September 2015. Refer to review of the facility's policy and procedure for "Alert Charting Protocols" dated August 2015. Refer to review of the facility's undated Alert Charting Log (Hot Box) instructions.	D 270		

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D 270	Continued From page 39 5. Review of Resident #3's current FL-2 dated 6/27/17 revealed: -Diagnoses included Dementia, Essential Hypertension and Anxiety Disorder. -Resident #3 was constantly disoriented and wandered. -Resident #3 was ambulatory and continent of bowel and bladder. -Resident #3 needed assistance with toileting, bathing and dressing. Review of Resident #3's current care plan dated 3/6/17 revealed: -Resident #3 was ambulatory and independent with transfers. -Resident #3 required verbal reminders for toileting. Review Resident #3's quarterly assessments dated 10/28/17 and 1/28/18 revealed: -The ambulation ability and/or need for assistance was not completed. -Resident #3 required one staff to assist with transfers. -Resident #3 had sustained fall(s) since the last quarterly assessment. -The notations were the same on the 10/28/17 and 1/28/18 assessments. Interview with the Resident Care Director (RCD) on 2/5/18 at 12:00pm revealed: -She was responsible for completing resident assessments and care plans which were done on admission to the facility, annually and if there was a change in the residents condition such ambulatory to non-ambulatory. -She had not done an updated care plan for Resident #3 since 3/6/17.	D 270		

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D 270	Continued From page 40 Upon request 2/1/18, 2/2/18 and 2/5/18, a fall review or fall intervention sheet for Resident #3 was not available for review. Observations on 1/30/18 from 12:54pm until 1:21pm revealed: -At 12:54pm, Resident #3 and nine other residents were sitting in the living room area. -All staff were assisting residents from the dining room to the living room area or their rooms. -One resident was pushing another resident in a wheelchair around the living room area. -At 1:14pm, Resident #3 began yelling loudly, "Come on, come on with [name]. Will you just come on?" -At 1:17pm, there were 13 residents in the living room area with no staff monitoring the residents; the MA was sitting at the nurse's station talking to the PCA whose back was turned to the residents in the common area. -The ambulatory resident who was pushing another resident in a wheelchair, went over to Resident #3. -Resident #3 was asking for help for a resident sitting next to her and trying to get out of her wheelchair. -The resident sitting next to Resident #3 was leaned over to her left side and slightly forward. -Resident #3 tried to get up from her wheelchair to assist the resident that was leaned over in her wheelchair. -The ambulatory resident tried to assist Resident #3 to get out of her wheelchair. -The PCA assisted Resident #3 with sitting back in her wheelchair and told her the resident sitting next to her "was alright" and called to the MA to assist. -The MA came and moved the resident in the wheelchair, who was sitting next to Resident #3, to the center of the living room away from	D 270		

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D 270	Continued From page 41 Resident #3. Based on observations, interviews and record reviews, Resident #3 was not interviewable. Telephone interview with Resident #3's Power of Attorney (POA) on 2/5/18 at 2:43pm revealed: -Facility staff had contacted her that Resident #3 fell two nights in a row on Sunday and Monday night last week (1/28/18 and 1/29/18). -The staff said that Resident #3 did not have any injuries with either fall. -Resident #3 having had two falls in two days was concerning because the reason Resident #3 was in a wheelchair was because she fell three times in five days near the end of October 2017; the first time, Resident #3 fell out of her bed and had a terrible hematoma on her forehead, the second time Resident #3 fell in the dining room having lost her balance while reaching reaching over, and the third time Resident #3 fell in her room and broke her arm; the POA did not know the details of what happened on the third fall. -Since the falls in October 2017, Resident #3 had been in a wheelchair and on Hospice. -She thought the falls on 1/28/18 and 1/29/18, happened because Resident #3 was left in her wheelchair in her room and tried to get up and go to bed. -She felt Resident #3 needed to be supervised. -She had emailed the Administrator the Tuesday after the falls (1/31/18), and requested Resident #3 be kept in the common area until she was ready to go to sleep, that staff assist Resident #3 to bed and not leave her in her wheelchair in her room. -The Administrator had emailed her back on the Thursday after the falls (2/1/18) and she thought the facility had been doing as she requested.	D 270		

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D 270	Continued From page 42 Review of progress notes and incident reports dated 10/20/17 for Resident #3 revealed: -At 9:45pm, staff documented Resident #3 was found on the floor in another resident's room, had a large knot on her forehead over her right eye and was sent to the emergency room (ER). -The incident report revealed at 9:30pm, staff documented Resident #3 fell out of another resident's bed, had a large knot on her forehead and was sent to the ER. The Administrator documented Resident #3 was to follow up with her PCP, had no apparent injuries and the Power of Attorney (POA) did not want Resident #3 to follow up with an orthopedic physician. Review of ER discharge instructions for Resident #3 dated 10/20/17 revealed: -Resident #3 was seen for anemia, a fall and a hematoma of the scalp. -Resident #3 was to follow up with an orthopedic physician around 10/26/17. Review of progress notes and incident reports dated 10/23/17 for Resident #3 revealed: -At 2:06pm, staff documented Resident #3 was slightly off balance, used a walker and ambulated without difficulty. -The incident report revealed at 3:40pm, staff documented Resident #3 had an unwitnessed fall, was found on her bottom on the living room floor, range of motion exercised were not done and there were no injuries. Review of progress notes and incident reports dated 10/24/17 for Resident #3 revealed: -At 3:40pm, staff documented Resident #3 was found on her bottom on the living room floor, had no complaints and staff would continue to monitor. -At 10:30pm, staff documented Resident #3 fell	D 270		

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forward reaching for the aide and lost her balance, complained of left shoulder and left leg pain, and was sent to the ER.
-The incident report revealed at 10:34pm, staff documented Resident #3 was reaching for the aide, but lost her balance and fell forward. Resident #3 was grabbing her right arm and leg, had a cut over her nose and was sent to the ER.

Review of ER discharge instructions for Resident #3 dated 10/24/17 revealed:
-Resident #3 was seen for a fall from standing and a broken arm.
-Resident #3 was to follow up with an orthopedic physician around 11/1/17.

Review of progress notes for Resident #3 revealed:
-On 12/26/17 at 8:35 (am/pm not specified), staff documented Resident #3 was found sitting on the floor beside her bed.
-On 1/28/18 at 4:00pm, staff documented Resident #3 slid out of her chair to the floor in the living room with no injury and the resident had been trying to get up out of her chair.
-On 1/31/18 at 2:49pm, staff documented Resident #3 had a bruise on her left inner arm and had a prior fall.

Review of progress notes, incident reports, care plan and quarterly assessments for Resident #3 dated 10/20/17 through 2/2/18 revealed there was no documentation of interventions such as increased supervision and safety checks to decrease falls and injury for Resident #3.

Interview with a PCA on 2/2/18 at 3:50pm revealed:
-Resident #3 had "one big fall" just after the PCA started working at the facility in October 2017.

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D 270	Continued From page 44 -After the fall, Resident #3 had her arm in a sling and staff had to be "more delicate with her." -At that time, Resident #3 could still stand, but a second staff was needed to assist the resident because of her broken arm. Interview with a second PCA on 2/2/18 at 4:40pm revealed: -Ever since Resident #3 fell in October 2017, the resident had been more of a fall risk. -Resident #3 was more of a high fall risk because she was not able to keep her balance when she stood. -Staff kept Resident #3 in a wheelchair to help prevent falls and every now and then, Resident #3 would try to get up out of the wheelchair. -Resident #3 had not had any falls since the fall in October 2017 when the resident broke her arm. Interview with a third PCA on 2/5/18 at 4:40pm revealed: -She did not know anything about Resident #3 having fell on 1/28/18 and 1/29/18. -Resident #3 did not spend a lot of time in her room; "it depended on what kind of mood Resident #3 was in, sometimes she liked to lay down." -She did not what interventions were put in place for Resident #3 to prevent falls. Interview with a fourth PCA on 2/5/18 at 4:45pm revealed: -She thought at one time staff were checking on Resident #3 every 15 minutes after the falls in October 2017. -Around the same time (October 2017), Resident #3 got the lower bed and floor mat. -She was not aware of any other fall prevention interventions for Resident #3.	D 270		

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D 270	Continued From page 45 Interview with a Medication Aide (MA) on 2/5/18 at 3:05pm revealed: -She had written the note dated 10/23/17 at 2:06pm which was a post fall monitoring note. -She could not really say what interventions were put in place after Resident #3 fell on 10/20/17, except that staff monitored the resident more frequently. -She thought Resident #3 had been placed on 15 or 30 minute checks, but did not know where the documentation of the checks was. -She was notified by the PCA on 1/31/18 that Resident #3 had a bruise on her inner left arm. -Resident #3 had fell a few days before the bruise was noticed. Upon request 2/1/18, 2/2/18 and 2/5/18, documentation of 15 and 30 minute checks from 10/20/18 through 2/5/18 for Resident #3 were not available for review. Telephone interview with Resident #3's Hospice Nurse on 2/5/18 at 3:51pm revealed: -Resident #3 was admitted to Hospice 10/27/17 for Anemia and Adult Failure to Thrive. -She had just started seeing Resident #3 this past week (1/29/18). -The Hospice PCA that worked with Resident #3 reported the bruise under her left arm. -She was only aware of one fall occurrence since Resident #3 was admitted for Hospice services on 12/27/17 when the resident rolled out of the bed, the resident did not sustain any injuries and that was when Hospice put the floor mat in place. -Hospice had also put the low bed and wheelchair in place in October 2017, to help prevent falls for Resident #3. Observations of Resident #3 in her room on 2/5/18 at 4:40pm revealed:	D 270		

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D 270	Continued From page 46 -Resident #3's bed frame was lower to the floor than a standard bed and there was a mat approximately the length and width of the bed and two inches thick underneath Resident #3's bed. -The resident had a large bruise approximately the size of a grapefruit on the inner side of her left arm just above the elbow. -The bruise was yellow at the center and deep purple around the edges. Interview with the RCD on 2/5/18 at 12:00pm and 5:26pm revealed: -Resident #3 was able to stand, but was unsteady on her feet and needed one person assistance for transfers and ambulation. -Resident #3 did continue to try and get up without assistance. -Fall prevention interventions for Resident #3 included a Hospice referral, a low bed and floor mat. -Resident #3 had fallen in her room, but not all of the falls had occurred in her room. -She could not recall if she knew about a fall for Resident #3 on 1/28/18 and 1/29/18. -She thought staff may have called her about Resident #3 sliding out of her wheelchair and then maybe another fall in the bathroom. -She was not sure and the falls started to "run together." Interview with Resident #3's PCP on 2/2/18 at 9:16am revealed: -Resident #3 had had "quite a few falls" with the one on October 2017 being the "major fall and the reason (the resident) was on Hospice." -As far as she could remember, Resident #3 had fell in her room and hit her head on her night stand leaving a large hematoma, but no skull fracture. -Resident #3 fell again not long after hitting her	D 270		

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D 270	Continued From page 47 head and broke her left arm, but was not compliant with the sling. -It was not her area of expertise to know how often staff should perform safety checks on residents. -The facility staff was very good about notifying her whenever a resident fell. -She had had detailed discussions with staff during her weekly visits to the facility about possible fall prevention interventions such as chair alarms, scoop mattresses and pool noodles under bed sheets. Interview with the Administrator on 2/2/18 at 11:01am revealed: -He was aware of Resident #3's falls and injuries since September 2017. -Staff tried to keep Resident #3 close to the staff in the common area up front as much as possible. -The staff could not keep Resident #3 up front all the time, but so far the resident had not voiced disapproval of being up front. -"We check residents as often as we can and as often as they need." -He was unable to provide specific time frames for safety checks on Resident #3. Refer to interview with a Personal Care Aide (PCA) on 1/31/18 at 3:40pm. Refer to interview with a Medication Aide (MA) on 2/5/18 at 4:50pm. Refer to interview with the Resident Care Director (RCD) on 2/1/18 at 11:10am and 2/5/18 at 12:00pm. Refer to interview with the Administrator on 2/2/18 at 11:01am.	D 270		

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D 270	Continued From page 48 Refer to review of the facility's policy and procedure for "Fall Management Program" dated September 2015. Refer to review of the facility's policy and procedure for "Alert Charting Protocols" dated August 2015. Refer to review of the facility's undated Alert Charting Log (Hot Box) instructions. Confidential interview with a staff revealed: -Residents with dementia were like young children that needed someone to keep an eye on them at all times. -Residents had decreased awareness of what was around them and some had behaviors. -The facility needed more staff to supervise the residents. -Some of the staff at the facility would disappear for long periods. -The staff would take longer than necessary to complete tasks, take extended breaks and just not do what they were supposed to do. -The staff were supposed to supervise the residents, but they were not always doing that. -The MAs were too busy on the medication cart to chase down where staff were at all the time. Interview with a Personal Care Aide (PCA) on 1/31/18 at 3:40pm revealed: -When a resident was labeled a high fall risk that meant staff were supposed to watch that resident. -Watching the resident meant checking on the resident more often. -There were some residents that were checked every 15 minutes, some residents that were checked every 30 minutes and some that were	D 270		

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checked in between the PCAs "doing other stuff."
-The PCAs documented 15 and 30 minute checks.
-There were no residents on 15 or 30 minute checks that she could think of.
-Residents that had fallen were put on more frequent checks.
-The resident's PCP, the facility nurse or the Supervisor decided when a resident was put on more frequent checks and how often the resident was checked on.

Interview with a Medication Aide (MA) on 2/5/18 at 4:50pm revealed:
-Whenever a resident fell, the MAs put the resident on hotbox charting which meant the MAs would chart on the resident in the progress notes for a few days and monitor whatever was going on with the resident.
-The resident was also placed on falls precautions which meant the staff kept an eye on the resident more often.
-The fall intervention sheet was pulled up in the PCS book so that all staff knew to check on those residents.
-Residents were checked when staff did their rounds.
-There were no set times for staff rounding on residents.
-Residents were checked every two hours and in between when staff had a minute.
-Residents at high risk for falls were kept in the common areas where staff could see them.

Interview with the Resident Care Director (RCD) on 2/1/18 at 11:10am and 2/5/18 at 12:00pm revealed:
-There was no specific time frames for staff to check on residents.
-Staff checked on residents "throughout the day"

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D 270	Continued From page 50 and rounds were done "as needed all throughout the day." -Toileting and incontinence care was done before and after meals, before bedtime, in between those times and as often as needed. -If a resident was walking, pacing or searching that might have been an indication the resident had a toileting need, but was unable to say I need to use the bathroom. -She could not say the PCAs performed toileting and incontinence care "rounds at 10:00am, 12:00pm, 2:00pm and so on." -Residents at high risk for falls were kept out in the common areas. -There was a staff member in the common areas at all times so that residents were "not just left alone." -When a resident had a fall, the resident was placed on "increased supervision for a couple of days;" increased supervision could mean 15 or 30 minute checks. -She was responsible for determining when a resident was placed on 15 or 30 minute checks, the frequency was based on what was happening with the resident, PCAs documented 15 and 30 minute checks, and she was unable to give specific examples for the choice of 15 or 30 minute checks. -"Hotbox" charting was initiated for 72 hours following a resident fall, the MA was responsible for documenting every shift what and how the resident was doing and if there were any changes such as new bruising. -The MAs were responsible for communicating to the PCAs that a resident had a fall and the PCAs were expected to monitor the resident and know what was going on with that resident. -The PCAs documented the care provided to each resident each shift on the resident's PCS log.	D 270		

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(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 51 -Each resident had a fall intervention sheet that was kept with the Personal Care Service (PCS) log in the PCS book which was kept at each nurse's station and that was how PCAs knew which resident were at high risk for falls. -The fall intervention sheet noted generalized and individualized interventions for residents at high risk for falls. -The RCD completed the fall intervention sheet for each resident on admission to the facility, annually and if there were any changes in the resident's condition such as physical therapy or a fall. -The MAs were able to update the fall intervention sheet if there were changes in the resident's condition. -If there was "anything going on" with a resident, the Medication Aides (MAs) documented the concerns on the 24-Hour Log, communicated the concern to the oncoming MA at change of shift and the oncoming MA communicated the concern to the PCAs on the oncoming shift. -The 24 Hour Log was for changes in a resident's condition and/or incidents and accidents and was kept in the log book at each nurse's station. -She and the Administrator tried to involve staff to come up with ideas for individualized interventions to prevent falls for each resident with frequent falls. Interview with the Administrator on 2/2/18 at 11:01am revealed: -Staff were expected to "respond accordingly" to resident falls which meant for staff to check the resident and make sure the resident was okay. -Staff were expected to notify the Supervisor when a resident had a fall. -The Supervisor was responsible for evaluating the situation and deciding what to do next. -A fall was a fall whether it was witnessed or	D 270		

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D 270	Continued From page 52 unwitnessed and if a resident was unable to say what happened the staff were expected to follow the same process. -The Supervisor was responsible for determining if a resident needed to be sent to the emergency room (ER), calling Emergency Medical Services (EMS) and notifying the PCP and responsible party. -Residents were seen by the Primary Care Provider (PCP) on the next PCP visit day after a fall. -The PCPs visit days at the facility were on Tuesdays and Fridays each week. -The policy and procedure for repeated falls with or without injury was a question for the RCD. -The facility's practice was to implement interventions to decrease falls especially with the memory care population of residents. -The Administrator and facility staff would put their heads together to come up with interventions to decrease falls and the RCD would implement the interventions. -He was aware of the number of falls residents at the facility had had with serious injuries such as broken bones. -There was no formal system for monitoring staff interactions with residents, but staff were always being observed by the Administrator, the RCD, the family members, visitors, volunteers and other staff. -He assumed everyone knew what to do with any concerns related to resident care and care of residents with behaviors. -There were weekly fall meetings that reviewed overall tends for falls, especially for residents with behaviors and frequent falls, and looked for possible interventions. -The Administrator, RCD, Activity Director and Rehabilitation Director attended the weekly fall meetings.	D 270		

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D 270	Continued From page 53 Review of the facility's policy and procedure for "Fall Management Program" dated September 2015 revealed: -A fall is any sudden, unintentional change in position that causes an individual to land at a lower level on an object, the floor or ground. -Falls included: found on floor, slides to floor unassisted, rolls out of bed or chair onto the floor, fall off or out of any equipment/apparatus used for therapy or a transfer and/or resident is lowered to the floor. -To establish a fall management program, three main elements are needed: review of the resident's risk factors, planned service plan and interventions that are resident specific and continuous review of effectiveness of the service plan and interventions. -Intrinsic fall risk factors: medication regime and/or side effects; infections, acute illness or exacerbation of a chronic illness ...cognitive disorders, dementia related disorders; gait/balance or foot disorders; and history of previous falls. -Extrinsic fall risk factors: environmental issues in the resident apartment or common areas. -A fall review is completed for each resident within eight hours of move-in/re-move-in, when the service plan is updated, after returning from hospitalization and when indicated by a designated healthcare professional if there is new or changed risk factors that may lead to injury for the resident. -Upon determination that a resident is at risk, the RCD will contact the resident's physician to determine if follow up is indicated. -A service plan with resident specific interventions will be developed with the resident/responsible party by the RCD, Resident Care Coordinator (RCC), or designee.	D 270		

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D 270	Continued From page 54 -The resident's service plan will be reviewed/revised in conjunction with fall review or whenever a resident fall occurs. -Facility staff, residents and families need to be aware of the resident specific resident interventions to minimize falls. -Fall interventions will be reviewed for continued effectiveness. -Interventions will be revised as indicated by the incident and current resident needs. -Revised interventions will be routinely reviewed and updated to ensure effectiveness. -Interventions will be reviewed with the staff, family and resident for compliance. -A careful review and analysis of the possible contributing factors to the fall with or without injuries will be completed using [licensee's] incident report by the RCD or designee. -All resident falls will be investigated, reported, and documented by a qualified healthcare professional. -The resident's attending physician will be notified of individual residents with multiple falls, to modify interventions as indicated, and document accordingly. Review of the facility's undated Alert Charting Log (Hot Box) instructions revealed: -Falls: Document appearance of any redness or bruising, any changes in condition or complaints noted (or lack of) for 3 three days. If sent out to the hospital, note day of incident, return note, and then three days following or until resolved. Note any follow up with MD. -Situation #4 Resident needs requiring increased supervision: Maintain hotbox until need for supervision is no longer evident. The facility's failure to implement standardized	D 270		

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D 270	Continued From page 55 increased supervision for residents with a history of frequent falls in the Special Care Unit resulted in Resident #2 dying shortly after surgical repair of a femur fracture sustained from a fall and Resident #10 sustaining a subdural hematoma from a fall which demonstrates serious physical harm and neglect and constitutes a Type A1 Violation. Review of the facility's Plan of Protection dated 2/02/18 included: - Residents with a fall will be placed on increased supervision with documentation post fall until root cause analysis can be identified and/or trended. - At that time, follow-up interventions will be identified and put into place. - Documentation of increased supervision interventions will include one hour checks or less during analysis period (72 hours or less). - A daily call including the Executive Director (ED), Resident Care Director (RCD), Area Director of Clinical Services (ADCS) and Regional Vice President of Operations (RVPO) or designee will occur on Monday through Friday to review falls, immediate supervision plan, root cause analysis follow-up and intervention follow-up. - Daily calls will occur for four weeks and periodically thereafter. - Intervention follow-up will include a review of the effectiveness of the new interventions. - After four weeks of calls the facility will resume the falls protocol program. - Ongoing bi-weekly monitoring will include RCD "Drivers" (documentation reviews), ED "Drivers (documentation reviews), and falls meetings. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 7,	D 270		

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D 270	Continued From page 56 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to assure health care referral and follow up for 2 of 9 residents sampled (#8, #9) regarding medical evaluation of observations of blood in the urine and incontinence brief for 7 to 10 days (#8), and notifying the primary care provider regarding blood pressure refusals (#9). The findings are: 1. Review of the most recent FL-2 for Resident #8 dated 06/09/2017 revealed: -Diagnoses included Vascular Dementia with behavioral disturbances, Benign Neoplasm of parotid gland, Heart Failure, Muscle Weakness, Sleep Apnea, Pain of Right Hip, and Chronic Kidney Disease. -The resident was continent of bowel and bladder. -The resident was ambulatory. Review of progress notes documented for Resident #8 revealed: -On 12/10/2017 at 1:43pm, staff documented	D 273		

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blood noticed in the resident's incontinent brief and a family member was notified.
-On 12/10/2017 at 10:40pm, another staff documented resident had some blood in his incontient brief which seemed to be in his urine, the family and the Resident Care Director (RCD) had been notified; the resident had not complained of any pain or discomfort, and staff would continue to monitor".
-On 12/11/2017 at 10:25pm, staff documented the resident still had blood in his urine, the resident had not complained of any pain or discomfort, a family member had been notified, and staff would continue to monitor.
-On 12/12/2017 at 10:00pm, staff documented resident is in hospital.
-On 12/16/2017 at 9:45pm, staff documented the resident's family member came in today around 7:00pm and stated Resident #8 expired today.

Telephone interview with Resident #8's family member/Power of Attorney (POA) on 01/31/2018 at 11:15am revealed:
-He was the POA for Resident #8.
-He took Resident #8 to doctor appointments at the local veteran's hospital.
-He visited Resident #8 at the facility weekly while the resident lived at the facility.
-Resident #8 died at a local veteran's hospital on 12/16/2017.
-The facility staff had called him on the afternoon of the Sunday before the resident died [12/10/2017] and made him aware that Resident #8 was "passing blood".
-The POA understood the bleeding had happened Friday or Saturday, but there was not a lot of bleeding.
-He visited the resident on Monday (12/11/2017) at the facility. The resident "didn't complain of anything. If he had been in pain or complaining,

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[the POA] would have taken him to hospital".
-He did not remember who had called him.
-He took Resident #8 to the hospital on Tuesday (12/11/2017). The resident had pneumonia, his lungs were full of fluid, the resident was put on oxygen, the doctor wanted to put him on a respirator but [the resident] declined, [and the resident's] oxygen was low. [Resident #8] died from complication to pneumonia and severe urinary tract infection. He wasn't passing much urine. There was a little bit of blood. Once the catheter was inserted, [the resident] passed a lot of fluid and blood.

Interview with a Personal Care Aide (PCA) on 01/31/2018 at 4:35pm revealed:
-She would assist Resident #8 with toileting in the bathroom sometimes.
-She saw blood in the resident's urine and commode "about a couple weeks before [named family member] took him to the hospital. I guess he had to get an appointment or whatever because [named family member] was responsible to get him to the hospital."
-The PCA would report the bleeding to the MA who was working during the shift and when the next shift came to work, the PCA would let them know what had been observed.
-The PCA did not remember which MA she had reported the observation of blood in Resident #8's urine to.
-She was not sure how many times she had seen blood in Resident #8's urine or commode but it was probably about 2 or 3 times maybe, and each time she had reported it to the MA.
-She did not know if the MAs documented what was reported to them, but if she reported something to the MAs, they were supposed to document it.
-Sometimes she documented what she observed

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on the assignment sheets.
-She had noticed during the last two weeks Resident #8 was in the facility the resident slept more in his wheelchair and was "a little more ornery".

Interview with another PCA on 01/31/2018 at 2:45pm revealed:
-She worked with Resident #8 every day she worked at the facility.
-She assisted the resident with toileting every two hours.
-The resident wore incontinent briefs.
-She saw "a small amount" of "a little pinkish" blood in the urine in the commode when assisting the resident with toileting on a Friday and was off that weekend.
-She reported what she saw to the Medication Aide (MA) [named].
-The resident's family member (POA) took the resident to the hospital on the following Monday and the resident was admitted to the hospital.
-She denied anybody else talking to her about seeing blood in Resident #8's incontinent brief.
-She did not know if anyone else had seen blood in Resident #8's incontinent brief or urine; "they should have if they came in after me".
-The resident did not complain to the PCA.

Interview with a third PCA on 02/02/2018 at 6:50am revealed:
-She helped Resident #8 with toileting.
-During the last month of Resident #8's stay at the facility, the resident's incontinent brief would have to be changed "a couple times at night".
-Resident #8 would go to the bathroom during the night.
-The resident started passing blood a couple weeks before he left the facility.
-The blood started as a streak; then, when the

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resident urinated, his urine was the color of blood.
-She occasionally saw streaks of blood in the resident's urine a couple times a week.
-She did not see streaks of blood every day.
-She did not remember who the MA was she reported to, but would have been one of the four MAs [named] who worked the 11pm - 7pm shift.
-The MA she reported her observations to said someone else had reported it on another shift, so she already knew.
-The bleeding got worse the last days that Resident #8 was in the facility and she had never seen it like that.
-The last day or so, there was a strong urine smell and there was blood in the urine.
-The resident did not complain of pain when she asked the resident if there was any burning when he urinated.
-The bleeding would have occurred the early part of December 2017. The PCA could not provide specific dates for when the bleeding had been observed.
-She documented what she saw on the assignment sheets.
-She always documented on the assignment sheets.
-The assignment sheets were kept in a notebook at the desk and she did not know what was done with them every month.
-She was concerned about the resident and would ask the MA about the resident with regards to the bleeding and the resident being seen by a doctor.
-She was told that the resident's POA had been contacted and the POA had to make a decision about the resident going for evaluation.
-Someone told her the POA wanted to wait to make an appointment to take the resident to the veteran's hospital, but she did not recall who had told her that.

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D 273	Continued From page 61 -She did not know the process for sending a resident out for medical evaluation but knew there was a doctor that came to the facility. -She felt the resident needed to be evaluated. Interview with a fourth PCA on 02/02/2018 at 10:05am revealed: -She had worked with Resident #8 a couple of times since employed at the facility. -She had seen blood in the resident's urine and incontinent briefs when she went to get the resident up for breakfast and assisted the resident to the bathroom. -The bleeding had already been reported when she saw the blood, because when she reported it to the MA, the MA told her that it had already been reported and action was going to be taken. -It was either the same day she saw it, or the next day that Resident #8's POA took him to the hospital, and the PCA did not see the resident anymore. -She never heard Resident #8 complain, and the resident did not complain of feeling a burning sensation. -She overheard people talk about the resident having blood in his urine and that the resident might have had a urinary tract infection. -She was not aware of a facility policy on what needed to be done if a resident was seen bleeding and did not remember anyone ever discussing that with her. Interview with a MA on 01/31/2018 at 3:10pm revealed: -She would sometimes assist Resident #8 with toileting. -A PCA had come to her on a Friday and reported that "he's [Resident #8] got a large amount of blood in his [incontinent brief], bright red blood". -The blood was "more than usual, like a woman	D 273		

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D 273	Continued From page 62 on her menstrual cycle". -There was a soiled spot in the incontinent brief the size of a lemon. -There was a blood clot that "might" have been the size of a pea. -She saw the blood in the morning. -Every time the PCAs changed Resident #8's incontinent brief, they saw blood. The resident was changed twice and blood was noticed. -The MA called the resident' POA that morning before 12:00 noon. -The MA then stated she was not sure of the timeframe when the POA was called and could not recall. -The MA documented notes in the resident's record. -The POA told the MA he would get the resident to the emergency room. The POA did not come that Friday. The POA came to the facility the following Monday. The resident went to the hospital and was admitted. -The process for Resident #8 getting medical help was to contact the POA if there was a non-emergency, and if there was an emergency, call 911. -The MA knew the bleeding was a concern so she called the POA who told her that he [POA] would take care of it. -The MA reported to the oncoming shift and the Resident Care Director (RCD). -The MA did not remember if she reported it on the Friday or following Monday, but thought it was on the Friday. -The MA did not recall if anyone had reported anything to her prior to that Friday about Resident #8 bleeding. -Resident #8 was able to verbalize his needs and tell staff if he was in pain. Interview with the same MA on 02/01/2018 at	D 273		

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D 273	Continued From page 63 2:35pm revealed: -Once a PCA identified something about a resident, the MA was supposed to assess what the PCA found and call the resident's doctor. -If there was something that needed attention right away, the MA would call the RCD who would advise the MA on whether to send the resident out of the facility by emergency medical services (EMS). -She considered bleeding to require attention. Interview with a second MA on 02/01/2018 at 4:35pm revealed: -A first shift MA [named] reported to her that Resident #8 had blood in his incontinent brief that looked as if it were coming when the resident urinated. -The bleeding occurred the month the resident died. -The MA was told by the reporting MA that the resident's POA had been notified of what was going on and that she had called the POA "several times" about the bleeding. -She could not remember days, dates, or specifics. -The reporting MA did not specify how many times she had called the POA. -When she found out, it was a day or two afterwards that Resident #8 went to the doctor and never came back to the facility. -She saw the blood in Resident #8's incontinence briefs which was "not a huge amount but was a lot" and there was no odor. -If she was not mistaken, she first saw the blood on a Tuesday; the resident was taken to the doctor on a Wednesday, and POA came back and told staff the resident had a "bad UTI". Interview with the RCD on 02/01/2018 at 12:00noon revealed:	D 273		

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D 273	Continued From page 64 -She may not have the December 2017 assignment sheets. -The December 2017 assignment sheets may have been shredded because she "went on a shredding binge". -She had been told by management that she did not have to retain 24 hour logs and assignment sheets. -She had assignments sheets for 12/2016, 1/2017, 2/2017, 3/2017, 4/2017, and 8/2017. Interview with the RCD on 02/01/2018 at 2:45pm revealed: -She had not been able to find the December 2017 assignment sheets which was a tool for PCAs to use to communicate if something was going on with a resident. -The MAs signed the assignment sheets indicating their review of the form and indicating they had reviewed and were looking over the form for any abnormalities that needed to be reported to the doctor. -If the PCA saw something, the PCA was supposed to find the MA and bring what they saw to the attention of the MA, who was then supposed to assess the resident, call the RCD and/or fax communication to the resident's doctor if intervention was needed aside from what was covered in the standing orders. Interview with the RCD on 02/01/2018 at 2:55pm revealed: -Resident #8 received medical services at the local veteran's hospital. -The resident's POA transported the resident to doctor appointments. -Resident #8's POA came to take the resident to an appointment in December 2017. -She did not know why the POA was taking the resident to the doctor at the time.	D 273		

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-The resident's POA called back to the facility and said the resident had pneumonia.
-The resident never returned to the facility.
-The MAs were supposed to call the RCD with "any deviation from a resident's norm" and she considered a deviation might be a change in the resident's status, condition, behavior, falls, or skin tears. "Anything that changes [such as] burning on urination, anything, I need to be aware. If blood [observed] in the urine, I would need to be notified".
-She had no awareness of Resident #8 having blood in his urine prior to the resident being deceased, and no PCAs had come to her about finding blood in the resident's urine or incontinent brief.
-She became aware of the blood in the residents' urine and incontinent brief for the first time when she read the progress notes in the resident's record after the resident was deceased.
-If the PCAs saw any bleeding, they could have documented it on the assignment sheets or communicated verbally to the MAs. Some PCAs use the assignment sheet as a communication tool and others don't.
-The only place she could think of to find documentation if staff saw anything, would be in the resident's progress notes.

Interview with the Administrator on 02/02/2018 at 11:50am revealed:
-When staff came across bleeding, there was a policy and procedure to follow.
-The MA/Supervisor evaluated the situation and decided what would be the next move.
-Supervisors determined the need for a resident to be sent out for evaluation, then contacted the family and doctor.
-The facility staff was going to send the residents out for evaluation if the facility deemed resident

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needed to go out.
-The Executive Director/Administrator never really made the call to send a resident out for evaluation. That would be a conversation between the Supervisors in the facility. If the Supervisor felt there was a "gray area", they would look for further guidance from their Supervisor.
-Staff called the RCD "a high percentage of time".
-Staff was not expected to document when they called the RCD.
-Staff knew they could report things to the next person above their supervisor if the staff did not see any changes or action taken on their concerns.
-He told staff in orientation to tell their supervisors first and then go to that supervisors' supervisor if the staff did not see that anything happened to address their issue of concern.

Interview with the Regional Vice President, Area Director of Clinical Services, and Administrator on 02/02/2018 at 5:30pm revealed:
-Resident #8 had been the only veteran resident at the facility.
-Resident #8's medical care was provided through the veteran's hospital.
-Resident #8 had to be seen at the veteran's hospital to prevent interruption in benefits.
-Resident #8 was not seen at the facility by the physician's service that came to the facility.

2. Review of Resident #9's current FL-2 dated 8/29/17 revealed:
-Diagnoses included Alzheimer's Dementia, Congestive Heart Failure and Depression.
-There was an order to check Resident #9's blood pressure (BP) and pulse every week.

Review of the September 2017 Blood Pressure

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D 273	Continued From page 67 Flow Sheet for Resident #9 revealed there was documentation Resident #9 refused BP checks on 9/4/17, 9/11/17, 9/18/17 and 9/25/17. Review of the October 2017 Blood Pressure Flow Sheet for Resident #9 revealed: -There was documentation Resident #9's BP was 143/58 and her pulse was 58 on 10/4/17. -There was documentation Resident #9's BP was 136/67 and her pulse was 70 on 10/11/17. -There was documentation Resident #9 refused BP checks on 10/18/17 and 10/25/17. Review of the November 2017 Blood Pressure Flow Sheet for Resident #9 revealed: -There was documentation Resident #9 refused BP checks on 11/1/17, 11/8/17, 11/15/17 and 11/22/17. -There was no entry made for 11/29/17. Review of the December 2017 Blood Pressure Flow Sheet for Resident #9 revealed: -There was documentation Resident #9 refused a BP check on 12/5/17. -There was no entry made for 12/12/17. Review of a progress note dated 12/14/17 at 2:00pm revealed staff documented Resident #9 was in the hospital. Based on observations, interviews and record reviews, Resident #3 was not interviewable. Telephone interview with Resident #9's Power of Attorney (POA) on 1/31/18 at 10:28am revealed: -He was not aware Resident #9 had been refusing weekly BP and pulse checks. -He would expect that facility staff would notify him or a family member if Resident #9 was repeatedly refusing checks, care, meals and/or	D 273		

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D 273	Continued From page 68 medications. -He was Resident #9's POA, but another family member was the resident's primary contact. -The facility staff may have notified the other family member. -Resident #9 was hospitalized on 12/13/17 for injuries related to a suspected fall and was discharged to a skilled nursing facility from the hospital. Telephone interview with Resident #9's family member on 1/31/18 at 1:20pm revealed: -She was not aware of Resident #9 refusing weekly BP and pulse checks from September through December 2017. -Resident #9 was "feisty" at times, but had medications to help her not be so agitated. Interview with a Medication Aide (MA) on 1/31/18 at 2:40pm revealed: -Resident #9 did not like the BP cuff on her arm. -She would try a few times, but Resident #9 knew what the BP cuff was and continued to refuse. -She was sure she notified Resident #9's Primary Care Provider (PCP) about the BP and pulse check refusals. -She should have documented the contact with the PCP, but she wasn't sure if she had. Interview with the Resident Care Director (RCD) on 2/1/18 at 11:10am revealed: -She was not aware Resident #9 had refused BP and pulse checks from September through December 2017. -The MAs were expected to notify the PCP for continued refusals and document the contact with the PCP in the notes. -Staff also faxed PCP communications that were kept in the resident's record.	D 273		

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D 273	Continued From page 69 Review of Resident #9's record revealed there was no fax communication sheet notifying the PCP of BP and pulse check refusals from September through December 2017. Interview with Resident #9's PCP on 2/2/18 at 9:16am and 10:25am revealed: -She visited the facility weekly to see residents. -The facility would update her on her weekly visits and called her with urgent resident care issues. -Normally, BP and pulse check results were provided when the resident was seen at the facility. -It did not surprise her that Resident #9 had refused BP and pulse checks from September through December 2017. -Resident #9 was on weekly BP and pulse checks for routine monitoring of Congestive Heart Failure (CHF) and the beta blocker and diuretic medications used to treat CHF. -Had she been aware that Resident #9 was refusing weekly BP and pulse checks, she would have discontinued the order because the family was looking for more conservative measures. Interview with the Administrator on 2/2/18 at 11:01am revealed: -He was not aware Resident #9 had refused BP and pulse checks from September through December 2017. -Staff were expected to notify the RCD and from there the RCD would decide if the PCP needed to be notified. -The RCD would notify the PCP or direct staff to notify the PCP. _____ The facility failed to notify the physician and seek immediate care for Resident #8 who had	D 273		

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D 273	Continued From page 70 experienced blood in his urine and incontinent brief for more than a week and died 4 days after being hospitalized from complications of pneumonia and severe urinary tract infection. The facility's failure placed the resident at substantial risl for serious physical harm, which constitutes a Type A2 Violation. Review of the facility's Plan of Protection dated 2/2/18 revealed: - Staff will be educated on alert charting protocols that now allow caregivers to document acute healthcare needs on alert charting logs. - Care staff will be educated to report changes in health care needs to the Medication Aides MA) on duty, that shift. - MA will review alert charting log each shift and follow alert charting protocols. - MA will insure Resident Care Director (RCD) is notified during shift of any changes in acute health care needs. - Staff education on alert charting protocols began 2/2/18 and will continue. - Personal Care Physicians (PCP) will be notified during that shift of all health care changes that are acute. - We will monitor the process in the following ways. - The RCD, Executive Director/Administrator or designee will review alert charting log daily while on site. - Any changes in acute health care needs will be communicated to the PCP during that shift for follow-up and direction. - Any observed acute health care need changes will be cross referenced to the alert log to ensure system is effective. CORRECTION DATE FOR THE TYPE A1	D 273		

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D 273	Continued From page 71 VIOLATION SHALL NOT EXCEED MARCH 7, 2018.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to obtain a urinalysis and culture as ordered by the primary care provider (PCP) for 1 of 1 sampled residents (#12). The findings are: Review of Resident #12's F-2 dated 2/21/17 revealed: -Diagnoses included generalized weakness, hypertension, insomnia, type 2 diabetes, anxiety disorder, difficulty walking, and Alzheimer's dementia. -Resident #12 was intermittently disoriented. -The resident was ambulatory. -The resident was continent of bladder and bowel. -The resident exhibited inappropriate behaviors of wandering and being verbally abusive, injurious to others, and injurious to property. Review of Resident #12's PCP orders revealed: -On 9/29/17, the PCP wrote an order to collect	D 276		

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urine for UA (urinalysis) C&S (culture and sensitivity) to rule out a urinary tract infection.
-On 10/6/17, an order was written to collect urine for UA and C&S as orders had still not been completed.

Interview with a Medication Aide (MA) on 2/1/17 at 2:15 pm revealed:
-The typical way to obtain urine samples from residents would be to put a urine hat in the resident's toilet and check occasionally to see if it was full.
-The MA recalled having difficulty getting Resident #12 to provide a urine sample.
-The Resident Care Director (RCD) usually followed up on making sure PCP orders were completed and let the PCP know the situation.
-She did not recall who notified the PCP on the delay in getting the urine sample for Resident #12.
-The facility now used swabs for urine cultures, which provided much faster results.

Interview with the RCD on 2/1/17 at 5:15pm revealed:
-The MAs were expected to report to the RCD when an order was not completed.
-She was not aware of the repeated orders due to not fulfilling the original order.
-Staff would put a urine hat in the toilet when there was a urine sample order, and check it throughout the day.
-Now, facility staff collected urine screens with a swab.

Interview with the Administrator on 2/5/17 at 6:10pm revealed:
-The Administrator was not aware of orders not being completed.
-It would be the expectation of the MA to notify

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D 276	Continued From page 73 the RCD and let the PCP know if a urine sample could not be obtained. -He was aware of Resident #12's falls, but not aware of the urine order. Interview with Resident #12's PCP on 2/2/17 at 9:15am revealed: -She was aware of the issue with the urine collection. -She was concerned the resident had a urinary tract infection due to all of the falls and behaviors. -The facility staff had trouble collecting the urine for urinalysis, as the residents would not always cooperate. -She did not have it documented if she was notified that the urine was not collected or difficult for this resident. -The resident was positive for urinary tract infection and started antibiotics on 10/25/17. -The staff now used urine swabs for urine samples in difficult residents when they could not get a sample; the process seemed to be much better.	D 276		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) Sufficient staff shall be available for individual feeding assistance as needed. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff offered and provided feeding assistance in the dining room during 3 of 3 meal services observed to 1 of 3 sampled residents (#5), who required feeding	D 311		

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assistance.

The findings are:

Review of Resident #5's current FL-2 dated 06/23/2017 revealed:
-The resident's diagnoses included Dementia, Diabetes Mellitus, Myocardial Infarction, Hypertension, and Cerebrovascular Accident.
-The resident was constantly disoriented.

Review of the Resident Services - Level of Care Program Review completed upon admission on 12/08/2015 revealed Resident #5 required "stand-by assistance; may need directions/cueing to complete meal."

Review of the Dementia Quarterly Assessment for Resident #5 dated 10/14/2017 and 07/15/2017 revealed Resident #5 required one person assistance with eating/feeding.

Review of the Dementia Quarterly Assessment for Resident #5 dated 01/12/2018 revealed Resident #5 required reminders with eating/feeding.

Observations of Resident #5 during the lunch meal on 01/30/2018 at 12:15pm revealed:
-The resident was seated at a table with two other residents.
-Resident #5 was trying to eat her meat with the knife instead of using the fork or spoon provided.
-The resident seated to the right of Resident #5 stood up and began to scoop food in Resident #5's spoon and placed the spoon to Resident #5's mouth.
-There were three Personal Care Aides (PCA) seated at the table next to where Resident #5 was seated who were providing feeding

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D 311	Continued From page 75 assistance to four other residents. -The MA then approached Resident #5 and told the resident to take her spoon and start eating. -The MA gave Resident #5 a spoonful of food. -The MA then placed the spoon in Resident #5's hand while providing verbal directions, and the resident fed herself with the spoon. -The MA placed a chair at the table beside Resident #5 while the resident continued to eat. Interview with a PCA on 01/30/2018 at 5:00pm revealed Resident #5 ate by herself but needed "a little coaching every now and then". Observations of Resident #5 during the breakfast meal on 01/31/2018 at 8:25am revealed: -Resident #5 was seated at the dining room table with her eating utensils in front of her that were in a clear plastic sleeve. -The resident picked up the eating utensils in the clear plastic sleeve, opened her mouth, and began to put the utensils between her lips, when a PCA who was passing by the resident was notified. -The PCA sat in a chair next to Resident #5, removed the residents' utensils from the plastic sleeve, and cut the residents' pancakes in small pieces. Interview with the PCA on 01/31/2018 at 8:25am revealed Resident #5 sometimes needed assistance during meals, but would usually feed herself once she got started. Interview with the PCA on 02/05/2018 at 2:50pm revealed staff would start Resident #5 off with eating by putting a spoonful of food in her mouth, watch the resident, and staff may have to start the resident off eating again.	D 311		

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D 311	Continued From page 76 Observations of Resident #5 during the lunch meal on 02/05/2018 from 11:58am to 12:35pm revealed: -She removed her eating utensils from the clear plastic sleeve. -She played with her utensils by pressing them against the white paper placemat that was on the table in front of her chair. -The resident was served her food at 12:08pm by the PCA. -At 12:25pm the resident picked up another residents' cup and began to take the cup toward her mouth. The MA who was seated at the next table with three other staff, was notified.. The MA immediately got up from the table and approached Resident #5. -At 12:35pm, the resident poured tea in her dessert bowl and used her spoon to feed herself the tea from the bowl. The resident then picked up the bowl and drank the tea from the bowl. There was no assistance or intervention provided by the staff. Interview with the MA on 02/05/2018 at 12:40pm revealed: -Resident #5 was monitored by "peeping at her every once in a while". -The resident ate good but was "figidty". -The staff were focused on feeding other residents. -Staff were not able to watch everything. Interview with a third PCA on 02/05/2018 at 12:55pm revealed: -Resident #5 needed cueing for feeding assistance. -The resident had, just within the last couple days, started bothering other residents food. -The PCA was taught to feed only one resident at a time.	D 311		

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FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

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D 311	Continued From page 77 -Resident #5 might need to be moved to another seat at the same table so staff could see her and intervene with feeding assistance when needed. Interview with a fourth PCA on 02/05/2018 at 2:30pm revealed: -Resident #5 needed cueing to get started with eating. -Sometimes a staff person would sit with Resident #5 during meal time. -The resident needed assistance with opening her silverware. -She had seen the resident "struggle with getting the silverware". -Breakfast and lunch meal times were "hectic" and there were so many residents that needed feeding assistance. -She did not think there were enough staff to feed residents during meal times. -There were usually 5 PCAs in the dining room at mealtimes and the MAs came in the dining room after their medication pass was finished. -She thought there were 10 residents in the facility that needed feeding assistance. Interview with the Resident Care Director (RCD) on 02/05/2018 at 3:05pm revealed: -Resident #5 could feed herself "at times". -Resident #5 needed cueing and redirection. -Resident #5 would try to eat with her hands or pour milk in her plate. -She did not know why there were four staff feeding residents at the same table. -There were plenty of staff in the dining room for assistance with feeding residents, but all the staff were at one table. -The dining room seating arrangement was usually determined by the Administrator. Interview with the Administrator on 02/05/2018 at	D 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	C 02/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 311	Continued From page 78 4:50pm revealed: -He was aware of the feeding assistance observations. -He had immediately implemented changes in the dining room during meal times that included adjusting the seating arrangement, removing the plastic sleeve from the eating utensils, and having the Administrative Assistant and Activity Director monitor the dining room by walking around and assisting residents who needed cueing. Based on observations, interviews, and record review, Resident #5 was not interviewable.	D 311		
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 assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care referral and follow-up for 3 of 8 residents sampled. The findings are: Based on record reviews and interviews, the facility failed to assure health care referral and follow up for 2 of 9 residents sampled (#8, #9)	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	C 02/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 79 regarding medical evaluation of observations of blood in the urine and incontinence brief for 7 to 10 days (#8), and notifying the primary care provider regarding blood pressure refusals (#9). [Refer to Tag 0338 10A NCAC 13F. 0902 Health Care (Type A2 Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect and abuse related to supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision for 5 of 10 residents in the Special Care Unit (SCU) with histories of frequent falls (#2, #3, #10, #11 and #12) which resulted in serious injuries including a femur fracture (#2) and a subdural hematoma (#10), and other injuries including bruises and skin tears (#3, #10 and #12). [Refer to Tag 0270 10A NCAC 13F.0901 Personal Care and Supervision (Type A1 Violation).]	D914		

D 311 10A NCAC 13F .0904(f)(1) Nutrition and Food Service

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the plan of correction is prepared solely as a matter of compliance with State Law.

Franklin Manor shall have sufficient staff available for individual feeding assistance as needed.

1. Resident Care Director or Designee will complete Level of Care assessment on potential residents prior to admission to determine level of feeding assistance needed.
2. Community staff will document any changes in feeding assistance on Alert Charting Log.
3. Resident Care Director will document on Dementia Quarterly Review the level of feeding assistance needed for the resident.
4. Resident Care Director and Executive Director will monitor dining room seating arrangements as warranted to ensure sufficient staff are available for individual feeding assistance.
5. Community staff have been educated to report and document changes in healthcare needs on Alert Charting Log.

Correction Date: 3/23/18

D270 10A NCAC 13F .0901(b) Personal Care and Supervision

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.

Franklin Manor shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

1. Community staff have been in-serviced regarding increasing supervision for residents that have been identified to need more observation. 2/2/18
2. Residents deemed to need increased supervision will be placed on one hour checks or less for 72 hours or less during which time the community will determine reason for increased supervision.
3. Interventions will be put in place when reason for increased supervision has been determined.
4. Interventions will be placed on Falls Risk Form, resident name placed on Acute Charting Log, and increased supervision will be documented until Resident Care Director or designee has determined that increased supervision is no longer needed.
5. Resident Care Director, Executive Director, or designee will monitor daily while in community.

Correction Date: 3/7/18

D914 G.S. 131D-21(4) Declaration of Resident Rights

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.

Franklin Manor shall assure that every resident shall have the following rights: to be free of mental and physical abuse, neglect, and exploitation.

1. Community staff have been in-serviced regarding increasing supervision for residents that have been identified to need more observation. 2/2/18
2. Residents deemed to need increased supervision will be placed on one hour checks or less for 72 hours or less during which time the community will determine reason for increased supervision.
3. Interventions will be put in place when reason for increased supervision has been determined.
4. Interventions will be placed on Falls Risk Form, resident name placed on Acute Charting Log, and increased supervision will be documented until Resident Care Director or designee has determined that increased supervision is no longer needed.
5. Resident Care Director, Executive Director, or designee will monitor daily while in community.

Correction Date: 3/7/18

D273 10A NCAC 13F .0902(b) Health Care

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.

Franklin Manor shall assure referral and follow-up to meet the routine and acute health care needs of residents.

1. Community staff have been in-serviced on reporting and documenting changes in healthcare needs of residents. 2/2/18
2. Community staff will document changes in healthcare needs of residents on Alert Charting Log daily.
3. Any changes in acute healthcare needs will be communicated to Primary Care Physician for follow-up and direction.
4. Resident Care Director, Supervisor-in-charge, or designee will review the Acute Charting Log daily to ensure follow-up and health care needs of residents are met.

Correction Date: 3/7/18

D912 G.S. 131D-21(2) Declaration of Resident Rights

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.

Franklin Manor shall assure that every resident have the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

1. Community staff have been in-serviced on reporting and documenting changes in healthcare needs of residents. 2/2/18
2. Community staff will document changes in healthcare needs of residents on Alert Charting Log daily.
3. Any changes in acute healthcare needs will be communicated to Primary Care Physician for follow-up and direction.
4. Resident Care Director, Supervisor-in-charge, or designee will review the Acute Charting Log daily to ensure follow-up and health care needs of residents are met.

Correction Date: 3/7/18

D276 10A NCAC 13F .0902(c)(3-4) Health Care

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.

Franklin Manor shall assure documentation of the following in the resident's record: written procedures, treatments or orders from a physician or other licensed health personnel and implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this rule

1. Medication Technician, Resident Care Director, or designee will complete New Order Tracking Form when receiving new orders from physician or other licensed health personnel.
2. Resident Care Director or designee will review New Order Tracking Form daily until order is completed.
3. Resident Care Director, Medication Technician, or designee will notify and document in resident chart if unable to complete order and also document direction of physician.

Correction Date: 3/23/18