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D 000	Initial Comments The Adult Care Licensure Section conducted a desk review state involved complaint investigation survey on May 12-15, 2020, May 18-22, 2020, May 26-29, 2020, June 1-5, 2020, and June 8, 2020, including an onsite visit conducted on May 26, 2020.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on video conference observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards by not properly treating and delaying treatment for bed bugs in rooms #218, #401, #403 where residents resided. The findings are: Confidential telephone interview with a staff member revealed: -Staff reported seeing bed bugs in resident room #401, in a resident's bed, chair, and the room's ceiling, several times since December 2019 but was unable to give specific dates. -Staff reported that one of the residents in resident room #401 had been bitten several times	D 079		

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since December 2019 and the bed bug bites caused the resident to get up several times throughout the night.
-Staff reported the bed bugs to the supervisor on duty whenever bed bugs were found; stripped the resident's bed, put the sheets in a plastic bag, and put the bag in the dryer.
-That was what staff was supposed to do when they found bed bugs in the residents' rooms.
-The staff member did not specify who told them to do this.
-The facility "continued to have a bad problem" with bed bugs into April 2020 and a previous Administrator was supposed to have the facility sprayed.
-Staff was not sure if the facility was sprayed for bed bugs in April 2020 because the previous Administrator left.

Confidential telephone interview with a second staff member revealed:
-Staff reported seeing bed bugs on the walls and in the beds of resident rooms #401 and 403 sometime between March 2020 and April 2020.
-Staff reported between sometime in March 2020 or April 2020, staff had to move a resident in resident room #401 from her bed because the resident was being bitten by bed bugs in the bed.
-When staff put the resident in her chair in the resident's room, staff saw the resident was still being bitten by bed bugs and bed bugs crawling on the resident.
-Staff reported the incident to the medication aide on duty but was not sure of the date.
-Staff were supposed to check the furniture and the frames of the resident's beds when they found bed bugs in residents' rooms.
-Then staff was supposed to let the housekeeping staff know where the bed bugs were so the residents' rooms could be cleaned

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and mopped.

Telephone interview with a resident in room 218 on 05/28/20 at 09:30am revealed:
-There had been live bed bugs in his room for a while.
-His room had not been treated for bed bugs since last summer (2019) and he did not see any live bed bugs in his room until about three months ago.
-His bed was against the wall and the bed bugs were crawling down the wall onto his bed and were "tearing him up". He treated the bed bug bites with his skin barrier cream at his bedside.
-About two weeks ago a personal care aide (PCA) observed bed bugs crawling on my arms, legs and head and found a red bite area on my arm.
-When staff find live bed bugs in his bed, they removed his linen and placed in the facility dryer, then wash the linen.
-Last night (05/27/20) when the PCA was turning back the covers on the resident's bed, she observed live bed bugs crawling on the linen. The PCA killed the bug and placed the bed linen in the dryer and washed the linen.
-An exterminator came to his room last Friday or Saturday and sprayed for roaches.
-The exterminator checked his room/bed for bed bugs and informed me live bed bugs were in my bedframe and in the wall.
-The exterminator did not treat the room for bed bugs but informed the resident someone would be back this week to treat his room for bed bugs, but no one had come to the facility to treat his room this week.
-The Administrator was aware there were live bed bugs in his room and on his bed.
-The resident took some bed bugs to the Administrator's office, showed them to her, and

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informed her he had been bitten.
-The Administrator, the medication aides (MA) and the Resident Care Director (RCD) were aware of the live bed bugs in his room and were informed of the recent bed bug bites.

Observation of resident room #218 via video conference on 05/28/20 at 3:55pm with the Administrator revealed:
-There was a white flaky substance noted on the dark blue mattress cover.
-There were dark black and white spots noted in the corners of the bedframe.
-There were multiple dark spots in the corner of the wall at the head of the bed.

Telephone interview with the Administrator during the video conference on 05/28/20 at 3:55pm revealed:
-The white flaky substance on the dark blue mattress cover looked like dry skin.
-The dark black and white spots in the corners of the bedframe looked like dirt or dust.
-The spots in the corner of the wall at the head of the bed did not move when touched or when the flashlight was beaming on the spots.

Observations via video conference of rooms 401 and 403 on 05/28/20 could not be completed due to residents sleeping in the bedrooms.

Telephone interview with the Administrator on 05/15/20 at 9:25am revealed:
-She had a call in "now" about the reporting of bed bugs.
-There was a "continual issue" with room #218 and bed bugs.
-There was "a chronic thing" with the resident in room 218 "thinking he saw bed bugs".
-The resident would probably be moved out of the

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room.
-The housekeeping staff had sprayed resident room #218 using an alcohol solution.
-Staff had looked all around Resident #8's bed with a flashlight.
-She was not aware of any staff seeing any bedbugs and no one had brought her any bed bugs.
-Bed bugs had not been reported to her in any other space.

Second telephone interview with the Administrator on 05/27/20 at 11:54am revealed:
-The resident in room #218 had been the only person at the facility that had said anything about bed bugs.
-The resident brought two bed bugs to her in a plastic container.
-The resident told her the bed bugs were on the bed.
-She performed a body check of the resident and he had no bites.
-The baseboards were checked with a flashlight.
-She had not physically seen any bed bugs in the resident's room.
-A pest control company representative came and checked the whole facility for bed bugs.
-Rooms #218 and #401 were "positive" for bed bug activity.
-She was not sure if anyone from the pest control company had come back to the facility but was told by the pest control company representative that they would come back every 14 days to spray and check.

Third telephone interview with the Administrator on 05/28/20 at 4:35pm revealed:
-The resident rooms had not been treated by the pest control company for bed bugs as of yet.
-Housekeeping staff had sprayed the rooms with

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"what they treat with".
-She had not seen any signs of bed bugs in the rooms.
-She had not seen any blood or remnants of pest activity.
-She was still waiting for the pest control company to come to the facility to treat the rooms for bed bugs.

Fourth telephone interview with the Administrator on 05/29/20 at 11:20am revealed:
-She was aware there were bed bugs in room 218.
-She instructed the housekeeper to spray his room with bed bug spray provided by the exterminator company contracted by the facility.
-She did not know how long room #218 had been infested with bed bugs because she had only worked at the facility for approximately one month.

Telephone interview with a PCA on 05/13/20 at 11:40am revealed:
-She heard about bed bugs about two months ago.
-The resident in room #218 said he saw a bed bug in his bed.
-The pest control man came to the facility and sprayed on the men's hall.

Telephone interview with a second PCA on 05/15/20 at 10:00am revealed:
-She had heard random people talk about seeing bed bugs and did not know if it was true.
-She could not name anyone who talked about seeing bed bugs.
-It had been a couple months ago when she heard about the bed bugs.

Telephone interview with a third PCA on 06/01/20

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at 4:15pm revealed:
-The resident in room #218 complained of bed bugs in his room.
-She had also complained about bed bugs in room #218.
-She last saw a bed bug in room #218 bed on 05/28/20 when she turned his covers back to put the resident in bed.
-She killed the bed bug that was in the middle of the bedspread and changed the resident's bed linen.
-Room #218 was the only room she saw bed bugs in.
-She reported her findings of bed bugs to the RCD and to the housekeeping manager on 05/29/20.
-She had reported seeing bed bugs "plenty of times" and every time she saw a bed bug, "more than 10 times."
-The RCD went to room #218 about 2-3 weeks ago with her and the resident.
-Someone came in the room and identified themself as an exterminator. The PCA left the room. The resident told the PCA the exterminator would be coming back.
-The resident had never reported to her that he had been bitten by a bed bug, but she had seen the bed bugs on the resident "biting him, he was red".
-She saw bed bugs on his legs, arms, and up by his head.
-She saw "someone" come to the facility couple weeks ago but did not remember seeing anyone before that.

Telephone interview with a medication aide (MA) on 05/15/20 at 9:20am revealed:
-There had been "a few reports of bugs, some roaches".
-She did not know if the facility was spraying

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anything.
-It had "been a while about 2-3 months, not sure of exact date" when bed bugs were in resident room #218.
-The resident told her about the bed bugs.
-She had not seen any bed bugs and was not sure if anybody else had reported bed bugs.
-She reported what the resident in room #218 told her to the Resident Care Manager (RCM).

Telephone interview with a second MA on 05/21/20 at 3:20pm revealed she had not seen any treatments for bed bugs at the facility in the last 2 - 3 months.

Telephone interview with a third MA on 06/01/20 at 1:37pm revealed:
-The resident in room #218 told her there were bed bugs in his room.
-She had seen bed bugs in room #218 in the corner of the mattress.
-She saw one in resident room #218 in mid-May and the bed bug was on the resident's pillow.
-She could not tell if there was new bed bug activity because the bedbug stains came back after the area cleaned had dried.
-The old mattress in resident room #218 was thrown away, and the resident now had a blue mattress.
-She thought the old mattress was recently thrown away either on the 28th or 29th of the month because she was off and when she returned the whole bed was gone.
-There were two beds in resident room #218 and both beds had bed bugs on them.
-The resident was not sleeping on the bed.
-The previous maintenance man told her to "look at the bed bugs on the bed in the middle of the day".
-She went in resident room #218 to look and saw

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bed bugs on the bed. This happened at the beginning of May 2020.
-The resident was not moved out of the room during this time.
-The room was treated that day by the housekeeper who sprayed the room with "pure alcohol" after the MA told the housekeeper about seeing the bed bugs in resident room #218.
-She knew the housekeeper sprayed the room with alcohol because "they tell us it's alcohol".
-It had "not been too long ago" that someone had come to the facility and sprayed.

Telephone interview with a fourth MA on 06/02/20 at 12:25pm revealed:
-The staff reported live bed bugs in room 218/bed multiple times for the last 2-3 months.
-Staff reported seeing bed bugs in the resident's bed and crawling in his linen.
-The MA has not seen an exterminator in the facility treating room 218 for bed beg nor had he received any reports from staff of bed bug treatments.
-A PCA reported recently (about 2 weeks ago) that she found bed bugs crawling on the resident in room 218 and a red spot on the resident's arm where she saw a bed bug.
-The MA did not check the resident's skin when staff reported bed bugs in his room, nor did he check the resident's bed/room for live bed bugs.
-The PCAs stripped the resident's bed and placed the linen in the dryer on high heat for about 30 minutes and washed the linen before placing back on the resident's bed.
-The MA did not report bed bugs to the RCM or the Administrator and was not sure if they knew there were bed bugs in the resident's room/bed.

Telephone interview with the RCM on 06/02/20 at 10:15pm revealed:

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-There was bed bug activity in room 218 "on and off' for a while but got "bad" in the last 2-3 months.
-About 2 weeks ago, a PCA informed the RCD of live bed bugs in the bed in room 218 and blood stains on the resident's sheets.
-She instructed the PCA to strip the bed, place the linen in the dryer, wash the linen, and report the bed bugs to the housekeeper manager.
-The RCD reported the bed bug activity to the former Administrator, but the rooms were not treated for bed bugs by an exterminator.
-She also reported bed bug activity to the current Administrator (but did not remember the date).
-An exterminator came to the facility recently and checked room 218 but she did not know what he did.
-Last year when room 218 was treated for bed bugs, the resident was moved out of his room for a few hours.

Review of the facility bed bug protocol revealed the protocol included the following:
-Suspected rooms must be cleaned thoroughly.
-Beds must be taken apart and every crack and crevice vacuumed and cleaned thoroughtly with one cup of white vinegar to one gallon warm water solution and isolated until pest control can treat.

Telephone interview with the Housekeeping Manager on 05/27/20 at 11:35am revealed:
-Housekeeping staff were responsible for managing pest control.
-There had been a "room or two, 218 and 401 [with], bed bugs".
-There were bed bugs about two weeks ago.
-A man came to the facility to spray [company named] both of those rooms.
-The facility's process for pest management used

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by housekeeping was housekeeping stripped and sprayed the beds, bagged the resident clothes, sent the clothing to laundry for dry heating for 30 - 40 minutes, laundry washed the clothes and sent them back to the resident.
-The resident rooms were sprayed with a solution [named] and the resident stayed out of the room for four hours.
-She had been going back to the rooms each day checking for bed bugs.
-She had not made it down to room 218 today to check for bed bugs.
-A pest control company had come to the facility and sprayed the rooms.

Telephone interview with the Housekeeper Supervisor on 06/02/20 at 11:30am revealed:
-She had not seen in bed bugs in rooms 218 and room 401 in 2 or 3 weeks.
-When she observed bed bugs in the residents' room, she sprayed the room, the mattress and bed frame with Sterilight which was "like an alcohol base" solution that she used to kill bed bugs.
-Three weeks ago, the resident in room 218 asked her to check his bed for bed bugs because he found a bed bug in his bed.
-When she checked, she only found one bed bug that "looked" dead, but she sprayed the bed.
-She reported the bed beg activity to the Administrator who stated the exterminator would be at the facility in 3-4 weeks and he would inspect the rooms.
-The exterminator inspected room 218 over a week ago and informed the Administrator he would be back to the facility in 2 weeks to treat the resident's room for bed bugs.
-Room 218 had not been treated for bed bugs since last year (2019).
-At that time the resident was moved out of the

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room and the room was treated for bed bugs and the resident remained out of the room for six hours.
-She did not know if the resident in room 218 had sustained bed bug bites.

Review of pest control invoices for the facility revealed:
-On 12/05/19, a pest control company treated rooms 204, 207, 213, 220, 401, and 403 for bed bugs.
-On 05/21/20, a second pest control company inspected rooms 107, 218, 401 and 403 for bed bugs.
-On 06/02/20, the second pest control company inspected rooms 218 and 401 for bed bugs, and treated room 218 per maintenance request for bed bugs.

Review of a pest control invoice from a second company dated 05/21/20 revealed:
-Room #218 had bed bugs in the adjustable bed and possibly in motorized wheelchair.
-Room #401 had bed bugs in bed next to window and possibly in recliner also wants it heat treated.
-Room #403 - could prospect to good with patients in bed.
-Room #107 - none.

Telephone interview with the manager for the first pest control company on 05/26/20 at 4:15pm revealed:
-The pest control company was last at the facility for bed bug treatment on 12/05/19 and treated rooms 204, 207, 213, 220, 401, and 403.
-If the rooms were treated for bed bugs, there was active bed bugs.
-Some rooms were treated with heat and chemical powder.
-The pest control company did not have a

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contract with the facility and was no longer doing business at the facility.
-She did not see where room #218 was treated.
-The pest control company charged by the room.
-It would be on the invoice if room 218 had been treated.

Telephone interview with the Vice President of Logistics for the facility corporation on 05/27/20 at 12:42pm revealed:
-The facility was under contract with a pest control company and was on every other month schedule for basic pest control.
-The pest control company had been to the facility once or twice and as recent as last week for a bed bug inspection.
-He did not know the exact date of contact about the bed bugs in the facility but thought it may have been 05/20/20

Telephone interview with the Senior Sales Inspector from the second named pest control company on 06/01/20 at 3:00pm revealed:
-The facility was on a bi-monthly contract for general pest control treatment which included roaches, ants, silverfish, spiders, paper wasps, mice and rats.
-The pest control company started providing services to the facility corporation in March 2020.
-If the facility saw bedbugs, the facility staff would call their contact at their corporate office who called the pest control company for an inspection to be conducted.
-An inspection included using a flashlight to look underneath wheelchairs, recliners, take sheets off beds and check corners of beds and box springs, and check any tables in the rooms identified for inspection.
-If active bed bugs were found at the inspection a contract was drawn up.

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D 079	Continued From page 13 -The bed bug inspector usually wrote their findings on the invoice and if there were findings of active infestation the inspector would let the facility Administrstor know so they could remove the furniture where the bed bugs were found. -Findings of an active infestation may not be written on the invoice. -A contract for bed bug treatment was a "stand alone" contract and treatment was not done without a bed bug contract. -A pest control technician would go to the facility when available and the pest control company tried to provide services within 24 hours. -The facility was inspected for bed bugs on 05/21/20. -The pest control company would be going to the facility on 06/02/20 to treat for bed bugs in room #'s 218 and 401. Telephone interview with the pest control Inspector of the second company on 06/02/20 at 12:40pm revealed: -He was at the facility to check rooms #218 and #401 for bed bugs and roaches on 06/02/20. -He did not find any bed bugs or roaches. -There was bed bug "old fecal matter" on the top right corner of the bed to the left and closest to the window in room 401. -He did not know how many times the facility had been treated for bed bugs and this was his first time at the facility. -A bed bug inspection entailed taking the mattress off bed, unzipping the mattress cover so the foam mattress could be seen, looking at the box spring, curtains, behind the baseboard, dressers, corners, bedrails, bedframes, and any area that could be accessed without damaging anything. -He inspected the rooms today. -Room #218 did not have a box spring.	D 079		

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D 079	Continued From page 14 -He reported to the Administrator his findings and provided the facility with a copy of the work order ticket that included his findings. -He did not know who or when the request for the bed bug treatment was called to the pest control company. Telephone interview with the Administrator on 06/05/20 at 11:45am revealed: -The facility staff checked rooms reported to have bed bug activity constantly. -The bed bugs could have come from staff. -The residentin room #218 had an electric wheelchair brought in by family that had to be removed. When the current wheelchair came to the facility it was treated in heat and sprayed before coming in the facility. -She was responsible for calling the corporate office to arrange for pest control treatments for bed bugs. -She did not remember the date the corporate office was contacted about the bed bugs in resident room #218. -She would expect the pest control company to come to the facility within 5 - 7 days. _____ The facility failed to maintain an environment free of hazards by not reporting bed bug activity, and properly treating and delaying treatment of bed bugs. The resident in room #218 had continued complaints of bed bugs in his room, bed bug bites, and staff reports of bed bugs seen in the resident's room.. The failure of the facility was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/20 for this violation.	D 079		

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D 079	Continued From page 15 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 23, 2020.	D 079		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 3 of 6 sampled staff (Staff C, Staff D, and Staff F) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire, in accordance with G.S. 131E-256. The findings are: 1. Review of Staff C, personal care aide's (PCA), personnel record revealed: -Staff C was hired on 05/31/17. -There was no documentation of a Health Care Personnel Registry check (HCPR) being completed upon hire. -There was documentation a HCPR check was completed on 05/08/19. -There were no findings on Staff C's HCPR that was completed on 05/08/19. Refer to the telephone interview with the Administrator on 06/05/20 at 11:36am.	D 137		

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D 137	Continued From page 16 2. Review of Staff D, personal care aide's (PCA), personnel record revealed: -Staff D was hired on 03/19/19. -There was no documentation a Health Care Personnel Registry check (HCPR) being completed upon hire. -There was documentation a HCPR check was completed on 01/31/20. -There were no findings on Staff D's HCPR that was completed on 01/31/20. Refer to the telephone interview with the Administrator on 06/05/20 at 11:36am. 3. Review of Staff F, medication aide (MA), personnel record revealed: -Staff F was hired on 04/05/18. -There was no documentation a Health Care Personnel Registry check (HCPR) was completed upon hire. -There was documentation a HCPR check was completed on 07/24/19. -There were no findings on Staff F's HCPR that was completed on 07/24/19. Refer to telephone interview with the Administrator on 06/05/20 at 11:36am. _____ Telephone interview with the Administrator on 06/05/20 at 11:36am revealed: -HCPR checks were supposed to be completed before staff's first day of employment. -The Business Office Manager was responsible to complete HCPR checks after the criminal background checks were done. -This was their corporate process.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications	D 139		

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D 139	Continued From page 17 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 6 sampled staff (Staff F) had a statewide criminal background check completed upon hire. The findings are: Review of Staff F's, Supervisor (S)/Medication Aide (MA), personnel record revealed: -Staff F was hired on 04/15/18. -There was documentation of a statewide criminal background check completed on 08/07/19. Telephone interview with the Administrator on 06/05/20 at 11:36am revealed: -Criminal background checks were sent to corporate office by the Business Office Manager. -Criminal background checks for new hires were supposed to be completed before Health Care Personnel Registry checks were completed and before the first day of employment for new staff. -She received emails from their corporate office regarding new hire's criminal background approval results. -This was their corporate process.	D 139		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a	D 255		

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D 255	Continued From page 18 significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	D 255		

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This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure an assessment was completed within 10 days following a significant change for 2 of 12 sampled residents for a resident who developed a new stage 2 pressure ulcer (#4) and a resident with mobility status changes (#9).

1. Review of Resident #4's FL2 dated 07/16/19 revealed:
-Diagnoses included Alzheimer's disease, bradycardia, hypertension, diabetes mellitus (DM), and coronary artery disease.
-The resident was ambulatory, wandered, was constantly disoriented, and intermittently incontinent of bowel and bladder.
-There was a medication section with documentation "see signed physician orders".

Requests of the facility for Resident #4's signed physicians orders on 05/13/20, 05/14/20, 05/19/20, and 05/21/19 were not provided prior to survey exit.

Review of Resident #4's Special Care Unit (SCU) Resident Profile and Care Plan Update Form dated 06/12/19 revealed Resident #4 had a care plan review due to a significant change.

Requests of the facility for additional Assessments and Care Plans for Resident #4 on 05/13/20, 05/14/20, and 05/21/20 were not provided prior to survey exit.

Review of Resident #4's Quarterly Care Plan review dated 11/07/19 revealed:
-The resident's assessed changes and

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interventions for ambulation, transfers, toileting, grooming, dressing, and bathing were documented as "no changes"
-The Quarterly Care Plan was completed by the Memory Care Manager (MCM).

Review of Resident #4's Primary Care Provider (PCP) visit notes dated 08/07/19 revealed:
-The resident was examined in bed, nonverbal, and would not follow commands.
-The resident had cognitive impairment and was unable to communicate effectively.
-The reason for the visit was the resident had a wound on the bony area of the right hip.
-The resident had a diagnosis of DM, Alzheimer's disease, and failure to thrive.
-The resident was on Metformin (an oral diabetic medication used to control the blood sugar) and Insulin (an injection medication used to lower blood sugar).
-The resident had a 4-centimeter (cm) x 2.5cm stage 2 pressure ulcer over the right hip bony prominence.
-Home health (HH) nursing was to provide wound care.
-The resident was to have frequent position changes.
-Pressure over the wound area was to be avoided.
-The facility was to provide a safe and secure area for the resident.
-The facility was to continue to assist with Activities of Daily Living (ADLs) as needed.
-The resident required staff assistance with bathing, dressing, transferring, and toileting.
-The resident required a wheelchair for mobility.

Review of Resident #4's progress notes from 08/01/19 revealed:
-On 08/01/19 at 10:02pm there was

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documentation by a medication aide (MA) the resident had a "sore on right hip will continue to monitor".
-There was no documentation a significant change care plan was completed.

Telephone interview with a MA on 05/13/20 at 1:05pm revealed it was facility policy when resident status changes were noted the PCP and family would be notified.

Telephone interview with Resident #4's previous PCP on 05/26/20 at 1:40pm revealed:
-Resident #4 was diagnosed with a stage 2 pressure ulcer of the right hip on 08/07/19.
-She was not informed of Resident #4's wound until 08/07/19.
-She expected to have been notified of Resident #4's wound when discovered on 08/01/19 because it was a change in the resident's condition.
-She would have ordered a barrier cream for the resident on 08/01/19 until evaluated that day if it was a Stage 1 wound to the right hip.
-She would have ordered HH for the residents right hip wound on 08/01/19.
-The resident could have developed an infection to the right hip pressure ulcer, increase in pain, worsening of the wound, and/or bone infection with deepening or worsening wound.

Telephone interview with the MCM on 05/28/20 at 9:07am revealed:
-A significant change was any change with the resident that was not normal for the resident.
-A significant change would indicate a need for an updated care plan.
-The PCP would be notified of the significant change.

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Telephone interview with the Administrator on 05/29/20 at 1:46pm revealed:
-A significant change was anything that was not normal for the resident such as a new wound.
-All staff should be able to recognize a significant change.
-There was no scheduled in-service on significant changes.
-She did not know the last time a significant change in-service was provided.
-The PCA would notify the MA if they noted a significant change, the MA would tell the MCM, the MCM would assess the resident and the MA would notify the PCP.
-If the MCM was not available the MA would tell the Administrator and the Administrator would assess the resident.
-The resident assessment should occur the day the significant change occurred.
-The significant change care plan would be updated within 24 hours.
-A new wound would signify the need for an updated care plan.
-She did not know anything about Resident #4 because she started employment with the facility in April 2020.
-She did not know if a process was in place in August 2019 to ensure residents who had significant changes were assessed.
-She expected a significant change care plan to have been done when Resident #4 developed the right hip wound by the MCM.
-There was no reason a significant change care plan was not done.

A second telephone interview with the MCM on 05/29/20 at 3:02pm revealed:
-A new wound was considered a significant change in a resident.
-Any staff would be able to recognize a significant

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change.
-When a significant change was noted the MCM would be notified.
-The MCM would assess the resident, update the care plan, and notify the PCP by telephone, text message, or email.
-The resident would be assessed, and care plan updated when the significant change occurred.
-If she was not at the facility when the significant change occurred the resident would be assessed on her return to the facility.
-She was available to update care plans on weekends and holidays.
-Provider notification of the significant change would be documented in the resident's progress notes.
-Significant change care plan documentation would not be documented in the progress notes.
-A significant change note would be documented electronically in the "current events" section that were displayed in the progress notes.
-Resident #4's wound was a significant change.
-A significant change care plan should have been done because the resident had a change in care.
-She was not informed of Resident #4's wound.
-She would have been responsible to do the significant change care plan.
-She did not know why she did not do a significant change care plan when the PCP gave orders for home health because she would have reviewed the orders.

Review of the "events" section of Resident #4's progress notes from 06/11/19 to 11/27/19 revealed there was no documentation of a significant change care plan being done.

A second telephone interview with the Administrator on 06/05/20 at 8:41am revealed:
-She believed there was no facility policy

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regarding significant changes.
-The significant change regulation states the care plan was to be updated and the PCP notified.
-A pressure ulcer or skin breakdown were examples of a significant change.
-A care plan must be updated within ten days of the significant change.
-Care plans were updated electronically and sent to the PCP to sign then placed in the resident's record.
-If care plans were not updated at the time of change staff communication would need to take place to know what resident care to provide.

Refer to the telephone interview with the MCM on 06/04/20 at 3:47pm.

2. Review of Resident #9's current FL-2 dated 08/06/19 revealed:
-Diagnoses included dementia, fracture of left femur, falls, and muscle weakness.
-The resident was intermittently disoriented and was semi-ambulatory with a walker.
-The resident's recommended level of care was a special care unit (SCU).

Review of Resident #9's Assessment and Care Plan dated 08/13/19 revealed:
-There was no documentation regarding the resident's orientation level.
-There was documentation in the Social/Mental Health History section the resident was admitted to the SCU and had an order from the primary care provider (PCP) for the resident to have access to the Assisted Living (AL) area as he pleased, ate his meals on the AL side and only slept in the SCU.
-The resident was ambulatory with the use of a walker.

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-The resident was continent of his bowels and bladder.
-The resident required limited staff assistance with ambulation, dressing and transferring.

Telephone interview with Resident #9's family member on 05/27/20 at 11:57am revealed:
-The resident had drastically changed in December 2019.
-The resident's memory had changed, the resident fell a lot.
-When the resident decided to "get up and go, he goes", however, when he realized he could not walk without his walker, would turn around and fall.

Telephone interview with the Area Rehab Manager with Resident #9's Physical Therapy provider on 06/02/20 at 9:06am revealed:
-The resident had received therapy services from 09/10/19 - 04/17/20.
-The resident was discharged on 04/17/20 due to increased pain and was re-admitted to therapy services on 04/22/20.
-On 04/17/20, the resident was a stand by contact guard assistance which meant hands on the resident was required but no physical assistance while the resident was using a front wheeled walker when ambulating.
-The resident had poor safety awareness and lost his balance to one side or the other.
-On 04/22/20, the resident was minimal assistance with mobility meaning the caregiver would be required to do 25% of the work and hands on physical assistance with a two wheeled walker and the resident was moderate assistance with the use of his wheelchair mobility meaning the caregiver did 50% of the work.
-The resident's prior level of function was supervision assistance for safety meaning no

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hands-on assistance for safety and the resident had an abnormality of posture leaning forward and flexing his posture when walking.

Telephone interview with the Memory Care Manager (MCM) on 05/28/20 at 3:36pm revealed:
-When Resident #9 was admitted to the SCU last year the resident was able to do his own care independently, then started declining and needed more assistance with his activities of daily living (ADL).
-She estimated the resident had a significant change in his ability to perform his own ADLs approximately one month ago.
-Resident #9's care plan had been updated since 08/2019 and she would look though the information that was faxed to follow up to ensure the new care plan was included in the fax sent.
-The resident had falls and when he stood up without assistance, he would fall.

Telephone interview with a medication aide (MA) on 06/01/20 at 12:50pm revealed Resident #9 was independent when he was admitted to the SCU (the resident was admitted to the SCU 06/06/19) but started declining physically and mentally, requiring more assistance with his activities of daily living needs.

Telephone interview with a second MA on 06/04/20 at 11:49am revealed:
-Resident #9 was independent when he was first admitted to the facility.
-Resident #9 used a walker when ambulating, but now, the resident was not stable when he walked, his legs were wobbly and could fall at any time.

Telephone interview with a third MA on 06/04/20 at 5:14pm revealed:
-Resident #9 was a fall risk.

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D 255	Continued From page 27 -Resident #9 was checked by staff every "30 minutes", "every 45 minutes', and "every hour" because Resident #9 was always falling. -Staff had to work with these residents and the residents' care plans needed changing because the residents' level of care was changing. -Resident #9's level of care just recently changed around January 2020 - February 2020; the resident was independent but now having difficulty with forgetfulness and having problems walking. -When Resident #9's level of care changed his care, plan needed to change. Telephone interview with the MCM on 06/04/20 at 3:47pm revealed she was not sure why Resident #9 had not had an updated plan of care after his care needs changed. A second request for Resident #9's most recent Assessment and Care plan was done on 05/29/20 however not provided by the date of the exit. Refer to the telephone interview with the SCC on 06/04/20 at 3:47pm. _____ Telephone interview with the Special Care Coordinator (SCC) on 06/04/20 at 3:47pm revealed: -She was responsible to update the residents' care plan when the resident had a significant change. -She would be responsible to make the changes to the residents' care plan within 48 hours after becoming aware of the significant change.	D 255		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

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D 269	Continued From page 28 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure staff provided personal care for 2 of 12 sampled residents regarding a resident who required every two-hour repositioning (#4) and daily mouth care including care for upper and lower dentures (#1). The findings are: 1. Review of Resident #4's FL2 dated 07/16/19 revealed: -Diagnoses included Alzheimer's, bradycardia, hypertension, diabetes mellitus (DM), and coronary artery disease. -The resident had wandering behaviors, was ambulatory, constantly disoriented, and intermittently incontinent of bowel and bladder. -There was a medication section with documentation "see signed physician orders". Review of Resident #4's Assessments and Care	D 269		

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Plan dated 01/14/20 revealed:
-The resident wandered and was oriented.
-The resident was incontinent of bowel and bladder.
-The resident required extensive assistance with bathing and dressing.
-The resident required limited assistance with ambulation and toileting hygiene
-The resident required supervision with transfers.
-The resident's skin was normal.

Requests of the facility for additional Assessments and Care Plans for Resident #4 on 05/13/20, 05/14/20, and 05/21/20 were not provided prior to survey exit.

Review of Resident #4's progress notes from 06/11/19 to 11/27/19 revealed:
-On 07/23/19 at 10:11pm there was documentation by a medication aide (MA) the resident " ...stayed in bed most of the evening ...will continue to monitor".
-On 08/01/20 at 10:02pm there was documentation by the same MA the resident had a "sore on right hip will continue to monitor".
-There was no documentation the resident was repositioned every two hours.

Review of Resident #4's Primary Care Provider (PCP) visit notes dated 08/07/19 revealed:
-The resident was examined in bed, nonverbal, and would not follow commands.
-The resident had cognitive impairment and was unable to communicate effectively.
-The reason for the visit was the resident had a wound on the bony area of the right hip.
-The resident had a diagnosis of DM, Alzheimer's disease, and failure to thrive.
-The resident had a 4-centimeter (cm) x 2.5cm stage 2 pressure ulcer over the right hip bony

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prominence.
-Home health (HH) nursing was ordered for wound care.

Review of Resident #4's Point of Care log for November 2019 revealed there was no documentation regarding repositioning the resident.

Requests for Resident #4's additional Point of Care logs on 05/13/20, 05/14/20, and 05/21/20 were not provided by survey exit.

Telephone interview with a MA on 05/21/20 at 11:07am revealed:
-She was taught the care residents needed by classes provided by her previous employer, online training, and classes provided by the facility.
-She did not know the classes that were provided by the facility.
-When asked how she was taught in the last facility offered class to know what care to provide the residents she responded, "I can't answer that".
-She would look at the care documented as being provided on the residents Point of Care log to determine the care needed.
-She did not know how to provide care for the residents.
-She would observe the residents to determine what care they needed.
-She did not remember if she provided repositioning for Resident #4.
-Every two-hour repositioning would be documented in the resident progress notes if provided.

Telephone interview with Resident #4's previous PCP on 05/26/20 at 1:40pm revealed:

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-On 07/29/19 the resident could not self-position/turn independently.
-The resident was bed and wheelchair bound.
-The resident was demented, could not communicate, could not follow commands, weighed 96 pounds (lbs), did not have fatty tissue to protect bony prominences.
-On 08/07/19, she evaluated the resident for a wound to the right hip.
-The residents wound was a stage 2 pressure ulcer.
-The resident required every two-hour repositioning by staff because the resident could not reposition herself independently.
-She expected staff to have provided every two-hour position change for the resident.
-Pressure ulcers could develop within hours.
-Increased pressure and infrequent position changes would contribute to pressure ulcers.
-The resident could have developed an infection to the right hip pressure ulcer, increase in pain, worsening of the wound, and/or bone infection with deepening or worsening wound.

Telephone interview with another previous PCP for Resident #4 on 05/27/20 at 8:45am revealed:
-On the resident's 07/23/19 evaluation the resident had progressive Alzheimer's Dementia and increased weakness, could not turn and/or reposition independently, was non-ambulatory, bed/wheelchair bound, and total care for ADLs.
-The resident was a "very frail lady prone to developing pressure ulcers".
-Resident #4 required total care from staff.
-It was an expected standard of care to reposition total care residents every two hours.
-Facility staff did not need an order for every two-hour repositioning for total care residents.
-He expected Resident #4 to have been repositioned every two hours to prevent pressure

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ulcers.

Telephone interview with Resident #4's home health nurse on 05/27/20 at 2:00pm revealed:
-Resident #4's pressure ulcer to the right hip developed from not repositioning the resident at the least of every two hours.
-Pressure ulcers could be avoided by repositioning the resident every two hours and keeping the resident clean and dry from urine and other moisture.
-Repositioning every two hours keeps pressure off areas that would cause skin breakdown.
-Keeping a resident in the same position more than two hours or being wet would cause skin breakdown.
-Lack of incontinent care would contribute to skin break down and pressure ulcers because of the hip area being wet.
-Staff were educated at every visit to have Resident #4 stand up from the wheelchair often, reposition every two hours, and to keep her clean and dry.

Telephone interview with a personal care aide (PCA) on 05/27/20 at 3:07pm revealed:
-Resident #4 was placed in a wheelchair and parked for in the hallway for observation.
-Resident #4 would stay in the wheelchair located in the hallway for a "couple of hours".
-Resident #4 would let staff know when she wanted to go back to bed.

Telephone interview with the Memory Care Manager (MCM) on 05/28/20 at 9:07am revealed:
-There was no specific frequency to reposition total care residents.
-An order was needed to reposition a resident every two hours.
-Resident repositioning was not documented.

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-All residents who required repositioning every two hours had a "turn sheet" on their door.
-The turn sheets were used to prompt staff to turn the residents.
-The turn sheets were initialed and the time and position the residents were placed in documented.
-The turn sheets were kept for one to three years.
-Repositioning would prevent pressure ulcers.
-Resident #4 had progressive dementia and could not follow commands.
-Resident #4 was total care "towards the end" of 2019.
-She could not remember if Resident #4 required repositioning.
-She could not remember if Resident #4 had turn sheets.
-If Resident #4 had turn sheets they would be stored in the "barn".
-She would look for Resident #4's turn sheets to submit.
-Resident #4 would be placed in a wheelchair at 5:00am and taken to the nurse's station.
-Resident #4 would not sit at the nurse's station "all day".
-She expected Resident #4 to have been repositioned every two hours because she was total care.
-Staff would look at the Point of Care logs to determine what personal care to provide for residents.
-Staff did not follow the care plans to determine resident care needed because the care plans were kept in the resident records.
-Staff could look at the care plans in the resident's records if they wanted to.
-She did not know what education staff had been given regarding care plans or who provided the staff education.
-She did not know who was responsible for

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D 269	Continued From page 34 educating staff regarding care plans. A second telephone interview with the MCM on 05/29/20 at 3:02pm revealed: -If staff provided care for a resident other than what was on the Point Care log, they would tell her because she would need to update the residents care plan. -She could not locate Resident #4's every two hour turn sheets. -Resident #4 was repositioned every two hours when in bed. -Resident #4's wound was on the bony part of her hip. -Residents who were wheelchair dependent could not be repositioned while in the wheelchairs. -She had never seen staff reposition a wheelchair bound resident. -She did not know how a wheelchair resident would be repositioned in the wheelchair. -She did not remember if training had been provided on how to reposition residents who required wheelchairs. -A normal day for Resident #4 was to stay in the wheelchair from 7:30am for breakfast until 10:00am for snack then placed in bed, in the wheelchair at 12:30pm for lunch then back to bed at 4:30pm after dinner by second shift. -If a resident was nodding and sleeping in the wheelchair the resident would be placed back to bed. Telephone interview with a second PCA on 05/29/20 at 3:55pm revealed: -She had been employed at the facility for three months. -She had watched videos at the facility regarding every two-hour repositioning. -She had not received direct education from staff regarding repositioning total care residents.	D 269		

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-She was not sure how to reposition residents who were in wheelchairs.

Telephone interview with the Administrator on 06/05/20 at 3:49pm revealed:
-She began employment with the facility in April 2020.
-She did not know anything regarding Resident #4.
-She expected residents to receive personal care immediately and as needed.
-An order was not needed to reposition residents.

Telephone interview with a second MA on 05/27/20 at 11:20am revealed:
-The MA did not know anything about Resident #4 because she was recently employed at the facility.
-Bed and wheelchair bound residents were total care.
-Bed and wheelchair bound residents required two person staff assistance for bathing, toileting, and repositioning every two hours.
-Repositioning every two hours was documented on the electronic Point of Care log for residents that required every two-hour repositioning.
-An order was not needed to reposition a resident every two hours.

Confidential interview with staff revealed:
-Resident #4 was ambulatory in February 2019.
-Toward the end of 2019, Resident #4 progressed to a wheelchair and bed bound status.
-Resident #4 was placed in a wheelchair behind the nurse's station before first shift would start.

Confidential interview with a second staff revealed:
-Resident #4 was placed in a wheelchair and taken to the nurse's desk before first shift staff

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would arrive.
-Resident #4 could not reposition herself independently.
-The staff member would turn Resident #4 every two hours.
-There was nowhere to document every two-hour repositioning.
-She thought every two-hour repositioning would have been documented on the residents Point of Care log.
2. Review of Resident #1's current FL-2 dated 12/23/19 revealed diagnoses included dementia, atrial fibrillation, congestive heart failure, coronary artery disease, cardiomyopathy, hypertension, diabetes mellitus and Parkinson's disease.

Review of Resident #1's current care plan dated 12/10/20 revealed there was no documentation for presence and care of dentures and/or oral care for Resident #1.

Review of Resident #1's special care unit (SCU) resident profile dated 12/27/19 revealed there was no documentation for presence and care of dentures and/or oral care for Resident #1.

Review of Resident #1's current special care unit quarterly profile dated 04/18/20 revealed there was no documentation for presence and care of dentures and/or oral care for Resident #1.

Review of Resident #1's point of care history dated 04/01/20 revealed there was documentation mouth/oral/denture care was provided daily 04/01/20 and twice daily on 04/15/20, 04/20/20, 04/23/20 and 04/28/20.

Telephone interview with Resident #1's responsible person (RP) on 05/14/20 at 1:54pm revealed:

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-Resident #1 wore dentures.
-Before COVID 19, he had to clean Resident #1's dentures because the staff did not remove and clean the resident's dentures.
-The dentures were in terrible condition when he saw them.
-He had not been able to visit since mid-March 2020, so he did not what kind of condition Resident #1 was in.

Second telephone interview with Resident #1's RP on 05/28/20 at 4:50pm revealed:
-He last cleaned Resident #1's dentures the Sunday before the state of emergency was announced (03/08/20).
-Resident #1 had her upper denture plate in her mouth when he last cleaned them; the bottom plate had been lost at the facility.

Telephone interview with a personal care aide (PCA) on 05/21/20 at 3:45pm revealed:
-She would have to assist Resident #1 with eating because the resident would not sit down to eat.
-She assisted Resident #1 with brushing her teeth after each meal.
-Resident #1 had her own natural teeth, the resident did not wear dentures.

Telephone interview with a second PCA on 06/02/20 at 5:04pm revealed:
-She worked as a 1st shift PCA on the special care unit (SCU) since October 2019.
-Resident #1 one had top teeth; she did not know if they were the resident's natural teeth or dentures.
-She documented providing mouth care 9 days for Resident #1 on the April 2020 point of care history.
-Mouth care marked as done meant the resident's teeth were brushed when the resident

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was dressed for the day.
-She had not seen any dentures for the residents on the SCU since she started working at the facility.
-She was trained as a nursing assistant to remove dentures and place them in a cup with water and denture cleaning tablet, but she had not done that for any resident since working at the facility.

Telephone interview with a medication aide (MA) on 06/04/20 at 11:49am revealed:
-Resident #1 had natural teeth.
-Dentures were stored in a plastic cup labeled with the resident's name in the medication room on the SCU.
-She had not come across any residents with dentures at the facility.
-Most residents had their own teeth.
-There were some residents who had dentures but did not wear them.

Telephone interview with the Memory Care Manager (MCM) on 05/22/20 at 3:36pm revealed:
-She was responsible for completing and updating resident care plans and communicating resident needs verbally to staff.
-Staff were also able to see what care and assistance a resident needed on the activities of daily living (ADL) tasks on the computer system.
-Resident #1 wore dentures; staff were trained to provide oral care for dentures and natural teeth.
-Staff were expected to provide oral care daily at the time the resident was bathed or showered.

Second telephone interview with the MCM on 06/04/2020 at 3:48pm revealed:
-Resident #1's lower dentures were in a labeled cup in the medication room on the SCU; she knew the dentures were there because she had

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D 269	Continued From page 39 put there. -Resident #1 would frequently remove the lower dentures and did not eat with the lower dentures in so she put them in the medication room. Telephone interview with the Administrator on 05/28/20 at 9:02am revealed: -The MCM was responsible for completing care plans for residents on admission to the facility and quarterly there after in the SCU. -The MCM was responsible for updating resident care plans whenever changes occurred or interventions were added. -Staff verbally communicated with each other any changes in what needed to be done for residents. -She did not know if Resident #1 wore dentures. -Staff were expected to assist residents with oral care every morning and every night. -Staff were expected to remove dentures and clean them every night for residents who wore dentures. -She was not sure where dentures were kept for residents when they were not being worn. The facility failed to assure Resident #4 who had progressive dementia, could not follow commands, could not cognitively communicate, was wheelchair and bed bound, and total care was repositioned every two hours to prevent pressure ulcers causing the resident to develop a stage 2 pressure ulcer to the right hip placing the resident at risk for skin and bone infection and worsening wound. The failure of the facility was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/26/20 for this violation.	D 269		

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D 269	Continued From page 40 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 10, 2020.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 12 residents sampled (#1, #3, #9) with multiple falls resulting in serious physical injuries to include a facial laceration requiring sutures and an orbital wall fracture (#9); a resident who experienced increased weakness and unsteady gait resulting in 4 documented falls and an unknown number of undocumented falls for the month of May 2020 with extensive bruising to the resident's face, arms, chest, buttocks and thighs (#1), and resident who had increased weakness and unsteady gait who suffered multiple falls resulting in physical injuries including facial lacerations and bruising to his right shoulder (#3).	D 270		

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D 270	Continued From page 41 The findings are: Review of the facility's Fall Management Program revealed: -A fall assessment tool was completed for all residents admitted determining factors that may contribute to possible falls. -Staff would receive formal training on Fall Prevention Awareness. -Staff were reminded of fall prevention techniques during staff meetings. -Staff completed an Incident Report in its entirety for any falls. -The Executive Director and/or the Care Managers should determine any immediate interventions required, based on circumstances of the fall. -Staff were responsible for completing a 72 hour Follow Up on resident falls to investigate possible circumstances contributing to the fall and documents observations for the period of 72 hours after the fall. -72 hours after incident documentation included vital signs initially and every 72 hours, additional vital signs may be taken. -Assessment of possible risk/contribution factors for falls included where the resident fell, was the area cluttered, pathways, furniture, and if the fall was in bathroom remove any bath mats. Review of the facility's Accident/Falls/Emergency and Fire Safety Policy revealed: -An accident was an unexpected, unplanned event which may or may not cause harm. -When an accident or emergency occurred staff should remove the resident from immediate danger, if possible, send or call for help, evaluate the situation, call 911 or have someone else call, evaluate the resident, if injury is apparent or possible, do not move the resident, administer	D 270		

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first aid as appropriate, call and notify the residents physician and family, and if injury complete the Accident and Incident report.

Confidential telephone interview with a staff revealed:
-There were 2 personal care aides (PCAs) for the women's hall on the special care unit (SCU) and 27 residents.
-When the 2 PCAs were both assisting other residents, there was no staff to watch residents who fell frequently.

Telephone interview with a medication aide (MA) on 06/04/2020 at 11:49am revealed:
-The PCAs normally checked on residents every 2 hours at the most but usually every 30 minutes to an hour because there were so many falls.
-There were 5 residents on the SCU that staff had to watch for falls.
-Staff could meet the needs of the residents if there were 4 PCAs on the women's hall and at least 2 aides on the men's hall.
-There was one resident on the women's hall who needed one PCA exclusively for constant monitoring of that resident alone.

Telephone interview with a third MA on 06/05/2020 at 1:44pm revealed:
-There were a lot of falls that went unreported; staff had been told they would be written up if a resident fell on their shift.
-There was not enough staff to supervise all the residents; she told the Memory Care Manager (MCM) and Administrator all the time about the short staffing issues.

Telephone interview with the MCM on 05/28/2020 at 3:36pm revealed:
-Even with every 30 minute checks staff could not

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keep residents from falling so she told the staff "you just have to watch them."
-Staff had assignments on the SCU; there were two male residents on one assignment, a third male resident on a second assignment and a female resident that staff had to be kept with staff all the time.

Interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed all residents were on quarantine in their own rooms with no communal dining/activities.

Observations on the special care unit (SCU) on 05/26/2020 at 2:20pm revealed:
-Upon entering the SCU there was a front desk area at the center of one long hall.
-The fire doors to each hall (300 and 400 halls) were closed; residents and staff on the halls were not visible from the front desk area.

1. Review of Resident #9's current FL-2 dated 08/06/19 revealed:
-Diagnoses included dementia, fracture of left femur, falls, and muscle weakness.
-The resident was intermittently disoriented and was semi-ambulatory with a walker.
-The resident's recommended level of care was a SCU.

Review of Resident #9's current Assessment and Care Plan dated 08/13/19 revealed:
-There was no documentation regarding the resident's orientation level.
-The resident was ambulatory with the use of a walker.
-The resident required limited staff assistance with ambulation, dressing and transferring.

Review of Resident #9's Accident/Incident

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Reports for February 2020 revealed:
-The resident had a witnessed fall on 02/21/20 at 10:28am and 02/22/20 at 6:31am.
-The facility's Fall Prevention Program was initiated after each fall.

Telephone interview with the Memory Care Manager (MCM) on 05/28/20 at 3:36pm revealed the facility's 72 hour fall prevention program was initiated as a supervision intervention for Resident #9 after the resident's two falls in February 2020 which included taking the resident's vital signs each shift and monitoring for a change in his status and was "put down" to follow up with the PCP.

Review of an electronic progress note for Resident #9 on 03/02/20 at 6:46am revealed the resident had a bruise on his left hip, will let next shift know to monitor the area for any changes.

Review of an electronic progress note for Resident #9 on 03/02/20 at 2:35pm the resident was complaining of pain on the left side, seen by the primary care provider (PCP) and another x-ray was done.

Review of an Accident/Incident report dated 03/02/20 at 10:35pm for Resident #9 revealed:
-Resident #9 had an unwitnessed fall in the resident's bedroom with no injury.
-The resident was screaming upon entering his room, the resident did not know who the medication aide (MA) was or where he was. The resident's "arms drawed [sic] very tight, couldn't get him to wake completely up".
-Resident #9 was sent to the emergency department (ED).
-Resident #9's status after the ED/discharge diagnoses was documented as dementia.

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D 270	Continued From page 45 -The facility's Fall Prevention Program was initiated for Resident #9. Review of an ED visit notes for Resident #9 dated 03/02/20 revealed: -The reason for the visit was dementia. -The resident was diagnosed with fall and altered mental status. -The resident had an x-ray of both hips with "...degenerative changes ossific, a fragment overlying the left femoral neck likely avulsion from the greater trochanter", likely not new and long-standing. (Ossific fragments means an area changing into bone and avulsion is a fracture when tendon or ligament has pulled off pieces of the bone). Review of an Accident/Incident report dated 03/05/20 at 5:19am for Resident #9 revealed: -Resident #9 was observed sitting on the floor of the resident's room with no injuries and no complaints of pain. -Resident #9's PCP and family member were notified. -The resident was seen by the PCP. -There was no documentation the facility's Fall Prevention Program was initiated for Resident #9. Review of Resident #9's March electronic medication administration record (eMAR) revealed: -There was an entry to monitor status for 72 hours with a frequency every shift and special instructions to document progress notes daily with a start date of 03/02/20 and discontinued date on 03/05/20. -There was no documentation to initiate a fall prevention program for the residents documented fall when the resident was found on the floor on 03/05/20.	D 270		

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D 270	Continued From page 46 Review of a PCP's visit note for Resident #9 dated 03/09/20 revealed: -The resident had osteoarthritis of both hips. -The residents gait remained unstable causing falls, continued to use walker despite ongoing abnormal look of the left hip, the resident did not appear to be in any pain. -The recent x-ray did not show any acute findings of a fracture or dislocation, continue to monitor. Review of an electronic progress note for Resident #9 revealed on 04/03/20 at 4:10pm the resident's family member was contacted the resident was moved up closer (to the nurse's station) due to a change in status and needing more assistance. Telephone interview with the MCM on 05/28/20 at 3:36pm revealed: -Resident #9 was placed on the facility's 72 hour fall prevention program after the resident's falls in March 2020 and followed up with the PCP. -She was not sure what other supervision interventions were done for the resident but thought some medication changes were made. -She was not sure why the facility's 72 hour fall prevention program was not initiated as a supervision intervention for Resident #9 after the resident was observed sitting on the floor on of the resident's room 03/05/20. -Resident #9 was moved closer to the nurse's station the first of April because his room was at the end of the hall. Review of Accident/Incident Reports for Resident #9's witnessed falls for April 2020 revealed: -The resident had a witnessed fall on 04/08/20 at 8:14pm, on 04/11/20 at 11:05am and 04/20/20 at 4:23pm.	D 270		

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-The facility's Fall Prevention Program was initiated after the witnessed falls for Resident #9 to check vital signs for three days every shift and monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall and documentation to include any changes or no changes.
-There were no other instructions or documentation related to increased supervision.

Review of Resident #9's April 2020 eMAR revealed:
-There was an entry Fall: Initiate Fall Prevention Program with instructions to check vital signs for three days once a shift.
-On 04/10/20 during third shift, there was no documentation the resident's vital signs were checked and in the reason comments, there was an entry "other, cuff couldn't read measurements".

Review of an electronic progress note dated 04/11/20 for Resident #9 revealed:
-At 6:38am, the resident was "monitored".
-The resident had a bruise on left cheek, side of left knee and hip.
-There was no documentation of increased staff supervision monitoring checks.
-The resident had no complaints of pain at the time and staff would alert next shift.
-At 11:08am, the resident had a fall that was witnessed by a personal care aide (PCA) at 10:35am, the resident was not in any pain and the PCP was called .
-The staff was concerned the resident was leaning to the right from a previous fall and the staff called the resident's PCP's office again to make sure the resident was not injured from any previous falls that the resident had.
-At 2:38pm, the staff did not receive a return call

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from the resident's PCP office.
-The facility nurse was in the building and wanted staff to send the resident out to the hospital because the resident had an area on his left hip that was the size of a 'soft ball" and the resident was still in pain even after an as needed Tylenol was given.
-The resident was sent out to the hospital.

Review of an ED visit notes for Resident #9 dated 04/11/20 revealed:
-In the initial section of the report there was entry the resident "apparently fell yesterday" and according to emergency medical services the resident had been walking but had a large bruise on his hip.
-The patient denied any significant pain.
-The reason for the exam was fall yesterday, large hematoma.
-The resident had an x-ray of the left hip with an avulsion fracture that was unchanged when compared to the x-ray done 03/02/20.

Confidential telephone interview with a former staff revealed:
-There had been an incident in April 2020 when the staff returned to work and Resident #9 had a bruise on his face, leg and hip.
-The staff knew that Resident #9 did not have any facial bruising the day prior when the staff last saw Resident #9.
-The staff was concerned because a third shift personal care aide (PCA) had received a report from 2nd shift that the resident had fallen out of his chair on 2nd shift.
-The PCA was concerned because it was questionable if the fall was reported to the prior shift, second shift MA. There was not a third shift MA working on third shift for the PCA to report to concerning Resident #9 falling out of his chair.

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-The staff later that same day spoke with the MA that worked 2nd shift the day prior and was told the MA did not know anything about Resident #9 falling out of his chair.
-Residents were falling and it was not always reported because staff were told if a resident falls the MA and the PCA would be written up.

Review of an electronic progress note dated 04/11/20 at 6:52pm for Resident #9 revealed the resident was back from the hospital, the resident would be on 48 hour isolation, "..will continue to monitor".

Review of an Accident/Incident report dated 04/11/20 at 9:18pm for Resident #9 revealed:
-Resident #9 had an unwitnessed fall with an injury documented as a "bump" in the resident's bedroom.
-Resident #9 was not sent to the ED.
-Resident #9's PCP and family member were notified.
-In the evaluation section of the form there was an entry "follow up initiated" and to monitor status for 72 hours and chart progress notes daily.
-There was no other instructions or documentation related the frequency of staff monitoring for the resident's supervision.

Review of an electronic progress note for Resident #9 dated 04/11/20 at 9:29pm revealed:
-The resident fell again.
-Staff encouraged the resident to stay seated or in bed.
-The resident had a "bump on head".
-The resident's PCP was called, staff obtained the residents vitals every 2 hours and check on him every 15 minutes for the rest of the night.
-The residents vital signs were 158/84, pulse 88, temperature 98.6 and respirations 17.

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D 270	Continued From page 50 -The staff would continue to monitor. Review of an electronic progress note for Resident #9's electronic progress notes dated 04/11/20 at 10:42pm revealed: -Staff continued to monitor the resident. -The resident's vital signs were 176/106, 81, 98.9 and 18. -There was no documentation of increased supervision or the every 15 minute checks as ordered by the PCP. Review of Resident #9's April 2020 eMAR revealed: -There was an entry Fall: Initiate Fall Prevention Program with a frequency as every shift and instructions to check vital signs for three days. -There was an entry to monitor the resident status for 72 hours for bruising, change in mental/condition, pain or other injuries related to the fall every shift with special precautions to document any changes or no changes. -There was no documentation the resident was checked every 15 minutes for the for the rest of third shift on 04/11/20. -There were no documentation the resident's vital signs were checked every 2 hours for the for the rest of third shift on 04/11/20. -On 04/12/20 during third shift 04/12/20, there was no documentation the resident's vital signs were checked and the reason was documented as "other". Telephone interview with a second MA on 06/04/2020 at 1:12pm revealed when there was one MA for the facility the residents' vital signs did not get done. Telephone interview with the MA who documented the electronic progress note for	D 270		

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Resident # on 04/11/20 at 9:29pm and at 10:42pm on 06/04/20 at 11:49am revealed:
-Resident #9 was placed on isolation after returning to the facility from an ED visit on 04/11/20.
-The resident was in his room at the end of a hall and at that time the resident did not have a roommate.
-A PCA was assisting Resident #9 with incontinent care and stepped away to retrieve an item.
-Resident #9 was "determined" he was going to "still" walk, and he stood up and fell.
-A PCA was in the hallway most of the time sitting in a chair while Resident #9 was on isolation because staff knew Resident #9 would not stay seated while on 04/11/20.
-She called Resident #9's PCP or she could have called the "on call" provider, they "told us what to do and we did it".
-On 04/11/20 when she called Resident #9's PCP, she did not document who she had spoken with.
-The PCAs had assignments and knew to "tend to their residents".
-Resident #9 usually sat in his room in his "easy chair".
-Supervision checks were done by staff every 30 minutes to one hour "at the most".
-When she worked as a MA she done every 30 minute to one hour checks because Resident #9 and other named residents were having so many falls.

Telephone interview with the Area Rehab Manager with Resident #9's Physical Therapy provider on 06/02/20 at 9:06am revealed:
-The resident had been receiving therapy services from 09/10/19 - 04/17/20.
-The resident was discharged on 04/17/20 due to

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increased pain and was re-admitted to therapy services on 04/22/20.
-On 04/17/20, the resident was a "stand by contact guard assistance" which meant hands on the resident was required but no physical assistance while the resident was using a front wheeled walker when ambulating.
-The resident had poor safety awareness and lost his balance to one side or the other.
-On 04/22/20, the resident was minimal assistance with mobility meaning the caregiver would be required to do 25% of the work and hands on physical assistance with a two wheeled walker.
-The resident was moderate assistance with the use of his wheelchair mobility meaning the caregiver did 50% of the work.
-The resident's prior level of function was supervision assistance for safety meaning no hands-on assistance for safety and the resident had an abnormality of posture leaning forward and flexing his posture when walking.

Review of an electronic progress note for Resident #9 on 04/13/20 at 12:58pm revealed:
-The resident was seen by the PCP for a virtual visit.
-The PCP observed that the resident was not able to stand.
-The PCP was shown the bruising on the residents left hip where the resident stated he was having pain.
-The Memory Care Manager (MCM) told the PCP the resident was having extreme pain and the medication prescribed was being used as needed.
-The resident was not able to start physical therapy because he was not comfortable with standing.
-The PCP stated that she would order lab work.

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-The PCP wanted to try to keep the resident in bed and calm.
-The resident kept stating he had to go to different places.
-The resident was getting person, place and time confused.
-The MCM spoke with the family member and the wife suggested that the resident might need a wheelchair.

Review of an electronic progress for Resident #9 on 04/20/20 at 6:19am revealed:
-The resident was refusing to stay in bed.
-The resident was getting up and walking .
-The resident was placed in a wheelchair at the nurse's station so a close watch could be kept on the resident so he would not fall and reinjure his hip.

Review of an Accident/Incident report dated 04/27/20 at 2:38pm for Resident #9 revealed:
-Resident #9 had an unwitnessed fall, sitting on the floor beside his bed with no injury noted.
-Resident #9 was not sent to the ED.
-Resident #9's PCP and family member were notified.
-There was no documentation the facility's Fall Prevention Program was initiated for Resident #9 in the order section of the reported.
-There was no other instructions or documentation related the frequency of staff monitoring for the resident's supervision.

Review of Resident #9's electronic progress note dated 04/28/20 at 10:59pm revealed the resident was reminded that he must always get help and to use the call bell because the resident continued to get up and walk by self, would alert next shift and continue to monitor.

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D 270	Continued From page 54 Review of Resident #9's April 2020 eMAR revealed there was no documentation to initiate a fall prevention program for the resident's documented fall on 04/27/20. Telephone interview with the MCM on 05/28/20 at 3:36pm revealed: -She was not sure what interventions were implemented after Resident #9's falls in April, however, staff took turns watching the resident and another named resident and used redirection when the residents' attempted to get up independently but, this was not documented. -Staff had assignments, there was not one assigned staff or extra staff to watch Resident #9 and the other named residents that had a fall history, staff were responsible for all the residents on that assignment. -She told staff "y'all just got to watch them" and monitor the resident so they would not have any falls. -She could understand why Resident #9 had falls at times when staff were trying to care for the other residents. -Resident #9 did not have a fall mat. -She had discussed a fall mat for Resident #9 with his PCP but the provider was afraid it would be a fall and trip hazard. Review of Resident #9's electronic progress notes revealed: -On 05/08/20, at 1:38pm, the resident had been walking around without assistance and without his walker and had to be redirected several times during the shift. -On 05/12/20, at 9:22pm the resident was observed trying to walk by himself multiple times after being told that he needed assistance and was forgetful, the staff would alert next shift and continue to monitor.	D 270		

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D 270	Continued From page 55 Review of an Accident/Incident report dated 05/17/20 at 1:30pm for Resident #9 revealed: -Resident #9 had an unwitnessed fall with a laceration injury. -Resident #9 was sent to the ED. -Resident #9's PCP and family member were notified. -The facility's Fall Prevention Program was initiated for Resident #9 to check vital signs for three days every shift and monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall and documentation to include any changes or no changes. -There was no other instructions or documentation related to the frequency of staff monitoring for the resident's supervision. Review of an ED visit for Resident #9 dated 05/17/20 revealed: -The resident was seen due to a fall. -The resident was diagnosed with an orbital wall fracture, eyebrow laceration, and a periorbital hematoma of the left eye. -The resident received sutures for the closure if the laceration. Review of Resident #9's electronic progress note dated 05/18/20 at 10:07pm revealed the resident was observed, continued to get up without assistance after being asked multiple times to ask for help; will continue to monitor. Review of Resident #9's May 2020 eMAR revealed: -There was an entry to check the resident every 30 minutes for safety and free from falls with a frequency of every 30 minutes and special instructions to document every 30 minutes	D 270		

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whether the resident was free from fall, sitting in wheelchair, eating a meal, watching television, etc.
-There was documentation the resident was checked every 30 minutes starting on 05/22/20 at 11:00pm through 05/24/20 at 1:30pm (run date of report was 05/24/20 at 2:43pm) with the exception of no documentation on 05/23/20 at 9:00pm and 9:30pm.

Review of Resident #9's electronic progress notes revealed:
-On 05/26/20 at 11:33am, the resident had a fall in his bedroom, resident was observed sitting on the floor.
-On 05/26/20 at 11:39am the resident had been checked on every 30 minutes.

Telephone interview with Resident #9's family member on 05/27/20 at 11:57am revealed:
-The resident's mental status had declined.
-When the resident decided to "get up and go, he goes", however, then would realize he could not walk without his walker, would turn around to retrieve his walker and fall.
-The facility moved the resident closer to the nurse's station because the resident was requiring a lot more assistance.
-Before the resident was moved toward the nurse's station, the resident was in a room at the end of the hall.
-In the last 6 months the resident had a minimum of 12 falls, some of the falls had been more severe than others.
-She was not sure what other interventions the facility had put into place to help prevent the resident from falling but was aware staff tried to get the resident to sit more but the resident still thought he could get up independently.
-The resident had a wheelchair for approximately

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a year, but the family member was concerned that a wheelchair might not be as safe because the resident would might attempt to get up and not lock the wheels when used by himself.
-She was not sure how often staff monitored the resident.

Telephone interview with a PCA on 05/27/20 at 3:20pm revealed:
-Resident #9 was a fall risk.
-The amount of assistance Resident #9 needed from staff depended on the strength he had to stand up at the time.
-Staff told Resident #9 things he should not do to keep the resident from falling and sometimes the resident would listen.

Telephone interview with a MA on 06/01/20 at 12:50pm revealed:
-Resident #9 was independent when he was admitted to the SCU but started declining physically and mentally, requiring more assistance with his activities of daily living needs.
-Resident #9 was having a lot of falls and the resident had reached the point he was falling all the time.
-MAs assisted to monitor the residents when medication passes were completed.
-Staff tried to keep Resident #9 with the PCA but one time when Resident #9 fell she was the only MA for the SCU and it was "chaotic, running back and forth watching" all of the fall risk residents.
-The only way staff could keep Resident #9 from falling was if the resident was always kept with staff.
-There were no specific "orders" from management for increased supervision for Resident #9's falls.

Telephone interview with the MA who

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documented the electronic progress note for Resident # on 04/11/20 at 9:29pm and at 10:42pm on 06/04/20 at 11:49am revealed:
-She had worked with Resident #9 last night (06/03/20).
-Resident #9 used a walker when ambulating, but the resident was not stable when he walked, his legs were wobbly and could fall at any time.
-Resident #9 required monitoring by staff very closely, the resident could be redirected to sit when he stood to walk "for a couple of minutes" then he would move again.
-Resident #9 was encouraged to stay seated and staff tried to assist him when he tried to walk.
-Resident #9's mobility was "not very good these days" and the resident had several falls.
-When she worked at the facility, she would observe Resident #9 come to the door of his room with his walker and one staff would go find out what the resident wanted.
-Staff tried to keep Resident #9 sitting as much as possible but the resident would not ask staff when he wanted something and "the next thing you know you see him going" and "we have to keep our eyes on him every few minutes".
-She was not sure why 72-hour monitoring was not initiated at times when Resident #9 had fallen.

Telephone interview with the MCM on 06/04/20 at 3:47pm revealed:
-There should not have been incidences that the 72-hour monitoring was not initiated after Resident #9 had fallen.
-She was not aware there were times within the 72-hour monitoring that vital signs were not done on a shift in March and April 2020 for Resident #9.
-Resident #9 had been placed on 30-minute supervision checks.
-She did not know the exact date Resident #9's

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D 270	Continued From page 59 30-minute supervision checks started but it was in May 2020. -She could not answer why the 30-minute checks were not implemented until May 2020 for Resident #9. -Resident #9 was checked on every 30 minutes prior to May 2020 or possibly even more because the resident was trying to do things without assistance from staff but there was no documentation anywhere for the supervision monitoring staff done for the resident prior to May 2020. -The MA usually positioned the medication cart by Resident #9's room "if need be" to provide monitoring for the resident. -Resident #9's hall was staffed with two PCAs and one MA. Telephone interview with Resident #9's PCP on 06/02/20 at 2:03pm revealed: -She expected the facility to have interventions in place that kept the resident from falling. -She had checked on the resident's medical end for reason for falls such as possible urinary tract infections and had made medication changes tapering off a medication the resident was taking for dementia. -Resident #9's mental health provider was also tapering off Resident #9's depression medication that could be contributing to falls. -The 30-minute monitoring checks that were recently put into place (05/22/20) for Resident #9 was "definitely helping". Telephone interview with the Administrator on 06/04/20 at 3:49pm revealed: -Resident #9 had a scoop bed and fall mat intervention in place. (A scoop bed is designed with raised sides to prevent a person from rolling out of bed).	D 270		

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-She did not know how long Resident #9 had the scoop bed and fall mat.
-The scoop bed and fall mat were in place when she started employment with the facility on 04/17/20.
-Resident #9 had not fallen since 05/26/2020
-Resident #9 was placed on increased checks with the 05/26/20 fall.
-On 05/26/20 Resident #9 was checked on every 30 minutes as part of the 72 hour falls monitoring.
-On 06/01/20 Resident #9 was checked on every 30 minutes as part of the 72 hour falls monitoring.
-Resident #9's 72-hour monitoring ended 05/29/20.

Telephone interview with Resident #9's PCP on 06/03/20 at 2:53pm revealed:
-She expected the facility to reach out if there were concerns for any supervision needs for the resident.
-The facility had not contacted her with any supervision concerns or intervention requests for Resident #9.
-She knew the facility had vital sign monitoring every shift when the resident had a fall.

Based on interviews and record reviews, it was determined Resident #9 was not interviewable.

Refer to the telephone interview with a PCA on 05/13/2020 at 10:59am.

Refer to the telephone interview with a MA on 05/13/20 at 1:11pm

Refer to the telephone interview with a MA on 06/04/2020 at 11:49am.

Refer to the telephone interview with the MCM on 06/04/20 at 3:47pm.

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D 270	Continued From page 61 2. Review of Resident #3's current FL-2 dated 06/19/19 revealed: -Diagnoses included severe dementia, uncontrolled diabetes mellitus, hypertension, benign prostatic hyperplasia, gastroesophageal reflux disease, and hyperlipidemia. -Resident #3 was intermittently disoriented and ambulated with a cane. Review of Resident #3's physician's orders revealed: -There was an order for a chair/bed alarm dated 01/27/20. -There was an order to discontinue the chair/bed alarm dated 03/30/20. Review of Resident #3's care plan dated 03/19/20 revealed: -Resident #3 was always disoriented and had a history of wandering. -He was ambulatory with a wheelchair and needed to be monitored continuously by staff because he would try and get up of chair without assistance and lose his balance which caused multiple falls. -Resident #3 was able to hear loud sounds and voices only. -Resident #3 required limited assistance with eating and extensive assistance with dressing and grooming. -Resident #3 was totally dependent for assistance in bathing, toileting, transferring, and ambulation. -There was no assessment of Resident #3's needs related to fall precautions. Review of Resident #3's licensed health professional support review dated 04/05/20 revealed:	D 270		

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-Resident continued to require assistance from staff for transfers.
-He was able to stand and pivot during the process.
-Resident #3 was dependent on the manual wheelchair for mobility, but able to self-propel in the wheelchair.

Review of electronic care notes for Resident #3 revealed:
-On 11/03/19, Resident #3 slipped and fell while getting up to go to the bathroom at 6:41am (location not specified).
-Staff "would continue to monitor".
-The frequency of monitoring and fall prevention interventions were not noted by staff.
-On 11/04/19, Resident #3 was found lying on the floor in the dining room at 11:51am.
-Resident #3's physician and responsible party were notified.
-There was no documentation of any increased supervision by staff of Resident #3.
-On 11/17/19, staff documented a late entry of a fall that occurred on 11/14/19.
-There was no documentation of any increased supervision by staff of Resident #3 as a result of this fall.
-On 11/24/19, Resident #3 was found sitting on the dining room floor but had no injuries at 12:23pm.
-Resident #3's physician and responsible party were notified.
-There was no documentation of any increased supervision by staff of Resident #3.
-On 12/25/19, staff documented an event related to fall at 9:56pm.
-Resident #3's location was not specified for the event and Resident #3 suffered a skin tear below his right elbow.
-No other information was documented for this

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event.
-There was no documentation of any increased supervision by staff of Resident #3.

Review of an accident/incident report for Resident #3 dated 12/26/19 revealed:
-Resident #3 was found lying on the floor in the hallway of the Special Care Unit (SCU)
-The fall was not witnessed by staff and Resident #3 was not able to explain how the fall occurred.
-Resident #3 complained of pain to the back of head and he was sent to the emergency room.
-Resident #3's physician and responsible party were notified.
-Resident #3 was sent to the emergency room for treatment of abrasions to left knee and left arm.
-There was no documentation of any increased supervision by staff of Resident #3.

Review of Resident #3's emergency room provider notes dated 12/26/19 revealed:
-Resident #3 was seen in the emergency room at approximately 5:05pm for a fall.
-Resident #3 reported hitting his head and complained of pain to his right posterior shoulder area.
-Final emergency room diagnosis was a contusion of Resident #3's right shoulder and Resident #3 was prescribed Tylenol for pain.

Review of electronic care notes for Resident #3 revealed:
-On 12/30/19, staff documented a late entry of a fall that occurred on 12/27/19.
-There was no documentation of any increased supervision by staff of Resident #3 as a result of this fall.
-On 01/19/20, staff documented a late entry of a fall that occurred on 01/17/20.
-There was no documentation of any increased

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supervision by staff of Resident #3 as a result of this fall.
-On 01/20/20, staff documented a late entry of a fall that occurred on 01/19/20.
-There was no documentation of any increased supervision by staff of Resident #3 as a result of this fall.
-On 01/24/20, Resident #3 was found sitting on the floor of his bedroom with a small cut on left ear at 2:02pm.
-Basic first aid was provided by staff.
-Resident #3's physician and responsible party were notified.
-There was no documentation of any increased supervision by staff of Resident #3.

Review of an accident/incident report for Resident #3 dated 02/21/20 revealed:
-Resident #3 was found on the floor of his bedroom by staff at 9:11pm.
-The fall was unwitnessed.
-Resident #3 had an abrasion to his forehead and staff provided basic first aid.
-Resident #3's physician and responsible party were notified.
-Resident #3 was sent to the emergency room for treatment of a laceration to his forehead.
-There was no documentation of any increased supervision by staff of Resident #3.

Review of electronic care notes for Resident #3 revealed:
-On 02/21/20, staff documented at 9:20pm that she had been calling Resident #3's physician non-stop since his accident and staff could not leave a message.
-Staff notified Resident #3's family about his accident.
-Staff documented Resident #3 was still at the emergency room at 10:14pm.

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D 270	Continued From page 65 -On 02/26/20, staff documented at 2:51pm that Resident #3 was found sitting on the floor in his bedroom on his buttocks and did suffer any injuries. -Resident #3's physician and responsible party were notified. -On 03/15/20, staff documented a late entry of a fall that occurred on 03/14/20. -There was no documentation of any increased supervision by staff of Resident #3 as a result of this fall. Review of an accident/incident report for Resident #3 dated 04/22/20 revealed: -Resident #3 was found on the floor of his bedroom by staff at 6:25pm. -The fall was unwitnessed. -Resident #3 had a laceration but it was not specified where and staff provided basic first aid. -Resident #3's physician and responsible party were notified. -There was no documentation of any increased supervision by staff of Resident #3. Review of an electronic care note for Resident #3 dated 04/22/20 revealed: -Staff documented at 9:52pm that Resident #3 fell off the bed and landed on his nose. -There were no other visible injuries and staff would continue to monitor. -There was no documentation of the frequency of monitoring of Resident #3 and or the implementation of any fall prevention interventions by staff. Telephone interview with a medication aide (MA) on 05/21/20 at 3:50pm revealed: -Resident #3 had a couple of falls in the last 6 months, but she could not specify when the falls occurred.	D 270		

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-Resident #3 did not require increased supervision related to his falls and staff normally checked on him every 2 hours just like the rest of the residents in the SCU.
-Resident #3 fell a lot because "his legs do not work, and he forgets that he cannot walk and tries to walk".
-If staff left Resident #3 alone, then he would try to get up and fall.
-She had tried to distract him by taking him down the hall with her medication cart when she passed medications.
-"Sometimes, we sit him in his wheelchair in the hallway or the nurse's station so that someone can keep an eye on him".

Telephone interview with a previous MA who worked at the facility on 06/04/20 at 5:12pm revealed:
-Resident #3 had approximately 20 falls between January 2020 and May 2020.
-She was not sure if all of Resident #3's falls were documented on injury reports.
-Resident #3 fell because he could not remember he could not walk anymore and would fall when he tried to get up from his wheelchair without staff assistance.
-Staff had not been given any instructions from management about increased supervision for Resident #3.
-She tried to check on Resident #3 every hour when she worked to keep him from falling.
-"It was hard for the staff to try keep up with him (Resident #3) because he needed increased supervision and there was not enough staff to provide one-to-one care to keep him from getting up out his wheelchair to keep him safe."
-She did not remember if she had told the Memory Care Manager (MCM) or the Administrator about her concerns to the

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D 270	Continued From page 67 supervision of Resident #3. Confidential telephone interview with a second staff member revealed: -Nothing was put in place for interventions after most residents' falls at the facility. -Staff were not given any specific instructions after Resident #3 had falls other than to check the resident every two hours during rounds and there were no instructions given to staff on how often to supervise Resident #3. -Staff tried to monitor Resident #3 for falls because he needed to be watched almost constantly because he had a history of frequent falls. -It was hard for staff monitor Resident #3 or any other residents in the SCU for falls when staff had to help inside other residents' rooms and staff were not available to monitor to Resident #3 then he would try to get up and fall. Telephone interview with a second MA on 05/21/20 at 11:00am revealed: -Resident #3 was a fall risk, but he did not require increased supervision. -She usually checked on Resident #3 every 20 or 30 minutes, but there were no instructions on how frequent he was supposed to be checked by staff. -Resident #3 had a history of frequent falls and staff had to watch him closely after he had a fall. -She could not explain what she meant by "watch closely" after Resident #3 had a fall. -She was not sure how many falls Resident #3 had or when Resident #3 last had a fall. -She did not know how it was communicated to staff if a resident needed increased supervision. Telephone interview with Resident #3's family member on 05/15/20 at 9:56am revealed: -Resident #3 had a history of frequent falls.	D 270		

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D 270	Continued From page 68 -He had a significant change in his ambulatory status in the last six or seven months that resulted in Resident #3 going using a cane to require a wheelchair. -His legs were extremely weak, and he sometimes forgot that he could not walk. -Resident #3 was receiving physical therapy for strengthening, but he still needed assistance for transfers, and he could not walk with assistance. -She was not sure of the number of falls Resident #3 had in the last 6 months, but he had several falls, at least two or three falls a week especially before he got the wheelchair. -She was not sure when Resident #3 last fell. -She was not sure what intervention had been put in place to prevent Resident #3 from falling besides getting his wheelchair and physical therapy. -She did not know if supervision had been increased by staff to decrease Resident #3's falls. Telephone interview with a family nurse practitioner with Resident #3's physician's office on 05/21/20 at 2:50pm revealed: -Resident #3 had a history of frequent falls, but she was not sure how often staff supervised Resident #3. -Staff at the facility had called the physician's office "fall line" and reported falls for Resident #3 on 11/03/20, 11/15/20, 11/18/20, 11/24/20, 12/01/20, 12/26/20, 01/19/20, 01/24/20, 02/11/20, 02/12/20, 02/21/20/, 02/26/20, 03/02/20, 03/19/20, and 03/24/20. -She did not see where the facility called their office to report the fall on 04/22/20 for Resident #3. -She had not given any specific instructions to the staff for how often to supervise Resident #3 to prevent his falls. -She saw the staff bring Resident #3 out into the	D 270		

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hallway and to the nurse's station to keep him from falling on different facility visits.
-When staff left Resident #3 alone to attend to other duties on the floor and Resident #3 realized there were no staff available to supervise him, then Resident #3 would try to get up and fall.
-The facility was doing all they could do to supervise Resident #3 outside of one-to-one supervision.
-In reviewing Resident #3's history of falls, the facility may not be able to provide for Resident #3's care and supervision.

Interview with the MCM on 05/28/20 at 9:07am revealed:
-There were currently 42 residents in SCU, and she identified 2 residents were bed bound and the other 40 residents had wandering behaviors.
-The SCU was being staffed with one medication aide and five personal care aides during the 7:00am - 7:00pm shift and one medication aide and six personal care aides during the 7:00pm - 7:00am shift.
-There were no residents at the facility who required increased supervision for falls or wandering.
-Resident #3 had a history of frequent falls since he was admitted to the facility because his gait was unsteady and Resident #3 forgot that he could not walk.
-She was not sure of the number of falls Resident #3 had but he did not have any major injuries from his halls.
-"He was one of the residents they must keep sitting out in the hallway so they could watch him."
-Resident #3 "would be sitting in his wheelchair and if staff was not watching; he would just get up and fall".
-"We have things that we do to redirect him

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(Resident #3), but he knows when we leave him; then he gets up, tries to walk, and falls".
-The medication aides sometimes pushed Resident #3's wheelchair down the hallway with them when they administered medications or Resident #3 was kept with staff by the nursing station.
-She could not specify how often Resident #3 was kept with the medication aides during their medication rounds.
-Resident #3 had a chair alarm in January 2020, but Resident #3 kept getting up out of his wheelchair.
-Resident #3 kept turning the chair alarm off until he broke his chair alarm in March 2020.
-The chair alarm was discontinued in March 2020 because Resident #3's family member did not want to purchase another one.
-She could not specific what additional interventions had been put in place to prevent Resident #3 from getting out of wheelchair since his alarm had been discontinued.
-Staff monitored Resident #3 closely but she could not explain what 'monitored closely' meant.
-Staff needed to monitor Resident #3 constantly to keep him from falling.
-Resident #3's "level of care needed to be changed and he was not appropriate for the facility" because Resident #3 had to be monitored so closely to prevent his falls.
-She would not say how long she knew Resident #3's level of care needed to be changed and she had never discussed this concern with Resident #3's physician.
-The staff was doing the best they could to take care of Resident #3 and keep him safe.
-Resident #3's physician wrote an order for staff to perform checks on Resident #3 every 30 minutes to monitor his safety on 05/23/20.
-Prior to 05/23/20, there were no written physician

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orders or instructions given to staff for how often to supervise Resident #3, but staff knew Resident #3 needed to be monitored closely because she told them verbally (no time specified).
-She could not explain why Resident #3 had falls documented by staff in his progress notes and there were coinciding injury reports.
-Staff were supposed to document all falls on an injury report form when they occurred.
-She was not sure when Resident #3 last had a fall risk assessment done.
-Fall risk assessments were supposed to be done after any resident falls.

Telephone interview with the Administrator on 05/29/20 at 11:25am revealed:
-She was not aware of the number of falls Resident #3 had in the last six months since she had only taken over the role of the Administrator at the facility in April 2020.
-She knew Resident #3 had history of frequent falls and staff usually checked on the resident every two hours.
-She did not know when Resident #3 last fall occurred.
-Resident #3 did not require increased supervision related to his falls and she did not know about what interventions were currently in place to prevent Resident #3 from falling.
-Resident #3 was not currently receiving physical therapy related to the pandemic.
-She did not know when Resident #3 had last been assessed for risk for falls at the facility.
-She could not explain other than verbally how it was communicated to staff if a resident needed increased supervision.

Telephone interview with MCM on 06/04/20 at 3:45pm revealed:
-She could not explain why increased supervision

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had not been started on Resident #3 prior to 05/23/20.
-Resident #3 needed to be checked at least every 30 minutes because he would try to get up out his wheelchair without staff supervision.

Refer to the telephone interview with a PCA on 05/13/2020 at 10:59am.

Refer to the telephone interview with a MA on 05/13/20 at 1:11pm

Refer to the telephone interview with a MA on 06/04/2020 at 11:49am.

Refer to the telephone interview with the MCM on 06/04/20 at 3:47pm.

3. Review of Resident #1's current FL-2 dated 12/23/19 revealed diagnoses included dementia, atrial fibrillation, congestive heart failure, coronary artery disease, cardiomyopathy, hypertension, diabetes mellitus and Parkinson's disease.

Review of Resident #1's current care plan dated 12/10/19 revealed:
-Resident #1 was sometimes disoriented, forgetful and needed reminders.
-Resident #1 was ambulatory without problem and did not use an assistive device.
-Resident #1 required limited assistance with toileting.
-There was no documentation of agitation or aggressive behaviors.
-There was no documentation of fall prevention measures.

Review of Resident #1's special care unit (SCU) resident profile dated 12/27/19 revealed Resident

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#1 walked independently but needed assistance with transfers.

Review of Resident #1's current special care unit quarterly profile dated 04/18/20 revealed:
-Resident #1 walked constantly and needed redirection.
-Resident #1 needed to be monitored due to wandering behavior.
-There was no documentation of the frequency of monitoring for Resident #1.

Review of a primary care provider (PCP) order dated 01/20/20 for Resident #1 revealed an order to start Eliquis 2.5mg twice daily. (Eliquis is a blood thinner used to prevent blood clots.)

Telephone interview with Resident #1's responsible person (RP) on 05/14/2020 at 1:54pm revealed:
-The staff had called him twice this week related to falls and injuries; Resident #1 fell and had a knot and bruise on her forehead.
-Staff had called him this morning and said Resident #1 was sent to the emergency department (ED) for a urinary tract infection (UTI).

Confidential telephone interview with staff revealed:
-Resident #1 had several falls in the last couple of months.
-Staff was not sure of the number of falls Resident #1 had and could not give specific dates.
-Resident #1 had suffered bruises to her face, legs, and hips, but did not suffer any fractures.
-Management had not given the staff any specific instructions about supervision for Resident #1 except to check on Resident #1 every two hours.

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D 270	Continued From page 74 Telephone interview with a medication aide (MA) on 05/13/20 at 1:11pm revealed: -Resident #1 ambulated by herself "to a certain extent;" staff had to help Resident #1 because she was a fall risk. -All the residents on the SCU were a fall risk; Resident #1 fell frequently. -Resident #1 fell on 05/12/20 and was probably a little sore from the fall but did not have any injuries. -Resident #1 had behaviors and became defensive by pushing and grabbing at staff when staff tried to assist and/or redirect the resident. -Staff followed the fall management program which meant initiating 72 hour monitoring after a resident fell. -72 hour monitoring meant the MA checked the residents vital signs and checked for injuries every shift and documented in the resident's electronic record. Review of an electronic progress note dated 04/27/20 for Resident #1 revealed: -Resident was in and out of other residents' rooms and became violent with staff when asked to leave. -There was no documentation of increased supervision for Resident #1 wandering in and out of other residents' rooms. Review of an accident/incident report dated 05/10/2020 at 9:12am for Resident #1 revealed Resident #1 was found on the floor in another resident's room and had a knot on her head. Review of an electronic progress note dated 05/10/20 at 9:20am for Resident #1 revealed: -Resident #1 was found on the floor in another resident's room and had a knot on her head.	D 270		

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D 270	Continued From page 75 -There was no documentation of implementation of any fall prevention measures or increased supervision. Second telephone interview with a MA on 05/21/20 at 2:20pm revealed: -She documented the electronic progress note on 05/10/20 at 9:20am; Resident #1 wandered all the time. -The knot was present on Resident #1's forehead prior to the fall on 05/10/20. -Resident #1 had falls prior to 05/10/20. -Resident #1 was on 72 hour monitoring prior to the fall on 05/10/20 because she had fallen before 05/10/20. -The fall on 05/10/20 was an unwitnessed fall. -She checked the resident and called the PCP's office and RP. -The PCP's on call provider did not want Resident #1 sent to the ED. -72 hour monitoring was restarted and the MAs checked Resident #1's vital signs every shift and made sure there were no injuries and/or pain. -There were no other fall prevention measures put in place for Resident #1 after the fall on 05/10/20. -She contacted the Memory Care Manager (MCM) and notified the MCM of Resident #1's fall. Review of Resident #1's May 2020 electronic medication administration record (eMAR) revealed: -There was no entry for fall prevention or monitoring (72 hour monitoring) dated before 05/10/20. -There was an entry for fall prevention program with a start date of 05/10/20 and end date of 05/13/20. -There were vital signs documented every shift	D 270		

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05/10/20 from 7:00am to 3:00pm through 05/13/20 from 3:00pm to 11:00pm except for 7:00am to 3:30pm on 05/11/20.

Telephone interview with Resident #1's PCP on 05/15/20 at 10:46am revealed:
-She was contacted on 05/10/20 regarding Resident #1 being agitated again and had fallen after an altercation with another resident.
-She had a virtual visit with Resident #1 on 05/11/20; Resident #1 was not engaged and frequently walked away during the visit.
-She did not see any bruises during the visit.

Review of a telephone encounter for the PCP's office dated 05/10/20 at 9:00am for Resident #1 revealed:
-A MA contacted the PCP's office reporting Resident #1 was agitated and given an as needed medication that did not help.
-Resident #1 wandered into another resident's room and started an altercation which led to Resident #1 falling over a table.
-Resident #1 had a bump her head but was otherwise okay.

Review of an accident/incident report dated 05/12/20 at 7:24pm for Resident #1 revealed Resident #1 had a bruise on her forehead.

Review of an electronic progress note dated 05/12/20 at 7:28pm for Resident #1 revealed staff found a bruise on Resident #1's forehead.

Review of Resident #1's May 2020 eMAR revealed:
-There was an entry for monitoring status for 72 hours every shift with a start date of 05/12/20 at 3:00pm to 11:00pm and end date of 05/15/20.
-There was no documentation for 11:00pm to

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7:00am on 05/13/20 and 05/14/20 and 7:00am to 3:00pm on 05/15/20.

Telephone interview with a second MA on 05/21/20 at 4:33pm revealed:
-She remembered being told about the bruise on Resident #1's forehead; she did not know how the bruise got there.
-She documented the bruise in the electronic progress note dated 05/12/20 at and completed an accident/incident report because she did not know how Resident #1 got a bruise on her forehead.

Review of an electronic progress note dated 05/13/20 at 6:24am for Resident #1 revealed the right side of Resident #1's face was swollen from her fall.

Telephone interview with a third MA on 06/04/20 at 5:14pm revealed:
-She had written the electronic progress note dated 05/13/20 at 6:24am for Resident #1.
-She had been documenting follow up on the bruise from a fall on a previous shift.
-Resident #1 had at least 13 falls since 04/01/20; definitely more than 5.

Review of electronic progress notes dated 03/26/20 through 05/10/20 revealed there were no falls, injuries or preventative measures documented.

Upon request on 05/15/20 through 06/05/20, there were no accident/incident reports dated between 04/01/20 and 05/10/20 for Resident #1.

Review of an accident/incident report dated 05/13/20 at 7:35am for Resident #1 revealed Resident #1 was found on the floor in her room

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bedside the bed with no injuries documented.

Review of an electronic progress note dated 05/13/20 at 9:50am for Resident #1 revealed:
-Resident #1 was found on the floor in room by the bathroom with no visible bruises.
-There was no documentation of implementation of any fall prevention measures or increased supervision.

Review of an accident/incident report dated 05/13/20 at 11:30am for Resident #1 revealed Resident #1 was found on the floor near her bathroom with no injuries documented.

Review of an electronic progress note dated 05/13/20 at 11:30am for Resident #1 revealed:
-Resident #1 rolled off her bed onto the floor; did not appear to hit her head or anything.
-There was no documentation of implementation of any fall prevention measures or increased supervision.

Second telephone interview with the first MA on 05/21/20 at 2:20pm revealed:
-She documented the falls on 05/13/20 in Resident #1's electronic progress notes.
-Resident #1 had unwitnessed falls on 05/13/20 at 7:35am and 11:30am.
-She found Resident #1 while doing rounds lying on her side flat on the floor.
-The second fall on the morning of 05/13/20 Resident #1 was in her bed and rolled off the bed onto the floor.
-She found Resident #1 lying flat on the floor as if the resident rolled out of her bed.
-She checked Resident #1 and could tell the resident did not hit her head because of the way she fell.
-She did not find Resident #1 the second time the

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resident fell on 05/13/20; she could not remember who found the resident.
-On 05/12/20, Resident #1 had a rough day was upset on 05/13/20; the resident did not want to be bothered by staff and was "wobbly" while walking up and down the hall.
-After each fall Resident #1 was placed on 72 hour monitoring; staff would see the resident every 15 to 20 minutes.
-There were 27 residents on the women's hall in the Special Care Unit (SCU) with 3 personal care aides (PCAs); staff did the best they could to keep an eye on Resident #1.
-72 hour monitoring included checking vital signs every shift and checking for signs of pain and/or injury every shift.
-Staff did rounds all the time; there were no specific time frames and rounds were not documented.
-Staff sometimes tried to sit with the residents with frequent falls around the clock.
-Sitting with a resident was not a PCP order, but something the staff would try to do.
-Staff did not sit with Resident #1.
-Resident #1 was the only resident on the women's hall in the SCU that staff had to keep an eye on.
-The process was the same for witnessed and unwitnessed falls; the MA called the PCP and PCP decided if the resident was sent to the emergency room.
-There was no difference in what the MA did following a fall for a resident on a blood thinning medication.

Telephone interview with a personal care aide (PCA) on 05/21/20 at 3:45pm revealed:
-Resident #1 walked by herself without weakness and did not have an unsteady gait.
-She did not know of Resident #1 having any

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falls.

Telephone interview with Resident #1's PCP on 05/15/20 at 10:46am revealed:
-Staff reported Resident #1 would not sit still and had fallen almost every shift from 05/10/20 through 05/13/20.
-Staff reported they were doing one on one monitoring for Resident #1 because the resident was constantly getting up.
-The MCM was instructed to send Resident #1 to the ED on 05/14/20 by the Administrator.

Review of electronic progress noted dated 05/10/20 through 05/13/20 revealed there was no documentation of Resident #1 having a falls between 05/10/20 at 9:20am and 05/13/20 at 7:35am.

Upon request 05/15/20 through 06/05/20, there were no accident/incident reports dated between 05/10/20 at 9:20am and 05/13/20 at 7:35am for Resident #1.

Review of an electronic progress note dated 05/14/20 at 10:15am revealed:
-The Administrator was told Resident #1 "continued to fall frequently daily."
-The Administrator saw that Resident #1 had bruising to her face and right buttocks.
-The Administrator sent Resident #1 to the emergency department (ED) due to the nature and severity of the bruising.

Telephone interview with the Administrator on 05/15/20 at 10:20am revealed:
-She had documented the electronic progress note dated 05/14/20 at 10:15am.
-Resident #1 was sent to the ED for evaluation on 05/14/20 because she had a couple of falls with

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bruising.

Review of Resident #1's ED record dated 05/14/20 revealed Resident #1 presented to the ED for evaluation after having a fall 2 days ago (05/12/20) and diagnosed with a hematoma of her frontal scalp and a UTI.

Review of an electronic progress note dated 05/14/20 at 4:15pm revealed:
-Resident #1 returned from the ED.
-There was no documentation of implementation of any fall prevention measures or increased supervision.

Confidential telephone interview with staff revealed:
-On 05/15/20, Resident #1 was in her room alone wrapped in a sheet with her room door closed because she was still under 48-hour quarantine because she had just gotten out of the hospital.
-Resident #1 did not have the cognitive ability to ring her call bell to ask for assistance.
-The staff was not given any instructions about monitoring Resident #1 during quarantine.
-Staff checked on Resident #1 about every two hours while she was in quarantine.
-Resident #1 had history of frequent falls.
-Resident #1 had bruises to her face, right thigh, and right hip from to her most recent fall.
-Resident #1 had not been identified to need increased supervision due to falls.

Review of an accident/incident report dated 05/15/20 at 5:03pm for Resident #1 revealed Resident #1 was found on her bedroom floor with no injuries.

Review of electronic progress notes dated 05/15/20 for Resident #1 revealed:

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D 270	Continued From page 82 -There was no documentation of Resident #1 falling on 05/15/20 at 5:03pm. -There was no documentation of any fall prevention measures or increased supervision. Review of Resident #1's May 2020 eMAR revealed: -There was an entry for fall prevention program with a start date of 05/15/20 and end date 05/18/20. -There were 6 occasions of vital signs documented starting on 05/15/20 at 3:00pm to 11:00pm through 05/18/20 from 7:00am to 3:00pm. -There were no vital signs documented for 11:00pm to 7:00am on 05/15/20 and 05/16/20 7:00am to 3:00pm on 05/17/20. Review of an accident/incident report dated 05/18/20 at 2:30am for Resident #1 revealed Resident #1 was found on the community bathroom floor with no injuries. Review of electronic progress notes dated 05/18/20 for Resident #1 revealed: -There was no documentation of Resident #1 falling on 05/18/20 at 2:30am. -There was documentation Resident #1 was sent to the ED by the PCP for low oxygen saturation levels between 2:13pm and 3:00pm. -There was no documentation of any fall prevention measures or increased supervision between 2:30am and 2:13pm on 05/15/20. Review of Resident #1's hospital record dated 05/18/20 through 05/21/20 revealed; -Resident #1 was admitted for acute on chronic heart failure. -There was documentation Resident #1 had bruises on her right forehead and generalized	D 270		

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bruising to her face, chest, arms and buttocks.

Telephone interview with a fourth MA on 06/05/20 at 1:44pm revealed:
-Resident #1 did not sit still, the resident walked so much she would exhaust herself and fall.
-Residents were supposed to be on quarantine when they returned from the hospital.
-Residents on quarantine were kept in their rooms for two days with the door kept closed.
-Resident #1 stayed in her bed when she returned from the hospital on 05/14/2020 and 05/21/20.
-Staff were always on the hall but a staff sat in a chair outside Resident #1's room when she was on quarantine.
-There was no set routine or time for checking on residents.
-Residents were checked every 2 hours, sometimes every 1 hour and when staff were walking up and down the hall.
-Staff opened the door of residents to check on them whenever they did rounds.
-She was told the process was the same for witnessed and unwitnessed falls; the only thing that was "stressed" was to call the PCP.
-Residents on blood thinners were not monitored more frequently after a fall; there was no certain procedure for residents on blood thinners.

Telephone interview with Resident #1's PCP on 06/05/20 at 9:44am revealed:
-She was not notified of any falls in April 2020 for Resident #1.
-She was notified of a fall on 05/10/20, a fall every shift from 05/10/20 through 05/13/20 on 05/13/20 and then on 05/15/20.
-There were no further falls reported between 05/15/20 and 05/18/20.
-There was an increased risk of bleeding and

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injury when taking Eliquis.
-If the facility called and said Resident #1, who was on Eliquis, fell and the staff did not know what happened, she would expect increased monitoring of every 15 minutes for 24 hours.
-Someone on blood thinners was at higher risk for bleeding and therefore needs increased monitoring and supervision.

Telephone interview with the MCM on 05/22/20 at 3:36pm revealed:
-She was responsible for completing and updating resident care plans and communicating resident needs verbally to staff.
-Staff were also able to see what care and assistance a resident needed on the activities of daily living (ADL) tasks on the computer system.
-Due to Resident #1's falls the resident required more assistance from staff with bathing, dressing and toileting.
-Resident #1 was able to walk unassisted, walked up and down the halls and wandered in and out of other residents' rooms.
-Resident #1 was seated by the medication cart or in the hall because of frequent falls.
-She had communicated Resident #1's increased need for supervision and assistance with ADLs to staff at shift change.
-She did not know the date she first told staff about Resident #1's increased needs.
-Falls were new for Resident #1; she did not know when the resident started falling.
-She did not know of any undocumented falls for Resident #1; staff were expected to document every fall, complete an incident report and initiate 72 hour monitoring.
-Staff were expected to notify her anytime a resident fell.
-She did not know why a fall prior to 05/10/20 causing a knot to Resident #1's forehead and

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falls every shift between 05/10/20 and 05/13/20 were not documented.
-She did not know the details of Resident #1 being involved in an altercation with another resident prior to the fall on 05/10/20.
-Fall prevention measures after Resident #1's falls included keeping the resident at the medication cart or in the hall.
-The increased supervision for Resident #1 was not documented; she told staff verbally to "keep up with" Resident #1 and monitor for falls.
-She had tried talking to the PCP about Resident #1's falls and for a medication review.
-She did not remember the date but thought she spoke with the PCP before the resident started antibiotics for a UTI (05/11/20); contact with the PCP should have been documented in the electronic progress notes.
-There was no way to determine if staff were following the facility's fall management program if there was no documentation of the fall and 72 hour monitoring was not initiated.

Review of electronic progress notes dated 04/27/20 through 05/10/20 for Resident #1 revealed there was no documentation of contact with the resident's PCP regarding fall prevention measures and/or a medication review.

Telephone interview with the Administrator on 05/28/20 at 9:02am revealed:
-Resident #1 was a fall risk and needed increased supervision.
-Resident #1 was mobile but was now in a wheelchair; she did not know the exact date of the change only that the falls started after the resident moved to the SCU from the assisted living (AL) side (12/30/19).
-Resident #1 would get up from the wheelchair in her room and was unsteady on her feet.

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D 270	Continued From page 86 -Resident #1 needed staff to assist with toileting and ambulation. -Increased supervision meant staff needed to keep eyes on Resident #1; she did not specify how often. -Resident #1 liked to walk constantly and had a lot of falls so staff were expected to "keep watch" on the resident. -Resident #1 resided in the SCU where many residents liked to get up and walk a lot so staff were constantly on the halls. -Fall prevention measures for Resident #1 included "looking" at clutter in the room and contacting the PCP for a medication review. -Staff tried to be more attentive to Resident #1 by keeping the resident at the medication cart. -There were no incident reports for Resident #1 between 02/08/20 and 05/09/20. -The 05/10/20 accident/incident report did not include information about a resident altercation prior to Resident #1's fall. -She did not know any details about an altercation involving Resident #1 on 05/10/20. -Resident #1 had atrial fibrillation, congestive heart failure and had been on Eliquis; the Eliquis was discontinued on 05/14/20. -The staff were expected to know the basics of caring for a resident on Eliquis including increased bruising and bleeding with any injury and/or trauma. -It was the facility's policy to contact the PCP prior to calling emergency medical services (EMS) for a resident after an unwitnessed fall. -The PCP normally determined if the resident was sent to the ED. Refer to the telephone interview with a PCA on 05/13/20 at 10:59am. Refer to the telephone interview with a MA on	D 270		

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D 270	Continued From page 87 05/13/20 at 1:11pm Refer to the telephone interview with a MA on 06/04/20 at 11:49am. Refer to the telephone interview with the MCM on 06/04/20 at 3:47pm. _____ Telephone interview with a personal care aide (PCA) on 05/13/20 at 10:59am revealed: -PCAs were responsible for notifying the medication aide (MA) when a resident fell. -MAs were responsible for checking the resident's vital signs, to see if the resident had any injuries after a fall and making sure the resident was okay to get up. -PCAs were responsible for monitoring residents for pain after a fall. -The MAs were responsible for completing accident/incident reports. -The process was the same for witnessed and unwitnessed falls. Telephone interview with a MA on 05/13/20 at 1:11pm revealed: -After a fall, she checked the resident's vital signs and checked the resident for injuries. -MAs were responsible for notifying the Memory Care Manager (MCM) and completing an accident/incident report. -MAs checked vital signs every shift and monitored the resident for pain and/or injury. -72 hour monitoring was initiated when the accident/incident report was done on the computer system. -Residents with aggressive behaviors were monitored every shift with a vital signs check for 72 hours. -The MA notified the primary care provider (PCP) and responsible person.	D 270		

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-Staff checked the resident every 15 minutes.
-Residents returning to the facility from the hospital were monitored for 72 hours; vital signs were checked every shift and staff checked the resident every 15 minutes for pain and/or complications.
-There were no residents in the SCU on 72 hour monitoring at that time (on 05/13/20).
-For unwitnessed falls, she would have checked the resident's body for injuries, vital signs and if the resident was alert and oriented.
-She would have someone stay with the resident while she contacted the PCP and MCM; residents were not left unattended after a fall.
-MAs contacted the PCP, responsible person and the MCM right after the fall happened and documented in the electronic progress notes.
-MAs completed accident/incident reports for all falls and behavior incidents.

Telephone interview with a MA on 06/04/20 at 11:49am revealed:
-For residents on the SCU with unwitnessed falls, the only way she could determine if the resident hit their head was to look and see if there were any marks or bumps.
-She was told by the MCM and Administrator not to send residents to the emergency department (ED) if there was no need and to call the PCP first.
-Anytime a resident fell the resident was placed on every 15 to 30 minute checks; there were some residents staff had to check every 5 minutes or every 2 minutes.
-The PCP or Supervisor decided when to place a resident on every 15 or 30 minute checks.
-Staff started documenting every 30 minute checks for residents on 05/22/20.
-As a supervisor, she made the decision herself to keep eyes on the residents every few minutes.

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-Anything that went on the eMAR came from the residents' PCP or care managers but was not sure if the PCP order was needed to increase supervision.

Telephone interview with the MCM on 06/04/20 at 3:47pm revealed:
-She expected the 72 hour monitoring to be initiated after a resident had fallen.
-It was also expected for staff to make sure no changes occurred with the resident after the fall such as skin tears, new abrasions.
-There was no way for staff to know if a resident hit their head in an unwitnessed fall if they were not present to see the resident fall.
-She spoke with the Administrator and had planned to put a system in place to review all monitoring documentation and vital signs.
-This process was new, not done prior and not initiated yet.
-She was aware of problems in the past with staff not entering residents 72 hour monitoring in the system after a residents' fall had occurred.
-Currently, the facility had staff monitoring the residents at fall risk so the resident did not leave out of staffs site because that was the only way to prevent the residents from falling.
-If increased supervision checks were not documented then she could not show where staff were doing the checks.
-Residents needed increased supervision after a resident had fallen but staff did not document increased supervision checks prior to May 2020.
-An order was not needed to increase supervision for a resident.
-When a resident's increased supervision interventions were not working, she would discuss that with the Administrator and if she contacted the PCP to rule out a urinary tract infection and if they still could not explain why the

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D 270	Continued From page 90 resident was falling the only other step would possible seek a higher level of care. -When a resident needed to be quarantined after getting out of the hospital, the resident was placed in a room without another resident and the door was kept closed. -Staff went into the room to provide the resident with personal care and meals when a resident was on post hospital quarantine. -She was not sure if a resident could be placed on 72 hour monitoring after a fall if an incident/accident report was not done. The facility failed to provide supervision for 3 of 12 residents sampled (#1, #3, #9) on the special care unit (SCU) with known risks for falls. The facility's failure to supervise residents resulted in Resident #9, who had increased generalized weakness, having multiple falls with injuries including orbital wall fracture, facial lacerations, and extensive bruising and contusions; Resident #3 who had an unsteady gait, having multiple falls injuries including facial lacerations and bruising to his right shoulder; and Resident #1, who had wandering behaviors and an unsteady gait, having 4 documented and numerous undocumented falls in May 2020 with extensive bruising to her face, arms, chest, buttocks and thighs. The facility's failure to supervise Residents #1, #3 and #9 placed the residents at risk for serious injury and neglect and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/22/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 8, 2020.	D 270		

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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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs were met for 6 of 12 sampled residents (#7, #8, #1, #9, #4, and #11) related to failing to notify the primary care provider (PCP) of increased temperatures for several days during a viral pandemic and a scant dark urine output with foul odor for Resident #7, failed to assure Resident #8 was sent out for urinary bleeding x 2 weeks before being sent out to the emergency department with diagnosis of urinary tract infection and cystitis and failed to notify PCP of bed bug bites, failed to notify the PCP of acute behavior change on 04/27/2020, three occasions of weight loss between 6 and 11 pounds and lower extremity bite marks with itching, scratching and bleeding and follow up a cardiology referral order 12/18/19 and quarterly pacemaker monitoring for Resident #1, failed to assure a resident was referred as ordered to a Ear, Nose, and Throat (ENT) specialist after being treated for an orbital wall fracture in the emergency department and failed to notify the PCP of falls with one fall resulting in a bump on the resident's head (#9), failed to assure a resident was referred as ordered to a cardiology specialist for evaluation of her pacemaker (#1), Stage 2 ulcer right hip with 6 day delay in reporting to PCP for	D 273		

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Resident #4, and failing to notify the PCP for alleged staff to resident abuse dated 12/25/19 and for resident to resident verbal altercation on 04/30/20 for Resident #11.

1. Review of Resident #7's current FL-2 dated 02/13/20 revealed diagnoses included hypertension, chronic systolic heart failure, muscle weakness, cardiomyopathy, anemia, diabetes mellitus type 2, multiple sclerosis, and hyperlipidemia.

Review of Resident # 7's May 2020 electronic medication administration records (eMARs) revealed:
-A computer entry to check and record weight and vitals monthly.
-On 05/05/20, there was a computer entry for vital signs with temperature 98.8 degrees Fahrenheit (°F), pulse 85, respirations 14, blood pressure 113/58 and a weight of 228.1 pounds.
-There was a computer entry for an order for COVID-19 precautions to be done every shift with special instructions "if a resident begins to display respiratory symptoms/fever greater than 99.6/difficulty breathing, the community should do the following: complete the COVID-19 form and Matrix add all vitals for every shift add O2 sats".
-There was a computer entry for acetaminophen (used for fever reduction and pain) 325 mg to be given two tablets to equal 650 mg by mouth every eight hours.
-There were computer entries for it to be administered at 6:00am, 2:00pm and 10:00pm.
-There was documentation on 05/10/20 at 10:00pm that the resident refused.
-All other documentations from 05/01/20 to 05/11/20 were documented as being administered.
-There was a computer entry for acetaminophen

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D 273	Continued From page 93 500 mg to be given every six hours as needed for fever and pain reduction. -There were special instructions this was a standing order. -The instructions were to take one tablet by mouth every six hours as needed (not to exceed 2000 mg) for fever 99.5°F to 101°F and to monitor for three days or until normal if above 101 call MD for headache minor discomfort. -There was no documentation from 05/01/20 through 05/09/20 as it being administered. -On 05/10/20 at 10:39pm there was a computer entry that it was administered. -The reason noted for administration was for a fever of 102.8°F. -On 05/11/20 at 5:43am there was a computer entry that it was administered. -The reason for administration was not documented. Review of Resident #7's progress notes revealed: -Resident #7 began complaining of being cold and refusing to get out of bed on 05/04/20. -On 05/08/20 at 1:52pm, there was an entry that stated she slept all day and did not eat. -On 05/09/20 at 6:42am, there was an entry that stated, she seemed a little confused and didn't know where she was at. -On 05/09/20 at 1:18pm, there was an entry that stated, she had to be fed lunch and only ate a few spoonfuls. Vital signs were documented as blood pressure 109/73, pulse 93, respirations 18, and temperature 98.2° F. Review of Resident #7's electronic medication administration records and progress notes revealed there was no documentation provided revealing vital signs being checked every 4 hours from 05/09/20 until transported to the hospital on 05/12/20.	D 273		

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D 273	Continued From page 94 Review of the incident and accident report dated 05/12/20 at 10:29am revealed: -Resident #7 was being sent to the emergency department (ED) for a decline in health status. -The vital signs were documented as temperature 97.7 degrees Fahrenheit (°F), pulse 98, respirations 16, and blood pressure 114/53. Telephone interview with an Emergency Medical Technician (EMT) on 05/28/20 at 9:50am revealed: -The EMTs were called to the facility on 05/12/20 to pick up Resident #7 for transport to ED. -He was informed that the resident had been running a fever for several days. -Resident #7 was unresponsive and moaning. -Her temperature was 101°F (normal temperature is 98.6°F) orally. -Her blood pressure (BP) was 89/42 (normal BP is 120/80). -They put her on the stretcher and took her to the truck (ambulance). -Her oxygen saturation (O2 Sat) was 74% (normal oxygen levels range from 95 - 100 and under 90 is considered low). -They started her on oxygen (O2) at 2 Liters/minute (L/min) via a nasal cannula (a tube that fits into the nostrils for delivery of O2 therapy). -Her BP was 67/33. -The EMTs started 2 IV's (intravenous catheters-a tube placed in a vein to administer fluids or medications). -They gave her some pain medication since she was moaning as if she were in pain. -We checked her O2 sats again and they were only 83% so they increased her O2 up to 4 L/min. -When they arrived at the ED, her O2 sats were between 91-92%.	D 273		

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D 273	Continued From page 95 Telephone interview with the second Emergency Medical Technician (EMT) on 05/28/20 at 4:24pm revealed: -The EMTs were called to the facility on 05/12/20 for a routine sick call to pick up Resident #7 for transport to ED. -He was informed by a staff member (didn't remember her name) that the resident had been running a fever for a couple of days. -He asked if anyone was COVID-19 positive (no one responded). -He was later told by one of his fellow staff EMTs that there had been COVID-19 in the facility. Telephone interview with Resident #7's first family member on 05/15/20 at 2:33pm revealed: -There was a lot of confusion about her going to the emergency department. -The facility had not told me much but said she had a fever for 3 days. -They said she had a urinary tract infection (UTI). Telephone interview with Resident #7's second family member on 05/15/20 at 6:15pm revealed: -Resident #7 was in the ICU (intensive care unit) at that time because her UTI (urinary tract infection) was so bad. -She had a fever for 3 days before going to the hospital. - "Now she has pulmonary edema". -Her COVID-19 test was "okay" (negative) but they are doing another one. Second telephone interview with Resident #7's first family member on 06/03/20 at 8:15pm revealed: -Resident #7 had passed away. -She had tried to call her mom on 05/10/20 but her mom didn't answer her cell phone.	D 273		

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-She usually answered her cell phone.
-She called the facility and finally got someone on the phone who went down to Resident #7's room.
-She said the staff couldn't get Resident #7 to wake up enough to talk on the phone.

Review of Resident #7's hospital medical records from the Emergency Department revealed:
-She was admitted from a nursing facility on 05/12/20 where she had been noted to have fever and altered mental status.
-On emergency medical service (EMS) arrival, Resident #7 had a blood pressure of 66/34 which was hypotensive (related to or suffering from abnormally low blood pressure - normal blood pressure is 120/80).
-She was hypoxic (the absence of enough oxygen in the tissues to sustain bodily functions and normal oxygen levels range from 95 - 100 and under 90 is considered low).
-She remained hypoxic on 4 liters of oxygen via nasal cannula.
-The hospital was unable to complete a review of systems due to Resident #7 being unable to answer due to decreased responsiveness.
-She was found to have septic shock (which is a life-threatening condition cause by an infection that causes organ failure and dangerously low blood pressure) due to Urinary Tract Infection (UTI).
-She had received IV fluids and was admitted to the intensive care unit (ICU) in critical condition for further management of septic shock, pneumonia, UTI, and acute renal failure (a condition is which the kidneys can't filter waste from the blood and develps rapidly; may be fatal and most commonly seen in critically ill patients who are already hospitalized) .
-The hospital contacted the Resident Care Manager (RCM) at the facility regarding details

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surrounding events leading up to Resident #7 presenting to the ED.
-They were informed Resident #7 had exhibited spiking fevers since 05/08/20 with no appetite and noted to be very tired and fatigued.

Review of Resident #7's hospital medical records from the Intensive Care Unit (ICU) revealed:
1. Her laboratory records revealed her C-Reactive Protein (CRP is a marker of inflammation and is typically not detected in the blood unless some degree of inflammation is present in the body) was elevated at 400.0 mg/ml (normal is <5mg/ml).
-The hospital ordered Covid-19 testing on 05/13/20.
-The initial COVID-19 test came back negative but was ordered on 05/15/20 to be repeated which came back positive on 05/17/20.-According to the emergency department and hospitalist's admission notes, Resident #7 had a gradual decline in her mental status and decreased appetite.
2. Her chest x-ray showed bilateral irregular infiltrates with possible atypical infectious process.
-Chest x-ray consistent with bilateral infiltrates and with COVID-19 test being positive was the likely etiology for hypoxia.
3. The nursing notes from the ICU revealed:
-On 05/21/20 the certified nursing assistant (CNA) at the hospital went into Resident #7's room at 6:20pm and found patient was drooling all over her gown.
-The CNA went and got the nurse who performed a sternal rub (used for stimulation for response from a patient who is unresponsive to other stimuli).
-Resident #7 was still unresponsive and the doctor was called.

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-It was believed that she had a seizure.
-The family was contacted and were to decide on comfort care measures.
-Resident #7's family members came to visit on 05/22/20 at 7:27pm.
-On 05/24/20 at 1:17am, Resident #7 was found without a pulse or respirations.
-Doctor and family were notified.

Review of Resident #7's death certificate revealed the cause of death documented as Acute Respiratory Failure.

Telephone interview with Resident #7's PCP on 05/15/20 at 10:51am revealed:
-There was no documentation in our system that the facility had called on the weekend of 05/09/20 or 05/10/20.
-If the facility called and left a message, there would be documentation.
-Especially right now during the Coronavirus pandemic, they would expect to be notified of any low-grade fevers.
-She was told on 05/11/20, Resident #7 had a low-grade fever and they had given her Tylenol and had a change in her mental status.
-She ordered an O2 sat per the COVID-19 protocol which was listed on the MARs.
-She did not remember getting the O2 sat results.
-On 05/11/20, she did a teleconference with the personal care aid (PCA) assisting with Resident #7.
-She received conflicting information about Resident #7, regarding whether, she had a fever or not and any other symptoms.
-She was not informed regarding the dark urine with foul odor or decreased urine output.
-If she had, she would have ordered a urinary swab as well as the respiratory swab and ordered for them to continue to monitor vital signs and

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report any concerns or decrease in symptoms or any new symptoms.
-She was not informed the facility had sent Resident #7 out on 05/12/20 with a 101°F temp and BP of 89/43.
-She was unable to say whether the delay in notification would be different since she had not received any information from the hospital.

Telephone interview with the Resident Care Director (RCD) on 05/19/20 at 1:45pm revealed:
-The COVID-19 protocol included checking residents' vital signs every shift and notifying the PCP for temperatures greater than 99.6 degrees F.
-The temperature for reporting had been changed to 99.6 degrees F, but she could not remember from what temperature and when.
-The COVID-19 protocol was put in place by the corporate office
-There was staff training completed on 05/15/20 which included documentation, the facility's COVID-19 protocol and when staff were supposed to notify the PCP.

Telephone interview with the Memory Care Manager (MCM) on 05/19/20 at 1:45pm revealed:
-The last training for staff was done on 05/15/20 and included documentation, but she could not remember what else what included in the training.
-The COVID-19 protocol was started when the state of emergency was initiated (03/10/20).
-On 04/01/20, the COVID-19 protocol was to report resident temperatures greater than 100 degrees F to the PCP.
-When the Governor implemented executive orders for long term care facilities, the protocol was changed to report temperatures greater than 99.6 degrees F (she did not remember the date).
-The COVID-19 protocol was sent via email from

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the corporate office (requested emails but did not receive).
-Staff at the facility had been following the COVID-19 protocol.
-Staff on the Assisted Living (AL) side would report to the RCD and the staff on the Special Care Unit (SCU) would report to the MCM.

Confidential telephone interview with staff revealed staff were told by the Resident Care Director (RCD) to call her first for any fevers.

Confidential telephone interview with a second staff revealed:
-The RCD told the MAs to call her first instead of the physician on 04/30/20.
-The RCD knew when Resident #7 had an elevated temperature for three or four days (dates not specified-the weekend before she went to the ED) but didn't do anything about it.
-Staff kept calling the RCD about Resident #7's elevated temperature and the RCD told the MA to give Resident #7 acetaminophen to get the resident's temperature down (they were told not to document).
-Resident #7's temperature would not go down and the RCD did not want staff to notify the physician to avoid possible COVID-19 diagnosis.
-Resident #7 was eventually sent out to the hospital (date not specified) and "found to have COVID-19 and later died".

Confidential telephone interview with a third staff revealed:
-Resident #7's temperature was 102 on that weekend before she went out to the hospital.
-She ran a fever of 104 that whole night on Sunday and they were checking her temperature every hour and giving her Tylenol.
-Her temperature never decreased.

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D 273	Continued From page 101 -The Medication Aides (MAs) had been told to contact the RCM not the PCP. Interview with the Administrator on 05/19/20 at 1:45pm revealed: -Resident #7 was the first resident to test positive for COVID-19 on 05/17/20. -There were three additional residents who lived on the same hall as Resident #7 who had also tested positive for COVID-19. -The staff did not document contacting Resident #7's PCP which was part of the COVID-19 protocol. -As soon as the medication aide (MA) saw that a resident had a fever, the MA was expected to contact the PCP. -The MA documented all PCP contact in the electronic care notes unless it was documented in an accident/incident report. -The MAs follow the facility's standing order to notify the PCP; MAs were expected to continue to call the PCP until they got a response. -She was a Licensed Practical Nurse (LPN) and the RCD was also an LPN; if they could not reach the PCP or had concerns, they would send the resident to the emergency department. Interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed staff were expected to notify the PCP for residents with temperatures greater than 99.6° F. 2. Review of Resident #8's FL-2 dated 05/07/19 revealed: - Diagnoses included myalgia and myositis. -The resident was semi-ambulatory (used wheelchair to ambulate) and incontinent of bowel and bladder. a. Telephone interview with Resident #8 on 5/28/20 at 9:30am revealed:	D 273		

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-There was blood coming from his penis in December 2019.
-Blood was found in his brief by a personal care aide (PCA) about 2 weeks before he was sent to the emergency department (ED).
-Blood was coming from his penis and the bleeding occurred several times during December 2019, including about one week before he was sent to the ED and again about 2-3 days before he was sent to the ED a second time.
-The PCA informed the medication aide (MA) of the bleeding from his penis and the MA told him she would "keep an eye on it".
-He did not know whether the bleeding was reported to his primary care provider (PCP), the Resident Care Director (RCD) or the Administrator.
-When EMS came to the facility to transport him to the ED, he told them that the bleeding started 2 weeks ago.

Review of Resident #8's local ED report dated 12/31/19, revealed:
-Resident #8's chief complaint was bloody urine (hematuria) for several months.
-The resident reported something similar to this in the past.
-The resident was on a blood thinner, Xarelto.
-A urinalysis was completed, and the primary impression included hemorrhagic cystitis and urinary tract infection/cystitis.
-The resident was treated with intravenous (IV) fluids and IV Rocephin (an antibiotic used to treat urinary tract infections (UTI)).
-The resident was discharged back to the facility with a prescription for Keflex 250mg by mouth two times a day for 10 days (an antibiotic used to treat UTIs).

Review of Resident #8's second local ED report

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dated 01/02/2,0 revealed:
-Resident #8 was seen at the local ED for hemorrhagic cystitis and hematuria.
-Discharge instructions were given to follow-up with urologist in 2-3 days and continue medications as prescribed.

Review of Resident #8's electronic Resident Progress Notes revealed:
-On 12/24/19 at 10:10pm, a MA documented Resident #8's PCA stated that there was blood inside his underpants. Will continue to monitor throughout the night.
-On 12/31/19 at 1:44am, the MA documented Resident #8 had blood in his urine and was sent to the ED for further evaluation per supervisor request.
-On 12/31/19 at 1:59am, the MA documented Resident #8 told the emergency medical technician (EMT) that he had blood in his urine for the last two weeks and he was just now being sent out.
-On 12/31/19 at 5:40am, the MA documented Resident #8 was to follow-up with his primary doctor. There was one prescription for bladder infection. Will continue to monitor.
-On 01/02/20 at 2:42pm, Resident #8 was sent to the ED due to blood in his urine.

Telephone interview with Resident #8's PCP on 05/29/20 at 3:40pm revealed:
-The facility did not notify her of blood in Resident #8's urine, nor did she recieve any calls or messages regarding any blood in the resident's urine at any time in December 2019.
-She worked on 12/24/19 and the facility could have reached her.
-She was concerned that Resident #8 did not receive treatment for a UTI until 7 days after reporting urinary symptoms/blood in his urine.

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-A urine sample should have been obtained and treatment for UTI should have been started immediately for a UTI.
-The resident could have become septic which was a medical emergency.
-She "absolutely" expected the facility to report the resident's bloody urine immediately.

Telephone interview with a PCA on 06/01/20 at 4:15pm revealed:
-She provided care for Resident #8 in December 2019.
-He was having bleeding from his penis (bloody urine) two weeks before he was sent to the local ER.
-She observed blood in his brief each time she performed incontinent care.
-Resident #8 never complained of pain or discomfort.
-She reported the bloody urine to the MA and the RCD.
-Resident #8 was sent to the ED after 12/25/19, but she did not remember the date after bleeding was reported to the MA and RCD.
-She did not know if anyone else reported the bloody urine to the MA or RCM.
-Resident #8 continued to have blood in his urine when he returned back to the facility from the ED.

Telephone interview with the RCD on 06/02/20 at 10:15am revealed:
-A PCA reported blood in Resident #8's brief (did not remember dates) in December 2019 but the resident had a cardiac catheter procedure done earlier in December 2019. She thought the bleeding was coming from the catheter site.
-She did not check the resident to confirm where the bleeding was coming from.
-She did not report the bleeding to the resident's PCP or to the medical provider who performed

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the cardiac catheter procedure.
-She did not know if the MAs reported the blood in Resident #8's urine to his PCP because there was no documentation that the PCP was contacted.
-She received a call from a MA on 12/24/19 who reported there were a "couple" of bloody spots in the resident's brief. She instructed the MA to watch him, to check for bleeding. But she id not instruct the MA to call the resident's PCP or send him to the ER for evaluation.
-A PCA called her at home on 12/31/19 and informed her that Resident #8 had blood in his brief. She instructed the PCA to tell the MA to "look at it" and send the resident to the ED.
-The resident was diagnosed with a UTI and received an antibiotic order.
-On 01/02/20, Resident #8 was sent back to the ED due to blood in his urine continued. The resident was diagnosed with cystitis.
-There was no documentation in the resident's record of the staff contacting the resident's PCP to report the bleeding.
-When there was a change in a resident's status, she expected the staff to report the change to the resident's PCP and document in the resident's electronic progress notes.

Second Telephone interview with the RCM on 06/04/20 at 4:25pm revealed:
-If the staff were aware of Resident #8's bloody urine before 12/24/19, they should have reported the bloody urine to Resident #8's PCP without delay.
-She did not know why the MAs did not report the changes to the PCP.
-The MAs or the RCD should have reported the resident's bleeding to his PCP and she did not know why it was not reported sooner.

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Telephone interview with the Administrator on 06/05/20 at 8:40am revealed:
-She was not working at the facility in December 2019.
-She did not know why the staff did not report Resident #8's urinary complaints/bleeding to his PCP immediately.
-The MAs and the RCD were required to notify the PCP immediately of changes in a resident's status and document all notifications.

b. Telephone interview with Resident #8 on 05/28/20 at 9:30am revealed:
-There were currently live bed bugs in his room and on his bed.
-The bed bugs were coming down the wall onto his bed and "tearing" him up at night.
-At night the bed bugs crawled in his sheets and pillow and bit him on his arms.
-His last bed bug bite was about 2 weeks ago when he was in bed.
- A PCA pulled the covers back and found bed bugs crawling on the resident's arms, legs and head.
-The PCA observed a red area where the bed bug was crawling and had bit his arm.
-The PCA killed the bed bug and the resident applied barrier cream which was kept at his bedside to the bite.
-The resident had been bit in the past by bed bugs and used the barrier cream to treat the bites.
-Bed bugs were found in his room about 2-3 months ago and he had been bit a few times, but he kept barrier cream on his arms and did not have any pain or itching from the bites.
-The Administrator, the MAs and the RCD were aware he had been bitten by the bed bugs since April 2020, but he did not know if anyone at the facility had reported the bites to his PCP since

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she had not made a visit to the facility in about two months.
-He had talked to the PCP on the phone (April or May 2020) but did not mention the bed bug bites since he was treating the bites himself with the barrier cream.

Telephone enterview with the Aministrator on 05/29/20 at 11:20am revealed:
-She was aware there were currently live bed bugs in Resident #8's room.
-The resident bought 2 bed bugs to her office recently.
-She was not aware the resident had sustained recent bed bug bites.
-She did not know if the MA or the RCD performed a skin assessment for bed bug bites.
-The RCD or a MA should have reported bed bug bites or suspected bed bug bites to the resident's PCP.

Telephone interview with Resident #8's PCP on 05/29/20 at 3:40pm revealed:
-She was not aware there were bed bugs in the facility.
-The facility never reported Resident #8 had bed bug bites.
-Her last visit to the facility was in April 2020 and the staff nor the resident reported bed bug bites.
-She had talked to Resident #8 and facility staff on the phone (Telehealth) since her last visit and neither the staff nor the resident informed her of bed bug activity in his room or bed bug bites.
-She reordered Resident #8's skin barrier cream to apply to his perineal area after incontinent care but was not aware the resident was using the cream to treat bed bug bites.
-She expected the facility to report bed bug bites immediately and she would have ordered treatment for the bites.

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D 273	Continued From page 108 Telephone interview with a PCA on 06/01/20 at 4:15pm revealed: -She usually worked second shift and provided care for Resident #8. -She had observed bed bugs in Resident #8's room (on his bed) multiple times for about 2-3 months. -She had reported bed bugs activity in the resident's room more than ten times to the RCD and the MAs since she first observed them 2-3 months ago. -About 2 weeks ago, she had observed bed bugs on Resident #8's legs, arms, and head. -She observed a red area on the resident's arm and a bed bug was on the red area and appeared filled with blood, the bed bug was "fat". -Even though the resident stated he could not feel the bed bug bites, she reported the bites to the MA who was working. -The MA did not go to the resident's room to look at the bite area on the resident's arm. -The MA did not tell her he called the resident's PCP. -She was not aware the resident had been applying barrier cream on the bite areas. Telephone interview with the RCD on 06/02/20 at 10:15am revealed; -Resident #8 had bed bug activity in his room "on and off" for a while. -The bed bugs got "bad" about 2-3 months ago. - A PCA informed the RCM of bed bugs in the resident's bed about 2-3 weeks ago. -The PCA reported there was blood on the resident's sheets after killing bed begs on the resident's linen. -The PCA reported there were live bed bugs crawling on the resident, but no one reported bed bug bites or red areas on the resident's skin.	D 273		

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-She expected the MAs to assess the resident's skin for signs of bites and report any signs of bed bug bites to the resident's PCP, and the RCD, but she did not instrct the MAs to report the bites to the resident's PCP.
-The RCD did not follow-up with the MAs to confirm the bed bug bites were reported to his PCP.
-The RCD was not aware Resident #8 was treating bed bug bites with barrier cream.

Interview with a MA on 06/02/20 at 12:25pm revealed:
- A PCA reported to him live bed bug activity in resident #8's room, on his bed about 2-3 months ago.
-Bed bugs were reported in the resident's bed about 2 weeks ago by a PCA.
-The PCA reported to him that there were bed bugs on the resident and a red spot on the resident's arm, but no bites were reported.
- He did not assess the resident for bites after the PCA reported the red spot and did not report to the resident's PCP.
-He did not know if the Resident #8's PCP had been informed of the red spot or bed bugs found on his body.
-If a resident had sustained bed bug bites, the bites were reported to the MA (supervisor-in-charge) or the RCD and the MA or RCD reported the bites to the resident's PCP or on-call medical provider.

Interview with the Administrator on 06/05/20 at 8:40am revealed:
-When bed bug bites were reported to the MAs or RCM, they should have completed a skin assessment for signs of bed bug bites.
-Resident 8's PCP should have been notified of live bed bugs found crawling on the resident's

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skin and any signs of bed bug bites.
-She expected the RCM to complete skin assessments and contact the resident's PCP.

3. Review of Resident #1's current FL-2 dated 12/23/19 revealed diagnoses included dementia, atrial fibrillation, congestive heart failure, coronary artery disease, cardiomyopathy, hypertension, diabetes mellitus and Parkinson's disease.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 10/28/19.

a. Review of a consultation visit note dated 12/18/19 for Resident #1 revealed a primary care provider (PCP) note for the resident to follow up with cardiology for congestive heart failure (CHF) and coronary artery disease (CAD).

Telephone interview with Resident #1's responsible person (RP) on 05/14/20 at 1:54pm revealed:
-Resident #1 had a pacemaker/defibrillator that was due for a remote monitoring check.
-He had brought the machine for the remote monitoring check to the Special Care Unit (SCU) on a weekend sometime in January or February 2020.
-He did not remember the name of the staff that he had left the machine with.
-The physician's office called him six weeks ago and said the remote monitoring check had still not been done.
-He could not get through on the phone to anyone at the facility for several weeks.

Telephone interview with Resident #1's family member on 05/15/20 at 4:10pm revealed Resident #1 had a pacemaker/defibrillator; it was

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concerning because she did not know the last time the resident had seen the cardiologist.

Telephone interview with Resident #1's PCP on 05/15/20 at 10:46am revealed Resident #1 had a pacemaker; she was followed by an outside cardiologist and she did not know how often monitoring was required.

Telephone interview with Resident #1's PCP on 05/22/20 at 11:03am revealed:
-She did not have any documentation Resident #1 was seen by her established cardiologist following her 12/18/19 initial visit with the resident.
-Specialty providers did not always send a visit note back to the PCP for confirmation.
-Staff would have been responsible for scheduling the referral appointment because it was not a new referral.

Telephone interview with the Practice Manager for Resident #1's cardiologist's office on 06/03/20 at 4:05pm revealed:
-Persons with pacemakers were supposed to have the device leads and battery checked along with their heart rhythm every 90 days.
-A pacemaker was placed to control the rhythm of a person's heart; if the pacemaker battery was dead the pacemaker would not be able to do that.
-Resident #1's last pacemaker check was in September 2019; the resident missed appointments in December 2019 and March 2020.

Review of Resident #1's hospital record dated 05/18/20 through 05/21/20 revealed:
-Resident #1 was admitted for acute on chronic heart failure with an elevated pro-B-type Natriuretic Peptide of 2210 (normal value is 0 to

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D 273	Continued From page 112 450. -Resident #1 had a permanent pacemaker placed and the device was last checked on 0917/19. -Resident #1's family requested the pacemaker be checked while the resident was hospitalized. -A complete check of Resident #1's device and cardiac monitoring was completed on 05/21/20. Telephone interview with the Memory Care Manager (MCM) on 05/22/20 at 3:36pm revealed: -She was sure she had made the referral and Resident #1 had seen the cardiologist. -She would have to check Resident #1's record for the documentation on the resident seeing the cardiologist following the referral order from 12/18/19. -Resident #1's pacemaker monitoring was done while the resident was at the hospital; she did not know the date. -Orders from the PCP were faxed or emailed; she was responsible for follow up on referral orders for residents in the SCU. Telephone interview with Administrator on 05/28/20 at 9:02am revealed: -Resident #1 had atrial fibrillation, congestive heart failure and had been on Eliquis. (Eliquis is a blood thinner used to prevent blood clots.) -The MCM or Resident Care Director (RCD) were responsible for making referrals ordered by the PCP. -The MCM and/or RCD would have documented the referral in the resident's electronic progress notes. -The MCM and RCD accompanied the PCP on facility visits with residents; the MCM/RCD discussed concerns, orders and referrals at the time of the visit. -The PCP faxed and/or emailed visit notes, orders and referrals.	D 273		

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-The MCM and RCD used a hot box system to assure PCP orders and referrals were implemented and completed.
-There was no system in place for monitoring the referral process.
-She knew Resident #1 had a pacemaker; the resident had to stay in the hospital an additional day to have the pacemaker checked and charged.
-The pacemaker was checked during the resident's last hospitalization 05/18/20 through 05/21/20.
-She did not know about a remote monitoring device for the pacemaker being brought to the facility by Resident #1's responsible person (RP).
-She did not know if Resident #1 was seen by a cardiologist following the referral ordered 12/18/19.

Attempted interview on 05/15/20 at 1:44pm with Resident #1's cardiologist was unsuccessful.

b. Review of an electronic progress note dated 04/27/20 at 7:35pm revealed Resident #1 was "very agitated and physically attacking staff."

Review of an electronic progress note dated 04/27/20 at 10:28pm revealed Resident #1 was constantly in and out of other resident's rooms and when asked to leave became violent; the resident was also having trouble getting to sleep.

Telephone interview with Resident #1's responsible person (RP) on 05/14/20 at 1:54pm revealed:
-He did not know Resident #1 had a change in behavior with agitation and aggression towards staff and residents.
-Resident #1 was not normally aggressive and did not normally attack anyone.

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-Staff had called him this morning (05/14/20) and said Resident #1 was sent to the emergency department (ED) for a urinary tract infection (UTI).
-Resident #1 had behavior changes and falls whenever she had a UTI.

Telephone interview with a medication aide (MA) on 05/21/20 at 4:33pm revealed:
-She documented the electronic care note dated 04/27/20 for Resident #1.
-Resident #1 walked constantly, wandered into other resident's rooms, laid in other resident's beds and would swing at staff when redirected.
-Resident #1 swinging at staff was not normal behavior the resident.
-Resident #1 had "a lot of medical things" going on with her in the last two weeks.
-Resident #1 had a UTI and was admitted to the hospital a few days ago (05/18/20).
-She assumed the primary care provider (PCP) was already notified of Resident #1's abnormal behavior that she had documented on 04/27/20.
-She had not notified the PCP of Resident #1's behavior changes documented on 04/27/20; she only documented it in her note.

Telephone interview with Resident #1's PCP on 05/15/20 at 10:46am revealed:
-She was contacted on 05/10/20 regarding Resident #1 being agitated "again" and had fallen after an altercation with another resident.
-She had a virtual visit with Resident #1 on 05/11/20; Resident #1 was not engaged and frequently walked away during the visit.
-A urine specimen had been sent on 05/10/20 which came back positive for a UTI and orders were written for an antibiotic.

Second telephone interview with the PCP on

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05/22/20 at 11:03am revealed:
-With dementia, sudden behavior changes were an early sign of a UTI.
-She would have wanted the staff to notify her of Resident #1's behavior changes on 04/27/20.
-There was no record of any notification on 04/27/20 at her office; she was contacted on 05/10/20.

Telephone interview with Resident #1's mental health provider (MHP) on 06/04/20 at 8:23am revealed:
-She saw Resident #1 on 05/07/20 for a routine medication management visit.
-At the time of the visit, staff reported Resident #1 had been pacing the halls and was more combative with staff.
-Resident #1 was fighting staff off when the staff attempted to redirect the resident back to her room and combative with other residents.
-She did not know the details of Resident #1 being combative with other residents.
-The staff had not contacted her with concerns about Resident #1's behavior between 04/27/20 and 05/07/20.
-Resident #1 was not able to tell you if something was wrong.
-Staff did not pay attention to behavior changes that lead up to acute problems; often not reporting changes until the date of her visits with residents.

Telephone interview with the Memory Care Manager (MCM) on 05/22/20 at 3:36pm revealed:
-Resident #1 was on antibiotics for a UTI.
-She was told by Resident #1's RP the resident would have behavior changes, become unsteady with walking and fall frequently when she had a UTI.
-Resident #1 was "coming around" with less

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agitation and no longer constantly walking since getting treatment for the UTI.
-She did not know if staff had reported the behavior changes documented in the 04/27/20 electronic progress note for Resident #1.
-She did not know about the behavior changes documented in the 04/27/20 electronic progress note.
-Staff were expected to notify the PCP and her of all changes in condition including acute behavior changes at the time the changes occurred and document contact with the PCP in the electronic progress notes.

Telephone interview with the Administrator on 05/28/20 at 9:02am revealed staff would have been expected to notify Resident #1's PCP of the behavior change documented in the electronic progress note on 04/27/20 at the time the behavior change was seen.

c. Telephone interview with Resident #1's family member on 05/15/20 at 4:10pm revealed:
-Prior to COVID-19 (March 2020), she visited Resident #1 at the facility one to two times per week.
-Resident #1's legs were always itching and there were sores on her legs where she had scratched.
-Resident #1 would not sit in her recliner, she would constantly be getting up and walking up and down the halls.

Confidential telephone interview with a staff revealed:
-Resident #1 had bed bug bites on her legs since she moved from the assisted living (AL) side to the special care unit (SCU).
-The resident who was in Resident #1's room (401) before Resident #1 had bed bugs.
-Staff had told the Administrator several times

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between January and March 2020; the Administrator denied that bed bugs were in the facility.
-The bed bug bites on Resident #1's legs were bad; the resident scratched all the time and bled from the bites.
-The bed bug infestation in Resident #1's room was so bad the resident would lay down in the bed and then jump right back up out of the bed and start walking.
-Staff saw the bed bug bites on Resident #1's legs all the time; the last time bed bugs were seen in the resident's bed was approximately one month ago.

Confidential telephone interview with a second staff revealed:
-Resident #1 had been bitten several times on her face and body by bedbugs in her room.
-Staff got Resident #1 out of her bed because the resident was being bitten by bedbugs; staff put Resident #1 in a chair in the resident's room and Resident #1 was still bitten by bedbugs in the chair.
-Staff was not sure of the date when they got Resident #1 out of her bed into her chair.
-The staff reported Resident #1's bedbug bites to the medication aide (MA) on duty and the MA put cream on bedbug bites.

Review of an electronic progress note dated 04/22/20 at 10:27pm revealed Resident #1 kept scratching her legs until they bled; the MA put Band-Aids on the resident's legs.

Telephone interview with a MA on 06/04/20 at 11:49am revealed:
-She documented the electronic progress note dated 04/22/20 at 10:27pm for Resident #1.
-She was working that day and looked at

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Resident #1's legs; Resident #1 kept scratching her legs from knees to ankles.
-There was "like a rash" on Resident #1's lower legs that was red and had blood coming from spots on her legs.
-She had not reported the rash, itching and scratching to Resident #1's primary care provider (PCP) or Memory Care Manager (MCM)because she assumed the PCP and MCM knew.

Telephone interview with a second MA on 06/01/20 at 12:50pm revealed:
-She saw bed bugs in Resident #1's recliner on 05/17/20.
-Resident #1 scratched at her legs frequently until they would bleed.
-She had never notified the PCP about the bed bug bites on Resident #1.

Telephone interview with the PCP on 05/22/2020 at 11:03am revealed:
-She had not seen any rash, itching or bite marks on video visits with Resident #1 in April and May 2020.
-Video visits were limited in clarity of what she was able to see during the visits.
-Staff did not report any concerns related to rashes, itching or bite marks on Resident #1 in April and May 2020.

Telephone interview with the Memory Care Manager (MCM) on 06/04/20 at 3:48pm revealed:
-If staff told her a resident had red marks on their skin, she could not say it was from bed bug bites.
-When staff did see bed bugs in a resident's room there was a protocol to clean the room, notify her and/or the Administrator and complete a body check sheet.
-She knew about Resident #1 scratching her legs because the resident was doing that when she

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was on the AL side (November and December 2019).
-She had seen Resident #1 digging and picking at her legs.
-She thought the Resident #1 had a cream that staff used for her legs.

Review of Resident #1's May 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for triple antibiotic ointment topically as needed for minor skin tears and/or abrasions.
-There was no documentation any doses were administered.
-There were no entries for any other creams or ointments for Resident #1.

Telephone interview with the Administrator on 06/05/20 at 8:40am revealed:
-There should not have been a delay in reporting bed bug bites to the PCP.
-She would have expected the MCM to complete an assessment of Resident #1 for reports of bed bug bites.

d. Review of Resident #1's current FL-2 dated 12/23/19 revealed an order for daily weights; report weight to primary care provider (PCP) if there was a 3 pound gain.

Review of Physician's orders dated 03/31/20 for Resident #1 revealed an order for daily weights; report weight to PCP if there was a 3 pound gain.

Review of daily weight documentation for Resident #1 revealed:
-Resident #1's weight was documented as 180 pounds on 04/04/20.
-Resident #1's weight was documented as 173.4

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pounds on 04/05/20 for a 6.6 pound weight loss in one day.
-There was documentation Resident #1 was weighed daily from 04/06/20 through 04/11/20 with weight results of 174 - 174.3 pounds.
-Resident #1's weight was documented as 174 pounds on 04/12/20.
-Resident #1's weight was documented as 162.6 pounds on 04/13/20 for an 11.4 pound weight loss in one day.
-There was documentation Resident #1 was weighed daily from 04/14/20 through 04/30/20 with weight results of 158 - 161. 5 pounds.
-Resident #1's weight was documented as 165.2 pounds on 05/01/20.
-Resident #1's weight was documented as 159 pounds on 05/02/20 for a 6.2 pound weight loss.
-There was documentation Resident #1 was weighed daily from 05/03/20 through 05/13/20 with weight results of 157.3 - 158 pounds.

Review of Resident #1's hospital record dated 05/18/20 through 05/21/20 revealed Resident #1 weighed 148 pounds on 05/18/20.

Review of electronic progress notes and incident reports dated 04/01/20 through 05/18/20 for Resident #1 revealed there was no documentation Resident #1's primary care provider was notified of the weight loss documented on 04/05/20, 04/13/20 and 05/02/20.

Confidential telephone interview with a staff revealed:
-Resident #1 had lost a lot of weight, was not herself and declined since she was moved to the special care unit (SCU).
-There were 5 residents on the SCU who visibly lost large amounts of weight in the last 6 months including Resident #1.

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D 273	Continued From page 121 Telephone interview with a medication aide (MA) on 05/21/20 at 11:03am revealed: -MAs weighed residents every month and documented the weights on the resident's electronic medication administration record (eMAR). -The facility had two scales used for weighing residents; a wheelchair scale and stand up scale. -She used the same scale when she weighed each resident; she cleared out the scale making sure it was at zero before weighing each resident. -She used the stand up scale to weigh Resident #1. -She did not remember Resident #1 having a 6.6 pound loss on 04/05/20, an 11.4 pound loss on 04/13/20 and a 6.2 pound loss on 05/02/20. -It was the facility's procedure for MAs to contact the primary care provider (PCP) for a 5 pound weight change and document in the electronic progress notes. -She did not know if she contacted Resident #1's PCP for the weight loss on 04/05/20, 04/13/20 and 05/02/20. -She did not know why Resident #1 was ordered to have her weight checked every day. Telephone interview with a second MA on 05/21/20 at 4:33pm revealed: -She did not know Resident #1 had lost 6, 7 and 11 pounds. -She saw that Resident #1 had lost a bit of weight. -Resident #1 was a good eater; staff had to assist the resident with eating because the resident would not sit still to eat. -It was the facility's procedure for MAs to report weight changes of 5 pounds or more to the PCP. -Resident #1's weight loss could have been a typing error.	D 273		

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-When she entered a resident's weight in the computer system, she was not able to see the previous recorded weight so she did not see the weight loss.
-The Memory Care Manager (MCM) was able to review the previous weight recorded.

Telephone interview with Resident #1's PCP on 05/22/20 at 11:03am revealed:
-Staff had a weight change sheet to report weight changes of five pounds or more.
-She was not notified of Resident #1's weight changes in April and May 2020.
-Staff were expected to notify her of weight changes of 6 - 11 pounds in one day.
-Staff had not reported any issues or concerns with Resident #1's eating.

Second telephone interview with Resident #1's PCP on 06/03/20 at 2:52pm revealed:
-Some of Resident #1's weight loss could be attributed to diuretic medications but not the amount of weight loss Resident #1 had over the past 6 months.
-She had a weight of 215 pounds documented in December 2019 when she first saw Resident #1; she did not know if the weight was accurate.
-Different scales could show different weights but not a 10 pound or more difference.
-Resident #1 was supposed to have daily weights done because the resident had congestive heart failure and there was a concern for weight gain.
-Resident #1's weight loss should have been reported at some point; she would have requested the resident be re-weighed to verify the weight loss each time.
-Staff had not reported any concerns with Resident #1's appetite or ability eat.
-She would definitely have had a concern for nutritional deficiencies with that amount of weight

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loss.
-Resident #1's recent laboratory work from the hospital did not show signs of nutritional deficiencies.

Telephone interview with the MCM on 05/22/20 at 3:36pm revealed:
-Staff were expected to report weight changes of 5 or more pounds to the PCP and her.
-When the weight was being entered in the computer system, the computer system showed the resident's previous weight on the screen.
-If she had known about Resident #1's weight loss, she would have discussed it with the PCP.
-Weight changes were documented on a weight notification sheet and faxed to the PCP by her or the MA.

Telephone interview with the Administrator on 05/28/20 at 9:02am revealed:
-Resident #1 had congestive heart failure.
-The staff should know the basics of caring for a resident with congestive heart failure including the importance of monitoring and reporting weight changes, edema and shortness of breath.
-The MA or the MCM was responsible for notifying the PCP for weight changes of 5 pounds or more.
-The MA or MCM was expected to document contact with the PCP in the electronic progress notes.
-Staff should have reported the weight changes for Resident #1 on 04/5/20, 04/13/20 and 05/02/20.

Interview with the Administrator on 06/05/20 at 8:40am revealed:
-The MAs were responsible for documenting weights in the computer system.
-The MCM was responsible for reviewing weights.

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D 273	Continued From page 124 -She expected the MAs or MCM to notify the PCP immediately if weight discrepancies were within the physician ordered realm for notification. -The MAs were able to report weight discrepancies to the PCP if the MCM was not available. Upon request on 05/22/20, 05/27/20 and 06/01/20, weight change notification sheets for documented weight loss for Resident #1 for April and May 2020 was not available for review. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 4. Review of Resident #9's current FL-2 dated 08/06/19 revealed: -Diagnoses included dementia, fracture of left femur, falls, and muscle weakness. -The resident was intermittently disoriented and was semi-ambulatory with a walker. -The resident's recommended level of care was a special care unit (SCU). Review of Resident #9's current Assessment and Care Plan dated 08/13/19 revealed: -There was no documentation regarding the resident's orientation level. -The resident required limited staff assistance with ambulation, dressing and transferring. a. Review of an emergency department (ED) visit for Resident #9 dated 05/17/20 revealed: -The resident was seen in the ED due to a fall. -The resident was diagnosed with an orbital wall fracture, eyebrow laceration, and a periorbital hematoma of the left eye. -The resident required sutures for the closure of the eyebrow laceration.	D 273		

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D 273	Continued From page 125 -In the "Follow-up" section of the ED visit form, there were follow-up instructions to contact the named Ear Nose and Throat (ENT) provider to make an appointment in 2 days. -The ENT's address, contact number and fax number was documented on the form. Review of an accident/incident report dated 05/17/20 at 1:30pm for Resident #9 revealed: -Resident #9 had an unwitnessed fall with a laceration injury. -In the "Record status of Resident after ER/Hospital" section of the form, there was an entry the resident had an ENT follow up. -The form was created by a medication aide (MA) -The form was completed and closed by the Memory Care Manager (MCM). Review of Resident #9's electronic progress note dated 05/18/20 at 12:27am revealed: -The resident had returned from the ED. -The resident was discharged with a laceration of the face, suture removal in 7 days, prescribed antibiotics and an ENT referral over the next "3 days". -The progress note was "created" by a MA. Attempted telephone interview with the MA who documented the electronic progress note dated 05/18/20 at 12:27am was unsuccessful on 06/04/20 at 1:20pm. Telephone interview with a MA on 06/04/20 at 11:49am revealed: -The MCM was responsible for any referral and follow-up needs ordered when residents were treated in the ED. -The MAs were responsible for placing the residents' ED paperwork on the MCM's desk in a basket.	D 273		

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D 273	Continued From page 126 -The MAs always had accessibility to get into the MCM's office when the MCM was not there. Telephone interview with a receptionist at the ENT's office for Resident #9 on 06/01/20 at 3:56pm revealed: -There was no referral or information for Resident #9 to be seen for a follow up for an orbital wall fracture. -There was no scheduled, canceled or a "no show" appointment for Resident #9. Telephone interview with the MCM on 06/04/20 at 3:47pm revealed: -She was aware Resident #9 was evaluated in the ED on 05/17/20. -She was not aware Resident #9 had a need for an ENT and today (06/04/20) was the first time she was seeing the ENT referral. -She had to contact the local ED to obtain Resident #9's paperwork from the ED visit on 05/17/20 because the paperwork was not sent back with Resident #9. -The only information that was sent back from the ED with Resident #9 on 05/17/20 was "a top sheet" that the resident was there, an "informal page" that had the resident went to the hospital and the resident's diagnoses. -She had contacted the named ENT providers office today (06/04/20) to ensure they could take appointments and was told "yes". -The first time she saw any need for an ENT referral was when she saw the information for an ENT referral on the facility's accident/incident report for Resident #9 dated 05/17/20. -Resident #9's sutures were removed yesterday, (06/03/20). -She was responsible for the residents' follow-up needs and the residents' paperwork when the residents were evaluated in the ED.	D 273		

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D 273	Continued From page 127 Telephone interview with Resident #9's PCP on 06/05/20 at 3:16pm revealed: -The MCM contacted her office today, (6/04/20) and reported she had contacted the ENT provider for Resident #9 listed on the ED forms on 05/17/20. -The MCM reported that she was informed by the ENT provider Resident #9 did not need to be seen by an ENT for an eye laceration and needed to be seen by an eye doctor, the ENT referral from the ER was wrong and was told to contact the resident's PCP. -She informed the MCM Resident #9 was referred to an ENT for a periorbital fracture extending into the sinus and not for an eye laceration and instructions were given to the MCM to contact the ENT provider again and to explain the purpose of the referral. Based on record reviews and interviews, Resident #9 was not interviewable. Telephone interview with the Administrator on 06/05/20 at 11:30am revealed: -The MCM and the Resident Care Director (RCD) were responsible to ensure residents' orders were received from fax, hospitals or PCPs. -The MCM and RCD were responsible to document when a resident was seen by a referring provider. b. Review of an electronic progress note dated 04/11/20 at 6:38am for Resident #9 revealed: -The resident had a bruise on his left "cheek" and side of left knee and hip. -The resident had no complaints of pain at the time and staff would alert next shift. -The resident was "monitored".	D 273		

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D 273	Continued From page 128 Review of Resident #9's electronic progress notes and accident/incident reports revealed there was no additional documentation prior to 04/11/20 at 6:38am or on 04/10/20 of a fall or injuries. Review of an electronic progress note dated 04/11/20 at 11:08am for Resident #9 revealed the resident was witnessed by a personal care aide (PCA) when the resident fell at 10:35am. Review of an electronic progress note dated 04/11/20 at 2:38pm for Resident #9 revealed the resident was sent out to the hospital. Review of an emergency department (ED) visit notes for Resident #9 dated 04/11/20 revealed: -The resident was seen for a contusion of the left hip. -In the initial section of the report there was entry the resident "apparently fell yesterday" and according to emergency medical services the resident had been walking but had a large bruise on his hip. -The patient denied any significant pain. -The reason for the exam was fall yesterday, large hematoma. -The resident had an x-ray of the left hip with an avulsion fracture that was unchanged when compared to the x-ray done 03/02/20. Review of a electronic progress note dated 04/11/20 at 6:52pm revealed: -The resident was brought back from the hospital at 6:30pm. -The resident had a bruise on his left hip and would be kept on isolation for 48 hours. -The resident was given a Tylenol for pain, vital signs taken and "will continue to monitor".	D 273		

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Review of an accident/incident report dated 04/11/20 at 9:18pm for Resident #9 revealed:
-Resident #9 had an unwitnessed fall in the resident's bedroom with an injury documented as a "bump".
-Resident #9 was not sent to the ED.
-Resident #9's primary care provider (PCP) was notified at 9:28pm.
-In the evaluation section of the form there was an entry "follow up initiated" and to monitor status for 72 hours and chart progress notes daily.
-There were no additional orders in the order section of the form.

Review of an electronic progress note for Resident #9 dated 04/11/20 at 9:29pm revealed:
-The resident fell again.
-The resident had a "bump on head".
-The resident's PCP was called "check vitals every 2 hours and check on him every 15 minutes for rest of the night".
-The residents vital signs were 158/84, pulse 88, temperature 98.6 and respirations 17.
-The staff would continue to monitor.

Additional review of Resident #9's electronic progress notes revealed:
-On 04/11/20 at 10:42pm staff continued to monitor the resident. The resident's vital signs were 176/106, 81, 98.9 and 18.
-On 04/12/20 at 6:02am, the resident slept through the night without any complaints of pain and "would continue to monitor".
-There was no additional documentation the resident's vitals were checked every 2 hours, or the resident was checked every 15 minutes for the rest of the night.

Review of Resident #9's May 2020 electronic medication administration record (eMAR)

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revealed:
-There was not an entry for the resident to have vital signs checked every 2 hours.
-There was no documentation vital signs were checked every 2 hours or the resident was checked by staff every 15 minutes.

Review of Resident #9's PCP orders revealed there was no orders signed by the PCP for vital sign checks every 2 hours and every 15 minute checks on 04/11/20.

Telephone interview with the MA who documented the electronic progress note on 04/11/20 at 9:29pm and on 04/11/20 at 10:42pm on 06/04/20 at 11:49am revealed:
-It was hard for her to remember the exact incident because she normally worked the "women's hall" and was currently not at the facility.
-On 04/11/20 when she was working at the facility, a PCA was assisting Resident #9 with incontinence care and stepped away to retrieve an item.
-Resident #9 was "determined" he was going to "still" walk, and he stood up and fell when the PCA stepped out of the room.
-She called Resident #9's PCP or she could have called the "on call" provider (named), they "told us what to do and we did it"(The resident's vitals and checked on the resident every 15 minutes).
-The named on-call provider was not with the same practice as Resident #9's provider.
-She could not be certain who she had spoken with on 04/11/20, however, recently started documenting who she had spoken with when she called residents' PCP; she had not always documented that.
-Her shift ended at 11:00pm on 04/11/20 and could not provide any additional information.

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-She remembered another incident when Resident #9 had a fall and thought he bumped his head on the nightstand table when he fell between the bed and the nightstand. She could not remember when this occurred because the resident had so many falls. No other information was provided related the fall.
-When a resident had unwitnessed falls, the protocol was for the MA to assess the resident for wounds, abrasions, blood and would attempt range of motion to make sure everything was "looking right".
-MAs were not qualified to assess residents and if there were concerns of an injury staff sometimes went ahead and sent the resident out.
-If a resident had an unwitnessed fall and unsure if the resident hit their head, staff could only look to see if the resident had any marks or bumps.
-She was told by the MCM and the Administrator if the resident did not need to be sent to ED then do not send them out.

Attempted telephone interview with the MA who documented the electronic progress note on 04/12/20 at 6:02am was unsuccessful on 06/05/20 at 1:12pm.

Telephone interview with the Administrator on 05/13/20 at 1:11pm revealed:
-The MAs filled out the initial accident/incident report, the MCM and the Resident Care Director (RCD) then followed the MA and completed the accident/incident reporting process including sending the report to the Department of Social Services.
-If a resident had a head injury or any kind of bleeding after an unwitnessed fall, the resident was sent to the ED.
-For injuries greater than a skin tear and/or complaint of pain, the resident was sent to the

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ED.
-The process was the same for witnessed and unwitnessed falls.

Telephone interview with Resident #9's PCP on 06/02/20 at 2:03pm revealed:
-She was aware of the first reported fall the resident had on 04/11/20 when the resident was evaluated in the ED.
-There was no notification in the resident's record the resident had fallen again and had a bump on his head after returning to the facility on 04/11/20.
-The next entry in the resident's chart was a visit note made with the resident on 04/13/20.
-She had many concerns of what could happen when a resident fell and hit their head and it was not reported.
-If she had been notified of the unwitnessed falls and the resident had a bump on his head, she could have given staff orders to increase monitoring for the resident for the next 24 hours to check for signs of a head injury such as vomiting severe headaches and change in his mental status, but staff could not get those orders unless she was notified.

A second telephone interview with Resident #9's PCP on 06/04/20 at 1:13pm revealed:
-She was not sure if facility staff called the on-call provider with another provider's office on 04/11/20 but they should not have.
-If her on-call provider gave an order for Resident #9 on 04/11/20, those orders would have been in the resident's record and faxed to the facility and there was no order for 04/11/20 due to a fall after returning from the ED in the resident's record.

Review of an accident/incident report dated 04/27/20 at 2:38pm for Resident #9 revealed:
-Resident #9 had an unwitnessed fall, sitting on

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the floor beside his bed with no injury noted.
-Resident #9 was not sent to the ED.
-Resident #9's PCP was notified at 2:42pm.

Review of Resident #9's electronic progress notes revealed:
-On 04/27/20 at 8:50pm, there was an entry by a MA the resident was "monitored", ate 75% of supper and took all of his medication and "doing good".
-On 04/28/20 at 5:40am, there was an entry by another MA the resident slept though the night without any complaints of pain from his fall and would continue to monitor.

Confidential interview with a former staff revealed:
-The staff was told if a resident had an unwitnessed fall and if there were no lumps or evidence the resident hit their head staff could not send the resident out and to contact the PCP.
-When a resident fell, staff were expected to complete an accident/incident report and contact the PCP documenting the contact on the incident/accident report, however sometimes the MCM would tell staff to complete the report and document the PCP was notified and the MCM would notify the PCP.

Attempted telephone interview with the MA who documented the electronic progress note on 04/27/20 at 8:50pm on 06/04/20 at 1:20pm was unsuccessful.

Attempted telephone interview with the MA who documented the electronic progress note on 04/28/20 at 5:40am on 06/05/20 at 1:12pm was unsuccessful.

Telephone interview with the MCM on 06/04/20 at

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3:45pm revealed:
-If she did not witness a resident hit their head during a fall, then she could not say the resident hit their head.
-When a resident fell and staff were not able to contact the PCP, then it was expected for staff to send the resident out to the ED.
-There had been past issues when attempting to reach Resident #9's providers office and she would have to try to contact the provider herself but could only leave a message and would receive a return call that following morning.
-She expected if a resident fell and hit their head, the resident should be sent out to the ED and not wait for a return call from the PCP.

Telephone interview with Resident #9's PCP on 06/02/20 at 2:03pm revealed:
-She had not been notified Resident #9 fell on 04/27/20.
-She expected to be notified when a resident fell.
-There were no notifications from the facility regarding a fall in the resident's record from 04/22/20 - 05/05/20.
-She was not notified of another fall on 05/17/20 and found out about the fall on 05/18/20 when she was asked by the facility if the resident could be seen related to a blood pressure issue and when she saw the injuries on the resident's face, she asked staff "what the heck happened to him".

Telephone interview with Resident #9's PCP on 06/03/20 at 2:53pm revealed when a resident had an unwitnessed fall, the facility should call the PCP for advise unless the resident had obvious injuries then the resident should be sent to the ED.

Telephone interview with the Administrator on 06/04/20 at 3:49pm revealed:

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-An emergency in a fall would be resident bleeding, altered mental status (AMS), head injury, pain, or a body part that looked abnormal.
-If a resident fell and did not sustain bleeding, "rash", or have complaints or "issues" an assessment would be made by staff and the PCP notified.
-An accident/injury report would be completed by the MA.
-The MCM and the Resident Care Director (RCD) would review the AI report and complete.
-The MCM or the RCD would be called if not in the building at the time of the fall.
-The MCM or the RCD would review the accident/incident report on the following day.

Based on record reviews and interviews, Resident #9 was not interviewable.

5. Review of Resident #4's FL2 dated 07/16/19 revealed:
-Diagnoses included Alzheimer's, bradycardia, hypertension, diabetes mellitus (DM), and coronary artery disease.
-The resident was ambulatory, a wanderer and constantly disoriented, and intermittently incontinent of bowel and bladder.
-There was a medication section with documentation "see signed physician orders".

Requests of the facility for Resident #4's signed physicians orders on 05/13/20, 05/14/20, 05/19/20, and 05/21/20 were not provided prior to survey exit.

Review of Resident #4's Assessments and Care Plan dated 01/14/19 revealed:
-The resident wandered, was oriented, incontinent of bowel and bladder, required extensive assistance with bathing, dressing,

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limited assistance with ambulation and toileting hygiene, and supervision with transfers.
-The resident's skin was normal.

Requests of the facility for Assessments and Care Plans for Resident #4 on 05/13/20, 05/14/20, and 05/21/20 were not provided prior to survey exit.

Review of Resident #4's Primary Care Provider (PCP) visit note dated 07/29/19 revealed there was no wound to the resident's right hip.

Review of Resident #4's progress notes dated 08/01/19 at 10:02pm revealed:
-The resident had a "sore on right hip will continue to monitor".
-The wound was documented by a medication aide (MA).
-There was no documentation the resident's PCP was notified.

Review of Resident #4's progress notes dated 08/06/19 at 3:39pm revealed:
-The resident had an "open area on right hip".
-The wound was documented by a second MA.
-There was no documentation the resident's PCP was notified

Review of Resident #4's progress notes dated 08/07/19 at 10:31am revealed the wound was evaluated by the PCP.

Review of Resident #4's PCP visit notes dated 08/07/19 revealed:
-The resident was examined in bed, nonverbal, and would not follow commands.
-The resident had cognitive impairment and was unable to communicate effectively.
-The reason for the visit was the resident had a

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wound on the bony area of the right hip.
-The resident had a diagnosis of DM, Alzheimer's disease, and failure to thrive.
-The resident had a 4-centimeter (cm) x 2.5cm stage 2 pressure ulcer over the right hip bony prominence.
-Home health (HH) nursing was ordered for wound care.

Telephone interview with Resident #4's Power of Attorney (POA) on 05/08/20 at 2:09pm revealed:
-The resident was no longer at the facility.
-The resident had developed a right hip wound while at the facility.

Telephone interview with a MA on 05/13/20 at 1:05pm revealed:
-Any resident wound discovered with bathing/showering would be reported to the MA by the PCA.
-The PCA would document the wound on the shower sheet.
-The MA would assess the wound, the MA would document on the shower sheet they had seen the wound and notify the PCP if the wound was new or increasing in size.
-All wounds were documented on the shower sheet.
-It was facility policy that any resident changes noted with personal care would be reported to the PCP and family, then documented in the resident's progress notes.

Telephone interview with Resident #4's previous PCP on 05/26/20 at 1:40pm revealed:
-The resident did not have a wound when evaluated on 07/29/19.
-She was not notified of the residents right hip wound until 08/07/19 when she scheduled the appointment and evaluated the wound.

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D 273	Continued From page 138 -On 08/07/19 the Memory Care Manager (MCM) reported a "bump" had been on the resident's right hip. -The resident was diagnosed with a stage 2 pressure ulcer on 08/07/19. -HH was ordered on 08/07/19 for wound care to the resident's right hip wound. -She expected staff to have notified her of Resident #4's right hip wound when it was discovered by staff on 08/01/19 because the new wound was a change in condition. -She would have evaluated the resident on 08/01/19 if told about the wound that day. -She would have ordered a barrier cream for the resident on 08/01/19 until she could evaluate the wound. -She would have ordered HH for Resident #4's right hip wound on 08/01/19. -Pressure ulcers could develop within hours. -The resident could have developed an infection to the right hip pressure ulcer, increase in pain, worsening of the wound, and/or bone infection with deepening or worsening wound. Telephone interview with the MCM on 05/28/20 at 9:07am revealed: -She did not remember Resident #4's right hip wound. -She did not remember speaking with Resident #4's PCP on 08/07/19 regarding the residents right hip wound. -She did not remember being told by the MA on 08/01/19 of Resident #4's right hip wound. -She expected the PCA to report new wounds to the MA when discovered. -She expected the MA to report new wounds to the PCP when discovered. -She expected the MA to report new wounds to her when discovered so she could assess and follow up with the PCP and family.	D 273		

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-The PCP would be contacted either by email, phone, or text.
-The PCP notification would be documented in the resident's progress notes by the MA.

Telephone interview with the Administrator on 05/29/20 at 11:25am revealed:
-She was not employed with the facility when Resident #4 was a resident of the facility.
-She did not know anything about Resident #4's right hip wound.
-The MCM was expected to call the PCP "immediately" upon discovery/notification of a new wound.
-The PCP was to be notified immediately to assess the wound because it would be a new wound and aide in prevention of additional break down of the wound.

Confidential telephone interview with staff revealed:
-The MAs were responsible for reporting new wounds to the MCM.
-The MCM was responsible for reporting new wounds to the PCP.
-The staff member remembered Resident #4 having skin break down on the hip but was unsure when the wound originated.
-Resident #4 did not have a wound before July or August 2019.

Attempted interview on 06/05/20 at 1:40pm with the MA who documented Resident #4's right hip wound on 08/01/20 was unsuccessful.

Based on interviews and record reviews it was determined Resident #4 was not interviewable.

6. Review of Resident #11's current FL-2 dated 01/07/20 revealed diagnoses included

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symptomatic anemia, renal insufficiency, iron deficiency anemia, hypokalemia, lower extremity edema, acute kidney injury, neck mass, recurrent falls, and leukocytosis.

a. Review of the Compliant Intake and Health Care Personnel Investigation Report for Resident #11 dated 01/02/20 revealed:
-The report was completed by the previous Administrator.
-There were no named accused employees.
-The allegation/incident type was resident abuse.
-The date of the incident was 12/23/19.
-The date and time the facility became aware of the incident was 12/25/19 at approximately 7:00pm.
-The incident location description was the hallway by the nurse's and/or bedroom.
-Interviews were conducted with facility staff and the resident.
-Allegation was unsubstantiated.
-Staff would be in-serviced on neglect and abuse policy.

Review of an electronic accident/incident (A/I) report dated 12/25/20 at 7:00am revealed:
-The incident report was entered by the Resident Care Director (RCD).
-The location of the incident was Resident #11's room.
-Resident #11 stated staff pushed her.
-Resident #11 did not exhibit or complain of pain related to the incident.
-First Aid was not administered.
-She was alert and oriented.
-She was not taken to the emergency room or seen by her primary care provider (PCP).
-Resident #11's PCP and responsible party (RP) were notified.
-Resident #11 would be monitored for 72 hours

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(12/27/19-12/30/19) with progress notes charted daily.
-Evaluation notes outlined she would be seen by her PCP.

There was no documentation of an electronic progress dated 12/23/19 for Resident #11.

Telephone interview with the RCD on 06/01/20 at 2:22pm revealed:
-Resident #11 did not talk and get along with everyone.
-She had verbal disagreements with other residents but not "too often."
-For staff to resident abuse, she would send the facility staff home immediately; she would complete a full physical body assessment; the RCD or a medication aide (MA) would notify the PCP; the incident would be turned over to the Administrator for an internal investigation; and the Administrator would complete the 24 hour and 5-day reports to health care personnel registry (HCPR).
-On 12/25/20, Resident #11 made a complaint of staff abuse.
-Resident #11 stated a facility staff member pushed her.
-She changed her story and stated, "nothing happened."
-The suspected facility staff was suspended by the RCD, but nothing was proven after the internal investigation was completed by the Administrator.
-From the facility staff interviews, Resident #11 was upset because she wanted her Phenergan (the medication is used to control nausea and vomiting).

A second telephone interview with the RCD on 06/02/20 at 10:18am

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revealed she made Resident #11's PCP aware on 12/25/19 of the incident dated 12/23/19.

Refer to telephone interview with the RCD on 06/01/20 at 2:22pm.

Refer to the telephone interview with a nurse from Resident #11's PCP office on 06/03/20 at 2:00pm.

Refer to the telephone interview with the PCP on 06/04/20 at 10:55am.

Refer to the telephone interview with the Administrator on 06/05/20 at 11:36am.

b. Review of Resident #11's electronic progress note dated 04/30/20 at 10:21pm revealed:
-The note was entered by the Administrator.
-She spoke with Resident #11's family member about their concerns related to a previous altercation with another resident.
-The family member was reassured Resident #11 was safe and free from harm and was given the Administrator's personal phone for any concerns.
-The family member felt their concerns were addressed and did not warrant any further investigation.

Review of an electronic A/I report dated 04/30/20 at 9:53pm revealed:
-The incident report was entered by a MA.
-Resident #11 was "fussing" with another resident.
-Resident #11's PCP and RP were notified.
-The care plan was not reviewed.
-There were no behaviors noted.

Telephone interview with the RCD on 06/01/20 at 2:22pm revealed:
-Resident #11 did not talk and get along with

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everyone.
-She had verbal disagreements with other residents but not "too often."
-Resident #11's last verbal disagreement with another resident was about two months ago.
-She took up for her roommate and another resident said something to her roommate.
-If she witnessed resident to resident abuse, she would separate the residents; she would conduct one on one interviews with the residents; she would notify the PCP; the incident would be turned over to the Administrator; the facility staff would document further behaviors; and the RCD would update the medication aides (MAs).

Telephone interview with a MA on 06/02/20 at 4:45pm revealed:
-She was a MA at the facility and worked 2nd shift (3:00pm-11:00pm).
-If resident to resident abuse occurred, she would de-escalate the situation; she would ask the involved residents to go to their rooms; she would document in the resident's progress notes; she would report the incident to the oncoming 3rd shift MA; she would document the incident in the communication log; she would call or send a text message to the RCD about the incident; and she would notify the RP and the PCP.
-She was working 2nd shift on 04/30/20 with Resident #11.
-Resident #11 was in a verbal argument with another resident.
-There were no injuries or behaviors noted.
-Resident #11's RP and PCP were notified of the incident dated 04/30/20.

Refer to the telephone interview with the RCD on 06/01/20 at 2:22pm.

Refer to the telephone interview with a nurse from

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D 273	Continued From page 144 Resident #11's PCP office on 06/03/20 at 2:00pm. Refer to the telephone interview with the PCP on 06/04/20 at 10:55am. Refer to the telephone interview with the Administrator on 06/05/20 at 11:36am. _____ Telephone interview with the RCD on 06/01/20 at 2:22pm revealed: -Resident #11 did not talk to her. -She had verbal disagreements with other residents but not "too often." -Resident #11's last verbal disagreement with another resident was about two months ago. -She took up for her roommate when another resident said something to her roommate. -If she witnessed resident to resident abuse, she would separate the residents; she would conduct one on one interviews with the residents; the incident would be turned over to the Administrator; the facility staff would document further behaviors; and the RCD would update the medication aides (MAs). -For staff to resident abuse, she would send the facility staff home immediately; she would complete a full physical body assessment; the RCD or the MA would notify the primary care provider (PCP); the incident would be turned over to the Administrator for an internal investigation; and the Administrator would complete the 24 hour and 5-day reports to health care personnel registry (HCPR). -On 12/25/20, Resident #11 made a complaint of staff abuse. -She stated a facility staff member pushed her. -She changed her story and stated, "nothing happened." -The suspected staff facility was suspended by the RCD, but nothing was proven after the	D 273		

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internal investigation was completed by the Administrator.
-From the facility staff interviews, Resident #11 was upset because she wanted her Phenergan (the medication is used to control nausea and vomiting).

Telephone interview with a nurse from Resident #11's PCP's office on 06/03/20 at 2:00pm revealed:
-If the facility would call the PCP during the office hours of 8:00am to 5:00pm, the clinical staff would document the notification in the patient's notes.
-If the facility would call the PCP after office hours (5:00pm to 8:00am), the phone would be answered by the supervisor of the clinical staff and would be documented in the patient notes.
-The PCP was not notified about Resident #11's alleged staff abuse on 12/25/19.
-The PCP was not notified about Resident #11's verbal altercation with another resident on 04/30/20.

Telephone interview with Resident#11's PCP on 06/04/20 at 10:55am revealed:
-He was at the facility every other week.
-Resident #11 had a child-like nature and emotional outbursts.
-She had increased anxiety which resulted in increased fear.
-She had been relatively stable and had mild altercations with the "newer" residents.
-There was no documentation within his notes, that he was notified of the incidents dated 12/25/19 and 04/30/20.
-The PCP was not notified about Resident #11's alleged staff abuse on 12/25/19.
-The PCP was not notified about Resident #11's verbal altercation with another resident on

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D 273	Continued From page 146 04/30/20. -His expectation would be to be notify him of any resident changes from their baseline which included falls, acute mental changes, altercations, and fatigue. -He would want to assess the resident and address any concerns. -The communication with the facility and him had "fallen off a cliff." -Upon arrival to the facility for his visits to see his residents, he would hear from the facility staff, "Everything is fine." -Then he would go and talk with his resident and they had many "concerns." -He felt there was a broad feeling of distraction with the facility staff and the facility management. -They were distracted and not interested in communicating the resident's needs with him. -The facility had lost interest in their "responsibilities" and the lack of information had caused increased confusion and there was no timeline of events. -There were many things left "unaddressed." - "It was convoluted." -The organization was "fractured", and he felt "uneasy" about the facility. Telephone interview with the Administrator on 06/05/20 at 11:36am revealed: -She expected the primary care provider be notified for changes in health status immediately by the Resident Care Director (RCD), Memory Care Manager (MCM, or medication aide (MA) once the resident was stable or on the way to the emergency department. -A MA should let management know, so the resident could be assessed by management. -There should be documentation in the resident's progress notes. -The A/I report would be reviewed and closed out	D 273		

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D 273	Continued From page 147 by the care manager (RCD or MCM) within 72 hours. _____ The facility failed to ensure referral and follow-up for 6 of 12 sampled residents which included notifying the PCP of an increased temperature and scant urine output for several days during a viral pandemic for Resident #7 who was diagnosed with COVID-19 and later died; notifying the PCP of urinary bleeding which occurred for two weeks for Resident #8 who was diagnosed with a UTI and cystitis and required IV antibiotics; follow-up with a ENT after an orbital wall fracture and notifying the PCP of falls with head injury for Resident #9; and delaying reporting the development of a stage 2 hip ulcer to the PCP for Resident #4. The facility's failure resulted in serious physical harm and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/20 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 8, 2020.	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.	D 276		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure primary care provider orders were implemented for 1 of 12 sampled residents (#9) who had an order for the removal of sutures in 7 days for an eyebrow laceration.

The findings are:

Review of Resident #9's current FL-2 dated 08/06/19 revealed:
-Diagnoses included dementia, fracture of left femur, falls, and muscle weakness.
-The resident was intermittently disoriented and was semi-ambulatory with a walker.
-The resident's recommended level of care was a special care unit (SCU).

Review of an emergency department (ED) visit for Resident #9 dated 05/17/20 revealed:
-The resident was seen in the ED due to a fall.
-The resident was diagnosed with an orbital wall fracture, eyebrow laceration, and a periorbital hematoma of the left eye.
-The resident required sutures for the closure of the laceration.

Review of Resident #9's electronic progress notes dated 05/18/20 at 12:27am revealed:
-The resident returned from the ED.
-The resident was discharged with a laceration of the face, suture removal in 7 days and the

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resident was prescribed antibiotics.

Telephone interview with a medication aide (MA) on 06/04/20 at 11:49am revealed:
-She was aware Resident #9 had sutures and thought the sutures were supposed to be removed today, (06/04/20).
-She thought Resident #9's orders were for the sutures to be removed in a couple of weeks.

Telephone interview with the Memory Care Manager (MCM) on 06/04/20 at 3:47pm revealed:
-Resident #9's sutures were removed yesterday (06/03/20).
-A primary care provider (PCP) with the same practice as Resident #9's PCP was at the facility yesterday (06/03/20) and was supposed to have removed Resident #9's sutures.
-She called Resident #9's PCP and was told to contact another home health nurse to remove the sutures, however, the resident was not a current home health patient and the nurse could not provide a one-time visit for suture removal.
-Resident #9's PCP said there were two nurses in the facility that could have removed the sutures (the Resident Care Director (RCD) and the Administrator) but the order was just received yesterday, and she could not "tell" the RCD to remove the sutures.
-She had not documented any of the follow-up phone contacts or conversations made regarding her attempts to have Resident #9's sutures removed.

Telephone interview with Resident #9's PCP on 06/03/20 at 5:30pm revealed:
-The resident had discharge orders to remove the eyebrow sutures in 7 days from the ED on 05/18/20 when the resident was evaluated and treated for an eyebrow laceration and orbital wall

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D 276	Continued From page 150 fracture. -She had previously discussed having the resident's sutures removed with the MCM and was told it was not a problem to have the resident's sutures removed. -She saw the resident by a virtual visit on 05/27/20 and again told the MCM the resident should have already had the sutures removed and was told they would take care of it. -The MCM was told if there were any problems when removing the resident's sutures to contact her. -The facility had not contacted her until today (06/03/20) that the resident's sutures were still not removed. -She questioned the MCM why the resident's sutures were not removed and was told that she had tried to get a home health nurse to remove the sutures, however the home health nurse could not remove the sutures. -She asked the MCM why the RCD could not remove the sutures because she was a licensed nurse and was told supplies would be needed to remove the sutures. -She sent an order today for the Licensed Practical nurse (LPN) at the facility (RCD) to remove the sutures. -There was another provider at the facility today, (06/03/20) and the facility did not have that provider remove the sutures for the resident. (The provider at the facility today was another provider with the same practice.) -The resident's sutures were probably embedded and should have been removed on 05/25/20. -If the resident's sutures were embedded, it would cause increased pain for the resident when the sutures were removed, or the sutures would not be able to be removed and would need to be cut out.	D 276		

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D 276	Continued From page 151 A second telephone interview with Resident #9's PCP on 06/05/20 at 3:15pm revealed: -She was not sure why two nurses at the facility could not remove Resident #9's sutures because the facility had an order for the ED to remove the sutures in 7 days. -The MCM had her cell number and if an order was needed for the nurse at the facility to remove Resident #9's sutures then she could have called and got an order to remove the resident's sutures. Telephone interview with the Administrator on 05/19/2020 at 1:45pm revealed she and the RCD were both LPNs. Telephone interview with the Administrator on 05/28/2020 at 9:02am revealed the MCM and the RCD used a hot box system to assure PCP orders and referrals were implemented and completed. Based on interviews and record reviews, Resident #9 was not interviewable.	D 276		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone. (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and (3) It is not the home's obligation to pay for a resident's toll calls	D 324		

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This Rule is not met as evidenced by:
Based on interviews, the facility failed to ensure residents had access to a telephone to receive calls as evidenced by residents' family members being unable to reach residents when calling the facility.

The findings are:

Telephone interview with a resident's responsible party on 05/29/20 at 1:17pm revealed:
-There were problems with the facility's phone system.
-When calling the facility, the phone system would ring somewhere else other than the facility.
-The phone calls were transferred into the facility.
-No one would answer the phone on the weekends at the facility.
- "Once in a while" they turned on the phones when they wanted to.

Telephone interview with the Resident Care Director (RCD) on 06/02/20 at 11:07am revealed:
-The facility staff could not check their voicemails for around two months.
-She had not received any complaints about the phone system.
-The new phone equipment had been delivered but was not installed yet.
-The Administrator would be able to provide further details related to the new phone system.

Telephone interview with the Administrator on 06/05/20 at 11:36am revealed:
-There was a phone located in the main hall of the facility for residents' use.
-It did work and was in a private area.

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D 324	Continued From page 153 -The only issue has been if a resident was COVID-19 positive the facility staff were using their personal phones. -A complaint she had received was one resident would sit on the phone all day due to not having her own personal phone. -She was not aware of the facility staff having the ability to turn off the phones. -There were no reasons why residents could not use the phone to communicate with their family. -She checked the phone daily to ensure they were operating properly. Telephone interview with a residents's family member on 05/27/20 at 11:57am revealed: -The Administrator had given the family member her cell phone number because "their whole phone system is messed up". -The family member had not been able to get up with anyone "anywhere" at the facility when attempting to call the special care unit (SCU) or the Assisted Living (AL). -When attempting to call the facility a message was given that the facility's voicemail was full and could not leave any messages. -The family member was sent a letter from the facility in March 2020 when visiting restrictions were put into place due to the global pandemic and was giving a telephone number that went directly to the SCU. -The number given to the SCU worked for approximately 2 or 3 weeks, if any staff answered the phone. -The family member had to sometime leave a message and that was "60/40" that a call would be returned from the facility. -Approximately one month ago, the family member had spoken with the Administrator concerning the inability to reach anyone at the facility and was told by the Administrator that something was wrong with the phone system.	D 324		

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D 324	Continued From page 154 -The family member was told last week by the Administrator the facility would be getting a new phone system. -The Administrator had been helpful and would take her cell phone number to the SCU so the family could speak to the resident. -The family member was concerned because the isolation just from the global pandenic was stressful and with the facility's phone system not working added to the stress for the family member and the resident. Telephone interview with Resident #10's family member on 05/28/20 at 08:30am revealed: -No matter what time you call the facility no one answers the phone. -She has had to go to the facility and knock on the front door to find out how Resident #10 was doing. Telephone interview with the Resident Care Manager (RCM) on 06/05/20 at 11:20am revealed: -Phones were available for residents to use. -Phone use was not limited. -The only complaints they have had about phone use was from residents about someone being on their call too long. -The phones were never turned off. -There were no portable phones for residents to use. -Residents did not have a way to call their families during the COVID-19 unless staff let the residents use their phones. -If there was a problem with the phones the phone company would come to the facility and check the phone system. -New phones were to be installed but she did not know when.	D 324		

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D 324	Continued From page 155 -The Administrator would have the answers about new phones. Telephone interview with another resident's family member on 05/14/2020 at 1:54pm revealed: -He could not get through on the phone to anyone at the facility for several weeks. -Before the COVID-19 pandemic related visitor restrictions, he visited and took the resident out weekly. -The resident was not able to talk to him on the phone because she had significantly declined in her cognitive abilities. Telephone interview with a medication aide (MA) on 06/04/2020 at 11:49am revealed: -The phone in the special care unit (SCU) had been broken for a couple of weeks. -She gave her personal cellular phone number to residents' family members. -She had mentioned the phone issue to the Memory Care Manager (MCM) and the Administrator one week ago. -Sometimes the residents used the MCM's office phone to speak with family members. Telephone interview with the MCM on 05/28/2020 at 3:36pm revealed: -There had been issues with the facility's phone system since November/December 2019; most of the complaints came from the callers not being able to get through to anyone at the facility. -Calls to the facility went through the corporate office and when the call was connected if a staff was not at the desk to pick up the phone, they would not get the call. -She gave residents' family members her personal cellular phone number. -The management team started sending email alerts for missed calls about 1 to 2 months ago.	D 324		

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D 324	Continued From page 156 -Complaints about the phone system continued because the calls did not get through in the evening and night. -There were resident phones at station A on the assisted living (AL) side and station B on the special care unit (SCU). Interview with the Administrator on 05/26/2020 at 3:31pm revealed: -The only resident phone was in a room at the end of the hall which had been closed off due to COVID 19. -There were no cordless phones to bring to resident's rooms for use. -She had gotten new phones approximately 3 weeks ago, but the phones had not been installed. Telephone interview with the Administrator on 05/28/2020 at 9:02am revealed she was working on getting the resident on the COVID positive hall a cell phone to use today (05/28/2020). Interview with Resident #7's family member on 06/03/20 at 8:15pm revealed: -She had tried to call her mom on 05/10/20 (does not remember the exact time) on Mother's Day to wish her a Happy Mother's Day but her mom didn't answer her cell phone. -She called the facility and finally got someone on the phone who went down to Resident #7's room. -She said the staff couldn't get her mom to wake up enough to talk on the phone. Interview on 05/26/20 at 2:30pm with resident on the 100-Hall (COVID Hall) revealed: -She was unable to use the phone for some time now but it was worse now since they can't leave the floor. -She said she knew she needed to talk with the administrator about it.	D 324		

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D 324	Continued From page 157 Interview with administrator on 05/26/20 at 3:31pm revealed: -She was working on getting a new phone system in place. -She knew that the resident on the COVID hall wanted to talk with her family. -She knew the resident normally talked with her family every day. -She would make sure the resident would speak with her family member by using a staff members cell phone. -She was not sure how much longer it would be before the new phone system would be in place.	D 324		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews, observations and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) and directives from the local health department (LHD) were implemented and maintained when caring for 93 residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors, staff, and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing; restricting residents to their assigned	D 338		

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rooms; basic hand hygiene and infection control procedures; environmental cleanliness and safety precautions to reduce the risk of transmission and infection.

The findings are:

Review of the CDC guidelines for the prevention and spread of the Coronavirus disease in long term care facilities revealed:
-Personnel should always wear a face mask while in the facility.
-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.
-All personnel should practice social distancing (remain at least six feet apart) when in common areas.
-Implement social distancing among residents.

Telephone interview with the Administrator on 05/19/20 at 1:45pm revealed:
-She did not know about the facility's COVID-19 protocol because it was implemented before she started working at the facility on 04/16/20.
-The Memory Care Manager (MCM) and Resident Care Director (RCD) would have known about the facility's COVID-19 protocol.
-The facility was notified by the local hospital (did not give dates) that 4 residents in the hospital from the facility had tested positive for COVID-19.

Review of the resident roster dated 05/12/20 revealed there were 51 residents on the assisted living (AL) side and 42 residents in the special care unit (SCU).

Telephone interview with the MCM on 05/19/20 at 1:45pm revealed:
-The facility's COVID-19 protocol was started

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when the state of emergency was initiated (03/13/20).
-There were no residents in the facility who had tested positive for COVID-19 as of 05/19/20.

Telephone interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed:
-The COVID-19 protocol was rolled out to all facilities the beginning of April 2020 and all CDC guidelines were rolled out with each update on COVID-19 management.
-Facility staff would have to say when and how they were trained on the COVID-19 protocol.
-The corporate office notified facilities of updates via email and phone conferences and it was up to facility leadership team (Administrator, RCD and MCM) and Licensed Health Professional Support (LHPS) Nurse to train the staff on updates. (Documents were requested but never provided).
-There should have been documentation of trainings and in-services done by the facility's leadership team and LHPS Nurse. (These documents were provided however no specific information was provided other than the general topic of COVID-19 and signatures of the attendees. Requested the contact information for the LHPS Nurse but it was never provided).

Telephone interview with the DDCS on 05/20/20 at 10:24am revealed the corporate office monitored the CDC and DHHS for COVID-19 guidelines and updates at a minimum of weekly but often 2 to 3 times each week and emailed the facility leadership team on updates.

1. Observation of the front door on 05/26/20 at 2:10pm revealed signage on the front doors stated no visitors were allowed at this time due to the Coronavirus (a highly infectious disease

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spread primarily through droplets of saliva or discharge from the nose).
-There were 8.5 x 11 inch white signs taped to the outside of the door.

Review of signage posted on the entrance door of the facility revealed:
-"We are creating a haven of wellness. Our community is closed to visitors at this time, following official recommendation to limit the spread of COVID-19. We appreciated your help in keeping our residents safe and healthy during this time of heightened health concern".
- "Did you know? All of our team members are screened daily to ensure the safety of our community. Every team member has their temperature taken prior to every shift. They also complete a personal health assessment using an extensive screening process before entering the community."

Review of the facility's COVID-19 Screening Checklist for All Visitors and Staff revealed:
-ALL individuals (staff, other health care workers, family, visitors, vendors) entering the building must complete this screening checklist.
-It had spaces for date, community name, name of associate/visitor and name of screener:
-The following questions were listed on the screening checklist: have you washed your hands or used alcohol-based hand sanitizer for at least 20 seconds with a space to check Yes or No-Ask them to do so. Do you have any of the following symptoms? Yes or No with the following symptoms listed: fever (temperature of 99.6 degrees or higher), Sore throat, Cough, New shortness of breath, Pink eye, Recent loss of taste or smell, Diarrhea
-If YES to any, restrict them from entering the building.

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-If NO to all, proceed to question #3 for staff and question #4 for all others.
-3. For Staff & Health Care Providers (e.g. health care workers, such as home health, hospice, physical therapy):
a. Check temperature and document results:
Fever present? ? Yes ?No
If YES, restrict from entering the building. If NO, proceed to step 3b.
b. Ask if they have worked in facilities or locations with recognized COVID-19 cases?
? Yes ? No
If YES, ask if they worked with any person(s) with confirmed COVID-19?
? Yes ?No
If YES, require them to wear PPE including mask, gloves, gown before any contact with residents & proceed to step 4. if NO, proceed to step 4.
-4. Allow entry to building and remind the individual to: Wash their hands or use hand sanitizer throughout their time in the building. Do not shake hands with, touch or hug individuals during their visit. (Healthcare providers may examine their patients if necessary.) Limit movement within the facility to just medically necessary visits,

Telephone interview with an Emergency Medical Technician (EMT) on 05/22/20 at 11:25am revealed the EMT was called to the facility prior to 05/18/20 to pick up several residents with fevers; staff were not screening visitors, including the EMTs, when residents were being picked up.

Telephone interview with a resident's health care provider on 05/26/20 at 3:15pm revealed:
-During a visit to the facility on 03/30/20, the facility checked her temperature but did not ask COVID-19 questions from questionnaire.
-She did not discuss her observations with the

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RCD or Administrator.

Confidential telephone interview with staff revealed:
-Each staff member would do their own individual COVID -19 screening when they came to work.
-Sometimes if staff were running late, they would skip the screening.

Telephone interview with another EMT on 05/28/20 at 9:50am revealed:
-The EMT was called to the facility on 05/12/20 to pick up Resident #7.
-The EMT staff were in full personal protective equipment (PPE) upon entering the facility.
-They were directed to Resident #7's room.
-The EMTs were not screened at the door before entering the facility.

Confidential telephone interview with another staff revealed:
-No one told us anything about a staff having COVID-19 until 4 residents were hospitalized.
-Then we had a mandatory staff meeting and everyone (the staff and the residents) got tested.

Telephone interview with the Administrator on 05/20/20 at 10:24am revealed:
-On 05/09/20 she was notified by the local Health Department (LHD) that a personal care aide (PCA) staff tested positive for COVID-19.
-She did not have any idea the PCA had been tested.
-The PCA that tested positive for COVID-19 was a 1st shift staff who worked on the women's hall on the assisted living (AL) side.
-The PCA told the RCD she was tested that Thursday (05/07/20) and worked that Friday (05/08/20).
-She would have to go back and look to see what

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other days the PCA worked.
-The PCA had allergies and was being treated for sinusitis when she was tested for COVID-19; she did not know how long the PCA had allergy symptoms while at work.
-On 04/15/20, she told the staff if they felt they had symptoms, they need to get tested and stay home until they got results.
-She did not know why the PCA came to work sick.
-Staff with symptoms were sent home for quarantine until cleared by their own PCP.
-The staff that tested positive was not cleared to return as of 05/19/20.
-Staff were checking their temperatures and monitoring for symptoms every 4 hours; if any staff had a cough, the staff was sent home without exception.
-She had told the staff in every meeting that month (May 2020), if staff were not feeling well, they needed to stay home.
-The corporate office sent email updates on COVID-19; she monitored those emails.
-Visitors to the facility were restricted, with the exception of essential staff, home health and hospice.
-PCPs conducted virtual visits and did not come into the building.
-Visitors and staff signed in on a log and completed the screening tool on arrival.
-Copies of the sign in log and screening tools were kept and reviewed by the RCD and her.

Telephone interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed:
-The COVID-19 protocol included asking staff screening questions on arrival to work; if there were any yes answers the staff were sent home to follow up with their own primary care provider

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(PCP).
-She did not have access to the screening questions for staff.

2. Telephone interview with an outside health care provider on 05/19/20 at 2:52pm revealed:
-Staff could do a better job wearing their PPE (personal protective equipment).
-She had to remind staff to go back to the car and get their mask.
-She observed staff during her visits at the facility leaving their mask in the car.
-She observed staff wearing their mask incorrectly.
-Some staff would place the mask under their nose.
-Some staff did a better than others in wearing their masks.
-She did not say if she had reported this to management.

Telephone interview with the Administrator on 05/20/20 at 10:24am revealed:
-All staff were using PPE and washing their hands.
-She, the Resident Care Director (RCD), and Memory Care Manager (MCM) monitored staff via walking rounds no less than twice a day to see that staff were wearing PPE, performing hand hygiene after removing gloves, bagging up dirty clothes and not transferring between rooms; and making sure housekeeping was keeping halls clean and doors were wiped down.
-Equipment was cleaned with disinfected by medication aides (MAs) between residents.
-When she did "walking rounds", she checked that equipment was being cleaned.
-MAs monitored staff use of PPE and cleaning of equipment on the weekends and there was always a management person at the facility on

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weekends to monitor.
-Residents who smoked tobacco wore a mask in the halls and went outside at certain times to one area.
-Staff monitored the resident smoking area while residents were outside and kept residents a distance of 6 feet from each other.
-Residents on the assisted living side had to wear a mask in the hall or with any contact with staff such as when staff entered the resident's room.

Telephone interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed all residents were on quarantine in their own rooms with no communal dining/activities.

Interview with a resident's health care provider on 05/26/20 at 3:15pm revealed:
-She observed PPE in the facility (including gowns, face masks, and gloves) and available for the staff's use.
-She observed some of the staff wearing face masks, but not always.
-She observed some staff caring for the residents without PPE (such as assisting with ambulating).
-The staff did not wash their hands after removing their gloves.
-The facility staff was not keeping the residents in their rooms and was not observing social distancing; staff and residents were gathering in small groups in the halls and at the nurses' stations.
-She did not discuss her observations with the RCD or Administrator.

Confidential interview from concerned citizens revealed there was no cleaning of equipment between residents.

Interview with a resident on 05/28/20 at 9:30am

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revealed:
-Residents continued to ambulate in the hallway and sit in the hallway after COVID-19 changes in the facility were implemented per CDC guidelines.
-He continued to sit in his doorway in his wheelchair.
-He continued to go outside on the back porch (through the facility's back door) and usually stay outside 10-15 minutes with other residents.
-He declined to wear a mask because the germs stay inside the masks and go back inside the body.
-There were usually multiple residents on the back porch smoking, but he did not know how many.
-The other residents did not wear masks when they were on the back porch smoking.
-Usually the staff wore masks and gloves when providing incontinent care but sometimes the staff did not wear masks.
-The only hand sanitizer available for resident use on the 200 Hall was kept at the nurses' station.
(Review of residents progress notes dated 04/29/20 and 05/01/20 revealed documentation that he still refuses to wear his mask and will continue to be asked to wear his mask and be asked to follow policy per his safety and the safety of others).

Confidential telephone interview with a staff revealed not everyone had been wearing masks like they were supposed to until we found out there was COVID-19 in the building.

Confidential telephone interview with a second staff revealed:
-The facility ran out of gowns and masks frequently.
-There were times staff would not be wearing

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masks.
-Some of the staff wore personal homemade cloth mask.

Telephone interview with an Emergency Medical Technician (EMT) on 05/22/20 at 11:25am revealed:
-The EMT was called to the facility prior to 05/18/20 to pick up several residents.
-Staff were either not wearing a face mask or had the mask pulled down under their chin.
-There were a few residents walking through the halls and were not wearing masks.

Telephone interview with a second EMT on 05/28/20 at 9:50am revealed:
-The EMT was called to the facility on 05/12/20 to pick up a resident.
-The EMT staff were in full PPE upon entering the facility.
-He did not see any staff with masks on.
-The residents that he saw were not wearing masks either.

Telephone interview with third EMT on 05/28/20 at 4:24pm revealed:
-The EMT was called to the facility on 05/12/20 to pick up a resident.
-The EMT staff were in full PPE upon entering the facility.
-He did not see any staff wearing masks.
-The residents that he saw were not wearing masks either.

Observations on 05/26/20 from 2:20pm until 2:50pm on the 100-Hall (identified by staff as the "COVID-19 positive Hall") revealed:
-From the hallway looking into a resident's room, a resident who resided on one end of the hall was visiting another resident who resided at the other

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end of the hall in the resident's room.
-Both residents had on masks; the first resident was wearing her mask under her nose and the second resident had her mask on over both her nose and mouth.
-All staff were wearing yellow disposable paper gowns, disposable vinyl gloves and surgical paper masks.
-One staff member was wearing a gown with a hole in the sleeve.
-Another staff member was seen using hand sanitizer on her gloves and not changing them between residents. (Per CDC guidelines vinyl gloves are not designed to be sanitized and reused as sanitizers can create pinholes in the gloves; medical gloves are single use items and glove decontamination and reprocessing are not recommended and should be avoided.)
-One resident, not wearing a mask, was in the hallway sitting on her rollator walker; the staff in the hallway did not redirect the resident back to her room.

Observations on the special care unit (SCU) on 05/26/20 from 2:20pm until 2:52pm revealed:
-At 2:20pm, Resident #1 was not wearing a mask and was sitting in a wheelchair at the front desk with the MCM.
-There was a second resident not wearing a mask and sitting in a chair in the hall across from the front desk.
-The fire doors to the 300 and 400 halls were closed; residents and staff on the halls were not visible from the front desk area.
-There was a personal care aide (PCA) on the 400-hall with a covered cart.
-There were two boxes of gloves on the top of the cart which had cloth covering over shelves containing incontinence care supplies.
-There was no hand sanitizer on the cart or

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affixed to the walls on the 400-hall.
-The PCA was taking the cart from room to room down the hall.
-The cart remained in the hall while the PCA went inside several rooms.
-The PCA did not wash her hands or use hand sanitizer between resident rooms.
-None of the residents on the SCU were wearing face masks.
-The PCA redirected residents back to their rooms either by touching a resident's back or holding the resident's hand.
-The PCA did not wash her hands or use hand sanitizer after each interaction with residents.
-Residents were touching common surfaces in the hall and were not assisted with hand hygiene.
-At 2:28pm, seven staff responded to an acute resident care issue in room 406 going in and out of the room, opening and closing the door without hand hygiene.
-At 2:30pm, the MCM entered the room with gloved hands and a glucometer and supplies to perform a finger stick blood sugar check.
-A moment later the MCM left the room and closed the door with gloved hands and used equipment in hand.
-The MCM discarded the used supplies, removed her gloves and used hand sanitizer at the medication cart which was at the front desk.
-The MCM used a wipe to clean the glucometer before placing it in the drawer.
-Three staff opened and closed the door to room 406 with gloved hands with several other staff opening and closing the door with ungloved hands; there was no hand hygiene performed.
-At 2:44pm and 2:52pm, Resident #1 was sitting in a wheelchair at the front desk with the MCM.
-The MCM wore a face mask covering only her mouth and Resident #1 was not wearing a face mask.

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D 338	Continued From page 170 -There was a resident walking in the hall without a face mask on the 300-hall. -There was a housekeeper in the hallway on the 300-hall with face mask covering her mouth only. Interview with a PCA on 05/26/20 at 2:37pm revealed: -Staff had a designated area to wash their hands; staff used the sink in the shower room to wash their hands. -There were some places in the facility with hand sanitizer dispensers on the wall. -On the special care unit, there was hand sanitizer at the front desk and on the medication cart. -She carried her own personal hand sanitizer in her pocket. Interview with the MCM on 05/26/20 at 2:52pm revealed hand sanitizer was kept on the medication carts and at the front desk in the SCU. Interview with the Administrator on 05/26/20 at 3:31pm revealed: -She monitored staff compliance with proper use of face masks and hand hygiene closely on the COVID-19 positive hall; she had not monitored as closely on the SCU. -She had not considered the implications of one designated hand washing area on each hall in the SCU with no hand sanitizer affixed to the wall along the hall. -There was an unmonitored screening table in the decontamination tent for staff to complete prior to starting their shift on the COVID-19 positive hall. -Staff who worked on the COVID-19 positive hall were only allowed to leave the COVID-19 positive hall when the staff was leaving to go home. -Staff removed used PPE after exiting the	D 338		

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building from the exit door at the end of the COVID-19 positive hall.
-The decontamination tent had been provided by Emergency Medical Services (EMS).
-Staff sprayed a disinfectant inside the tent every shift and EMS was responsible for cleaning and disinfecting the tent.
-EMS provided online references for additional information, supplies and staffing; she was managing any staffing issues internally.
-Staff were going to require education and re-education on the proper use of PPE.
-The LHPS nurse conducted an in-person training for staff on donning and doffing PPE and provided resource card for staff to reference around 03/12/20.
-Staff were expected to remove worn gloves and perform hand hygiene; she did not know of anyone using hand sanitizer on worn gloves.

Telephone interview with the DDCS on 05/26/20 at 3:31pm revealed:
-Staff were expected to wear face masks which covered their nose and mouth for all resident care.
-Staff were expected to clean all equipment before and after each use with a disinfectant wipe.
-The Licensed Health Professional Support (LHPS) nurse conducted an in-service for staff on the use of PPE and COVID-19 monitoring in March 2020.

Upon request on 05/26/20 and 05/27/20, contact information for the LHPS Nurse was not provided.

3. Telephone interview with the Administrator on 05/14/20 at 4:29pm revealed:
-COVID-19 prevention measures included residents' vital signs were checked every shift, all

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residents were quarantined to their rooms, each resident had their own face mask and staff washed their hands between tasks.
-Medication aides (MAs) were responsible for checking residents' vital signs and documenting on the electronic medication administration record (eMAR).
-For residents having a fever, the MA notified the primary care provider (PCP) and administered Tylenol.

Telephone interview with the Administrator on 05/15/20 at 12:06pm revealed:
-She did not know of a specific facility protocol for COVID-19; the Resident Care Director (RCD) would know if there was a protocol.
-There were no specific PCP orders for COVID-19 screening and monitoring for residents.
-There was no standing order to check an oxygenation level if the resident's temperature was greater than 99.6 degrees Fahrenheit (F).
-Staff followed the facility's standing orders for fevers.
-For COVID-19, staff monitored residents for symptoms; if symptoms such as a cough were present with a fever that was different from the facility's standing orders for a fever.

Telephone interview with the RCD on 05/15/20 at 12:06pm revealed regarding a facility COVID-19 protocol, staff just checked residents' temperatures and called the PCP for temperatures greater than 101.5 degrees F.

Review of a resident's May 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for "COVID-19 Precaution" every shift with a start date of 05/01/20 and end

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date of 05/31/20.
-Special instructions read: If a resident begins to display symptoms/fever greater than 99.6/difficulty breathing, the community should do the following: complete the COVID-19 form in Matrix, add all vital signs for every shift, add O2 sat (oxygen saturation level).
-There was an entry for "Signs and/or Symptoms" every shift with a start date of 05/01/20 and end date of 05/31/20.
-Special instructions read: Does the resident have a fever, cough, shortness of breath, been in contact with any other person with COVID-19? If yes, please complete the COVID-19 observation form.

Telephone interview with the RCD on 05/19/20 at 1:45pm revealed:
-The COVID-19 protocol included checking residents' vital signs every shift and notifying the PCP for temperatures greater than 99.6 degrees F.
-The temperature for reporting had been changed to 99.6 degrees F, but she could not remember from what temperature and when.
-The COVID-19 protocol was put in place by the corporate office; she did not remember when.
-There was a staff training completed on 05/15/20 which included training on documentation, the facility's COVID-19 protocol and when staff were expected to notify the PCP.

Telephone interview with the Memory Care Manager (MCM) on 05/19/20 at 1:45pm revealed:
-The last training for staff was done on 05/15/20 and included documentation, but she could not remember what else what included in the training.
-The COVID-19 protocol was started when the state of emergency was initiated (03/13/20).
-On 04/01/20, the COVID-19 protocol was to

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report resident temperatures greater than 100 degrees F to the PCP.
-When the Governor implemented executive orders for long term care facilities, the protocol was changed to report temperatures greater than 99.6 degrees F.
-The COVID-19 protocol was sent via email from the corporate office; she did not remember the dates in March 2020.
-Staff at the facility had been following the COVID-19 protocol.

Confidential telephone interview with staff revealed staff were told by the RCD to call her first for any resident fevers.

Confidential telephone interview with a second staff member revealed:
-If there was only one MA on duty, they could not check every resident's vital signs for that shift and get them documented.
-It would take about 2 hours to check the residents' vital signs and document them for one hall.

Telephone interview with a MA on 05/28/20 at 1:47pm revealed:
-The MA was responsible for the checking the residents' vital signs every shift.
-If there was no MA on duty on 11:00pm-7:00am shift for the assisted living (AL) halls, then the residents' vital signs would not get taken.

Telephone interview with a second MA on 06/02/20 at 4:45pm revealed:
-The MA for each hall was responsible for checking the vital signs.
-If the vital signs were not documented, it meant there was no MA available on that hall to check the residents' VS.

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D 338	Continued From page 175 -The MA that was working the other hall did not have time to check vital signs on the other halls. Telephone interview with the Administrator on 05/29/20 at 11:22am revealed: -The order to check all residents' vital sign was put in place by the facility when a staff member tested positive for COVID-19 (05/09/20). -The MAs were responsible for checking and documenting the vital signs every shift. a. Review of Resident #7's current FL-2 dated 02/13/20 revealed diagnoses included hypertension, chronic systolic heart failure, muscle weakness, cardiomyopathy, anemia, diabetes mellitus type 2, multiple sclerosis, and hyperlipidemia. Review of Resident # 7's May 2020 electronic medication administration records (eMARs) revealed: -A computer entry to check and record weight and vitals monthly. -On 05/05/20, there was a computer entry for vital signs with temperature 98.8°F, Pulse 85, respirations 14, blood pressure 113/58 and a weight of 228.1 pounds. -There was a computer entry for COVID-19 precautions to be done every shift with special instructions "if a resident begins to display respiratory symptoms/fever greater than 99.6/difficulty breathing, the community should do the following: complete the COVID-19 form and Matrix add all vitals for every shift, add O2 sats". -There was a computer entry for acetaminophen (used for fever reduction and pain) 325 mg to be given two tablets to equal 650 mg by mouth every eight hours. -There were computer entries for it to be administered at 6:00am, 2:00pm and 10:00pm.	D 338		

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D 338	Continued From page 176 -There was documentation on 05/10/20 at 10:00pm that the resident refused. -All other documentation from 05/01/20 to 05/11/20 were documented as being administered. -There was a computer entry for acetaminophen 500 mg to be given every six hours as needed for fever and pain reduction. -There were special instructions this was a standing order. -The instructions were to take one tablet by mouth every six hours as needed (not to exceed 2000 mg) for fever 99.5°F to 101°F and to monitor for three days or until normal if above 101 call MD for headache minor discomfort. -There was no documentation from 05/01/20 through 05/09/20 as it being administered. -On 05/10/20 at 10:39pm there was a computer entry that it was administered. -The reason noted for administration was for a fever of 102.8°F. -On 05/11/20 at 5:43am there was a computer entry that it was administered. -The reason for administration was not documented. Review of Resident #7's progress notes revealed: -Resident #7 began complaining of being cold and refusing to get out of bed on 05/04/20. -On 05/08/20 at 1:52pm, there was an entry that stated she slept all day and did not eat. -On 05/09/20 at 6:42am, there was an entry that stated, she seemed a little confused and didn't know where she was at. -On 05/09/20 at 1:18pm, there was an entry that stated, she had to be fed lunch and only ate a few spoonful's. Vital signs were documented as blood pressure 109/73, pulse 93, respirations 18, and temperature 98.2° F.	D 338		

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Review of Resident #7's electronic medication administration records and progress notes revealed there was no documentation provided revealing vital signs being checked every 4 hours from 05/09/20 until transported to the hospital on 05/12/20.

Confidential telephone interview with a staff revealed:
-The Resident Care Director (RCD) told the MAs to call her first instead of the physician on 04/30/20.
-Resident #7 had an elevated temperature for three or four days (dates not specified) the weekend before she went to the emergency department (ED).
-Staff kept calling the RCD about Resident #7's elevated temperature and the RCD told the MA to give Resident #7 acetaminophen to get the resident's temperature down.
-Resident #7's temperature would not go down and the RCD did not want staff to notify the physician to avoid possible COVID-19 diagnosis.
-Resident #7 was sent out to the hospital (date not specified) and tested positive for COVID-19 and died at the hospital.

Confidential telephone interview with another staff revealed:
-Resident #7's temperature was approximately 102°F on that weekend before she went out to the hospital.
-She ran a fever of like 104°F that whole night on Sunday and they were checking her temperature every hour and giving her Tylenol.
-Her temperature never decreased.
-Medication aides (MAs) had been told to contact the RCD and not the PCP.

Telephone interview with the Administrator on

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D 338	Continued From page 178 05/19/20 at 1:45pm revealed: -Resident #7 was the first resident to test positive for COVID-19 on 05/17/20. - There were three additional residents who lived on the same hall as Resident #7 who had also tested positive for COVID-19. -The staff did not document contacting Resident #7's PCP which was part of the COVID-19 protocol. -As soon as the MA saw that a resident had a fever, the MA was expected to contact the PCP. -The MA documented all PCP contact in the electronic care notes unless it was documented in an accident/incident report. -The MAs follow the facility's standing order to notify the PCP; MAs were expected to continue to call the PCP until they got a response. -She was a Licensed Practical Nurse (LPN) and the RCD was also an LPN; if they could not reach the PCP or had concerns, they would send the resident to the emergency department. Telephone interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed staff were expected to notify the PCP for residents with temperatures greater than 99.6°F. Refer to telephone interview with the Administrator on 05/29/20 at 11:22am. Refer to the telephone interview with the Resident Care Director (RCD) on 06/01/20 at 2:30pm. Refer to the second telephone interview with the Administrator on 06/04/20 at 3:45pm. b. Review of Resident #12's current FL-2 revealed diagnoses included Alzheimer's dementia, open angel glaucoma, osteoarthritis and gout.	D 338		

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D 338	Continued From page 179 Review of Resident #12's April 2020 electronic medication administration record (eMAR) revealed: -There was a computer printed entry to take vital signs (VS) (temperature, pulse respiration, blood pressure, and oxygen saturation) every shift 7:00am-3:00pm (1st shift), 3:00pm-11:00pm (2nd shift), and 11:00pm-7:00am (3rd shift) starting on 04/07/20. -Vital signs were not documented on 4/20/20 and 04/26/20 on 2nd shift and no comment documented on the exception log. -Vital signs were not documented on 04/21/20 on 2nd shift and refused was documented on the exception log. -Vital signs were not documented on 04/12/20, 04/17/20, 04/22/20, 04/26/20, and 04/27/20 on 3rd shift and the 1st shift MA had documented the VS were to have been completed on 3rd shift on the exception log. -There was documentation VS were not documented 9 out of 71 opportunities. Review of Resident #12's May 2020 eMAR revealed: -There was a computer printed entry to take vital signs (temperature, pulse, respirations, blood pressure, and oxygen saturation) every shift 7:00am-3:00pm (1st shift), 3:00pm-11:00pm (2nd shift), and 11:00pm - 7:00am (3rd shift). -There was a computer printed entry for COVID-19 precaution if a resident begins to display respiratory symptoms/fever greater than 99.6/ difficulty breathing, the community should do the following: Complete the COVID-19 form in Matrix; Add all Vitals and add oxygen saturation for every shift 7:00am-3:00pm (1st shift). -Vital signs were not documented on 05/04/20 on 1st shift and no comment was documented on	D 338		

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the exception log.
-Vital signs were not documented on 05/01/20 on 2nd shift and no comment was documented on the exception log.
-Vital signs were not documented on 05/01/20, 05/05/20, 05/10/20, 05/11/20, 05/12/20, and 05/13/20 on 3rd shift and the 1st shift MA had documented the VS were to have been checked on 3rd shift on the exception log.
-There was documentation on 05/09/20 on 1st shift that Resident #12's temperature was 99.9° F.
-There was no documentation the COVID-19 form was completed on 05/09/20 when the resident's temperature was 99.9° F.
-Vital signs were not documented on 05/14/20 on 2nd shift and resident in hospital was documented on the exception log.
-There was documentation VS were not documented 8 out of 40 opportunities.

Interview with the Divisional Director of Clinical Services (DDCS) on 05/19/20 at 1:45pm revealed staff were expected to notify the PCP for residents with temperatures greater than 99.6 degrees F.

Telephone interview with the Resident Care Director (RCD) on 06/01/20 at 2:30pm revealed:
-The staff were taught the signs and symptoms of COVID-19 were sore throat, shortness of breath, cough, diarrhea, and fever.
-She did not know if a COVID-19 form was completed per the established protocol for Resident #12 on 05/09/20.
-Resident #12 complained of not feeling well and had loose stools on 05/14/20 and was sent to the emergency department.

Review of an emergency room (ER) provider

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record for Resident #12 dated 05/14/20 at 11:18am revealed:
-The resident presented to the hospital via emergency medical services (EMS) with altered mental status.
-The resident's temperature was 101.3° F in the ER.

Telephone interview with the Administrator on 06/04/20 at 3:45pm revealed when asked why VS were not taken for Resident #11 every shift, she replied, "I don't have an answer for that."

Refer to telephone interview with the Administrator on 05/29/20 at 11:22am.

Refer to the telephone interview with the Resident Care Director (RCD) on 06/01/20 at 2:30pm.

Refer to the second telephone interview with the Administrator on 06/04/20 at 3:45pm.

c. Review of Resident #10 's current FL-2 dated 05/23/19 revealed diagnoses included diabetes, dementia, seizures, hypertension and alcohol abuse.

Review of Resident #10's April 2020 electronic medication administration record (eMAR) revealed:
-There was a computer printed entry to take vital signs (VS) (temperature, pulse respiration, blood pressure, and oxygen saturation) every shift 7:00am-3:00pm (1st shift), 3:00pm-11:00pm (2nd shift), and 11:00pm-7:00am (3rd shift) starting on 04/07/20.
-Vital signs were not documented on 04/20/20 and 04/26/20 on 2nd shift and no comment was documented on the exception log.
-Vital signs were not documented on 04/21/20 on

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2nd shift and refused documented on the exception log.
-Vital signs were not documented on 04/07/20, 04/17/20, 04/22/20, 04/26/20, and 04/27/20 on 3rd shift and the 1st shift medication aide (MA) had documented the vital signs were supposed to have been completed on 3rd shift on the exception log.
-Vital signs were not documented on 04/12/20 on 3rd shift and refused documented on the exception log.
-There was documentation VS were not documented 9 out of 71 opportunities.

Review of Resident #10's May 2020 eMAR revealed:
-There was a computer printed entry to take vital signs (VS) (temperature, pulse respiration, blood pressure, and oxygen saturation) every shift 7:00am-3:00pm (1st shift), 3:00pm-11:00pm (2nd shift), and 11:00pm-7:00am (3rd shift).
-Vital signs were not documented on 05/04/20 on 1st shift and no comment was documented on the exception log.
-Vital signs were not documented on 05/01/20 on 2nd shift and no comment was documented on the exception log.
-Vital signs were not documented on 05/01/20, 05/05/20, 05/10/20, 05/11/20, 05/12/20, 05/13/20,05/16/20, 05/17/20, 05/18/20, 05/19/20, 05/20/20, 05/21/20, 05/22/20, and 05/23/20 on 3rd shift and the 1st shift medication aide (MA) had documented the vital signs were supposed to have been completed on 3rd shift on the exception log.
-There was documentation VS were not documented 16 out of 70 opportunities.

Telephone interview with the Administrator on 06/04/20 at 3:45pm revealed when asked why VS

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were not taken for Resident #10 every shift, she replied, "I don't have an answer for that."

Refer to telephone interview with the Administrator on 05/29/20 at 11:22am.

Refer to the telephone interview with the Resident Care Director (RCD) on 06/01/20 at 2:30pm.

Refer to the second telephone interview with the Administrator on 06/04/20 at 3:45pm.

d. Review of Resident #11's current FL-2 dated 01/07/20 revealed diagnoses included symptomatic anemia, renal insufficiency, iron deficiency anemia, hypokalemia, lower extremity edema, acute kidney injury, neck mass, recurrent falls, and leukocytosis.

Review of Resident #11's April 2020 electronic medication administration record (eMAR) revealed:
-There was a computed printed entry to take vital signs (temperature, pulse, respirations, and blood pressure) every shift 7:00am-3:00pm (1st shift), 3:00pm-11:00pm (2nd shift), and 11:00pm-7:00am (3rd shift) starting on 04/07/20 with no end date.
-Vital signs were not documented during 2nd shift on 04/20/20 and 04/26/20 and no comment was documented in the exception log.
-Vital signs were not documented on 04/20/20 and 04/26/20 on 2nd shift and no comment was documented on the exception log.
-Vital signs were not documented on 04/17/20, 04/22/20, 04/26/20, and 04/27/20 on 3rd shift and the 1st shift MA had documented the vital signs were to have been completed on 3rd shift on the exception log.
-Vital signs were not documented on 04/21/20

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during 2nd shift due to resident refusal.
-Vital signs were not documented on 04/08/20, 04/12/20, 04/13/20, 04/16/20, 04/19/20, 04/21/20, and 04/24/20 on 3rd shift due to resident refusal.
-There was documentation vital signs were not documented for 14 out of 90 opportunities from 04/01/20 to 04/30/20.

Review of Resident #11's May 2020 eMAR revealed:
-There was a computed printed entry to take vital signs (temperature, pulse, respirations, blood pressure, and oxygen saturation every shift 7:00am-3:00pm (1st shift), 3:00pm-11:00pm (2nd shift), and 11:00pm-7:00am (3rd shift) starting on 04/07/20 with no end date.
-Vital signs were not documented on 05/01/20, 05/05/20, 05/10/20, 05/11/20, 05/12/20, 05/13/20, 05/16/20, 05/17/20, 05/18/20, 05/19/20, 05/20/20, 05/21/20, 05/22/20, and 05/23/20 on 3rd shift and the 1st shift MA had documented the vital signs were to have been completed on 3rd shift on the exception log.
-Vital signs were not documented during 1st shift on 05/04/20 and no comment was documented in the exception log.
-Vital signs were not documented on 05/04/20 during 3rd shift due to resident refusal.
-There was documentation vital signs were not documented for 16 out of 70 opportunities from 05/01/20 to 05/24/20.

Telephone interview with the Administrator on 06/04/20 at 3:45pm revealed when asked why VS were not taken for Resident #11 every shift, she replied, "I don't have an answer for that."

Refer to telephone interview with the Administrator on 05/29/20 at 11:22am.

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D 338	Continued From page 185 Refer to the telephone interview with the Resident Care Director (RCD) on 06/01/20 at 2:30pm. Refer to the second telephone interview with the Administrator on 06/04/20 at 3:45pm. _____ Telephone interview with the Administrator on 05/29/20 at 11:22am revealed: -The order to check all residents' vital signs was put in place by the facility when a staff member tested positive for COVID-19. -The MA was responsible for checking and documenting the vital signs every shift for all residents. -The vital signs were taken but had not been documented in the computer. -The Resident Care Director had vital signs that were taken but needed to be documented. -The vital signs should have been documented in the eMAR. Telephone interview with the Resident Care Director (RCD) on 06/01/20 at 2:30pm revealed: -Checking vital signs on every shift had been implemented by the facility for all residents due to the COVID -19 screenings. -Vital signs should be checked and documented in the eMAR by the end of each shift. -There should not be any shifts without vital signs documented on the eMAR. -She did not know why there were shifts without vital signs documented. -She did not have any vital signs that needed to be documented. A second telephone interview with the Administrator on 06/04/20 at 3:45pm revealed: -She expected all residents' vital signs to be monitored each shift consisting of Oxygen (O2) levels, temperatures, and vital signs (VS).	D 338		

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D 338	Continued From page 186 -Her expectations for obtaining residents' VS was for staff to do what they are supposed to do. -"If it populates on the MAR, they should do it". _____ The facility failed to adhere to CDC and NC DHHS guidelines for COVID-19 to include recommendations for use of personal protective equipment (PPE) and infection control procedures related to the sharing of medical equipment and hand hygiene, social distancing, and screening of visitors, staff, and residents for fever and signs and symptoms of COVID-19. Resident #7 had a temperature of 102.8 degrees F on 05/10/20 was not screened with vital signs every 4 hours from 05/10/20-05/12/20 after the fever was noted on 05/10/20. The resident was sent to the hospital on 05/12/20 and later diagnosed with COVID-19. Resident #11 and Resident #12 were also not screened with vital signs to include temperature. The facility's failure to utilize PPE and screen residents and staff in accordance with CDC guidelines and their established protocol for COVID-19 resulted in the residents not receiving the services necessary to maintain their physical health and failed to protect the residents from exposure and transmission of the virus. This non-compliance constitutes a Type A1 Violation for serious neglect. _____ The facility provided a plan of protection on 05/15/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 8, 2020.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 187 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to complete a 24-hour Health Care Personnel Registry (HCPR) investigation report for alleged staff abuse for Resident #11 and failed to report and investigate according to the HCPR guidelines for facial and upper arm bruises of unknown origin on two occasions in January 2020 for Resident #1. The findings are: 1. Review of the 5-day Compliant Intake and Health Care Personnel Investigation Report for Resident #11 dated 01/02/20 revealed: -The report was completed by the previous Administrator. -There were no named facility staff. -The allegation/incident type was resident abuse. -The date of the incident was 12/23/19. -The date and time the facility became aware of the incident was 12/25/19 at approximately 7:00pm. -The incident location description was the hallway by the nurse's station and/or bedroom. -Interviews were conducted with community staff and the resident. -Allegation was unsubstantiated. -Staff would be in-serviced on neglect and abuse policy. There was no documentation of a 24-hour Health Care Personnel Investigation Report for Resident #11 provided from the facility.	D 438		

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D 438	Continued From page 188 Telephone interview with the Health Care Personnel Registry (HCPR) representative on 06/02/20 at 9:04am revealed there was no 24-hour report submitted for Resident #11's alleged staff abuse dated 12/23/19. Telephone interview with the Administrator on 06/05/20 at 11:36am revealed: -The accident/incident (A/I) report should be completed in the electronic documentation system by a medication aide (MA), the Resident Care Director (RCD), or the Memory Care Manager (MCM) then sent to Department of Social Services (DSS) and the facility's Divisional Registered Nurse (RN). -The Administrator would complete the 24-hour HCPR report and it was based off the A/I report. -An internal investigation would be completed by the Administrator. -The Administrator would also complete the 5-day HCPR report and would fax to DSS and NC HCPR. -She could not answer why the 24-hour report was not sent to HCPR for Resident #11 because she was not the Administrator of the facility until April 2020. 2. Review of Resident #1's current FL-2 dated 12/23/19 revealed diagnoses included dementia, atrial fibrillation, congestive heart failure, coronary artery disease, cardiomyopathy, hypertension, diabetes mellitus and Parkinson's disease. Review of an electronic progress note dated 01/03/2020 at 12:47am revealed Resident #1 had a bruise on the back of her right arm and the resident did not know how the bruise got there. Review of an electronic progress note dated 01/22/2020 at 10:02am revealed Resident #1 had	D 438		

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a bruise on her nose and swelling to the right side of her face.

Telephone interview with Resident #1's responsible person on 05/14/2020 at 1:54pm revealed:
-He did not remember Resident #1 having a bruise on the back of her arm on 01/03/20.
-He did know about the bruising on Resident #1's face and nose on 01/22/20; staff did not call, he saw the bruising when he visited Resident #1.
-Staff did not tell him what happened and how Resident #1 got the bruises.

Telephone interview with a personal care aide (PCA) on 05/21/2020 at 3:45pm revealed:
-She completed the bath sheets dated 01/03/2020 and 01/22/2020 for Resident #1.
-She could not remember seeing a bruise on Resident #1's right upper arm on 01/03/2020.
-The bruise on Resident #1's nose on 01/22/2020 came from the resident scratching her nose; she did not know anything about a bruise on the resident's face.

Telephone interview with a medication aide (MA) on 05/21/2020 at 2:54pm revealed:
-She could not recall the electronic progress note she wrote on 01/03/2020 regarding a bruise on the back of Resident #1's upper right arm.
-When she found a bruise on a resident, she reported the bruise to the Memory Care Manager (MCM) and the oncoming MA.
-During off business hours, she would text the MCM or call her the next morning.

Telephone interview with a second MA on 06/05/2020 at 1:44pm revealed:
-She had written the electronic progress note dated 01/22/2020 for Resident #1.

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-Outgoing staff had told her the bruise on Resident #1's face came from a fall or "something like that."
-She reported the bruise to the MCM who said she already knew about the bruise.

Telephone interview with the MCM on 05/21/2020 at 12:06pm revealed if staff reported a resident had bruises, she placed the resident on the PCP visit list.

Telephone interview with Resident #1's PCP on 05/15/2020 at 10:46am revealed:
-Resident #1 was seen by a covering provider on 01/06/2020 for a bruise on the back of the right upper arm.
-There was no documentation for the cause of the bruise.
-The PCP's office was contacted about bruising to Resident #1's nose and face on 01/22/2020; staff did not know how the bruising occurred and the resident was added to the next visit schedule.

Second telephone interview with the MCM on 05/22/2020 at 3:36pm revealed:
-She did not remember the bruise on Resident #1's right upper arm on 01/03/2020.
-It was not a bruise on Resident #1's nose on 01/22/2020, it was a scratch mark from the resident scratching her nose.
-She thought the bruise on Resident #1's face on 01/22/2020 came from a fall; she did not know if there was documentation of the fall.
-Resident #1 was on a blood thinner and bruised easily.
-Staff were expected to report new or worsened bruises to her and she reported to the Administrator.
-She did not know if any investigation was done to determine the cause of the bruises on

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D 438	Continued From page 191 Resident #1's right upper arm and face. -The Administrator was responsible for completing Health Care Personnel Registry (HCPR) reporting. Telephone interview with the Administrator on 05/28/2020 at 9:02am revealed: -Staff were expected to document on the condition of bruises daily to make sure the bruises were not worsening. -Staff reported bruises to the MCM and if the MCM was not able to determine the bruise came from a fall, the MCM reported the bruise to her. -The MCM was expected to document bruises identified as coming from a fall in the resident's electronic progress note. -Any bruises where the cause of the bruise was not known should have been investigated and reported to the HCPR. -There were no HCPR Initial or 5 Day reports for Resident #1 from 01/01/2020 through 05/13/2020. -She was responsible for completing HCPR reports and investigations. -She was not the Administrator at the facility until 04/16/2020. A second telephone interview with the Administrator on 06/05/20 at 11:36am revealed: -She had no idea why the facility failed to report and investigate Resident #1's facial and upper arm bruises of unknown origin on two occasions in January 2020. Refer to telephone with the Administrator on 06/05/20 at 11:36am. _____ Telephone interview with the Administrator on 06/05/20 at 11:36am revealed: -The accident/incident (A/I) report should be	D 438		

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D 438	Continued From page 192 completed in the electronic documentation system by a medication aide (MA), the Resident Care Director (RCD), or the Memory Care Manager (MCM) then sent to Department of Social Services (DSS) and the facility's Divisional Registered Nurse (RN). -The Administrator would complete the 24-hour HCPR report and it was based off the A/I report. -An internal investigation would be completed by the Administrator. -The Administrator would also complete the 5-day HCPR report and would fax to DSS and NC HCPR. -She could not answer why the 24-hour report was not sent to HCPR for Resident #11 because she was not the Administrator of the facility until April 2020. -She had no idea why the facility failed to report and investigate Resident #1's facial and upper arm bruises of unknown origin on two occasions in January 2020.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by:	D 465		

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D 465	Continued From page 193 TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure minimum staff were present to meet the needs of Special Care Unit residents (SCU) for 17 of 24 shifts sampled for 8 days from January 2020 to May 2020. The findings are: Review of the facility's current 2020 license revealed the facility was licensed as a SCU with a capacity of 64 beds. Review of the punch detail records for staff and census report dated 01/24/20 revealed: -The census was 47 residents. -The required staff hours for first shift was 47 hours. -There were 38.11 staff hours provided on the first shift, a shortage of 8.89 hours. -The required staff hours for second shift was 47 hours. -There were 37.57 staff hours provided on the second shift, a shortage of 9.43 hours. -The required staff hours for third shift was 37.6 hours. -There were 36.4 staff hours provided on the third shift, a shortage of 1.2 hours. Review of a progress note revealed Resident #3 had an unwitnessed fall on 01/24/20 at 2:02pm which resulted in a small cut on the left ear. Review of the punch detail records for staff and census report dated 02/21/20 revealed: -The census was 45 residents. -The required staff hours for first shift was 45 hours. -There were 29.83 staff hours provided on the	D 465		

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first shift, a shortage of 15.17 hours.
-The required staff hours for second shift was 45 hours.
-There were 38.26 staff hours provided on the second shift, a shortage of 6.74 hours.

Review of a progress note, and incident report Resident #3 had an unwitnessed fall on 02/21/20 at 9:11pm which resulted in a bleeding abrasion to the forehead and was sent out to the emergency department (ED).

Review of the punch detail records for staff and census report dated 03/02/20 revealed:
-The census was 43 residents.
-The required staff hours for second shift was 43 hours.
-There were 32.08 staff hours provided on the second shift, a shortage of 10.92 hours.

Review of the punch detail records for staff and census report dated 04/11/20 revealed:
-The census was 45 residents.
-The required staff hours for third shift was 33.6 hours.
-There were 28.15 staff hours provided on the third shift, a shortage of 5.45 hours.

Review of the punch detail records for staff and census report dated 05/06/20 revealed:
-The census was 42 residents.
-The required staff hours for first shift was 42 hours.
-There were 29.75 staff hours provided on the first shift, a shortage of 12.25 hours.
-The required staff hours for second shift was 42 hours.
-There were 36.26 staff hours provided on the second shift, a shortage of 5.74 hours.
-The required staff hours for third shift was 33.6

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hours.
-There were 28.16 staff hours provided on the third shift, a shortage of 5.44 hours

Review of the punch detail records for staff and census report dated 05/10/20 revealed:
-The census was 42 residents.
-The required staff hours for first shift was 42 hours.
-There were 40 staff hours provided on the first shift, a shortage of 2 hours.
-The required staff hours for second shift was 42 hours.
-There were 40 staff hours provided on the second shift, a shortage of 2 hours.
-The required staff hours for third shift was 33.6 hours.
-There were 30 staff hours provided on the third shift, a shortage of 3.6 hours.

Review of an accident/incident report dated 05/10/2020 at 9:12am for Resident #1 revealed Resident #1 was found on the floor in another resident's room and had a knot on her head.

Review of the punch detail records for staff and census report dated 05/13/20 revealed:
-The census was 42 residents.
-The required staff hours for first shift was 42 hours.
-There were 40 staff hours provided on the first shift, a shortage of 2 hours.
-The required staff hours for second shift was 42 hours.
-There were 40 staff hours provided on the second shift, a shortage of 2 hours.

Review of an accident/incident report dated 05/13/20 at 7:35am for Resident #1 revealed Resident #1 was found on the floor in her room

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bedside the bed with no injuries documented.

Review of an accident/incident report dated 05/13/20 at 11:30am for Resident #1 revealed Resident #1 was found on the floor near her bathroom with no injuries documented.

Review of the punch detail records for staff and census report dated 05/17/20 revealed:
-The census was 42 residents.
-The required staff hours for first second was 42 hours.
-There were 36.13 staff hours provided on the second shift, a shortage of 5.87 hours.
-The required staff hours for third shift was 33.6 hours.
-There were 28.6 staff hours provided on the third shift, a shortage of 5.0 hours.

Review of an accident/incident report dated 05/18/20 at 2:30am for Resident #1 revealed Resident #1 was found on the community bathroom floor with no injuries.

Review of Resident #1's hospital record dated 05/18/20 through 05/21/20 revealed there was documentation Resident #1 had bruises on her right forehead and generalized bruising to her face, chest, arms and buttocks.

Confidential telephone interview with staff revealed:
-The Special Care Unit was short a lot during third shift.
-The SCU was usually staffed with two personal care aides (PCAs) for the women's hall, one PCA for men's hall, and then usually one medication aide (MA) worked both the SCU and the assisted living unit.
-"A good night in the facility was when there were

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two MAs working during third shift."
-If a PCA called out on the women's hall then the other PCA was stuck to work the hall by themselves because the MA did not help them.

Confidential telephone interview with second staff revealed:
-Staffing was low, if staff called out, there was no relief especially on third shift" in the SCU.
-When staff tried to call the Memory Care Manager(MCM)or Resident Care Director (RCD) regarding staff calling out especially on third shift, they would not answer them.
-It was hard for staff to manage the residents in the SCU because of short staffing.
-Two PCAs were usually assigned to the women's hall in the SCU and at least 12 of those residents were considered wanderers.
-It was hard to keep up with the residents especially when the staff had to go into resident's rooms to provide personal care, so there were sometimes a lot of resident falls in the SCU because of short staffing.

Confidential telephone interview with a family member revealed:
-Their family member was a resident in the SCU.
-The family member visited often.
-The family member had seen a "marked" difference in staffing for the SCU and Assisted Living section of the facility.
-The family member observed that there was "almost no staff" working during the family members visit around the end of February 2020 and first of March 2020.
-The family member had observed "1-2 folks" during this time (February 2020 and first of March 2020) compared to prior staffing of 3 to 4 staff plus a MA assigned to one area of the SCU.
-The family member was told that staff were

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working very long hours and the family member was concerned for the staff and the residents working those long hours with so many residents to care for and was concerned it was not "doable".

Telephone interview with a medication aide (MA) on 06/04/20 at 1:12pm revealed:
-She worked on 05/17/20, she did not know that she was the only MA for the facility that night on 3rd shift.
-There had been short shifts on average 2 to 3 times a week due to call outs.
-The staff called the MA/Supervisor on duty and/or the Memory Care Manager (MCM) for call outs and they tried to get the shift covered with another staff.
-She primarily worked 2nd shift but would stay for 3rd shift if they needed help.
-When there was one MA for the facility the residents' every shift vital signs for COVID-19 screening did not get done.

Confidential telephone interview with a staff revealed:
-The SCU had been short staffed for months; having only one medication aide for the whole building and 3 personal care aides (PCAs) for the SCU.
-There were 2 PCAs for the women's hall on the SCU and 27 residents.
-When the 2 PCAs were both assisting other residents, there was no staff to watch residents who fell frequently like Resident #1 and 2 additional residents on the women's hall.
-PCAs had come to work and gotten sick with symptoms such as pink eye and were not allowed to leave because there was no other staff to work.

Telephone interview with a second MA on

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06/04/20 at 11:49am revealed:
-The PCAs checked on residents every 2 hours at minimum, but PCAs usually checked residents every 30 minutes to an hour because there were so many falls.
-There were 5 residents on the SCU that staff had to watch for falls including Residents #1, #3 and #9.
-Staff could meet the needs of the residents if there were 4 PCAs on the women's hall and at least 2 PCAs on the men's hall.
-One PCA was needed for Resident #1 alone.
-There were only 3 PCAs on the women's hall and 1 PCA on the men's hall last evening (06/03/20).
-She had told the MCM about the staffing and the MCM would help staff with resident care.

Telephone interview with a third MA on 06/04/20 at 5:14pm revealed:
-There was not enough staff in the building for 3rd shift.
-There were usually 2 PCAs on the women's hall in SCU and 1 PCA on the men's hall and there was only one MA for the SCU and the assisted living (AL) side.
-She understood staffing for the census, but there needed to be enough staff to give care to the residents.
-She had spoken to the MCM about the staffing but she could not remember the date.
-Staff worked together to do the best they could but each was just one person; she worried about residents falling because there was not enough staff.
-In a SCU, staffing needed to be determined by the needs of the residents, not just the number of residents.

Telephone interview with a fourth MA on 06/05/20

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at 1:44pm revealed:
-There were a lot of falls that went unreported; because staff had been told they would be written up if a resident fell on their shift.
-There was not enough staff to supervise all the residents; she told the MCM and Administrator all the time about the staffing.
-She was told the facility was staffed according to the census.

Telephone interview with the MCM on 05/28/20 at 3:36pm revealed:
-Even with every 30-minute checks staff could not keep residents from falling so she told the staff "you just have to watch them."
-Staff had assignments on the SCU; Resident #3 and Resident #9 were both on one assignment and staff were told to watch them.
-Resident #1 had to be kept with staff all the time; when PCAs and/or MAs had to attend to other residents, they would bring Resident #1 to sit with her.
-There was a 3rd male resident that staff needed to watch on another assignment.
-There were 2 PCAs on the men's hall; 3 PCAs on the women's hall and a medication aide (MA) for each hall.
-The requirements for 42 residents was 6 staff.
-There was one resident on the men's hall that needed assistance with eating and 4 on the women's hall.
-The staff on the SCU worked together as a team to assist residents with eating and supervising other residents.

Second telephone interview with the MCM on 06/04/20 at 3:48pm revealed:
-She did the schedule for staff on the special care unit (SCU); she alone was responsible for reviewing the schedule to make sure there was

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D 465	Continued From page 201 enough staff. -For 1st shift there were 5 PCAs for 42 residents; she scheduled 6 PCAs because the additional PCA was needed for monitoring residents due to falls. -On 06/04/20, there were 3 PCAs on the women's hall, 2 PCAs on the men's hall and 1 medication aide for the unit. -She had frequently worked as a direct care staff and was not counted in the numbers which made the shifts look short. -She would schedule 6 staff for 1st and 2nd shifts and then 5 on 3rd shift or 5 staff on 1st and 2nd shifts with 4 on 3rd shift. -The facility changed to 12 hour shifts around 05/20/20. -She did not know there was only one MA in the facility for 3rd shift on 05/17/20. -She did not know about the schedule for the AL side, the Resident Care Director (RCD) did that schedule. Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care & Supervision Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care & Supervision Refer to Tag 273, 10A NCAC 13F 0902(b) Health Care _____ The facility failed to assure staff hours met the minimum requirements for a special care unit at all times for 17 of 24 shifts. The facility's failure resulted in a lack of supervision with multiple unwitnessed falls that resulted in head injuries leading to an emergency department visit, extensive bruising to the face, chest, arms, hips and thighs. The facility placed residents at substantial risk of serious neglect and physical	D 465		

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D 465	Continued From page 202 harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 June 4, 2020 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 8, 2020.	D 465		
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 record review, observation, and interview of staff and residents, the facility failed to assure provision of adequate and appropriate care and services to residents regarding personal care and supervision, housekeeping and furnishings, and special care unit staffing. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure minimum staff were present to meet the needs of Special Care Unit residents (SCU) for 17 of 24 shifts sampled for 8 days from January 2020 to May 2020. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)]. 2. Based on interviews and record reviews the	D912		

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D912	Continued From page 203 facility failed to ensure staff provided personal care for 2 of 12 sampled residents regarding a resident who required every two-hour repositioning (#4) and daily mouth care including care for upper and lower dentures (#1). [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 12 residents sampled (#1, #3, #9) with multiple falls resulting in serious physical injuries to include a facial laceration requiring sutures and an orbital wall fracture (#9); a resident who experienced increased weakness and unsteady gait resulting in 4 documented falls and an unknown number of undocumented falls for the month of May 2020 with extensive bruising to the resident's face, arms, chest, buttocks and thighs (#1), and resident who had increased weakness and unsteady gait who suffered multiple falls resulting in physical injuries including facial lacerations and bruising to his right shoulder (#3). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 4. Based on video conference observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards by not properly treating and delaying treatment for bed bugs in rooms #218, #401, #403 where residents resided. [Refer to Tag D079, 10A NCAC 13F .0306(A)(5) Housekeeping and Furnishings (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D914		

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D914	Continued From page 204 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 record review, observation, and interview of staff and residents, the facility failed to assure residents were free from abuse and neglect regarding health care referral and follow up, residents' right, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs were met for 6 of 12 sampled residents (#7, #8, #1, #9, #4, and #11) related to failing to notify the primary care provider (PCP) of increased temperatures for several days during a viral pandemic and a scant dark urine output with foul odor for Resident #7, failed to assure Resident #8 was sent out for urinary bleeding x 2 weeks before being sent out to the emergency department with diagnosis of urinary tract infection and cystitis and failed to notify PCP of bed bug bites, failed to notify the PCP of acute behavior change on 04/27/2020, three occasions of weight loss between 6 and 11 pounds and lower extremity bite marks with itching, scratching and bleeding and follow up a cardiology referral order 12/18/19 and quarterly pacemaker monitoring for Resident #1, failed to assure a resident was referred as ordered to a Ear, Nose, and Throat (ENT) specialist after being treated for an orbital wall fracture in the emergency department and failed to notify the PCP of falls with one fall resulting in a bump on the resident's head (#9), failed to assure a resident was referred as ordered to a cardiology specialist for	D914		

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D914	Continued From page 205 evaluation of her pacemaker (#1), Stage 2 ulcer right hip with 6 day delay in reporting to PCP for Resident #4, and failing to notify the PCP for alleged staff to resident abuse dated 12/25/19 and for resident to resident verbal altercation on 04/30/20 for Resident #11. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, housekeeping and furnishings, residents' rights, personal care and supervision, and special care unit staffing. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 3. Based on interviews, observations and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) and directives from the local health department (LHD) were implemented and maintained when caring for 93 residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors, staff, and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing; restricting residents to their assigned rooms; basic hand hygiene and infection control procedures; environmental cleanliness and safety precautions to reduce the risk of transmission and infection. [Refer to Tag D338, 10A NCAC	D914		

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D914	Continued From page 206 13F .0909 Residents' Right (Type A1 Violation)].	D914		
D922	G.S. 131D-21(12) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 12. To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge. This Rule is not met as evidenced by: Based on interviews, the facility failed to ensure residents had access and use of personal possessions as evidenced by missing dentures (#4, #9) and a wedding ring (#1). The findings are: Telephone interview with Resident #9's family member on 05/27/20 at 11:57am revealed: -The family member had a mobile cell phone face to face visit with the resident approproximately 6 weeks ago and noticed the resident did not have his lower dentures. -The family member visited the resident the other day at the window of his room and the resident again did not have his lower dentures. -She told the staff about the resident not having his bottom dentures and was told "we will look for them". -The family member then called the Administrator last week and she advised she would have the staff look for Resident #9's lower dentures but	D922		

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D922	Continued From page 207	D922		

she had not heard back if staff found the resident's lower dentures.
-The family member questioned why staff had not noticed the resident was missing his lower dentures, especially now, because the residents were eating in their rooms and was concerned the resident had been eating all this time without his bottom dentures.

Telephone interview with a personal care aide (PCA) on 05/27/20 at 3:20pm revealed:
-Residents' dentures were kept in the medication room.
-She was not sure how the residents' dentures were stored, however thought the residents' dentures were kept with a name on them.
-The PCAs were not allowed in the medication room.

Telephone interview with a medication aide (MA) on 06/04/20 at 11:49am revealed:
-She did not know Resident #9 had any missing denture and was not aware the resident wore dentures.
-The facility had denture cups in the medication room, with a lid and the residents name labeled on the cup.
-The residents' dentures were kept in the medication room because of the unit having residents with dementia and if the dentures were left in the resident's room, other residents would be wearing someone else's dentures.

Telephone interview with the Memory Care Manager (MCM) on 06/04/20 at 3:47pm revealed:
-The residents' dentures were kept in the medication room in a denture cup.
-She could not say she was aware Resident #9 was missing his lower dentures and his family member might have them.

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D922	Continued From page 208 -She would look for Resident #9's lower dentures. Refer to telephone interview with the Administrator on 05/13/20 at 10:59am. Refer to telephone interview with a PCA on 05/13/20 at 11:00am. Refer to telephone interview with a MA on 05/13/20 at 1:05pm. Refer to telephone interview with the MCM on 06/04/20 at 3:48pm. Refer to a second telephone interview with the Administrator on 06/05/20 at 8:41am. 2. Review of an electronic progress note dated 12/26/19 at 2:39pm revealed the medication aide (MA) documented that she was told Resident #1 took off her wedding ring in the activity room and the ring was missing. Telephone interview with the MA on 05/15/2020 at 10:01am revealed: -She documented the electronic progress note dated 12/26/2020 at 2:39pm. -She was told by the Activity Director on 12/26/19 Resident #1 had taken off her wedding ring during an activity. -The wedding ring had not been found. -She had notified Resident #1's responsible person (RP) when the incident happened. Telephone interview with Resident #1's RP on 05/28/2020 at 4:50pm revealed: -He did not know anything about Resident #1 missing her wedding rings from the facility. -He thought a family member was going to pick up Resident #1's jewelry.	D922		

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D922	Continued From page 209 Telephone Interview with a housekeeper on 06/05/2020 at 9:24am revealed: -She was previously the Activities Director and was conducting an activity with residents when Resident #1's wedding rings went missing. -Other staff had told her Resident #1 kept taking off her set of wedding rings; the rings were supposed to be taken and put up for a family member to pick up for safe keeping, but that never happened. -She had seen Resident #1's wedding rings on the table where the resident was sitting during the activity. -She left out of the room to get something for the activity and when she returned the rings were gone. -When Resident #1 left the activity, the weddings were no longer on the table; the MA said the rings were missing. -She did not tell the Memory Care Manager (MCM) Resident #1's wedding rings were missing. -She looked for the rings and when she did not find them, she returned to the activity with the remaining residents. Telephone interview with the MCM on 06/04/2020 at 3:48pm revealed she did not know Resident #1 was missing her wedding rings. Refer to telephone interview with the Administrator on 05/13/20 at 10:59am. Refer to telephone interview with a PCA on 05/13/20 at 11:00am. Refer to telephone interview with a MA on 05/13/20 at 1:05pm.	D922		

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D922	Continued From page 210 Refer to telephone interview with the MCM on 06/04/20 at 3:48pm. Refer to a second telephone interview with the Administrator on 06/05/20 at 8:41am. 3. Review of Resident #4's FL2 dated 07/16/19 revealed: -Diagnoses included Alzheimer's, bradycardia, hypertension, diabetes mellitus (DM), and coronary artery disease. -The resident was ambulatory, a wanderer and constantly disoriented, and intermittently incontinent of bowel and bladder. Telephone interview with a second MA on 05/27/20 at 11:20am revealed: -Dentures would be labeled and in a denture box in the medication room because some residents would lose their dentures. -The family was informed when keeping resident dentures in the mediation room. Telephone interview with the MCM on 05/28/20 at 9:07am revealed: -Resident #4's dentures were missing at one time, but they were found. -Resident #4's dentures went missing again and she did not think they were ever found. -She did not remember when Resident #4's dentures were missing. -Resident #4 would spit out her dentures. -She had called Resident #4's family to tell them the resident was spitting out her dentures. -The family wanted Resident #4 to keep her dentures even though she would spit them out. -Resident dentures wore stored in a "cubby hole" with the resident's room number when the resident would not keep the dentures in their mouth.	D922		

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D922	Continued From page 211 -The dentures were not kept in their rooms because it was a dementia unit and the residents would take each other's dentures when sitting beside each other. Telephone interview with the Administrator on 06/05/20 at 8:41am revealed: -Resident dentures were taken out at night and stored in a container with water. -The container would be labeled with the residents' name and stored at the nurse's station or on the medication cart in a larger container. -There were no residents missing their dentures because they were in individual cups and labeled. -She had not been told residents had missing dentures. -Not having dentures could impact resident eating and weights. Confidential interview with staff revealed: -She did not remember putting dentures in Resident #4's mouth. -She did not know who was responsible for putting dentures in a resident's mouth. -She did not remember seeing dentures in Resident #4's room. -Resident dentures were kept in the medication room when not in use by the resident. -Some dentures would be stored in an unlabeled container in the medication room. -Some dentures would be stored loose and unlabeled on a shelf in the medication room. -Staff did not keep up with who the dentures belonged to. Confidential interview with a second staff revealed: -Resident #4 had her dentures around February 2019. -The staff last saw Resident #4's dentures around	D922		

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March 2019 or April 2019 in the resident's mouth.
-The staff had seen some unlabeled dentures in a denture cup on the medication cart. The staff member thought they were Resident #4's.
-The staff did not know when she saw the unlabeled dentures on the medication cart.
-The staff did not know what happened to the unlabeled dentures on the medication cart.
-The staff did not ask anyone about the dentures on the medication cart.
-The staff did not know what the storing denture policy was.
-The staff did not know anything about dentures in the medication room.

Based on interviews and record reviews it was determined Resident #4 was not interviewable.

Refer to telephone interview with the Administrator on 05/13/20 at 10:59am.

Refer to telephone interview with a PCA on 05/13/20 at 11:00am.

Refer to telephone interview with a MA on 05/13/20 at 1:05pm.

Refer to telephone interview with the MCM on 06/04/20 at 3:48pm.

Refer to a second telephone interview with the Administrator on 06/05/20 at 8:41am.

_____

Telephone interview with the Administrator on 05/13/20 at 10:59am revealed:
-Residents reported to the medication aides (MAs) when personal property was missing.
-The MA would look for the personal property.
-If the MA could not find the personal property the MA would then tell the Memory Care Manager

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D922	Continued From page 213 (MCM) -The MCM would tell the Administrator. Telephone interview with a Personal Care Aide (PCA) on 05/13/20 at 11:00am revealed: -The PCA would tell the MA of missing resident items. -The MA would tell the unit manager. Telephone interview with a medication aide (MA) on 05/13/20 at 1:05pm revealed: -If a resident was missing personal property the MA/PCA would look for the missing property. -If the resident's property could not be found the family would be called to see if they had it. -If the family did not have the missing property the MA/PCA would report the missing property to the MCM or Administrator. -The Administrator or Memory Care Manager (MCM) would be available over nights, weekends, and holidays to report missing items. Telephone interview with the MCM on 06/04/2020 at 3:48pm revealed: -When a residents' personal belongings like a ring or dentures went missing, staff were expected to look for the item. -If the belonging was not found staff notified her, she called the family and followed up with the Administrator for any additional steps such as contacting law enforcement. A second telephone interview with the Administrator on 06/05/20 at 8:41am revealed: -She was not aware of a policy for missing resident property. -Management should be notified of missing resident property. -Staff were supposed to look for missing resident property.	D922		

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D922	Continued From page 214 -If the property could not be found they were to inform the unit managers and the Administrator. -If the Administrator could not find the missing property a police report would be filed, and family notified.	D922		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, housekeeping and furnishings, residents' rights, personal care and supervision, and special care unit staffing. The findings are: Telephone interview with the Administrator on 05/15/20 between 9:05am - 9:25am revealed: -She was new to the facility [since April 17, 2020]. -There were "things" that staff at the facility may	D980		

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not have been doing that she expected them to do.
-She expected staff to document in residents progress notes any communication between the facility and any provider.
-She had been aware for "like two weeks" about bed bugs in resident room #218 and his room was a "continual issue".
-She would probably move the resident out of the room.
-She did not know the last time the facility had been treated for bed bugs.

Confidential telephone interview with a former staff revealed:
-The current Administrator tried to "keep everything covered up" and a "secret".
-She did not have any interaction with the current Administrator.
-She was not comfortable working at the facility because the Administrator was not doing things right.
-When staff initially started questioning the current Administrator about a resident that tested positive for COVID-19, the Administrator went into a "rant" that she was not going to have to be checked by the health department every week because of what staff were saying.
-The staff did not know anything that was going on in the building since the current Administrator came to the facility.

Telephone interview with a healthcare provider on 06/04/20 at 8:23am revealed:
-She started coming to the facility in April.
-There had been several interim administrators.
-She did not know who the current Administrator was.

Telephone interview with a medication aide (MA)

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D980	Continued From page 216 on 06/04/20 at 5:14pm revealed: -She did not have any interaction with the Administrator, and she had seen her twice. -Communication from management could be improved and staff should know what was expected and what to expect. Telephone interview with the Administrator on 06/05/20 at 8:40am revealed: -She was not aware of a company policy and procedure related to resident missing property. -She was not aware of a policy and procedure related to significant change reporting for residents but knew there was a state regulation about residents with significant changes. -She did not review the staffing schedule completed by the Memory Care Manager (MCM) and Resident Care Director (RCD). -She relied on the MCM and RCD to ensure staffing of the facility met the minimum state requirements. -She monitored the facility environment for safety when she made rounds of the units during the day. -She checked areas to ensure there were no hazards on the floor. -She conducted a morning stand-up with department heads which included discussing residents that were high risk for falls, and any family member concerns. -Prior to the survey, she was very involved with COVID-19. -The facility COVID-19 positive residents and staff had just been identified since this survey began, and the facility implemented changes at that time. -When she began employment at the facility on 04/17/20, the facility was monitoring resident and staff temperatures, and completing a screening tool on visitors and staff.	D980		

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D980	Continued From page 217 -COVID-19 training was completed on 03/30/20 or 03/31/20. Telephone interview with the Resident Care Director on 06/05/20 at 11:20am revealed: -The previous Administrator was not very involved in issues at the facility and called on her a lot. -Even though the current Administrator tour the halls every day, she did not tour the 100 hall because only the residents who were diagnosed with COVID19 lived on that hall and she was not allowed to go down that hall by the corperate managers. -She walked down 100 hall two times a day and was responsible for assuring the staff who worked on the COVID 19 hall wore their personal protective equipment (PPE) properly and was responsible for informing the Administrator if the staff was not following the Center for Disease Control (CDC) guidelines. -She was not aware of any concerns from anyone from the community/providers regarding improper use of PPE by the staff. -The resident's families have "our" personal phone numbers and can call our cell phones or email the Administrator since the facility phones were not working properly. -There were signs on the front door of the facility regarding COVID19 visiting policy/instructions, but the sign had been taken down and she was not aware there was no sign on the front door. -The former Administrator was not involved in the care of the residents or supervision of the staff. She depended on the RCD and the MCD to make decisions regarding all resident care. -The RCD and the MCM put "things in place to keep things going" in the facility. Telephone interview with a primary care provider (PCP) on 06/05/20 at 3:19pm revealed:	D980		

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-She had been unable to reach the Administrator.
-She had emailed the current Administrator multiple times with no responses.
-She had started including the Administrator on emails to the MCM and RCD communicating orders and follow up for the residents.
-She had emailed the Administrator directly regarding the needs of the residents.
-She had not received a response from the Administrator.

Non-compliance was identified in the following rule areas at violation level:

1. Based on interviews and record reviews, the facility failed to ensure minimum staff were present to meet the needs of Special Care Unit residents (SCU) for 17 of 24 shifts sampled for 8 days from January 2020 to May 2020. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)].

2. Based on interviews and record reviews the facility failed to ensure staff provided personal care for 2 of 12 sampled residents regarding a resident who required every two-hour repositioning (#4) and daily mouth care including care for upper and lower dentures (#1). [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)].

3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 12 residents sampled (#1, #3, #9) with multiple falls resulting in serious physical injuries to include a facial laceration requiring sutures and an orbital wall fracture (#9); a resident who experienced increased weakness and unsteady gait resulting in 4 documented falls and an unknown number of undocumented falls for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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
D980	Continued From page 219	D980		

month of May 2020 with extensive bruising to the resident's face, arms, chest, buttocks and thighs (#1), and resident who had increased weakness and unsteady gait who suffered multiple falls resulting in physical injuries including facial lacerations and bruising to his right shoulder (#3). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

4. Based on video conference observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards by not properly treating and delaying treatment for bed bugs in rooms #218, #401, #403 where residents resided. [Refer to Tag D079, 10A NCAC 13F .0306(A)(5) Housekeeping and Furnishings (Type B Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs were met for 6 of 12 sampled residents (#7, #8, #1, #9, #4, and #11) related to failing to notify the primary care provider (PCP) of increased temperatures for several days during a viral pandemic and a scant dark urine output with foul odor for Resident #7, failed to assure Resident #8 was sent out for urinary bleeding x 2 weeks before being sent out to the emergency department with diagnosis of urinary tract infection and cystitis and failed to notify PCP of bed bug bites, failed to notify the PCP of acute behavior change on 04/27/2020, three occasions of weight loss between 6 and 11 pounds and lower extremity bite marks with itching, scratching and bleeding and follow up a cardiology referral order 12/18/19 and quarterly pacemaker monitoring for Resident #1, failed to assure a resident was referred as ordered to a Ear, Nose,

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D980	Continued From page 220 and Throat (ENT) specialist after being treated for an orbital wall fracture in the emergency department and failed to notify the PCP of falls with one fall resulting in a bump on the resident's head (#9), failed to assure a resident was referred as ordered to a cardiology specialist for evaluation of her pacemaker (#1), Stage 2 ulcer right hip with 6 day delay in reporting to PCP for Resident #4, and failing to notify the PCP for alleged staff to resident abuse dated 12/25/19 and for resident to resident verbal altercation on 04/30/20 for Resident #11. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 6. Based on interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, housekeeping and furnishings, residents' rights, personal care and supervision, and special care unit staffing. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 7. Based on interviews, observations and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) and directives from the local health department (LHD) were implemented and maintained when caring for 93 residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors, staff, and residents; use of personal protective equipment	D980		

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D980	Continued From page 221 (PPE) by staff and residents; practicing social distancing; restricting residents to their assigned rooms; basic hand hygiene and infection control procedures; environmental cleanliness and safety precautions to reduce the risk of transmission and infection. [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Right (Type A1 Violation)]. The facility failed to ensure responsibility for the overall management, administration, supervision, and operation of the facility which resulted in staffing hours below the required hours needed to provide care to 42 residents residing in the special care unit where multiple residents had falls with injuries, acute and chronic health care needs not being referred for follow up including adherence to guidelines and recommendations established by the Center for Disease Control (CDC), local health department, and the North Carolina Department of Health and Human Services to protect the residents from infection and transmission during the global coronavirus (COVID-19) pandemic for a resident exhibiting symptoms of upper respiratory infection, and a urinary tract infection resulting in a diagnosis of sepsis (Resident #7), and a resident with weight loss and requiring a cardiology referral and pacemaker monitoring (Resident #1). This failure resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/05/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 8, 2020.	D980		