Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	C 09/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 08/20/20, a desk review survey from 08/20/20-08/21/20, 08/24/20-08/28/20, 08/31/20-09/03/20, and a telephone exit on 09/03/20.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and telephone interviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#2) who had a history of falls. The findings are: Review of Resident #2's FL-2 dated 11/22/19 revealed: -Diagnoses included Alzheimer's disease, falling episodes, and diabetes. -Resident #2 was ambulatory and continent. Review of Resident #2's Resident Register dated 11/25/19 revealed: -Resident #2 was admitted to the facility on 11/27/19.	D 270	1. Community will utilize Fall Prevention and Management Program. 2. Community will utilize risk assessments, weekly falls meetings, and post Fall investigations with interventions. 3. Resident Care Director, Executive Director, or Designee to monitor weekly.	10/18/20 10/18/20 10/18/20

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Toney — TITLE: Executive Director — (X6) DATE: 10/7/2020

Reviewed and accepted. SM 10/07/20

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D 270	Continued From page 1 -Resident #2 required assistance with orientation to time and place; she was less oriented in the morning. Review of the facility's Fall Prevention and Management Policy with an effective date of 12/09/19 revealed: -Fall risk assessments were to be completed at admission, after any fall, and as needed. -All falls were to be reviewed and investigated. -If risks were identified, preventive measures would be put in place. -Individualized interventions would be implemented based on the assessment. -Providers were to be consulted regarding risks and interventions, feedback, and other recommendations. Review of Resident #2's Fall Review dated 11/27/19 revealed: -The review was completed by the Resident Care Director (RCD). -Resident #2 had a history of falls in the previous three months before admission. -Resident #2 had cognitive impairment and poor safety awareness. -Resident #2 was prescribed antidepressants. -Resident #2 ambulated with an assistive device. -Resident #2 was admitted to the facility and had an assistive device (unspecified). -Resident #2 was considered a high fall risk. Review of Resident #2's care plan dated 01/17/20 revealed: -Resident #2 was sometimes disoriented. -Resident #2's gait was unsteady at times and she had had some falls. -Resident #2 required assistance with activities of daily living (ADLs) by staff. -Resident #2's ambulatory devices were a walker	D 270		

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D 270	Continued From page 2 and a cane. -Resident #2 experienced daily bladder incontinence and occasional bowel incontinence. -Resident #2 required supervision with ambulation and transferring. -Resident #2 required limited assistance with toileting, bathing, dressing, and personal hygiene. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 06/02/20 revealed: -Resident #2 was dependent on staff for transfers as well as wheelchair mobility. -Resident #2 required total assistance with her ADLs. -Resident #2 had fallen "several" times in the past quarter. -There was a fall mat beside Resident #2's bed. Review of the facility's Occurrence Report for Resident #2 dated 11/30/19 revealed: -The report was completed by a medication aide (MA). -On 11/30/19 at 11:40am, Resident #2 had an unwitnessed fall. -Resident #2 was found sitting on the floor beside a door. -Resident #2 had a laceration on the back of her head and was transported to the hospital for treatment. -The intervention written by the RCD was to follow-up with Resident #2's primary care provider (PCP). Review of Resident #2's progress notes dated 11/30/19 revealed: -There was a note written by a MA at 12:30pm. -Resident #2 was found on the floor in her bedroom with a laceration to the back of her head.	D 270		

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D 270	Continued From page 3 -Emergency medical services (EMS) transported Resident #2 to the hospital for treatment. -Resident #2's responsible party and the RCD were notified about the fall. -There was a note written by a second MA at 8:07 (no am or pm indicated). -Resident #2 had returned to the facility and had no new physician orders. -Resident #2 was on one-hour checks. Review of Resident #2's Hospital Discharge Summary dated 11/30/19 revealed: -Resident #2's diagnoses were a closed head injury and a scalp laceration. -A computerized tomography (CT) scan did not show any internal bleeding or fracture. -Resident #2 needed constant supervision to make sure she did not fall again. -Resident #2 was to follow-up with her PCP as needed for further care. Review of the Resident Observation sheets for 11/30/19-12/02/19 revealed: -Resident #2 had been on one-hour checks before she fell on 11/30/19. -There was documentation during these times indicating Resident #2 had been offered something to eat, was observed sleeping, was toileted, and was asked if she had any needs, but Resident #2 was out of the facility on 11/30/19 from 12:00pm-6:00pm receiving emergency care for her fall. -There was no documentation indicating Resident #2's checks had been upgraded to more frequent checks following her fall on 11/30/19. -Resident #2 remained on one-hour checks on 12/01/19 and 12/02/19. Telephone interview on 08/27/20 at 2:31pm with the personal care aide (PCA) who completed	D 270		

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D 270	Continued From page 4 Resident #2's 11/30/19 Resident Observation sheet revealed: -Resident #2 used to get up and try to walk. -She would try to walk in the hall using the handrail. -Residents were normally checked on every two hours. -After a fall, residents would be checked on every hour, every 30 minutes, or as often as could be, depending on the circumstances. -If a resident was on increased supervision, the MA would place a Resident Observation sheet in the PCA binder that was kept at the nursing station. -The observation sheet was supposed to be initialed right after the check had taken place. Telephone interview on 08/31/20 at 5:48pm with the PCA who completed Resident #2's 11/30/19 Resident Observation sheet revealed: -The MA checked the PCA's documentation on the observation sheet throughout the shift to make sure it was being done. -She was "not sure what to say" when asked about documenting on the observation sheet when Resident #2 was out of the facility. Telephone interview on 09/01/20 at 12:57pm with a MA, who completed the incident report for Resident #2 dated 11/30/19, revealed: -Supervision meant keeping residents in sight, checking on them, and supervising their meals and snacks. -Resident #2 would try to get out of bed at night. -She did not remember the details of Resident #2's fall on 11/30/19. -A PCA probably found Resident #2 on the floor during rounds. -Residents were routinely sent out to the hospital if they hit their head and were bleeding after	D 270		

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D 270	Continued From page 5 having a fall. -Residents who fell would also be examined by the PCP; the PCP was at the facility twice a week. -There was a spare fall mat at the facility and Resident #2 was provided with the mat sometime (date unknown) after her first fall. -She could not remember the date, but sometime after her first fall Resident #2 was provided with a wheelchair and was placed in the common area of the facility so staff could more readily check on her. -Sometime after her first fall (date unknown), Resident #2 would be toileted every two hours to prevent further falls. -Routine checks on residents were every two hours. -Residents would be upgraded to one-hour checks after having a fall. -The MA would update the observation sheet after a resident experienced a fall. -The observation sheet was placed in the PCA binder that was kept at the nursing station. -She regularly reviewed the observation sheets during the shift to ensure the PCAs were accurately documenting the care provided to the residents. -The RCD and the Administrator occasionally reviewed the observation sheets; she did not know if they had a scheduled time for reviewing the observation sheets. -She had not noticed any discrepancies in the documentation on the observation sheets. -The PCAs may not have been paying attention when they entered the inaccurate information on the observation sheets. -She did not recall discussing the inaccurate documentation with anyone. Review of Resident #2's post-fall assessment	D 270		

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D 270	Continued From page 6 dated 11/30/19 revealed: -There was no documentation indicating Resident #2 was provided with a fall mat and/or wheelchair after she fell on 11/30/19. -Resident #2's supervision was not increased after she fell on 11/30/19. -There were no interventions put in place after Resident #2's fall on 11/30/19. Review of the facility's Occurrence Report for Resident #2 dated 12/03/19 revealed: -The incident report was completed by a MA. -On 12/03/19 at 8:15pm, Resident #2 was found lying on her back in another resident's room. -The intervention written by the RCD was to follow-up with Resident #2's PCP. Review of Resident #2's progress notes dated 12/03/19 revealed: -There was a note was written by a MA at 9:15pm. -Resident #2 was found lying on her back in another resident's room, was assessed, and found to be injury-free. -Resident #2 was placed on one-hour checks. Review of the Resident Observation sheets for 12/03/19-12/05/19 revealed: -Resident #2 was on 30-minute checks before she had her fall on 12/03/19. -Resident #2 continued on 30-minute checks after she had her fall on 12/03/19. -Resident #2 continued on 30-minute checks on 12/04/19 and 12/05/19. -There was documentation on 12/05/19 indicating Resident #2 had been checked hourly from 2:30pm-10:30pm. Telephone interview on 08/27/20 at 3:31pm with a second shift MA, who completed the incident	D 270		

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D 270	Continued From page 7 report for Resident #2 dated 12/03/19, revealed: -The MA was responsible for completing an incident report whenever a resident fell. -Resident #2 was provided with a fall mat when she was first admitted. -Routine rounds were every two hours. -After a resident fell, supervision was increased to 15 minutes, 30 minutes, or one hour. -The observation sheet was kept in a binder at the nursing station. -The PCA was responsible for documenting on the observation sheet. -When the PCA performed rounds, residents' needs were to be addressed. -The PCA was supposed to initial the observation sheet and indicate the assistance they provided. Telephone interview on 09/01/20 at 3:46pm with the MA, who completed the incident report for Resident #2 dated 12/03/19, revealed: -The MA was responsible for assessing residents after a fall occurred. -Residents were routinely sent to the hospital if they hit their head during a fall. -She could not recall the details of the 12/03/19 fall. -She could not recall who found Resident #2 on 12/03/19. -She could not recall the interventions that were put into place after Resident #2's fall on 12/03/19. -She preferred to keep Resident #2 in her wheelchair in the common area in order to watch her more closely. -She reviewed the fall observation sheets during the shift. -Sometimes the PCA would forget to complete the observation sheets and would fill them out the next day. -She could have missed checking the observation sheets; she could not remember.	D 270		

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D 270	Continued From page 8 Based on record reviews and telephone interviews: -No interventions were put in place after Resident #2's fall on 12/03/19. -Resident #2's supervision was not increased after her fall on 12/03/19. -Resident #2 was not checked on within the time interval listed on the Resident Observation sheet on 12/05/19. Review of Resident #2's post-fall assessment dated 12/03/19 revealed: -Resident #2 was placed on increased supervision after her fall on 12/03/19. -No time interval was indicated for the increased supervision or for the length of time the increased supervision would be in effect. -There were no additional interventions put in place after Resident #2's fall on 12/03/19. Review of the facility's Occurrence Report for Resident #2 dated 12/08/19 revealed: -The incident report was completed by a MA. -On 12/08/19 at 5:50am, Resident #2 was found on the floor in her bedroom by a PCA. -Resident #2 was bleeding on the right side of her head and was sent to the hospital for treatment. -The intervention written by the RCD indicated Resident #2 had been seen by her PCP; no date for the PCP visit was documented. Review of Resident #2's progress notes revealed: -There was a note written by a MA on 12/08/19 at 5:55 (no am or pm noted). -Resident #2 was found lying beside her bed when the PCA was performing rounds. -Resident #2 was bleeding from the right side of her head and was sent out for emergency treatment.	D 270		

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D 270	Continued From page 9 -There was a note written by a second MA on 12/08/19 at 10:00pm indicating Resident #2 remained on 30-minute checks. -There was a note written by the RCD on 12/10/19 at 3:00pm indicating Resident #2 had an appointment at her PCP's office at 4:15pm on 12/10/19. -There was a note written by a third MA on 12/10/19 at 10:00pm indicating Resident #2 had been out of the facility for an appointment with her PCP earlier in the day. Review of Resident #2's Hospital Discharge Summary dated 12/08/19 revealed: -Resident #2's diagnoses were a closed head injury and a scalp abrasion. -Resident #2 needed increased surveillance for fall prevention. -Resident #2 was to follow-up with her PCP. Review of Resident #2's off-site physician's order dated 12/10/19 revealed there was an order for physical therapy (PT). Review of Resident #2's Resident Observation sheets for 12/08/19-12/10/19 revealed: -From 12/08/19-12/09/19, Resident #2 was on 30-minute checks. -Resident #2 was on one-hour checks on 12/10/19. -There was documentation during these times indicating Resident #2 was sleeping, was involved in activities, had been offered something to eat, and was toileted, but Resident #2 was out of the facility on 12/08/19 from 6:30am-1:00pm receiving emergency care for her fall . -There was documentation on 12/08/19 indicating Resident #2 had been checked hourly from 3:00pm-11:30pm. -There was documentation during these times	D 270		

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D 270	Continued From page 10 indicating Resident #2 was asked about her needs, but Resident #2 was out of the facility on 12/10/19 from 4:00pm-5:00am for an appointment at her PCP's office. Telephone interview on 08/31/20 at 5:05pm with the PCA listed on the 12/08/19 incident report revealed: -The RCD determined the supervision frequency after a resident fell. -Rounds were usually one hour if a resident fell or 30 minutes if a resident hit her head during a fall. -The MA would verbally inform the PCA if a resident's supervision frequency had increased. -The MA was responsible for putting the observation sheet in the PCA binder that was kept on the nursing station counter. -The PCA was responsible for completing the observation sheet. -She documented on the observation sheet shortly after completing the round. -Resident #2 would stand up and try to walk. -Resident #2 was usually situated in the common area so she could be more readily observed. -She did not remember the details of Resident #2's fall on 12/08/19 but knew Resident #2 had a fall mat next to her bed at the time of the fall. -Resident #2 had a fall mat before December 2019. -She did not know if any interventions were put into place after Resident #2 fell on 12/08/19. Telephone interview on 09/02/20 at 9:34am with a PCA who documented on Resident #2's 12/08/19 observation sheet revealed: -She worked from 7:00am to 3:00pm when scheduled. -She assisted residents with ADLs to include bathing, dressing, assistance with feeding, and toileting or incontinent care.	D 270		

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D 270	Continued From page 11 -She received information concerning residents from the third shift PCA; the MA told the oncoming staff if a resident had a specific need. -She documented on flow sheets the personal care she completed for residents and did this task near the end of her shift, usually at 2:00 pm. -She could not remember the date Resident #2 was moved to a room closer to the nursing station. -Resident #2 was moved because she tried to get up to walk on her own, and she could be observed "all the time" from her new room. -When a resident fell, the PCA documented on an observation sheet. -The PCA documented the resident's location or what the resident was doing at the time of the observation. -She did not know what she had documented in the past but thought nothing should be documented on the observation sheet if the resident was not in the facility. -She did not know she had documented on Resident #2's observation sheet dated 12/08/19 from 7:00am-1:00pm while Resident #2 was not in the facility. -She thought she might have mixed up the dates because if a resident fell the observation sheet was completed for three consecutive days. -The only thing she could recall put into place after Resident #2's fall on 12/08/19 was a fall mat at her bedside. Telephone interview on 09/02/20 at 10:22am with a third shift MA, who completed the incident report for Resident #2 dated 12/08/19, revealed: -As a MA, she ensured the PCAs were completing the frequent checks for residents, including Resident #2, on the "alert chart". -The alert chart was the system used to monitor residents who fell or returned from the hospital.	D 270		

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D 270	Continued From page 12 -Residents on the alert chart were documented on in the progress notes by MAs. -She remembered Resident #2 and she recalled she slept at night. -She was sure "something" was put into place after the 12/08/19 fall because Resident #2 had hit her head. -The RCD and regional clinical staff would have initiated "safety precautions" which included frequent checks and increased supervision. -Residents who fell were discussed during stand-up meetings; she could not recall specifics of the discussion related to Resident #2. -PCAs should not have documented on the observation sheet if a resident was at the hospital. -If the MA reviewed the observation sheet and noted the PCA was documenting falsely, the sheet should be redone by the PCA. -She could not recall what was put into place after the 12/08/19 fall to assist Resident #2 from falling again, but she thought the "safety precautions" program would have been started after the fall. Telephone interview on 09/03/20 at 9:10am with a second PCA who documented on Resident #2's 12/08/19 observation sheet revealed: -She did not remember the details of Resident #2's fall on 12/08/19. -She would routinely place Resident #2 in the common area so she could more readily observe her. -Supervision times would be increased after a resident fell. -Supervision might be every 30 minutes or every hour. -She would document her observation of Resident #2 on the sheet after completing the check. -Sometimes the paperwork would get mixed up.	D 270		

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D 270	Continued From page 13 -She was not sure why she documented checking on Resident #2 when Resident #2 was not in the facility. Based on record reviews and telephone interviews: -Resident #2 did not receive PT after her fall on 12/08/19 in accordance with the off-site physician's order dated 12/10/19. -Resident #2 was not checked on within the time interval listed on the 12/08/19 Resident Observation sheet following her fall on 12/08/19. Review of Resident #2's post-fall assessment dated 12/08/19 revealed: -Resident #2 was moved to another room. -There was no documentation indicating PT was implemented in accordance with Resident #2's off-site physician's order dated 12/10/19. -Resident #2 was placed on increased supervision after her fall on 12/08/19. -No time interval was indicated for the increased supervision or for the length of time the increased supervision would be in effect. Review of the facility's Occurrence Report for Resident #2 dated 01/13/20 revealed: -The incident report was completed by a MA. -On 01/13/20 at 9:58am, Resident #2 fell on her buttocks; no injury was noted. -The intervention written by the RCD was to increase Resident #2's supervision. -No time interval was indicated for the increased supervision or for the length of time the increased supervision would be in effect. Review of Resident #2's progress notes revealed: -There was a note written by a MA on 01/13/20 at 10:15 (no am or pm noted). -Resident #2 left the common area in her	D 270		

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D 270	Continued From page 14 wheelchair, got up, was unsteady, and fell; no injury was noted. -The MA asked for an order for PT. -Resident #2 was placed on one-hour supervision. Review of Resident #2's Resident Observation sheets for 01/13/20-01/14/20 revealed Resident #2 was on one-hour checks. Telephone interview on 09/02/20 at 9:26am with the MA, who completed the 01/13/20 incident report for Resident #2, revealed: -Resident #2 "always tried to stand up." -The details of Resident #2's fall on 01/13/20 were hard to remember. -Resident #2 stood up and fell on her buttocks and did not get hurt. -She asked Resident #2's PCP for an order for PT. -Resident #2 did not get PT services because she did not have insurance coverage. -Staff placed Resident #2 in the common area to more readily observe her. -Resident #2 had a fall mat. Review of Resident #2's post-fall assessment dated 01/13/20 revealed: -There was no documentation an order for PT had been received from Resident #2's PCP. -Resident #2 was placed on increased supervision after her fall on 01/13/20. -No time interval was indicated for the increased supervision or for the length of time the increased supervision would be in effect. Review of the facility's incident report for Resident #2 dated 01/14/20 revealed: -The incident report was completed by a MA. -On 01/14/20 at 9:00pm while in the common	D 270		

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D 270	Continued From page 15 area, Resident #2 got out of her wheelchair, started walking, and fell on her stomach after she turned around when staff called her name. -Resident #2 was sent to the hospital for treatment. -The intervention written by the RCD was to follow-up with Resident #2's PCP. Review of Resident #2's progress notes revealed: -There was a note written by a MA on 01/14/20 at 10:00pm. -Resident #2 had a fall at 9:00pm. -The RCD was notified and wanted Resident #2 sent to the hospital for evaluation. -Resident #2 did not have any injuries from the fall. -There was a note written by a second MA on 01/15/20 at 1:20am indicating Resident #2 returned from the hospital with no new orders. -There was a note written by a third MA on 01/15/20 at 6:20am indicating Resident #2 continued on one-hour checks. -There was a note written by the RCD on 01/15/20 at 4:00pm indicating Resident #2 had an appointment with her PCP in March 2020. Review of Resident #2's Hospital Discharge Summary dated 01/15/20 revealed: -Resident #2's diagnoses were a fall from standing position and acute right-sided low back pain without sciatica. -Resident #2 was to follow-up with her PCP. Review of a physician communication form dated 01/15/20 revealed the RCD notified Resident #2's off-site physician of the falls on 01/13/20 and 01/14/20. Review of Resident #2's physician's order dated 01/21/20 revealed:	D 270		

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D 270	Continued From page 16 -There was an order for a hospital bed, scoop mattress, and fall mat [durable medical equipment] (DME). -There was an order for PT, occupational therapy (OT), and speech therapy (ST) evaluations and treatment. Review of Resident #2's Resident Observation sheets for 01/14/20-01/20/20 revealed: -Resident #2 had been on one-hour checks before she fell on 01/14/20. -From 01/14/20-01/20/20, Resident #2 was on one-hour checks. -There was no documentation indicating Resident #2's checks had been upgraded to more frequent checks following her fall on 01/14/20. -There was documentation during these times indicating Resident #2 was sleeping, but Resident #2 was out of the facility on 01/14/20 from 10:00pm-11:00pm receiving emergency care for her fall. Telephone interview on 09/01/20 at 3:46pm with the MA, who completed Resident #2's 01/14/20 incident report, revealed: -She could not remember the details of Resident #2's fall on 01/14/20. -Resident #2 was already a fall risk when she was admitted to the facility. -Staff tried to keep Resident #2 in her wheelchair and in the common area to be able to watch her. -She reviewed the documentation on the observation sheet during the shift. -Sometimes the PCA would forget to complete the observation sheets and would fill them out the next day. -The PCA may have forgotten Resident #2 was out of the facility and documented an inaccurate observation. -She may have missed checking the flowsheets;	D 270		

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D 270	Continued From page 17 she could not remember. Based on record reviews and telephone interviews: -Resident #2 did not receive PT, OT, and ST evaluations and treatment after her fall on 01/14/20 in accordance with the PCP's order dated 01/21/20. -Resident #2 did not receive the DME in accordance with the PCP's order dated 01/21/20. -Resident #2's supervision level was not increased after she had a subsequent fall on 01/14/20. Review of Resident #2's post-fall assessment revealed there was no documentation of Resident #2's fall on 01/14/20. Review of the facility's Occurrence Report for Resident #2 dated 02/08/20 revealed: -The incident report was completed by a MA. -On 02/08/20 at 7:30pm, Resident #2 stood up from her wheelchair, walked towards the common area, and fell backwards. -Resident #2 was sent to the hospital for treatment. -The intervention written by the RCD was to follow-up with Resident #2's PCP. Review of Resident #2's progress notes revealed: -There was a note written by a MA on 02/08/20 at 10:00pm indicating Resident #2 had a fall and was transported to the hospital. -There was a note written by a second MA on 02/09/20 at 6:00am indicating Resident #2 returned from the hospital on 02/08/20 with no new orders. -Resident #2 was on one-hour checks. Review of Resident #2's emergency department	D 270		

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D 270	Continued From page 18 record dated 02/08/20 revealed: -Resident #2 had a hematoma on her scalp. -CT scans of Resident #2's head and neck were unremarkable. -Shoulder and spine x-rays did not show any fractures. -There were no signs of a hip fracture. Review of Resident #2's PCP visit form dated 02/13/20 revealed there were no new orders; the current care plan was to be continued. Review of Resident #2's request for therapy orders form dated 02/13/20 revealed there was a discontinue order for PT, OT, and ST evaluations and treatment. Review of Resident #2's Resident Observation sheets for 02/08/20-02/10/20 revealed: -Resident #2 was already on one-hour checks before she fell on 02/08/20. -There was no documentation indicating Resident #2's checks had been upgraded to more frequent checks following her fall on 02/08/20. -There was documentation during these times indicating Resident #2 was asked about her needs, was toileted, and was sleeping, but Resident #2 was out of the facility on 02/08/20 from 8:00pm-11:00pm receiving emergency care for her fall. Telephone interview on 08/31/20 at 5:05pm with the MA, who completed the incident report on 02/08/20, revealed: -Supervision meant keeping check on the residents according to their supervision frequency and making sure no one got hurt. -Resident #2 was visiting with family members in the common area when she fell on 02/08/20. -Resident #2 stood up and fell backwards.	D 270		

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D 270	Continued From page 19 -Staff kept Resident #2 in the common area to more readily observe her. -The MA was responsible for examining a resident after a fall. -A resident would be sent out for evaluation if she hit her head while falling. -The MA completed the incident report. -A resident's supervision time changed after a fall; rounds would change to hourly or every 30 minutes. -The RCD primarily decided the round time interval. -Rounds following a fall were mostly every hour but could be 30 minutes if a head injury occurred. -The MA was responsible for informing the PCAs if a resident was on increased supervision. -The MA placed the observation sheet in the PCA binder. -The PCA was responsible for completing the observation sheet during the time of the round. -She checked the observation sheets during the shift. -She had not noticed any discrepancies with the PCAs' documentation. -She did not know how to prevent Resident #2 from having falls. -Resident #2 had a fall mat beside her bed. Telephone interview on 09/01/20 at 3:57pm with the PCA, who documented on Resident #2's 02/08/20 observation sheet, revealed: -She did not remember Resident #2's fall on 02/08/20. -Resident #2 was placed on one-hour checks after she fell on 02/08/20. -She waited until the end of the shift to fill out the observation sheet. -She was not instructed on another way to complete her documentation. -She did not recall documenting she provided	D 270		

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D 270	Continued From page 20 care to Resident #2 during the time Resident #2 was not in the facility. -She had no explanation for documenting care for Resident #2 when Resident #2 was at the hospital receiving treatment for a fall. Based on record reviews and telephone interviews, Resident #2's supervision level was not increased after her fall on 02/08/20. Review of Resident #2's post-fall assessment dated 02/09/20 revealed: -Resident #2 was placed on the early get up list. -Resident #2 was placed on increased supervision after her fall on 02/08/20. -No time interval was indicated for the increased supervision or for the length of time the increased supervision would be in effect. Review of the facility's Occurrence Report for Resident #2 dated 02/21/20 revealed: -The incident report was completed by a MA. -On 02/21/20 at 8:35pm, Resident #2 was in the common area in her wheelchair. -Resident #2 stood up from her wheelchair, tried to walk, and fell and hit her head on the corner of the wall. -Resident #2 had two cuts on her right ear and a knot on the back of her head and was sent to the hospital for treatment. -The intervention written by the RCD was to follow-up with Resident #2's PCP. Review of Resident #2's progress notes revealed: -There was a note written by a MA on 02/21/20 at 9:30pm. -Resident #2 was in the common area. -Resident #2 stood up from her wheelchair, tried to walk, and fell and hit her head on the corner of the wall.	D 270		

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D 270	Continued From page 21 -Resident #2 had two cuts on her right ear and a knot on the back of her head and was sent to the hospital for treatment. -There was a note written by a second MA on 02/22/20 at 12:45am. -Resident #2 returned from the hospital with no new orders. -Resident #2 had two stitches in her right ear. -Resident #2 was on one-hour checks. -There was a note written by a third MA on 02/22/20 at 6:00am indicating Resident #2 was on one-hour checks. -There was a note written by a fourth MA on 02/23/20 at 6:30am indicating Resident #2 continued on one-hour checks. -There was a note written by a fifth MA on 02/23/20 at 10:54pm indicating Resident #2 continued on one-hour checks. -There was a second note written by a MA on 02/24/20 at 10:00pm indicating Resident #2 continued on one-hour checks. -There was a note written by the RCD on 02/25/20 at 5:10pm indicating Resident #2 continued on increased supervision (no time interval indicated). Review of Resident #2's Hospital Discharge Summary dated 02/21/20 revealed: -Resident #2's diagnoses were fall, laceration of right ear lobe, and injury of head. -A CT scan of Resident #2's head was negative for intracranial injury. -Resident #2 received two stitches and was to follow-up with the emergency department in ten days for removal of the stitches. Review of Resident #2's PCP visit form dated 02/25/20 revealed: -Resident #2's stitches were to be removed in one week.	D 270		

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D 270	Continued From page 22 -The current care plan was to be continued. Review of Resident #2's Resident Observation sheets from 02/21/20-02/25/20 revealed: -Resident #2 was already on one-hour checks on 02/21/20. -There was documentation during these times indicating Resident #2 was sleeping, but Resident #2 was out of the facility from 9:00pm-11:00pm receiving emergency care for her fall. -Resident #2 continued on one-hour checks from 02/22/20-02/25/20. -Resident #2's supervision was not increased when she returned from the hospital after her fall on 02/21/20. Telephone interview on 08/27/20 at 3:31pm with the MA, who completed the incident report on 02/21/20, revealed: -She did not recall the details of Resident #2's fall on 02/21/20. -When a fall occurred, the MA was responsible for completing an incident report. -Routine rounds were every two hours -A resident's supervision may be increased to one hour, 30 minutes or 15 minutes after a resident had a fall, depending on the circumstances. -The PCA documented rounds on the observation sheet. Attempted telephone interview on 08/31/20 at 2:26pm with the PCA who documented on the observation sheet for Resident #2 dated 02/21/20 was unsuccessful. Based on record reviews and telephone interviews, Resident #2's supervision level was not increased from one-hour checks to more frequent checks after she fell on 02/21/20.	D 270		

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D 270	Continued From page 23 Review of Resident #2's post-fall assessment revealed there was no documentation Resident #2 had a fall on 02/21/20. Review of the facility's Occurrence Report for Resident #2 dated 05/23/20 revealed: -The incident report was completed by a MA. -On 05/23/20 at 12:25am, Resident #2 rolled out of bed and hit the right side of her head. -A PCA found Resident #2 on the floor on her fall mat when the PCA was performing rounds. -Resident #2 was not sent out for treatment. -The intervention written by the RCD was to follow-up with Resident #2's PCP. Review of Resident #2's progress notes revealed: -There was a note written by a MA on 05/23/20 at 12:45am. -Resident #2 rolled out of bed while sleeping. -Resident #2's bedside mat was in place, but she hit her head and had a knot on the right side of her forehead. -Resident #2 was alert and was put back in bed. -Resident #2 was placed on one-hour checks. Telephone interview on 09/02/20 at 7:05am with the PCA listed on the incident report dated 05/23/20 revealed: -Resident #2 was a fall risk. -She was "constantly" observing Resident #2 to prevent falls. -She did not recall the details of Resident #2's fall on 05/23/20 but knew there was a fall mat beside Resident #2's bed. -Resident #2 was found in a seated position on the fall mat. -Resident #2 was placed on increased supervision after she fell on 05/23/20; she could not recall the frequency of the increased supervision.	D 270		

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D 270	Continued From page 24 -She made sure the fall mat was in place. Telephone interview on 09/02/20 at 10:22am with the third shift MA, who completed the incident report for Resident #2 dated 05/23/20, revealed: -She remembered Resident #2 and she recalled she slept at night. -The RCD and regional clinical staff would have initiated "safety precautions" after Resident #2's fall which included frequent checks and increased supervision. -During stand-up meetings residents who fell were discussed, but she could not remember specifics about Resident #2 because she was not the only resident discussed. Review of Resident #2's post-fall assessment revealed: -Resident #2 rolled out of bed on 05/23/20. -A fall mat was placed in Resident #2's room after she fell on 05/23/20. Telephone interview with Resident #2's PCP on 08/28/20 at 10:38am revealed: -He was notified every time Resident #2 had a fall. -They were not all falls; sometimes Resident #2 experienced "slips to the ground." -Resident #2 was quite debilitated. -The DME order he wrote on 01/21/20 may not have been effective at preventing all falls, but it may have helped. Telephone interviews with the RCD on 09/02/20 at 11:08am and 4:36pm revealed: -The MA was responsible for assessing a resident for pain and bleeding after a fall. -The MA was to assist the resident off the floor and take vital signs. -The MA was responsible for completing an	D 270		

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D 270	Continued From page 25 incident report and notifying the PCP, the resident's responsible party, and the RCD. -She was to be notified via text or phone call if she wasn't at the facility at the time of the fall. -The incident report would be given to her; she would review it, make sure all parties had been notified, and give the report to the Administrator. -The MAs were required to enter progress notes in the resident record for 72 hours until it was determined why the fall occurred. -If a resident had a fall, the supervision frequency would be increased to every hour. -If a resident had a subsequent fall, the supervision frequency would be increased to every 30 minutes. -Basically, falls resulted in increased supervision and subsequent falls resulted in a greater increased frequency of supervision. -The MA was expected to flag a new observation sheet and place it in the PCA binder that was kept at the nursing station. -The MA was supposed to document the fall on the 24-hour report and on the charting log so the oncoming shift would be aware of the fall. -She expected the PCA to document on the observation sheet after performing the check. -She understood the PCA sometimes could not get to the observation sheet right away, but she expected documentation to be completed while the observation was "still fresh." -The MAs were supposed to review the observation sheets for blanks during the shift. -She did not audit or review the observation sheets. -She or the Administrator made sure a new observation sheet was in place every day if a resident was on increased supervision. -The PCAs must not have been paying attention if they were documenting providing care to Resident #2 when she was not in the facility.	D 270		

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D 270	Continued From page 26 -She did not fill out a separate form for fall risk assessments. -She wrote the post-fall interventions on the second page of the fall review sheet that she initially completed on 11/27/19 when Resident #2 was admitted to the facility. -Resident #2's supervision was increased to one-hour checks after the 11/30/19 fall. -She did not know why the PCAs were performing one-hour checks instead of 30-minute checks after Resident #2's fall on 12/03/19; the checks should have been every 30 minutes. -Resident #2 was moved to a room closer to the nursing station after her fall on 12/08/19. -She could not say for sure if she instructed the MA to ask the PCP for PT after Resident #2's fall on 01/13/20. -She did not have information about interventions put into place after Resident #2's fall on 01/14/20. -Staff may have placed Resident #2 in the common area so they would be able to more readily observe her. -Resident #2 should have been on 30-minute checks after her fall on 01/14/20. -She did not know why Resident #2 was not placed on 30-minute checks after her fall on 01/14/20. -Resident #2 was placed on increased supervision and was added to the early get-up list after her fall on 02/08/20. -She did not have information about interventions put into place after Resident #2's fall on 02/21/20. -Resident #2 may have been placed on increased supervision. -It may have been an oversight that she had not listed Resident #2's falls on 01/14/20 and 02/21/20 on her fall risk assessment list. -Resident #2 "had so many falls." -She was not present on 05/23/20 when Resident #2 rolled out of bed.	D 270		

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D 270	Continued From page 27 -According to her list, a fall mat was placed next to Resident #2's bed after she fell on 05/23/20. -She did not know how to interpret her entry related to the 05/23/20 fall; a fall mat may have already been in place. -The progress note written by the MA on 05/23/20 indicating Resident #2 had a fall mat was probably more accurate than her fall assessment list. Telephone interview with the Administrator on 03/20 at 9:50am revealed: -When residents were admitted to the facility, they were placed on increased supervision for 72 hours. -Interventions were put in place after every fall. -He did not know the interventions that were put into place following each and every fall Resident #2 experienced. -He would have expected Resident #2's supervision to be increased following her fall on 11/30/19. -He knew Resident #2 was moved to a room closer to the nursing station after one of her falls. -After another fall, Resident #2 was placed on the early get up list so staff could assist her before she attempted to get out of bed on her own. -She was regularly placed in the common area so staff could more readily observe her. -Staff may have documented incorrectly on the observation sheets because they were trying to get assigned tasks done during or near the end of the shift. -The facility planned to continue using the same processes that were put into place. -The processes were "like a flat tire"; they needed new air in them. -Staff would review the processes again. Review of Resident #2's progress notes revealed:	D 270		

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D 270	Continued From page 28 -There was a note written by the RCD on 07/27/20 indicating Resident #2 was placed on hospice care. -There was a note written by a MA on 08/15/20 at 11:01pm indicating Resident #2 passed away at 10:50pm. _____ The facility failed to provide supervision of a resident (#2) who was intermittently oriented, had a diagnosis of Alzheimer's disease and falling episodes, and used assistive devices for ambulation. The resident experienced nine falls in less than six months, resulting in five visits to the emergency department, and diagnoses of closed head injuries and lacerations. The facility failed to implement increased supervision or any other interventions after the resident experienced subsequent falls. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection for this violation on 08/28/20 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION	D 273	1. Community to use New Order Tracking System to ensure implementation of all M.D. orders.	10/18/20

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D 273	Continued From page 29 Based on record reviews and telephone interviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#2) who required physical therapy (PT) and durable medical equipment (DME). The findings are: Review of Resident #2's FL-2 dated 11/22/19 revealed: -Diagnoses included Alzheimer's disease, falling episodes, and diabetes. -Resident #2 was ambulatory and continent. Review of Resident #2's Resident Register dated 11/25/19 revealed: -Resident #2 was admitted to the facility on 11/27/19. -Resident #2's responsible party had power of attorney. 1. Review of the facility's new medication order tracking policy revealed: -The new order tracking form was to be used for therapy and consult referrals. -The MA was responsible for beginning the order process upon receipt of any new order by completing a new order tracking form. -The RCD and/or designee would monitor the process daily to determine if follow-up was needed. -The RCD was to review and sign the form when it was complete. Review of Resident #2's physician visit form dated 12/10/19 revealed: -Resident #2 was seen by her off-site physician. -Resident #2 had three falls, two of which resulted in emergency room visits.	D 273	2. Staff who utilize the New Order Tracking System will be educated on using the system for new M.D. orders. 3. Resident Care Director, Executive Director, or designee to monitor weekly.	10/18/20 10/18/20

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D 273	Continued From page 30 -The physician ordered physical therapy (PT) for falling episodes. Telephone interview with a nurse from Resident #2's off-site physician's office on 09/01/20 at 8:50am revealed: -The last time the off-site physician treated Resident #2 was on 12/10/19. -A referral for PT was sent to the facility in December 2019. -PT was not completed because of financial concerns. Telephone interview on 09/02/20 at 5:15pm with a representative from the PT agency listed on Resident #2's off-site physician's order dated 12/10/19 revealed: -Referrals typically would be forwarded to the agency by the off-site physician's office. -He spoke with Resident #2's responsible party around 12/11/19 about Resident #2's insurance problems. -On 12/12/19, he spoke with a nurse at the off-site physician's office and gave her a referral to a home health (HH) PT agency because Resident #2 did not have insurance coverage that was accepted by his agency. -His agency did not provide PT to Resident #2. Review of an email provided by the Administrator on 09/01/20 revealed: -The email was dated 01/10/20 and time-stamped 10:08am. -The email was written by Resident #2's responsible party. -The email was sent to the Administrator and to the facility's contracted primary care provider (PCP). -Resident #2's responsible party outlined Resident #2's insurance problem.	D 273		

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D 273	Continued From page 31 -The responsible party was hoping to have the matter resolved "soon." -Until the matter was resolved, Resident #2's care was to be paid from her funds. -If Resident #2's funds were insufficient, the responsible party would cover any medical fees. -Resident #2 would be seen by her off-site physician, if needed, until the matter was resolved. Review of Resident #2's record revealed there was no documentation Resident #2 received PT in accordance with the off-site physician's order dated 12/10/19. Review of Resident #2's physician visit form signed and dated 01/21/20 revealed: -Resident #2 was seen by the facility's contracted PCP for debility and falls. -There was an order for PT, occupational therapy (OT), and speech therapy (ST) evaluations and treatment. Review of an undated request for therapy orders from the PT agency (on-site PT agency) contracted to provide services to residents of the facility revealed: -There was a request to discontinue the 01/21/20 order for PT, OT, and ST because of insurance non-coverage. -The request was signed by a representative of the on-site PT agency. -The order was signed by the facility's contracted PCP on 02/13/20. Review of Resident #2's record revealed there was no documentation Resident #2 received PT in accordance with the facility's contracted PCP order dated 01/21/20.	D 273		

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D 273	Continued From page 32 Telephone interview on 09/01/20 at 9:29am with a representative of the on-site PT agency revealed: -She was not familiar with the PT order from Resident #2's off-site physician dated 12/10/19. -The on-site PT agency did not provide services to Resident #2. -Resident #2 did not have insurance coverage for PT. -Resident #2's responsible party did not want to cover the cost of PT. -According to Resident #2's responsible party, insurance coverage would be reinstated in June or July 2020. -She routinely asked the PCP to write a discontinue order when a resident did not have insurance coverage or if the responsible party did not want to pay for PT. -She did not ask the facility's contracted PCP to write a subsequent order for PT after he had discontinued the order on 02/13/20. -Resident #2 may have received PT services from another agency in March 2020. Telephone interview with the facility's contracted PCP on 08/28/20 at 10:38am revealed he was not concerned about finding a therapy provider that would accept Resident #2's insurance; he was not sure if therapy would have made much of a difference. Telephone interview with the Administrator on 09/01/20 at 1:35pm revealed Resident #2's insurance coverage for PT had lapsed before she was admitted to the facility. Telephone interview with Resident #2's responsible party on 09/01/20 at 4:45pm revealed: -Resident #2's insurance coverage had lapsed before she was admitted to the facility.	D 273		

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D 273	Continued From page 33 -He could not remember when Resident #2's insurance was reinstated. -Resident #2 did not have PT because she did not want it. Telephone interview with a medication aide (MA) on 09/02/20 at 9:26am revealed: -Resident #2 never had PT or ST. -She did not know if Resident #2 ever had OT. Review of Resident #2's progress notes revealed: -There was a note dated 02/25/20 at 5:10pm written by the RCD. -Resident #2 had received HH PT services earlier in the day. -There were notes dated 03/03/20, 03/05/20, 03/10/20, and 03/14/20 written by the HH therapists indicating they had provided PT and ST services to Resident #2 on those dates. Telephone interview on 09/02/20 at 10:33am with a representative of a third PT agency revealed: -The agency was a HH provider. -Resident #2 was a patient of the agency from 02/20/20-03/18/20 for PT, ST, and OT. -Resident #2's insurance paid for the agency's services. -The agency received an electronic order for Resident #2 from the facility's contracted PCP on 02/18/20. -The last service provided was ST on 03/18/20. -The facility restricted agency visits starting in March 2020 as a result of COVID-19. Review of Resident #2's progress notes revealed: -There was a note dated 02/25/20 at 5:10pm written by the RCD. -Resident #2 had received HH PT services earlier in the day. -There were notes dated 03/03/20, 03/05/20,	D 273		

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D 273	Continued From page 34 03/10/20, and 03/14/20 written by the HH therapists indicating they had provided PT and ST services to Resident #2 on those dates. Telephone interview with the RCD on 09/02/20 at 11:08am revealed: -Resident #2 had insurance problems when she was first admitted, but Resident #2's insurance matter was cleared up in February or March 2020. -The MA was responsible for processing new orders, including orders for therapy. -The MA would inform her if an order had been received from an off-site provider. -She was unfamiliar with the PT agency listed on Resident #2's off-site physician's order dated 12/10/19. -She did not recall contacting Resident #2's off-site physician about completing the 12/10/19 PT order. -The on-site PT agency was supposed to receive a copy of the 01/21/20 order for PT, OT, and ST evaluations and treatment. -The MA would place a copy of the therapy order in the therapy box behind the nursing station. -The on-site PT agency would have checked the availability of insurance coverage and would have informed the resident's responsible party of the costs. -When the on-site PT agency was unable to treat a resident because of insurance reasons, the on-site agency would arrange for a HH agency to provide PT. -She did not know if the on-site PT agency used the 01/21/20 order to obtain PT services for Resident #2 in February 2020 or if the on-site PT agency called the facility's contracted PCP to get a new order. -Therapy services provided by HH agencies were suspended sometime in March 2020 as a result	D 273		

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D 273	Continued From page 35 of COVID-19. Telephone interview on 09/03/20 at 9:23am with a representative of the on-site PT agency revealed: -She was not present when Resident #2 was admitted in November 2019. -The RCD and Administrator informed her Resident #2 was ambulatory prior to admission. -She talked with Resident #2's responsible party in early December 2019, 1-2 weeks after Resident #2 was admitted. -The on-site PT agency usually tried to help with finding a HH PT agency that would accept a resident's insurance. -She could not recall if she helped to find a HH agency to provide PT for Resident #2. Telephone interview with the Administrator on 09/03/20 at 9:50am revealed: -Orders for PT were tasked to the on-site PT agency. -If the on-site PT agency could not provide services to a resident, the agency would inform the RCD and the on-site agency would contact another therapy provider. -He learned in the past week that Resident #2 was not referred to PT in December 2019. -Resident #2 did not have insurance in place when the referral for PT was ordered on 12/10/19. -He was not aware Resident #2 had a subsequent order for PT, OT, and ST evaluations and treatment dated 01/21/20. Refer to the telephone interview with the Administrator on 09/01/20 at 1:35pm. Refer to the telephone interview with the RCD on 09/02/20 at 11:08am.	D 273		

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D 273	Continued From page 36 Refer to the telephone interview with the Administrator on 09/03/20 at 9:50am. 2. Review of Resident #2's physician visit form dated 01/21/20 revealed: -Resident #2 was seen by the facility's contracted primary care provider (PCP) for debility and falls. -There was an order for a hospital bed, a scoop mattress, and a fall mat [durable medical equipment] (DME). Review of Resident #2's record revealed there was no documentation Resident #2 received DME in accordance with the PCP's order dated 01/21/20. Review of the facility's contracted PCP order dated 07/28/20 revealed there was an order to admit Resident #2 to hospice. Review of Resident #2's progress notes for 07/27/20 revealed: -There was a note written by the Resident Care Director (RCD) at 3:40 (no am or pm noted) indicating Resident #2 was receiving care from the hospice agency. -There was a note written by a medication aide (MA) at 6:25pm indicating the hospice agency had delivered a bed, mattress, fall mat, and wheelchair for Resident #2. Telephone interview with a personal care aide (PCA) on 08/27/20 at 2:31pm revealed Resident #2 was provided with a hospital bed, a scoop mattress, and a fall mat after she was admitted to hospice. Telephone interview with a MA on 08/27/20 at 3:31pm revealed: -Resident #2 was provided with a fall mat shortly	D 273		

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D 273	Continued From page 37 after she was admitted to the facility. -Resident #2 was provided with a hospital bed and a scoop mattress after she was admitted to hospice. Telephone interview with the facility's contracted PCP on 08/28/20 at 10:38am revealed: -Resident #2 was quite debilitated and had been transitioning to hospice care while in the facility. -The DME he ordered might not have been effective at preventing further falls but was ordered to help. -He thought Resident #2 had received the DME before July 2020. Telephone interview with a representative from the DME provider on 08/31/20 at 10:29am revealed: -The company was not contacted to provide DME on 01/21/20. -The company provided DME for the hospice agency servicing the facility. -The company delivered Resident #2's DME to the facility on 07/28/20 and picked it up on 08/16/20. Telephone interview with Resident #2's responsible party on 08/31/20 at 10:50am revealed: -He last visited Resident #2 in late February or early March 2020. -Resident #2 did not have a hospital bed when he last visited her. -He did not know if she had a scoop mattress. -There was no fall mat beside Resident #2's bed when he last visited her. Telephone interview with another MA on 09/01/20 at 12:57pm revealed: -She gave the RCD the 01/21/20 DME order to	D 273		

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D 273	Continued From page 38 fax to the DME distributor. -Resident #2 could not get the DME because she did not have insurance. -Resident #2's responsible party was trying to get her insurance matter resolved. -The PCP was aware of Resident #2's insurance problems. -Resident #2 received the hospital bed and scoop mattress in July 2020 when she was placed on hospice care. -The facility had a spare fall mat and provided it to Resident #2 after she had her first fall (could not recall date); Resident #2 had a fall mat for a long time. Telephone interview with the Administrator on 09/01/20 at 1:35pm revealed Resident #2's insurance coverage for DME had lapsed before she was admitted to the facility. Telephone interview with Resident #2's responsible party on 09/01/20 at 4:45pm revealed: -He did not know Resident #2 had an order for a hospital bed in January 2020. -He was first informed about Resident #2 needing a hospital bed when she was admitted to hospice; hospice provided the hospital bed immediately. -He may have talked with the PCP about Resident #2's insurance concern, but he never spoke with the PCP about a hospital bed. -He was not notified by anyone at the facility about paying for DME out of his pocket. Telephone interview with the RCD on 09/02/20 at 11:08am revealed: -There were problems with Resident #2's insurance and the facility was unable to get a hospital bed for her. -Resident #2 received a hospital bed after she	D 273		

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D 273	Continued From page 39 was admitted to hospice care in late July 2020. -Resident #2 was provided with a scoop mattress and a fall mat shortly after the 01/21/20 order was written because there were extras at the facility. -The MA probably kept informing the PCP that Resident #2 had not been provided with a hospital bed. -She did not recall speaking to the PCP about Resident #2 not receiving a hospital bed because she typically was not at the facility during the time of the PCP's visits. Telephone interview with the Administrator on 09/03/20 at 9:50am revealed: -The RCD or designee was responsible for contacting DME providers. -The facility had extra DME on hand because residents' families did not always take the equipment home when a resident was discharged from the facility. -Resident #2 received a fall mat and a scoop mattress earlier in the year, but he could not remember the date they were supplied. -He did not remember the date Resident #2 received a hospital bed. Refer to the telephone interview with the Administrator on 09/01/20 at 1:35pm. Refer to the telephone interview with the RCD on 09/02/20 at 11:08am. Refer to the telephone interview with the Administrator on 09/03/20 at 9:50am. Telephone interview with the Administrator on 09/01/20 at 1:35pm revealed: -All orders, including referrals for therapy and DME, were processed by the MA according to the new medication order tracking policy.	D 273		

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D 273	Continued From page 40 -Resident #2's responsible party had informed him and Resident #2's PCP of the insurance matter via an email on 01/10/20. Telephone interview with the Resident Care Director (RCD) on 09/02/20 at 11:08am revealed: -The PCP visited the facility twice a week. -She or the Administrator would check all orders after the PCP had visited the facility to make sure referrals were completed. -She or the Administrator was responsible for informing the PCP if a referral was not followed-up. Telephone interview with the Administrator on 09/03/20 at 9:50am revealed: -He did not know the details of every order that was written for Resident #2. -Resident #2 did not have all the insurance coverage needed to meet the expenses of her care. Review of Resident #2's progress notes revealed: -There was a note written by the RCD on 07/27/20 at 3:40 (no am or pm noted) indicating Resident #2 was placed on hospice care. -There was a note written by a MA on 08/15/20 at 11:01pm indicating Resident #2 passed away at 10:50pm. The facility failed to provide referral and follow-up for a resident (#2), who was intermittently disoriented and had diagnoses of Alzheimer's disease and falling episodes, including a fall from her bed after fall prevention equipment had been ordered. The facility failed to follow-up with physical therapists, occupational therapists, speech therapists, and suppliers of durable medical equipment to provide services to meet the resident's health care needs. The facility's	D 273		

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D 273	Continued From page 41 failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. [Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).] The facility provided a plan of protection for this violation on 09/01/20 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2020.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered 1 of 5 sampled residents (#1) to include a medication used to treat symptoms of dementia. The findings are:	D 358		

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D 358	Continued From page 42 Review of Resident #1's current FL-2 dated 06/26/20 revealed: -Diagnoses included Alzheimer's disease, dementia with behavior disturbances, overactive bladder, and insomnia. -There was no order for haloperidol lactate (used to treat mental and mood disorders). Review of Resident #1's physician orders revealed: -There was an order dated 05/07/20 for haloperidol 2 mg/ml 0.25 ml (0.5 mg) daily. -There was an order dated 05/19/20 for haloperidol 2 mg/ml 0.25 ml (0.5 mg) daily. -There was a handwritten entry for haloperidol 2 mg/ml 0.25 ml daily on the six-month physician orders and on the right side of the entry there was documentation to discontinue haloperidol 2 mg/ml "05/31/20" signed by the physician on 06/02/20 (05/31/20 was a Sunday). Review of Resident #1's June 2020 medication administration record (MAR) revealed there was no entry for haloperidol. Review of Resident #1's July 2020 medication administration record (MAR) revealed: -There was a printed entry for haloperidol oral concentrate 2 mg/ml give 0.25 ml (0.5 mg) daily, scheduled for 8:00 am. -There was documentation of administration of haloperidol 0.25 ml from 07/01/20 to 07/31/20 at 8:00 am. Review of Resident #1's August 2020 MAR revealed: -There was a printed entry for haloperidol oral concentrate 2 mg/ml give 0.25 ml (0.5 mg) daily, scheduled for 8:00 am. -There was documentation of administration of	D 358		

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D 358	Continued From page 43 haloperidol 0.25 ml from 08/01/20 to 08/20/20 at 8:00 am. Based on record reviews, and interviews, Resident #1 was not interviewable. Attempted telephone interview with Resident #1's family member on 08/24/20 at 9:37 am was unsuccessful. Attempted telephone interviews with Resident #1's physician on 08/25/20 at 11:26 am and 08/26/20 at 9:28 am were unsuccessful. Telephone interview with a Medication Aide (MA) to obtain Resident #1's medication on hand on 08/26/20 at 2:00 pm revealed there were 26 syringes of haloperidol 0.25 ml per syringe available for administration with a dispense date of 08/14/20. Telephone interviews with the facility's contracted pharmacist on 08/24/20 at 12:05 pm revealed: -There was an active order for Resident #1 for haloperidol 2 mg/ml 0.25 ml daily and the date of the order was 05/19/20. -There was 7.5 ml of haloperidol dispensed in syringes which were 0.25 ml per syringe for Resident #1 on 05/20/20, 06/22/20, 07/21/20, and 08/14/20 for a 30-day supply. -There was no documentation of a discontinue order for Resident #1's haloperidol. -Haloperidol was used to treat schizophrenia, dementia with delusions and other behaviors. -Resident #1 had a previous order for haloperidol three times a day and the physician appeared to be tapering the dosage because now Resident #1's haloperidol was daily. -Haloperidol was a medication that could not be stopped or discontinued right away, and it was	D 358		

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D 358	Continued From page 44 safer to taper the dosage of haloperidol due to the side effects. Telephone interview with the facility's contracted pharmacist on 08/28/20 at 9:56 am revealed Resident #1 had an order for haloperidol since 11/15/18. Telephone interview with the facility's contracted pharmacist who completed Resident #1's pharmacy review on 08/26/20 at 10:12 am revealed: -There was an active order for Resident #1's haloperidol 0.25 ml (.5 mg) daily. -He did not have a record of a discontinue order from 05/31/20. -If Resident #1 did not have haloperidol administered for one month, she might have an increase in behaviors. -He did not know why the haloperidol was not on the June 2020 MAR. -Haloperidol side effects were increased sedation which may lead to an increase of falls, and a risk of a movement disorder. Telephone interview with a representative from the medical records department of the facility's contracted pharmacy on 08/26/20 at 11:35 am revealed: -The facility's June 2020 MARs were printed for the facility on 05/19/20 and prepared for delivery to the facility. -If an order was sent to the pharmacy on 05/19/20 from the facility for Resident #1 after the June 2020 MARs were printed, it would not appear on the MARs. -The reason also that Resident #1's haloperidol was not on the June 2020 MAR was because all medication orders had to be verified first by a pharmacist before an order entry technician could	D 358		

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D 358	Continued From page 45 add it into the computer system. -Resident #1's haloperidol order dated 05/19/20 was verified by a pharmacist on 05/19/20 at 4:56 pm. -The date and time were after the June 2020 MARs were printed for the facility and it would be the responsibility of the facility's staff to place Resident #1's haloperidol on the June 2020 MAR. Telephone interview with the same MA on 08/27/20 at 10:00 am revealed: -The facility physician came to the facility every Tuesday and Thursday. -He gave the MAs orders after he wrote them. -MAs wrote the new orders on the MARs and faxed the orders to the pharmacy. -A tracking form was used to ensure medications were tracked from order initiation to medication delivery. -If there were any problems obtaining the medication such as insurance would not cover the cost or the order was unclear, it was documented on the tracking form. -Discontinued medication orders were given to the MAs. -With a discontinued medication order, the medication was discontinued on the MAR, and the discontinued medication was removed from the medication cart. -MAs did not take verbal orders, and the facility physician faxed over orders to the facility when called for clarifications or renewals. -The RCD reviewed the next months MARs and the next months MARs were delivered around the same time each month. -It took the RCD two days sometimes to review all the new MARs and the third shift MA placed the new MARs into the MAR binder. -She knew Resident #1 well and Resident #1 exhibited behaviors such as fighting staff when	D 358		

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D 358	Continued From page 46 incontinence care, dressing or bathing occurred and used curse words. -Resident #1 did better when she took her prescribed haloperidol. -She administered haloperidol to Resident #1 in the morning for a while, but she did not know how long. -She had not seen a discontinue order for Resident #1's haloperidol and the facility's physician told her Resident #1 needed the haloperidol because of her behaviors. -Resident #1's haloperidol was always available for administration on the medication cart and she did not recall a time when it was not available. -She did a medication cart inventory on each Wednesday and Saturday she was scheduled to work. -When she did a medication cart inventory, she compared the resident's MARs with the medications available on the medication cart. -If there was a medication missing, she notified the pharmacy and requested the medication. -If there was a medication available that was not listed on the MAR, she notified the pharmacy and the physician to clarify the order. -She did not recall following this process regarding Resident #1's haloperidol. -She did not know why Resident #1's haloperidol was not listed on the June 2020 MAR and maybe another MA discontinued the medication by mistake. -She did not know why Resident #1's haloperidol would be discontinued on a Sunday. -On Sundays, there was an on-call physician who could be notified for questions and orders. -She thought it was an oversight on the part of the pharmacy and the MAs. -MAs were responsible for administering medications as ordered and the MAs should have noticed Resident #1's haloperidol was not on the	D 358		

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D 358	Continued From page 47 June MAR. Telephone interview with RCD on 08/28/20 at 1:58 pm revealed: -She was responsible for supervising the MAs and personal care aides (PCAs), aided hospice services when in the facility, completed care plans, reviewed PCA flowsheets, but she did not administer medications. -When MAs had a question about medications or orders, the MAs came and asked her. -She notified pharmacy or the physician if an order needed clarification or there was difficulty obtaining medications for a resident. -She reviewed the next month MARs when delivered from the pharmacy near the end of every month. -She also had a MA complete a second review of the MARs. -The MAs were responsible for adding any new orders or changed orders if the physician provided orders after she completed her MAR review. -She was the only person who took verbal orders and had the physician sign them during his twice a week visits to the facility. -She did not write the discontinued entry for haloperidol on Resident #1 six-month physician orders and she did not recognize the handwriting. -She did not understand why the haloperidol was not on Resident #1's June 2020 MAR. -She did not know if Resident #1 had haloperidol administered during the month of June 2020 but "if it was not documented it was not administered." -She did not have documentation of a verbal order for the 05/31/20 to discontinue Resident #1's haloperidol. -She did not have documentation of a verbal order for 07/01/20 to restart Resident #1's	D 358		

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D 358	Continued From page 48 haloperidol. -She reviewed Resident #1's June 2020 MARs and did not notice the haloperidol was not on the June 2020 MAR. -She also depended on the MAs who reviewed the MARs to note if there was a missing entry on the MARs. -The MAs were responsible for administering medications as ordered by the physician. Telephone interview with Administrator on 08/31/20 at 2:22 pm and 09/03/20 at 9:50 am revealed: -He expected the MAs to follow the tracking form process to ensure medication orders were transcribed and faxed to the pharmacy. -The MAs who worked on the date an order was written were responsible for ensuring the medication orders were processed to the pharmacy and placed on the MAR. -He planned to review Resident #1's medication orders for haloperidol to determine what occurred and why the haloperidol was not entered on the June 2020 MAR. -He was not a part of the medication administration process. -He was told about Resident #1's missed haloperidol administration for June 2020 after 08/20/20. -The clinical staff were responsible for administering medications to residents.	D 358		
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	D912	1. All staff will be in-serviced on Resident Bill of Rights to ensure resident's →cont.	10/18/20

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D912	Continued From page 49 regulations. This Rule is not met as evidenced by: Based on observations, telephone interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, and health care. The findings are: 1. Based on record reviews and telephone interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) who had a history of falls. [Refer to Tag D 270, 10A NCAC 13F .901(b) Personal Care and Supervision (Type B Violation)] 2. Based on record reviews and telephone interviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#2) who required physical therapy (PT) and durable medical equipment (DME). [Refer to Tag D 273, 10A NCAC 13F .902(b) Health Care (Type B Violation)]	D912	→ receive care and services which are adequate, appropriate, and in compliance with federal and state laws.	