STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-092271	A. BUILDING: _____ B. WING _____	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #4	2030 MILLS CHASE LOOP APEX, NC 27523

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and a COVID-19 focused Infection Control survey with an onsite visit on January 12, 2021 and a desk review survey on January 13, 2021 through January 14, 2021 and a telephone exit on January 14, 2021.	C 000		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordence with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents Resident #3, who had a history of multiple falls, cognitive impairment, and was identified as fall risk. The findings are: Review of the facility's falls management program dated 08/27/20 revealed: -An initial comprehensive assessment was conducted at admission which included the identification of risk factors. -The Fall Assessment was completed by gathering specific information regarding history and risk factors from residents, family members, caregivers, and other healthcare professionals. -The Fall Assessment was also completed when a resident had two or more falls, unrelated to a transient health condition (i.e. urinary tract	C 243	Please see attached.	

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

2/17/21 Linda C Duncan
VINSON BANOSKY RN. AED 2/17/21

Reviewed and accepted AV 03/02/2021

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C 243	Continued From page 1 Infection, flu, upper respiratory, etc.) in a 1-month period. -Each fall must be investigated and analyzed to determine possible causative factors and the effectiveness of safety measures implemented to minimize falls. -All resident falls are reported to the resident's primary physician for and any possible recommendations they may have. -Incident report must be completed for any fall. -Interventions are to be documented on the resident's Individualized Service Plan as well as communicated to appropriate caregivers. 1.Review of Resident #3's current FL-2 dated 09/30/20 revealed: -Diagnoses included vascular dementia, anxiety, dermatitis, hypertension, anemia, decrease bone mineral density, B-12 deficiency, and recurrent major depressive disorder. -She was intermittently confused. -She was ambulatory with a walker. Review of Resident #3's Fall Risk Assessment dated 10/02/20 revealed: -The assessment areas reviewed were mental status, ambulatory/elimination status, gait/balance, visual status, orthostatic blood pressure, fall history, medication usage, and predisposing diseases/conditions. -Her fall risk review score was 6 out of 14. -A total score of 10 or higher may represent high fall risk. Review of Resident #3's Licensed Health Professional Support (LHPS) review dated 10/02/20 revealed Resident #3's LHPS tasks currently present was ambulation using an assistive device that required physical assistance.	C 243		

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C 243	Continued From page 2 Review of Resident #3's Assessment dated 07/30/20 revealed: -The assessment was completed at admission. -The assessment areas reviewed and points range were mobility/ambulation (0-4), fall risk review (0-6), transfer ability (0-6), bathing (0-4), grooming (0-3), dressing (0-5), continence management (0-5), dining assistance (0-4), cognitive functioning and behavior (0-5), wandering (0-10), diabetic management (0-3), and clinical support services (0-3). -Her fall risk review score was 6. -A fall risk review score of 6 indicated the resident had 2 or more falls in the last 3 months and had at least one of the following conditions: demonstrated lack of safety awareness; impaired vision; unstable gait; neuropathy; or other. -Her total points were scored at 31 out of 58. -Her summary of services was documented as a level of care at 3. -The level of care 3 had a minimum score of 31 and a maximum score of 40. Review of Resident #3's Assessment dated 10/13/20 revealed: -The Resident Assessment Tool was updated 08/27/20. -The assessment was completed at admission. -The assessment areas reviewed and points range were mobility/ambulation (0-5), fall risk review (0-7), transfer ability (0-8), bathing (0-6), grooming (0-8), dressing (0-8), continence management (0-8), dining assistance (0-8), cognitive functioning and behavior (0-6), wandering (0-10), diabetic management (0-8), and clinical support services (0-4). -Her fall risk review score was 4. -A fall risk review score of 4 indicated the resident had one or more falls in the last 6 months. -Her total points were scored at 42 out of 86.	C 243		

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C 243	Continued From page 3 -Her summary of services was documented as a level of care at 4. -The level of care 4 had a minimum score of 42 and a maximum score of 86. Review of Resident #3's Service Plan dated 09/30/20 -For the mobility section, her goal was to maintain safety with ambulation. -She was independent with ambulation. -She needed reminders to use her walker and then she could ambulate with it. -Staff would place the walker on a designated area while she was in the bed. Observation of Resident #3 on 01/12/21 between 12:45-1:00pm revealed: -Resident #3 walked from her room to the dining room table in the facility's common area without her walker. -Resident #3 sat down in a chair on the right side of the dining room table. -A walker was observed on the left side of the dining room table. -Staff member did not prompt or remind Resident #3 to use a walker when ambulating. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. a. Review of Resident #3's Accident/Injury (A/I) report completed on 10/22/20 revealed: -The time of incident was at 9:56pm. -The medication aide (MA) heard a "sound" from Resident #3's room. -She found Resident #3 on the bathroom floor. -It was documented as an unwitnessed fall. -She was checked for injury. -There was no injury observed.	C 243		

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C 243	Continued From page 4 -Her power of attorney was notified on 10/23/20 at 10:00pm. -Her primary care provider (PCP) was faxed without the date and time documented. Review of Resident #3's Post Fall Investigation report completed on 10/23/20 revealed: -The date of fall was 10/22/20. -The time of fall was 9:56pm. -There was no injury observed. -The fall was unwitnessed. -She was last seen/checked prior to the fall at 9:00pm. -She was last toileted at 9:00pm. -It was documented she was walking and attempted to go to the bathroom prior to her fall. -She ambulated with a walker. -Contributing factors were documented as dementia. -Other possible medication contributing factors were documented as greater than 5 medications. -Her medication review included hypnotics and antidepressants. -Safety measures/interventions for "fall prevention" in place prior to current was documented as yes. -In the Safety Review section, it was documented as the staff was informed of necessary changes going forward and the incident/investigation/interventions reviewed at the Comprehensive Resident Review Meeting. -In the Safety Review section, there was no documentation of the necessary changes that were provided to staff. -The document was reviewed by the Director of Clinical Services on 10/23/20. Telephone interview with a medication aide (MA) on 01/14/21 at 8:44am revealed: -She could not recall the personal care needs or	C 243		

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C 243	Continued From page 5 fall interventions in place for Resident #3 because she mostly worked in a sister building on the facility's campus. -She was the MA who was working when Resident #3 fell on 10/22/20. -She could not recall where and what happened related to Resident #3's fall on 10/22/20. Telephone interview with the Resident Care Coordinator (RCC) on 11/14/21 at 1:00pm revealed: -For an unwitnessed fall where the resident hit their head or yelled out in pain, they would automatically go to the hospital. -For an unwitnessed fall, the MA should go to the resident's room, make observations and complete a visional check of the resident's room upon arrival, call for help, talk with the resident, ask if the resident was having any pain, the MA would obtain vital signs, the MA would verify if the resident was able to move their extremities, and the MA would observe the resident's whole body. -The MA would notify the resident's primary care provider, responsible party, and RCC/Director of Clinical Services/Administrator. -For a resident post fall 72-hour monitoring would be implemented, the resident would be placed in the facility's hot box, and the resident would be placed on the 24-hour report shared between the MAs at shift change report. -The facility's hot box included residents who had a change in health/behavior/cognitive status, a resident began an antibiotic therapy, a resident had a fall, a resident returned from the hospital, or a resident who had skin impairments. -For a resident's 72-hour monitoring, the MA should be making observations of the resident's current ambulation status and document if there were any adverse effects post fall. -The staff did not document the supervision	C 243		

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C 243	Continued From page 6 checks of the residents because it was not a requirement. -Resident #3 would stand up on her own free will. -Resident #3 was supposed to use her walker when ambulating however she did require friendly reminders to use her walker when ambulating. -She expected the staff to check with Resident #3 to verify if she needed to use the bathroom, offer food or drink, or if she needed any bathing assistance. -She expected staff to keep a "closer eye" on her and engage her in activities because she liked to stay in her room most of the time. -Resident #3 should be supervised every 30 minutes. -After Resident #3's fall dated 10/22/20, the fall interventions in place were increased supervision which meant Resident #3 should have been supervised more often than every 30 minutes, encouraged use of her walker when ambulating, and she expected staff to verify upon the supervision checks Resident #3 was able to assess all of her belongings. Attempted telephone interviews with the Primary Care Provider on 01/13/21 at 4:25pm, 01/14/21 at 11:10am, 01/14/21 at 2:38pm were unsuccessful. Refer to a telephone interview with a medication aide (MA) on 01/13/21 at 2:11pm. Refer to a telephone interview with a personal care aide (PCA) on 01/31/21 at 2:31pm. Refer to a telephone interview with a MA on 01/14/21 at 8:44am. Refer to a telephone interview with a MA on 01/14/21 at 2:46pm.	C 243		

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C 243	Continued From page 7 Refer to telephone interview with the Administrator on 01/14/21 at 3:00pm. b. Review of Resident #3's Accident/Injury (A/I) report completed on 11/03/20 revealed: -The time of incident was at 12:20am. -She had an unwitnessed fall. -Staff heard a noise in the area of her room. -She was found on floor, behind the door. -She voiced she hit her head. -Staff checked her for injury, and called 911. -Staff notified management. -Staff attempted to contact her power of attorney, there was no answer. -The physician/healthcare provider notification section was blank. Review of Resident #3' emergency room discharge instructions dated 11/03/20 revealed: -The reason for today's visit was a fall, initial encounter and a bladder infection. -The following imaging tests were done, computed tomography (CT) Head, CT Spine, and an electrocardiogram (ECG) 12 lead (a CT is an imaging scan that uses X-rays to develop a 3D image of the head, spine, etc. and an ECG records the electrical signal from the heart to check for different heart conditions). Review of Resident #3's Post Fall Investigation report completed on revealed: -The date of fall was 11/03/20, and time of fall was 12:20am. -There was no injury. -She was sent to the hospital due to hitting her head. -She was last seen/checked prior to the fall at 11:30pm. -The resident was last tolleted was blank. -It was documented she was getting out of bed.	C 243		

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C 243	Continued From page 8 -She ambulated with a walker. -Safety devices in place at the time the fall occurred was blank. -Contributing factors were documented as pain. -Other possible medication contributing factors were documented as greater than 5 medications. -Her medication review included hypnotics and antidepressants. -Primary care physician was notified. -Safety measures/interventions for "fall prevention" in place prior to current was documented as yes. -In the Safety Review section, it was documented as the staff was informed of necessary changes going forward and the incident/investigation/interventions reviewed at the Comprehensive Resident Review Meeting. -In the Safety Review section, there was no documentation of the necessary changes that were provided to staff. -The document was reviewed by the RCC on 11/04/20. Telephone interview with a medication aide (MA) on 01/14/21 at 2:46pm revealed: -She worked 3rd shift (11:00pm-7:00am) at the facility and most times residents were in bed when she arrived for her shift. -She could not recall the personal care needs or fall interventions provided to Resident #3 because she mostly worked in a sister building on the facility's campus. -Resident #3 went to the bathroom on her own. -She knew if she observed Resident #3 peeking out of her door, she would immediately go to her room. -She knew to keep a "closer eye" on Resident #3 because she had a history of falls. -She had noticed Resident #3's name was on the MA's 24-hour report more frequently, so she	C 243		

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C 243	Continued From page 9 knew staff had been keeping a "closer eye" on her. -She thought a "closer eye" meant supervision checks every 1 hour but she could not recall how often staff were supervising Resident #3. -Resident #3's fall interventions in place were supervision checks every hour which were not documented by staff. -She was the MA who was working when Resident #3 fell on 11/03/20. -She could not recall where and what happened related to Resident #3's fall on 11/03/20. -The only fall she could recall for Resident #3 was when she was sitting on her bedroom floor. -She had noticed Resident #3 would squat on her floor when she had to use the bathroom. Telephone interview with the Resident Care Coordinator (RCC) on 11/14/21 at 1:00pm revealed: -After Resident #3's fall dated 11/03/20, the fall interventions in place were increased supervision which meant Resident #3 should have been supervised more, every 30 minutes, she expected staff to look at Resident #3's footing, and to make sure she was wearing the proper shoes. -The staff did not document the supervision checks of the residents because it was not a requirement. -She also discussed Resident #3's Cortisone injections with Resident #3's POA to verify if she had another scheduled Cortisone injection due because from her observations Resident #3's knees were worsening, and she was having an increased in falls. Attempted telephone interviews with the Primary Care Provider on 01/13/21 at 4:25pm, 01/14/21 at 11:10am, 01/14/21 at 2:38pm were unsuccessful.	C 243		

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C 243	Continued From page 10 Refer to a telephone interview with a medication aide (MA) on 01/13/21 at 2:11pm. Refer to a telephone interview with a personal care aide (PCA) on 01/13/21 at 2:31pm. Refer to a telephone interview with a MA on 01/14/21 at 8:44am. Refer to a telephone interview with a MA on 01/14/21 at 2:46pm. Refer to telephone interview with the Administrator on 01/14/21 at 3:00pm. c. Review of Resident #3's Accident/Injury (A/I) report completed on 11/14/20 revealed: -The time of incident was 1:30pm. -She was found on floor in bathroom, laying on her right side. -There was no apparent injury. -The medication aide (MA) would continue to monitor. -She did not have any shoes on when going to the bathroom. -She normally wore shoes when ambulating. -It was documented as an unwitnessed fall. -Involved body part was documented as her right hip. -She was checked for injury. -Her power of attorney, management, and primary care provider were notified on 11/14/20. Review of Resident #3's physician communication note dated 11/16/20 revealed she was found in the bathroom on her right hip on the floor with no apparent injury noted at this time would continue to monitor. Review of Resident #3's Post Fall Investigation	C 243		

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C 243	Continued From page 11 report completed on 11/14/20 revealed: -The date of fall was 11/14/20 and time was 1:30pm. -There was no injury observed. -She was not sent to the hospital and did not hit her head. -She was going to use the bathroom. -She was last seen/checked prior to the fall at 1:15pm. -She was last toileted at 1:15pm. -She was in her bed prior to the fall. -She ambulated with a walker. -Contributing factors were documented as Improper footwear. -Safety devices in place at the time of the fall were documented as low bed and bed in low position -Other possible medication contributing factors were documented as greater than 5 medications. -Her medication review included hypnotics and antidepressants. -In the Safety Review section, it was documented as the staff was informed of necessary changes going forward and the Incident/Investigation/interventions reviewed at the Comprehensive Resident Review Meeting. -In the Safety Review section, there was no documentation of the necessary changes that were provided to staff. -The document was reviewed by the RCC on 11/16/20. Telephone interview with a medication aide (MA) on 01/13/21 at 2:11pm revealed: -Resident #3 required assistance with basic activities of daily living, the facility staff would take her to the shower, provided stand-by assistance while she showered, however, she could dress herself. -She ambulated with her walker but needed	C 243		

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C 243	Continued From page 12 reminders to use her walker. -For Resident #3, she verified her bathroom needs every 2 hours. -With Resident #3's supervision checks, staff would go to her room. -Resident #3 was more at risk for a fall due to her chronic knee pain. -The last fall for Resident #3 was maybe in October 2020 or November 2020. -It happened during shift change, there was another MA on duty. -Resident #3 had spilled her water and another MA had found her on the floor within in her room. -The fall interventions in place for Resident #3 were to make sure her walking path within in her room was clear of obstacles, her room was well lit, her walker was beside her bed, and increased supervision of every 1 hour. Telephone interview with a MA on 01/14/21 at 10:12am revealed: -During the monitoring/supervision checks, she would verify the resident's needs were met, and would verify the resident's location by walking into the resident's room. -Sometimes Resident #3 would "jump" out her bed due to urinary urgency. -She was the MA who was working when Resident #3 fell on 11/14/20. -She could not recall where and what happened related to Resident #3's fall on 11/14/20. Telephone interview with the Resident Care Coordinator (RCC) on 11/14/21 at 1:00pm revealed: -Resident #3's fall occurred on 11/14/20 because she was not wearing her proper shoes when going to the bathroom. -After Resident #3's fall dated 11/14/20, the fall interventions in place were trying to keep	C 243		

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THE RESERVE AT MILLS FARM VILLA #4	2030 MILLS CHASE LOOP APEX, NC 27523

(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
C 243	Continued From page 13 Resident #3's door open to keep an eye on her, supervision every 30 minutes along with offering toileting assistance. Attempted telephone interviews with the Primary Care Provider on 01/13/21 at 4:25pm, 01/14/21 at 11:10am, 01/14/21 at 2:38pm were unsuccessful. Refer to a telephone interview with a medication aide (MA) on 01/13/21 at 2:11pm. Refer to telephone interview with a personal care aide (PCA) on 01/13/21 at 2:31pm. Refer to a telephone interview with a MA on 01/14/21 at 8:44am. Refer to a telephone interview with a MA on 01/14/21 at 2:46pm. Refer to telephone interview with the Administrator on 01/14/21 at 3:00pm. d. Review of Resident #3's Accident/Injury (A/I) report completed on 11/28/20 at 6:00pm revealed: -Resident #3 was found on the floor in her bedroom during a routine monitoring round. -Resident #3 was checked for injury, and no apparent injury was found. -Resident #3's power of attorney, management, and primary care provider were notified on 11/28/20. Review of Resident #3's Post Fall Investigation report completed on 11/28/20 revealed: -The date of fall was 11/28/20, and time was 6:00pm. -There was no injury observed. -She was not sent to the hospital and did not hit	C 243		

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C 243	Continued From page 14 her head. -She did not say how she fell. -She was last seen/checked prior to the fall at 5:45pm. -The time when the resident was last toileted was blank. -She was in her room prior to the fall. -She ambulated with a walker. -Contributing factors were documented as wet/slippery floor. -Safety devices in place at the time of the fall were documented as low bed, night light in room, night light in bathroom, night light working, and bed in low position -Other possible medication contributing factors were documented as greater than 5 medications. -Her medication review included hypnotics and antidepressants. -In the Safety Review section, it was documented as the staff was informed of necessary changes going forward and the incident/investigation/interventions reviewed at the Comprehensive Resident Review Meeting. -In the Safety Review section, there was no documentation of the necessary changes that were provided to staff. -The document was reviewed by the RCC on 11/29/20. Telephone interview with the Resident Care Coordinator (RCC) on 11/14/21 at 1:00pm revealed after Resident #3's fall dated 11/28/20, the fall interventions in place were increased supervision which meant Resident #3 should have been supervised more often, every 30 minutes, especially in the evenings and during night due to her "sundowners" which caused her to be more active and mobile, and she expected Resident #3's door to be left open to listen for her movement.	C 243		

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C 243	Continued From page 15 Attempted telephone interview with a medication aide (MA) on 01/14/21 at 8:29am was unsuccessful. Attempted telephone interviews with the Primary Care Provider on 01/13/21 at 4:25pm, 01/14/21 at 11:10am, 01/14/21 at 2:38pm were unsuccessful. Refer to a telephone interview with a MA on 01/13/21 at 2:11pm. Refer to telephone interview with a personal care aide (PCA) on 01/13/21 at 2:31pm. Refer to a telephone interview with a MA on 01/14/21 at 8:44am. Refer to a telephone interview with a MA on 01/14/21 at 2:46pm. Refer to telephone interview with the Administrator on 01/14/21 at 3:00pm. e. Review of Resident #3's physician communication dated 12/10/20 revealed: -She had an unwitnessed fall with no injuries. -The fall took place in her room at 5:00am while going to the restroom. -There were no vitals documented. -The physician's instructions included the power of attorney was notified and Resident #3's vital signs were requested. There was no Accident/Injury (A/I) report completed on 12/10/20. Telephone interview with the Director of Clinical Services on 11/14/21 at 12:29pm revealed: -She was unable to locate Resident #3's A/I for	C 243		

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C 243	Continued From page 16 Resident #3's fall on 12/10/20. -She would have expected an A/I report to be completed for a resident-to-resident altercation, increase in resident's behaviors, a resident's fall, anything out of the "normal." -She would have expected an A/I report for Resident #3's fall on 12/10/20 because she was not aware of the resident's fall without a completed A/I. -She was not sure why the A/I Report was not completed, "what we were expecting to happen did not happen consistently." -Post resident fall, she expected staff to increase their resident visional checks to every 1 hour versus every 2 hours. -Resident #3's visional checks were "probably" increased in November 2020 to every hour due to back-to-back falls, however, staff did not document Resident #3's increased visional checks because it was not a requirement. Telephone interview with a medication aide (MA) on 01/14/21 at 2:46pm revealed: -She worked 3rd shift (11:00pm-7:00am) at the facility and most times residents were in bed when she arrived for her shift. -She could not recall the personal care needs or fall interventions provided to Resident #3 because she mostly worked in a sister building on the facility's campus. -Resident #3 went to the bathroom on own. -She knew if she observed Resident #3 peeking out of her door, she would immediately go to her room. -She knew to keep a "closer eye" on Resident #3 because she had a history of falls. -She had noticed Resident #3's name was on the MA's 24-hour report more frequently, so she knew the facility staff had been keeping a "closer eye" on her.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 243	Continued From page 17 -She thought a "closer eye" meant supervision checks every 1 hour but she could not recall how often staff were supervising Resident #3. -Resident #3's fall interventions in place were supervision checks every hour which were not documented by the facility staff because it was not a requirement. -She was the MA who was working when Resident #3 fell on 12/10/20. -She could not recall where and what happened related to Resident #3's fall on 12/10/20. -The only fall she could recall for Resident #3 was when she was sitting on her bedroom floor. -She had noticed Resident #3 would squat on her floor when she had to use the bathroom. Telephone interview with the Resident Care Coordinator (RCC) on 11/14/21 at 1:00pm revealed: -There was not an A/I report completed by the facility staff for Resident #3's fall dated 12/10/20. -She was not sure why the A/I report was not completed on 12/10/20. -After Resident #3's fall dated 12/10/20, the fall interventions in place were increased supervision due to the fall on 12/10/20 which meant Resident #3 should have been supervised more often, every 30 minutes, she expected Resident #3's door to be left open to listen for her movements, staff to pay close attention to the "on goings" within her room which meant paying attention to verify if she was wearing proper shoes and she was using her walker. Attempted telephone interviews with the Primary Care Provider on 01/13/21 at 4:25pm, 01/14/21 at 11:10am, 01/14/21 at 2:38pm were unsuccessful. Refer to a telephone interview with a medication aide (MA) on 01/13/21 at 2:11pm.	C 243		

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C 243	Continued From page 18 Refer to telephone interview with a personal care aide (PCA) on 01/13/21 at 2:31pm. Refer to a telephone interview with a MA on 01/14/21 at 8:44am. Refer to a telephone interview with a MA on 01/14/21 at 2:46pm. Refer to telephone interview with the Administrator on 01/14/21 at 3:00pm. f. Review of Resident #3's Accident/Injury (A/I) report completed on 12/11/20 at 10:30pm revealed: -She was found on the floor in her bathroom during a routine monitoring round. -There was no apparent injury. -Her power of attorney, facility management team, and her primary care provider were notified on 11/28/20. Review of Resident #3's progress note dated 12/11/20 revealed: -The note was completed by a medication aide (MA). -Resident #3 had an unwitnessed fall and was found on the floor of her bathroom, she had wrapped herself with a blanket. -Resident #3's power of attorney was notified at 10:45pm. -The Director of Clinical was notified at 10:50pm. -The primary care provider was notified at 11:00pm. -Resident #3 denied having any pain. -The MA would continue to monitor her and would report the fall to the oncoming shift staff. Telephone interview with the Resident Care	C 243		

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C 243	Continued From page 19 Coordinator (RCC) on 11/14/21 at 1:00pm revealed after Resident #3's fall dated 12/11/20, the fall interventions from the previous fall on 12/10/20 were unchanged. Attempted telephone interviews with the Primary Care Provider on 01/13/21 at 4:25pm, 01/14/21 at 11:10am, 01/14/21 at 2:38pm were unsuccessful. Attempted telephone interview with a medication aide (MA) on 01/14/21 at 8:29am was unsuccessful. Refer to a telephone interview with a MA on 01/13/21 at 2:11pm. Refer to telephone interview with a personal care aide (PCA) on 01/13/21 at 2:31pm. Refer to a telephone interview with a MA on 01/14/21 at 8:44am. Refer to a telephone interview with a MA on 01/14/21 at 2:46pm. Refer to telephone interview with the Administrator on 01/14/21 at 3:00pm. _____ Telephone interview with a medication aide (MA) on 01/13/21 at 2:11pm revealed: -The facility did have a falls policy. -She received education on the falls policy during her new employee orientation. -The falls policy outlined what a facility staff member should do when a resident had a fall. -If a resident had a fall at the facility, the MA would obtain the resident's vital signs, the resident would be checked for injury and skin tears, the primary care provider would be faxed, the power of attorney(POA)/responsible party	C 243		

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C 243	Continued From page 20 (RP) would be notified, an A/I would be completed the same day the resident's fall occurred, and 72 hour monitoring would be in place. -For the 72-hour monitoring, the MA would obtain the resident's vital signs every shift, document any changes in the resident's condition, for example, increase in pain or the MA has observed changes in the resident's gait when ambulating. -If a resident hit their head they would automatically be sent to the hospital. -The resident's power of attorney (POA)/responsible party (RP) would sometimes refuse to send the resident to the hospital and then the resident's POA/RP would have to sign the refusal of care upon Emergency Management Services arrival to the facility. -For a resident's unwitnessed fall, it did not mean the resident was automatically sent to the hospital. -For a resident's unwitnessed fall, the MA would obtain the resident's vital signs, the MA would ask the resident if they were having pain, the resident would be checked for injury and skin tears. -The resident would be monitored for 72 hours by the MAs. -Resident #3 required assistance with basic activities of daily living, the facility staff would take her to the shower, provided stand-by assistance while she showered, however, she could dress herself. -She ambulated with her walker but needed reminders to use her walker. -All residents were supervised, the level of supervision varied among residents. -Some residents were more alert than others and could make their needs known. -The supervision checks could be less than 2 hours because the residents were in and out of their rooms.	C 243		

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C 243	Continued From page 21 -The staff did not document the supervision checks of the residents because it was not a requirement. -She considered all residents in the facility at risk for a fall. -For Resident #3, she verified her bathroom needs every 2 hours. -With Resident #3's supervision checks, staff would go to her room. -Resident #3 was more at risk for a fall due to her chronic knee pain. -The last fall for Resident #3 was maybe in October 2020 or November 2020. -It happened during shift change, there was another MA on duty. -Resident #3 had spilled her water and another MA had found her on the floor within in her room. -The fall interventions in place for Resident #3 were to make sure her walking path within in her room was clear of obstacles, her room was well lit, her walker was beside her bed, and increased supervision of every 1 hour. Telephone interview with a personal care aide (PCA) on 01/13/21 at 2:31pm revealed: -The facility did have a falls policy. -She received education on the falls policy during her new employee orientation. -All residents were at risk for a fall. -If a resident had a fall at the facility, she would notify the MA, she did not lift the resident, the MA would take the resident's vital signs, the MA would ask the resident if they hit their head, and the MA would notify the resident's primary care provider and POA/RP. -If the resident was bleeding from their head, she would place a pillow under their head. -In regard to the facility's supervision policy, she pretty much knew what to do. -She supervised the residents every 1 to 2 hours.	C 243		

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C 243	Continued From page 22 -Sometimes supervision checks were less than every 1 to 2 hours because residents were back and forth from their rooms to the facility's common area every 5 minutes. -Resident #3 used a walker when ambulating but would forget to use and needed reminders. -Resident #3 was a fall risk because of her bilateral knee pain and Resident #3 would receive "shots" to assist with the pain. -There were no fall interventions in place for Resident #3 besides monitoring. Telephone interview with a medication aide (MA) on 01/14/21 at 8:44am revealed: -Per the facility's falls policy, a facility staff member should not move a resident post fall. -If the resident complained of pain or hit their head they were automatically sent to the hospital. -The resident's vital signs would be taken by the MA. -The MA would notify the resident's primary care provider (PCP), family, the Director of Clinical Services (DCS) of the resident's fall. -Post fall, the resident's name would be added to the facility's hot box. -The resident would remain in the facility's hot box for 3 days; however, it was dependent on the resident's "situation" on how long the resident would stay in the facility's hot box. -The facility's hot box involved monitoring the resident's vital signs. -Residents were monitored all day because the staff "constantly" interacted with the residents. -She could not recall the personal care needs or fall interventions in place for Resident #3 because she mostly worked in a sister building on the facility's campus. -She was the MA who was working when Resident #3 fell on 10/22/20. -She could not recall where and what happened	C 243		

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C 243	Continued From page 23 related to Resident #3's fall on 10/22/20. Telephone interview with a medication aide (MA) on 01/14/21 at 2:46pm revealed: -There was a facility's falls policy. -Post fall, staff should assist the resident, make sure they can pivot. -The MA would notify the resident's primary care provider (PCP), family, Director of Clinical Services (DCS) of the resident's fall. -The MA would 911 if the resident needed to go out. -The MA would obtain vital signs and complete an A/I. -The resident's name would be added to the facility's hot box and would remain in the facility's hot box for 3 days. -If the resident was in the facility's hot box, the MA would document a note within the resident's chart outlining if resident issues were present or no issues present every shift. -She was not taught to obtain or document resident's vital signs every shift when the resident was placed in the facility's hot box. -She would supervise/monitor all residents at least every 2 hours. -The monitoring of the residents involved knocking on the door, calling their name, and announcement the purpose of her visit. -She worked 3rd shift (11:00pm-7:00am) at the facility and most times residents were in bed when she arrived for her shift. -She could not recall the personal care needs or fall interventions provided to Resident #3 because she mostly worked in a sister building on the facility's campus. -Resident #3 went to the bathroom on her own. -She knew if she observed Resident #3 peeking out of her door, she would immediately go to her room.	C 243		

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C 243	Continued From page 24 -She knew to keep a "closer eye" on Resident #3 because she had a history of falls. -She had noticed Resident #3's name was on the MA's 24-hour report more frequently, so she knew staff had been keeping a "closer eye" on her. -She thought a "closer eye" meant supervision checks every 1 hour but she could not recall how often staff were supervising Resident #3. -Resident #3's fall interventions in place were supervision checks every hour which were not documented by staff. -She was the MA who was working when Resident #3 fell on 11/03/20. -She could not recall where and what happened related to Resident #3's fall on 11/03/20. -The only fall she could recall for Resident #3 was when she was sitting on her bedroom floor. -She had noticed Resident #3 would squat on her floor when she had to use the bathroom. Telephone interview with the Administrator on 01/14/21 at 3:00pm revealed: -He expected an A/I report to have been completed when a resident fall occurred. -The facility staff member should complete the A/I report the same day as the incident. -His vision for the facility related to the monitoring/supervision of residents, he expected staff to know the residents intimately and take the time to get to know residents. -For example, he expected staff to observe the resident's body cues to learn and understand what the resident was communicating to them. -Staff were trying to work with Resident #3. -The supervision of Resident #3 was challenging at times because she stayed in her room with the door closed and it was her resident right for them to maintain her privacy. -Resident #3's falls were unobserved by the staff.	C 243		

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C 243	Continued From page 25 -It had been reported to him Resident #3 would sit herself on the floor as a cue to request assistance with using the bathroom. -The facility had done their "due diligence" with the completion of Accident/Incident reports, but they were not sure Resident #3 fell each time. -He expected staff to supervise Resident #3 every 15 minutes initially then 30 minutes post fall. -On supervision checks, he expected staff to identify if Resident #3 was wearing the right shoes, and she was using her walker when ambulating. -He expected if a resident had a fall, the resident's supervision should be increased to every 30 minutes to 1 hour for 72 hours of monitoring. -If a resident post fall, required supervision every 15-30 minutes he would question if the resident needed to be sent out to the hospital. -The resident's fall interventions and assessment of the fall interventions were the responsibility of the RCC and DCS, the Associate Administrator would drive the initiative, and the Administrator would provide oversight. -He expected a resident's fall interventions to be reviewed along with the effectiveness of interventions. The facility failed to provide supervision for Resident #3 who had multiple falls, who had a known history of repeated falls, cognitive impairment, anxiety, and was identified as a fall risk which resulted in 6 falls from 10/2020 to 12/2020, and on 11/03/20 she hit her head and was sent to the Emergency Room. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation.	C 243		

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	FCL-092271	A. BUILDING: _____ B. WING _____	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #4	2030 MILLS CHASE LOOP APEX, NC 27523

(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
C 243	Continued From page 26 The facility provided a plan of protection in accordance with G. S. 131D-34 on 01/14/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 01, 2021.	C 243		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents Resident #3, who had a history of multiple falls, cognitive impairment, and was identified as fall risk. [Refer to Tag C243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type B Violation)].	C 912	Please see attached	

The following is a summary of the Plan of Correction for The Reserve at Mills Farm Villa 4. This Plan of Correction is in regards to the Corrective Action Report dated January 28, 2021. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10A NCAC 13G .0901 Personal Care and Supervision.

Each resident was reassessed using Navion's Resident Assessment Tool by the Associate Executive Director (AED)/Director of Clinical Services (DCS)/ Resident Care Coordinator (RCC)/Designee no later than 2/18/21.

A Fall Risk Review was completed for each resident by the AED/DCS/RCC/Designee no later than2/18/21.

Each Care Plan was reviewed and updated, as indicated, with above findings by the AED/DCS/RCC/Designee no later than 2/18/21.

When a resident has had a fall, that resident's monitoring will be increased to assist with the resident's care needs.

The increased supervision will be reassessed by the AED/DCS/Designee to determine the need for additional interventions.

Associates will be re-educated on Fall Prevention program utilizing Slip, Trip and Fall Prevention training by the AED/DCS/Designee

A "weekly" Thera Care/Comprehensive Resident Review (CRR) meeting was implemented on 1/29/21, and will be led by the AED/DCS/Designee.

Residents with any falls since the last meeting will be reviewed to include the effectiveness of interventions discussed.

Notes from that meeting will be maintained by the AED/Designee for review and follow up.

131D-21 (2) Declaration of Resident Rights

Associates will be re-educated regarding Resident Rights no later than 2/26/21 by the AED/DCS/RCC/Designee.

Linda Gregory-Duncan
RN. AED
2/17/21