[redacted]

From: [redacted]@myvschome.com>
Sent: Thursday, November 18, 2021 4:44 PM
To: [redacted]
Cc:
Subject: [External] Edenton Primetime
Attachments: Scanner@mytahome.com_20211118_165211.pdf

CAUTION: External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to Report Spam.

Hi Mrs. [redacted] here is the rescan POC.

Begin forwarded message:

From: "Scanner@mytahome.com" <Scanner@mytahome.com>
Subject: Scanned image from MX-M3070
Date: November 18, 2021 at 4:52:11 PM EST
To: [redacted]@myvschome.com
Reply-To: <Scanner@mytahome.com>

Reply to: Scanner@mytahome.com <Scanner@mytahome.com>
Device Name: Not Set
Device Model: MX-M3070
Location: Not Set

File Format: PDF MMR(G4)
Resolution: 200dpi x 200dpi

Attached file is scanned image in PDF format.
Use Acrobat(R)Reader(R) or Adobe(R)Reader(R) of Adobe Systems Incorporated to view the document.
Adobe(R)Reader(R) can be downloaded from the following URL:
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Reviewed and Acknowledged
11/24/21 AV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021008	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

(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 an annual survey from September 28, 2021 to September 29, 2021.	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 observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs and the facility's falls protocol for 2 of 3 sampled residents (#2, #3), who sustained multiple falls with injuries including Resident #2 who required treatment at the emergency room for 2 of 3 falls for head injuries and facial bruising (#2); and sustained multiple skin tears and a left elbow fracture (#3). The findings are: Review of the facility's fall policy revealed: -There was not a date documented on the falls policy. -This policy aimed to provide guidance to residents and staff on fall prevention and education, steps to take when a fall occurred and actions for proper reporting. -When a fall occurred an incident report would be	D 270	Administrator/RCC identified needed interventions for residents exhibiting a need for supervision and ensured staff are trained on each individual residents needs. Facility (Administrator/RCC/SIC) will respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the residents, (such as obtaining assistive devices, increased supervision, seeking advice from physician,OT/PT, etc.) Administrator/Designee will conduct stand up meeting 5 days/week with staff to follow up on resident supervision concerns/issues and other medical/physical conditions. Administrator will monitor supervision provided to residents based on need identified in the care plan x 5 days per week	9/29/2021 & Ongoing 11/14/2021 & Ongoing 11/14/2021 & Ongoing 11/14/2021 & Ongoing

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Caperart — TITLE: administrator — (X6) DATE: 11/11/21

Reviewed and Acknowledged
11/24/21 AV

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D 270	Continued From page 1 completed. -Procedures for what to do after a fall occurred would be on a case by case basis. Review of the facility's fall protocol revealed: -There was not a date documented on the fall protocol. -Upon admission and as needed thereafter or after 3 falls in one month (for a resident who was not on the falls program) a falls risk assessment shall be completed. -All residents identified to be at risk for falls shall be placed on the fall's management program. -The physician shall be notified that the resident was on a falls management program to request further guidance of preventative measures via falls management fax. -The resident's care plan shall be updated to include preventative measures. -The falls investigation summary shall be completed by the medication aide/supervisor (MA/supervisor) after assuring the resident's needs are attended to from the fall. -The MA/supervisor shall assure the physician was notified and ask for further intervention guidelines. -The MA/supervisor shall document contact with the physician on the incident/accident report and implement any orders given. -Investigation summary shall be reviewed by the Resident Care Coordinator/Designee within 24-72 hours. -The Resident Care Coordinator/Designee shall assure all follow up was completed from the investigation and complete the falls risk assessment. -The Resident Care Coordinator/Designee shall add the resident to the falls management program if the falls risk assessment indicated such.	D 270		

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D 270	Continued From page 2 Review of the facility's admission and service agreement revealed residents would be provided with supervision on a 24-hour basis. 1.Review of Resident #2's FL-2 dated 02/02/21 revealed: -Diagnoses included coronary artery disease, paroxysmal atrial fibrillation, hypertension, diabetes mellitus type II, memory loss, hypothyroidism, and chronic dizziness. -She was intermittently disoriented. -She used a wheelchair and rollator. -She was continent of bladder and bowel. Review of Resident #2's care plan dated 01/25/21 revealed she required limited assistance with bathing, dressing, grooming/personal hygiene, and transferring. Observations on 09/28/21 at 10:20am revealed: -Resident #2 was sitting in wheelchair within her room. -The left side of her face from her forehead to her chin was dark purple in color. -Her entire forehead was yellowish in color. Interview with Resident #2 on 09/28/21 at 10:22am revealed: -She had fallen twice last week and that was why she had the bruising on her face. -She could not recall or share all the details of her falls. -Her face hurt to touch a little bit. Observations on 09/29/21 at 7:15am revealed: -Resident #2 was asleep in her wheelchair in the facility hallway next to the medication cart. -Her head was leaning forward while asleep in her wheelchair.	D 270		

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D 270	Continued From page 3	D 270		

Review of a primary care provider (PCP) order visit note dated 05/06/21 revealed Resident #2 was requesting physical therapy.

Review of Resident #2's incident/accident (I/A) report dated 09/13/21 at 2:45am revealed:
-Resident #2 was found on the floor within her room.
-There was no identified injury.
-She was not transported to the emergency department (ED).
-The intervention implemented was the resident was not to get up by herself; and ring the call bell if she needed help.

Review of Resident #2's falls investigation summary dated 09/13/21 revealed:
-She was found on the floor; it was an unwitnessed fall.
-The cause of the fall was the resident lost her balance.
-She was getting up from her wheelchair.
-She was wearing shoes at the time of the I/A.
-She did not have a mental status change or a change in her level of consciousness.
-There was no injury and she was not sent to the ED.

Telephone interview with a medication aide (MA) on 09/29/21 at 3:00pm revealed:
-She worked night shift (11:00pm-7:00am) at the facility and she was aware Resident #2 would get up every morning between 2:30am and 3:00am.
-She would adjust her heat settings and get herself dressed daily.
-She had several falls in September 2021.
-On 09/13/21, Resident #2 was found on the floor in her room at approximately 3:00am.
-There were no complaints of pain.

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D 270	Continued From page 4 -She was evaluated for injuries but was not sent to the ED. -She completed Resident #2's I/A and falls investigation summary dated 09/13/21. -The fall interventions in place after the fall dated 09/13/21 were she was encouraged not to get up by herself and she was encouraged to use her call bell when needed. -There were no other interventions in place except encouraging her to use her call bell and to provide assistance to her with transfers to her recliner when she was ready to go to sleep. Review of Resident #2's incident/accident (I/A) report dated 09/16/21 at 3:00pm revealed: -She had a fall/slip. -The location of I/A was blank. -The resident sustained an injury to her head and her left shoulder. -She had a bruise/hematoma. -She was transported to the emergency department (ED). -The resident was encouraged to use the call bell when needed. Review of Resident #2's record revealed there was no documentation of Resident #2's ED visit dated 09/16/21. Review of Resident #2's falls investigation summary dated 09/16/21 revealed: -It was a self-reported fall. -The cause of I/A was the resident lost her balance. -She was ambulating in her bedroom. -She was wearing slippers at the time of the I/A. -She did not have a mental status change or a change in her level of consciousness. -She had an injury to the left side of her head. -She was sent to the ED.	D 270		

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D 270	Continued From page 5 Review of Resident #2's care note dated 09/16/21 (no time) revealed: -She was sent to the ED due to a fall related incident. -The facility was "not sure" when she fell but the resident reported she did fall and there was bruising on her forehead and a bump on the top of her head. -All tests and scans came back okay. Review of Resident #2's care note dated 09/16/21 (no time) revealed she was back from the ED and there were no complaints currently. Review of Resident #2's care note dated 09/17/21 (no time) revealed she had no complaints and the staff would continue to monitor her. Review of Resident #2's care note dated 09/18/21 at 3:00pm revealed the bruising to her forehead was yellowish, blue. Telephone interview with a MA on 09/29/21 at 11:56am revealed: -Resident #2 was a fall risk due to her recent falls and she was unsure if she was currently receiving increased supervision. -She completed Resident #2's I/A and falls investigation summary dated 09/16/21. -On 09/16/21, Resident #2 self-reported a fall in her room. -The MA observed a bruise to the left side of the resident's head, and she was sent to the ED. -The fall interventions in place before and after her fall dated 09/16/21 were encouragement to use her call when needed; staff to check on her "periodically (which less than every two hours); staff to check on the resident if assisting a resident near Resident #2's room.	D 270		

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D 270	Continued From page 6 Review of Resident #2's incident/accident (I/A) report dated 09/24/21 at 7:00am revealed: -The resident was found on the floor in her room and there was an injury to her head, a contusion. She was transported to the emergency department (ED). -The intervention was she was encouraged to use the call bell for all assistance and when trying to ambulate. Review of Resident #2's after visit summary from the ED dated 09/24/21 revealed: -The reason for her visit was an accidental fall. -Her diagnoses were an accidental fall and a hematoma of the scalp (A hematoma is an abnormal collection of blood outside of a blood vessel.) -She had a computed tomography scan (CT) of her head and a CT of her cervical spine while at the ED (A computed tomography is a medical imaging technique to get detailed images of the body). Review of Resident #2's falls investigation summary dated 09/24/21 revealed: -The resident was found on the floor. -The cause of the I/A was unknown. -The resident was ambulating within in her bedroom and was wearing her shoes. -The resident was sent to the ED. Review of Resident #2's care note dated 09/24/21 revealed: -Resident #2 had an unwitnessed fall at 7:00am when she was ambulating in her bedroom and hit her head on the fireplace. -The resident reported her head was hurting. -Emergency Medical Services was called to transport her to the ED for further evaluation.	D 270		

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D 270	Continued From page 7 -The resident was discharged with a diagnosis of an accidental fall and hematoma of the scalp. -Staff would continue to monitor and report any changes. Review of Resident #2's care note dated 09/25/21 revealed: -Resident #2 complained of her head hurting. -MA administered her Tylenol during the 8:00pm medication pass (Tylenol is used to relieve mild to moderate pain). Review of Resident #2's care note dated 09/26/21 revealed: -The resident's face was bruised badly on the left side. -The resident had not complained of any pain and staff would continue to monitor. Review of Resident #2's care note dated 09/27/21 revealed there was bruising on Resident #2's face. Review of a PCP visit note dated 09/28/21 revealed: -The purpose of the visit was status post a fall. -Resident #2 had a hematoma to top of her head and the bruising to the left side of her face was severe. -There was an order to not let her sleep in her wheelchair. Interview with a personal care aide (PCA) on 09/29/21 at 10:22am revealed: -Resident #2 was "recently" more at risk for falls due to her leaning over in her wheelchair. -She was not aware of any fall interventions in place to prevent Resident #2 from falling. -She checked on Resident #2 less than every two hours.	D 270		

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D 270	Continued From page 8 -When she was working, she kept Resident #2 nearby her to supervise her. -On 09/24/21, she found Resident #2 on the floor near the fireplace in her room when she arrived to work for first shift (7:00am to 3:00pm). -The resident reported her head hurt. -It was unknown to her how long she had been on the floor. -She did not observe any bleeding; the resident just complained of her head hurting. -She reported the fall to the medication aide/supervisor (MA/supervisor) aware and the resident was sent to the ED. Interview with the MA/supervisor on 09/29/21 at 11:15am revealed: -Resident #2 was a fall risk because she leaned forward in her wheelchair. -She was not receiving increased supervision checks and there were no fall interventions in place for her. -Resident #2 was back and forth in the hallways in her wheelchair; and she would scream frequently for assistance. -She completed the I/A report dated 09/24/21. -On 09/24/21, the resident was found on the floor by a PCA at 7:00am. -The resident reported her head hurt and she had a contusion to her head. -She was sent to the ED. -She contacted Resident #2's PCP on 09/24/21, and the PCP did not say to do anything differently. Interview with the physical therapy assistant on 09/29/21 at 10:49am revealed: -He had working with Resident #2, but he was not sure when her physical therapy was initiated at the facility. -He was working with Resident #2 on her gait,	D 270		

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D 270	Continued From page 9 balance, and strengthening. -Most of Resident #2's falls were related to her decline in her cognitive ability and a recent urinary tract infection (UTI). -Residents with frequent falls needed 1:1 supervision but he knew that was not feasible at the facility. -Resident #2 leaned forward most times and this had gotten worse in the past month. -Resident #2 was now more lethargic and prior to her most recent UTI she was "lucid" or alert to her surroundings. Telephone interview with a MA on 09/29/21 at 11:56am revealed Resident #2 was a fall risk due to her recent falls and she was unsure if she was currently receiving increased supervision. Interview with the Administrator on 09/29/21 at 12:30pm revealed: -She was not sure if a fall risk assessment had been completed for Resident #2. -Resident #2's three falls in September 2021 were "new" to us. -The resident did not start having frequent falls until September 2021. -She had made a call to Resident #2's family member to discuss a chair alarm but the family did not agree with the chair alarm. -Resident #2 had an order for physical therapy since May 2021 and after her fall dated 09/13/21 the staff was completing 15 minutes checks (a specific length was not provided). -The staff was providing more assistance with the resident's activities of daily living and she did not transfer by herself anymore. -She was encouraged to use call bell when assistance was needed. -There were no new fall interventions after the resident sustained falls on 09/16/21 and	D 270		

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D 270	Continued From page 10 09/24/21. -On 09/28/21, an order was obtained from the resident's PCP for a hospital bed and a new wheelchair due to her series of falls. -The Resident Care Coordinator (RCC) was in the process of completing a new plan of care to reflect Resident #2's significant change. -Resident #2 was "always" at the nurses' stations so she was unsure why the three falls had occurred in September 2021. Telephone interview with Resident #2's PCP on 09/29/21 at 2:08pm revealed: -She was aware of Resident #2's three falls in September 2021. -The cause of Resident #2's falls was she was sleeping in her wheelchair and her face was essentially resting in her lap and she would fall out of her wheelchair. -She provided education to staff which included to not allow the resident to sleep in her wheelchair after the resident fall on 09/13/21. -She provided the staff education on this yesterday (09/28/21) and the staff was supposed to encourage the resident to use her call bell to call for assistance. -Resident #2 was consistently sleeping in her wheelchair versus her recliner or bed which could "absolutely" cause her to have a fall. -She expected staff to provide her assistance to her recliner or bed when she wanted to sleep. -She had concerns for Resident #2 due to her falls on 09/13/21, 09/16/21, and 09/24/21. -She was concerned that the only the fall interventions after the falls dated 09/13/21, 09/16/21, and 09/24/21 was encouragement to use her call bell if she needed any assistance. -Another intervention for Resident #2 to decrease falls was moving her to a room closer to the front of the facility, so staff could keep a better eye on	D 270		

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D 270	Continued From page 11 her. Refer to the interview with a PCA on 09/29/21 at 10:22am. Refer to the interview with the MA/supervisor on 09/29/21 at 11:15am. Refer to the telephone interview with a MA on 09/29/21 at 11:56am. Refer to the second telephone interview with a MA on 09/29/21 at 3:00pm. Refer to the interview with the Administrator on 09/29/21 at 12:30pm. 2. Review of Resident #3's FL-2 dated 01/12/21 revealed: -Diagnoses included a displaced intertrochanteric fracture of left femur, unspecified fall, chronic obstructive pulmonary disease, atrial fibrillation, prosthetic heart valve, and a history of transient ischemic attack. -She required personal care assistance with bathing and dressing. Review of Resident #3's care plan dated 06/24/20 revealed: -This was a significant change plan of care. -The resident resisted care and at times, she would forget she had received her morning medications and mealtimes. -The resident used a rollator and a walker. -The resident required supervision with transfers. -She required extensive assistance with bathing, grooming, and personal hygiene. Observation of Resident #3 on 09/28/21 at 9:41am revealed:	D 270		

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D 270	Continued From page 12 -There was brown stretchy medical tape wrapped on her right lower arm, right lower leg, and left lower leg. -There was a hard cast on her left lower arm. Interview with the medication aide/supervisor (MA/supervisor) on 09/28/21 at 9:42am revealed: -Resident #3 had been hallucinating recently that there were spiders coming down from the ceiling in her room and there were children in the hallway of the facility. -During the hallucinations, the resident had been trying to get out of bed without calling for assistance. -The bandages to her right arm and both legs were skin tears and she had a cast to her left arm due to a fracture. Review of Resident #3's incident/accident (I/A) report dated 09/17/21 at 11:05pm revealed: -Resident #3 had a fall/slip in the hallway. -The resident injured her right elbow. -The nature of injury was an abrasion/scrape and a skin tear. -First aid was administered. -The resident was not sent to the emergency department (ED). -The resident was encouraged to use the call bell when needed and to ensure resident had walker or wheelchair. Review of Resident #3's falls investigation summary dated 09/17/21 revealed: -The resident was found on the floor; it was an unwitnessed fall. -She lost her balance while ambulating in the hallway. -She was wearing shoes and she did not have an assistive device with her. -She did not have a mental status change or a	D 270		

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D 270	Continued From page 13 change in her level of consciousness. -She had a skin tear to her arm and leg. -She was not sent to the ED. Review of Resident #3's care note dated 09/17/21 (no time) revealed: -The care note was written by the third shift (11:00pm to 7:00am) MA. -The resident stated both arms were in pain. -The resident needed assistance today using the bathroom and standing to transfer. -There was a skin tear on her left elbow, and her lower right leg; the dressings to skin tears were changed and dressed per standing orders. Review of Resident #3's care note dated 09/18/21 (no time) revealed: -The care note was written by the second shift MA. -Resident #3 was complaining of pain in her left upper arm. -She was given Lorcet for pain (Lorcet is used to relieve moderate to severe pain). -The resident could not take her medication, because both arms hurt. -The supervisor gave the pills to her in applesauce. -Staff would continue to monitor her. Review of Resident #3's care note dated 09/18/21 revealed: -The care note was written by the first shift MA. -Resident #3 needed assistance using her left arm; she stated her left arm hurt to bend it. Interview with a MA on 09/29/21 at 11:56am revealed: -Resident #3 was a fall risk due to her recent falls and she thought Resident #3 was currently receiving increased supervision which meant she	D 270		

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D 270	Continued From page 14 was monitored every 15-minute checks due to her last fall on 09/27/21. -She completed Resident #3's I/A and falls investigation summary dated 09/17/21. -On 09/17/21 at approximately 11:00pm, the MA was at the nurses' station and assisted Resident #3 to bed. -She was last in Resident #3's room less than 5 minutes before she heard someone scream down the hallway from the nurses 'station. -She entered Resident #3's room and observed a skin tear to her left arm. -Resident #3 had no complaints of pain but she was aware a couple days later it was confirmed she had a fractured left elbow. -Fall intervention in place was to encourage the resident to use her call when needed. Review of Resident #3's incident/accident (I/A) report dated 09/21/21 at 10:30am revealed: -Resident #3 had a new onset of pain. -The location of I/A was her room. -The area of injury was documented as her left arm and left elbow and right knee. -The nature of injury was a bruise and a skin tear. -The resident was sent to the ED. -The intervention implemented was to ring call bell for all assistance to ambulate. Review of Resident #3's after visit summary from the ED dated 09/21/21 revealed: -Reason for her visit was an accidental fall. -Her diagnoses included a closed fracture of her left elbow. Interview with the medication aide/supervisor (MA/supervisor) on 09/29/21 at 11:15am revealed: -Resident #3 was a risk for fall due to having arthritis in both legs and weakness.	D 270		

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D 270	Continued From page 15 -On 09/21/21, Resident #3 was hallucinating and got out of her bed to get a baby in the hallway outside of her room. -On 09/21/21, the personal care aide (PCA) told her around 10:30am Resident #3 was having a pain to her arm. -Resident #3's PCP was notified, and she was sent to the ED. Review of Resident #3's incident/accident (I/A) report dated 09/27/21 at 2:40pm revealed: -Resident #3 was found on the floor in her room. -The area of injury was documented as her right arm, right elbow, right leg, and left leg. -The nature of injury was a skin tear. -She was sent to the ED. -The intervention was to ring call bell for any ambulation assistance. Review of Resident #3's falls investigation summary dated 09/27/21 revealed: -Resident #3 was found on the floor; it was unwitnessed fall. -She lost her balance while ambulating in her room. -She was wearing shoes and had an assistive device with her, a wheelchair. -She did not have a mental status change or a change in her level of consciousness. -She had an injury to her right arm and right and left legs. -She was sent to the ED. Review of Resident #3's after visit summary from the ED dated 09/27/21 revealed: -The reason for her visit was an accidental fall. -Her diagnoses included multiple skin tears, laceration of right middle finger without damage to her nail.	D 270		

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D 270	Continued From page 16 Interview with the medication aide/supervisor (MA/supervisor) on 09/29/21 at 11:15am revealed: -On 09/27/21, she was found on the floor in her room and reported spiders were coming down from the ceiling. -Resident #3's PCP was notified, and she was sent to the ED. -There were not any fall interventions in place for Resident #3. -Yesterday (09/28/21), she received orders for a hospital bed and a fall mattress because of falls in September 2021. Interview with a personal care aide (PCA) on 09/29/21 at 10:22am revealed: -She considered Resident #3 a risk for falls due to her falling and breaking a hip in January 2021. -Resident #3's fall interventions in place were trying to keep an eye on her and encourage her to use the call bell for assistance. -She was not aware of any details related to Resident #3's falls on 09/17/21, 09/21/21, and 09/27/21. Telephone interview with a medication aide (MA) on 09/29/21 at 3:00pm revealed: -Resident #3 became confused in the late evenings and early mornings. -She last worked on night shift (11:00pm-7:00am) on Sunday, 09/26/21; she was so confused about what the time of day it was. -She thought it was the daytime when it was really night time. -She was aware Resident #3 was hallucinating of babies in her room and the hallways of the facility. -A couple of weeks during night shift the resident thought she saw a baby in in her room. -She was always trying to get out of her bed without assistance and was mixed up on the time	D 270		

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D 270	Continued From page 17	D 270		

of the day.
-On 06/24/21, Resident #3 was found on the floor in her room at approximately 6:00am.
-She was evaluated for injuries and was not sent to the ED.
-She completed Resident #3's I/A and falls investigation summary dated 06/24/21.
-The fall interventions in place after the fall dated 06/24/21 was to encourage the resident to use her call when she needed help getting up.

Interview with the Administrator on 09/29/21 at 12:30pm revealed:
-She was not sure if a fall risk assessment had been completed for Resident #3.
-Resident #3 had started recently having hallucinating of spiders and babies.
-After Resident #3's fall dated 09/17/21, the fall interventions in place were every 15 minutes checks, staff was to place her call bell by her, and her wheelchair was moved next to a chair in her room away from her.
-There were no new fall interventions after Resident #3's falls dated 09/21/21 and 09/27/21.
-On 09/28/21, a request was sent to Resident #3's PCP for a hospital bed and a fall mat.
-She expected the MAs to discuss fall interventions when notifying the PCP of a resident fall.

Telephone interview with Resident #3's PCP on 09/29/21 at 2:30pm revealed:
-He was aware of Resident #3's three falls in September 2021.
-There was no notification from the facility she was hallucinating of spiders within in her room and babies in the facility's hallways and that she was trying to get out of bed when having the hallucinations.
-Until today, 09/28/21, he had not received any

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D 270	Continued From page 18 phone calls, faxes, or emails from the facility requesting fall interventions for Resident #3. -He was concerned the only fall interventions put in place after the falls dated 09/17/21, 09/21/21, and 09/27/21 were encouragement to use her call bell if she needed any assistance and to ensure she had her walker or wheelchair. -He expected the facility to discuss fall interventions with him to determine what was going on with Resident #3 so he could address and provide medical interventions. Refer to the interview with a personal care aide on 09/29/21 at 10:22am. Refer to the interview with the MA/supervisor on 09/29/21 at 11:15am. Refer to the telephone interview with a MA on 09/29/21 at 11:56am. Refer to the second telephone interview with a MA on 09/29/21 at 3:00pm. Refer to the interview with the Administrator on 09/29/21 at 12:30pm. Interview with a personal care aide on 09/29/21 at 10:22am revealed: -All residents were supervised by staff every 2 hours. -If she was in the residents' hallway, she would her "put her eyes" on the resident which was less than the expectation of every 2 hours. -For any resident fall, the post fall 72-hour monitoring would be implemented by the staff. -The 72-hour monitoring involved checking the resident's blood pressure, pulse, respirations, orientation, and skin for bruising and skin tears. -The 72-hour monitoring would be completed by	D 270		

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D 270	Continued From page 19 the MA every 15 minutes for 4 times; every 30 minutes for 2 times; every hour for 2 times; for 24 hours; for 48 hours; and for 72 hours. Interview with the MA/supervisor on 09/29/21 at 11:15am revealed: -She was trained on the facility's falls policy by the previous Administrator. -She was not sure if the PCAs were trained on the facility's falls policy. -When a resident had a fall at the facility, the MA would evaluate the resident for injuries, check vitals, check their skin, check their orientation, and complete a pain assessment. -The resident's PCP, the Administrator, and the resident's power of attorney/responsible party was contacted about the I/A. -If a resident hit their head during a fall, the resident would automatically go to the ED. -Most residents from the special care unit were automatically sent to the ED because they could not verbalize if they hit their head during a fall. -The MA would complete the I/A report and the falls investigation summary immediately after the fall. -Only when a resident hit their head during a fall, the post fall 72-hour monitoring would be implemented by the staff. -The 72-hour monitoring involved checking the resident's blood pressure, pulse, respirations, orientation, and skin for bruising and skin tears. -The 72-hour monitoring would be completed by the MA and the PCA every 15 minutes for 4 times; every 30 minutes for 2 times; every hour for 2 times; for 24 hours; for 48 hours; and for 72 hours. -The MAs would ensure the completion of the 72-hour monitoring documentation. -The MA would discuss fall interventions with the resident's PCP after the fall.	D 270		

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Telephone interview with a medication aide on 09/29/21 at 11:56am revealed residents were supervised by the staff every two hours which meant staff would enter their rooms to check to see if they were okay and verify if the resident needed any type of assistance.

Second telephone interview with a medication aide (MA) on 09/29/21 at 3:00pm revealed staff were responsible to check on all residents every 2 hours which included completing incontinent care, making sure the call bells were in place, and assistive devices were accessible for the residents.

Interview with the Administrator on 09/29/21 at 12:30pm revealed:
-The MAs were responsible for completing the I/A reports and the falls investigation summaries.
-The MAs were responsible for completing the post fall 72-hour monitoring when a resident hit their head or there was an unwitnessed fall.
-This assessment should be completed at the intervals as requested by the PCP.
-Any change in condition required a phone call to the resident's PCP.
-Fall interventions to prevent further resident falls would be discussed during an internal meeting between the MA/supervisor and herself after every resident fall.
-She would also discuss resident fall interventions with the Corporate Management Liaison and the Corporate Quality Improvement Director.
-The MA/supervisor or herself would then call the resident's PCP to discuss fall interventions and obtain an order.

The facility failed to provide supervision to 2 of 3 sampled residents (#2, #3) based on their

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D 270	Continued From page 21 assessed needs resulting in Resident #2 sustaining multiple falls with injuries which required evaluation by emergency medical services and transport to the emergency department resulting in injuries including two scalp contusions, left head hematoma, and severe bruising to her entire left side of her face (Resident #2) and Resident #3 required evaluation by emergency medical services and emergency department for injuries including a fracture to her left elbow and skin tears to her right arm and bilateral lower extremities. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14. 2021.	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: Based on interviews and record reviews, the facility failed to notify the primary care physician (PCP) for 1 of 3 sampled residents (#3) related to a change in a resident's health status (#3). The findings are:	D 273		

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D 273	Continued From page 22 1. Review of Resident #3's FL-2 dated 01/12/21 revealed: -Diagnoses included displaced intertrochanteric fracture of left femur, unspecified fall, chronic obstructive pulmonary disease, atrial fibrillation, prosthetic heart valve, and a history of transient ischemic attack. -There was no documentation of orientation status, behavior status, and ambulatory status. -She required personal care assistance with bathing and dressing. Review of Resident #3's personal care physician authorization and care plan dated 06/24/20 revealed: -It was a significant change plan of care. -At times, she would forget she had received her morning medications and mealtimes. -She refused showers and her preference was sponge baths. -She was incontinent during the night. -She used a rollator and a walker. -She required extensive assistance with bathing, grooming, and personal hygiene. Observation of Resident #3 on 09/28/21 at 9:41am revealed: -There was brown stretchy medical tape to her right lower arm, right lower leg, and left lower leg. -There was a hard cast to her left lower arm. Interview with the medication aide/supervisor (MA/S) on 09/28/21 at 9:42am revealed: -Resident #3 had been hallucinating recently that there were spiders coming down from the ceiling in her room and there were children in the hallway of the facility. -During the hallucinations, she had been trying to get out of bed without calling for assistance. -The bandages to her right arm and both legs	D 273	Administrator re-trained staff on reporting change in conditions to physicians with all direct care staff. SIC will notify physician of change in condition for acute health care needs of residents immediately; any orders obtained will be implemented timely. RCC and/or designee will review new orders x 5 days per week to ensure each order is referred to and appropriate agency if indicated. Administrator/Designee will audit all orders once per week x4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed	10/1/2021 10/1/2021 & Ongoing 10/1/2021 & Ongoing 11/14/2021 & Ongoing

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D 273	Continued From page 23 were skin tears and she had a cast to her left arm due to a fracture. Review of Resident #3's progress notes and primary care provider correspondence revealed there was no documentation of primary care provider notifications related to Resident #3's hallucinations from 09/17/21 to 09/28/21. Interview with the MA/S on 09/29/21 at 11:15am revealed: -On 09/21/21, Resident #3 got out of her bed trying to get a baby in the hallway outside of her room. -Resident #3's PCP was notified of Resident #3's fall; and she was sent to the ED. -On 09/27/21, Resident #3 was found on the floor within her room and reported to her spiders were coming down from the ceiling. -Resident #3's PCP was notified of Resident #3's fall; and she was sent to the ED. Telephone interview with a MA on 09/29/21 at 3:00pm revealed: -It was the responsibility of the MAs to notify the resident's PCP immediately by phone, when the resident had any acute health status changes, for example, an increase in pain, hallucinations, required more assistance with transfers, or a change in their vital signs (an increase in the blood pressure reading). -Resident #3 got really confused especially with what the time of day it was. -She last worked on night shift (11:00pm-7:00am) on Sunday, 09/26/21; Resident #3 was so confused about what the time of day it was. -She thought it was the daytime when it was really night time. -She was aware Resident #3 was hallucinating of babies in her room and the hallways of the facility.	D 273		

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D 273	Continued From page 24 -A couple of weeks ago during night shift Resident #3 saw a baby within in her room, the MA could not recall the exact date. -She was always trying to get out of her bed without assistance and was mixed up on the appropriate time of the day. Second interview with the MA/S on 09/29/21 at 3:15 pm revealed: -It was the responsibility of the MAs to notify the resident's PCP immediately, when they observe any acute health status changes. -The MAs would notify the resident's PCP by phone first and if unable to reach the resident's PCP by phone, they would send a fax notification. -The MAs would also notify the Administrator and the Resident Care Coordinator. -It was important to notify the resident's PCP because there could be "something" going on with the resident, staff did not know about and the PCP could provide medical interventions. -She was not sure when Resident #3's hallucinations started; she thought they started on approximately, 09/17/21 when Resident #3 had a fall during 2nd shift (3:00pm-11:00pm). -She did not work 2nd shift on 09/17/21; she received the update related to her hallucinations from the 3rd shift MA (11:00pm-7:00am) when she came to work on 09/18/21 at 7:00am. -She thought the 2nd shift MA had notified Resident #3's PCP on 09/17/21 and that was why she had not notified her PCP. -She was not aware Resident #3's PCP had not been notified of her hallucinations. Interview with the Administrator on 09/29/21 at 3:22pm revealed: -It was the responsibility of the MAs to notify the resident's PCP immediately which meant same shift if there was a change in the resident's health	D 273		

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	HAL021008	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

(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 273	Continued From page 25 status. -There was a facility specific form to send via fax to the PCP if the PCP notification was in the middle of night shift or early in the morning. -She expected the MAs to call the resident's PCP when there was a change in the resident's health status was reported to them. -She had worked night shift on 09/20/21 and provided care for Resident #3. -She became aware of Resident #3's hallucinations during night shift on 09/20/21. -She did not notify Resident #3's PCP because it had slipped her mind during her shift. -She should have notified her PCP because it was an acute change for Resident #3. -It was important to notify Resident #3's PCP because there could have been something going on that staff were not aware for example a urinary tract infection. -She was not sure why Resident #3's PCP was not notified of her hallucinations on 09/17/21. Telephone interview with Resident #3's PCP on 09/29/21 at 2:30pm revealed: -There were no notifications from the facility related to Resident #3 having hallucinations of spiders within in her room and babies in the facility's hallways and that she was trying to get out of bed when having the hallucinations. -This was the "first" time he was hearing the update about the hallucinations and her getting out of bed when she was having the hallucinations. -Until today, 09/29/21, he had not received any phone calls, faxes, or emails to discuss Resident #3's new onset of hallucinations. -He expected to be notified immediately of any acute changes for Resident #3 related to her hallucinations the same day of their onset. -He expected to be notified by the facility to	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021008	A. BUILDING: _____ B. WING _____	09/29/2021

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D 273	Continued From page 26 address and provide the facility medical interventions, for example, a mental health referral.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, 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 in accordance with the residents' assessed needs and the facility's falls protocol for 2 of 3 sampled residents (#2, #3), who sustained multiple falls with injuries including Resident #2 who required treatment at the emergency room for 2 of 3 falls for head injuries and facial bruising (#2); and sustained multiple skin tears and a left elbow fracture (#3). [Refer to Tag D270, 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type B Violation)].	D912	Kathy Copehart RD 11/11/21	