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SPRING ARBOR OF WILSON	2045 WARD BOULEVARD, NW WILSON, NC 27893

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/16/22 and 03/17/22.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to 15 residents including disposable razors unsecured in residents' private bathrooms and a butcher knife and several hazardous chemicals unsecured in the kitchen. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 72 residents with a Special Care Unit (SCU) capacity of 16 residents. The facility's census in the SCU was 15 residents. Review of FL-2s for residents on the SCU revealed: -There was one resident with a diagnosis of dementia who was intermittently disoriented, ambulatory with a walker and wandered. -There was one resident with a diagnosis of	D 079		

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Alzheimer's disease who was ambulatory and wandered; there was no documentation of the resident's orientation status.
-There were five residents with a diagnosis of dementia that were constantly disoriented and ambulatory.
-There were two residents with a diagnosis of Alzheimer's disease who were constantly disoriented and ambulatory.
-There were three residents with a diagnosis of dementia who were intermittently disoriented and ambulatory.
-There was one resident with a diagnosis of Dementia who was intermittently disoriented and semi ambulatory.
-There was one resident with a diagnosis of Dementia who was intermittently disoriented, there was no documentation of the resident's ambulatory status.
-There was one resident with a diagnosis of Alzheimer's disease who was constantly disoriented and non-ambulatory.

Review of the facility's undated hazard communication program revealed:
-A list of all hazardous chemicals was available to all employees and located in the Administrator's office, the medication rooms, the kitchen and the housekeeping and laundry work areas.
-There was no hazard policy provided by the facility that addressed securing hazardous materials from residents in the SCU.

1. Review of a resident's current FL-2 dated 02/02/22 who resided in room 507 revealed a diagnosis of dementia, he was constantly disoriented and ambulatory.

Observation of resident room 507 on the SCU on 03/16/22 at 9:58am revealed:

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-There was a cabinet with two doors in the resident's bathroom that was not locked and did not have a locking device to secure the cabinet.
-There were three shelves in the cabinet.
-There was a disposable razor on the second shelf with a shield covering it.

Interview with a MA on the SCU in the dining room on 03/16/22 at 12:25pm revealed:
-The Resident that resided in room 507 spent a lot of time in his room, was ambulatory and confused.
-She was not aware there was a disposable razor in his bathroom cabinet that was not locked.
-The PCAs shaved Resident #4.

2. Review of Resident #4's current FL-2 dated 02/23/22 revealed:
-Diagnoses included Alzheimer's and multi-infarct dementia (a type of dementia caused by strokes).
-The resident was ambulatory and constantly disoriented.

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

Observation of the SCU kitchen on 03/16/22 at 9:45am revealed:
-There were two doors to the SCU kitchen; one accessible from the resident dining room and one accessible from the SCU hallway.
-The SCU kitchen doors were unlocked and not closed.
-Both SCU kitchen doors were not closed completely.
-There were no staff or residents present in the kitchen.
-There was an unlocked utensil drawer to the left of the stove with one 4 inch butcher knife; the

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utensil drawer was closed.
-There were 4 bottles of cleaning products on the counter to the left of the sink.
-There were 2 one-quart spray bottles of disinfectant with a warning label to keep out of reach of children and that the product caused eye irritation, if contact with eyes hold eye open and rinse slowly and gently with water for 15-20 minutes. If swallowed or inhaled call a poison control center or doctor for treatment advice, avoid contact with eyes or clothing.
-There was a one quart spray bottle of carpet cleaner deodorizer with a warning label to keep out of reach of children and that the product should be stored in a closed container in an area inaccessible to children. There was a warning to not get in eyes, on skin or on clothing. If in eyes rinse cautiously with water for several minutes and if swallowed contact a poison control center.
-There was a one quart spray bottle of odor eliminator with a warning label to keep out of reach of children, avoid contact with eyes. If in eyes wash thoroughly with water and contact physician if irritation or redness continues.
-There was a 32-ounce container of professional fabric refresher liquid.
-The bottle of cleaner had a warning label to keep away from heat, sparks, open flames and hot surfaces, if on skin remove all contaminated clothing immediately, rinse skin with water, avoid contact with eyes, rinse with plenty of water, if ingested drink 1 or 2 glasses of water and get medical attention immediately if symptoms occur.
-There was 32-ounce container of professional ready to use sanitizing fabric refresher with a warning label to avoid ingestion, avoid contact with eyes and skin.
-There was a one-gallon container of disinfecting floor and surface cleaner with a warning label that the product was fatal if inhaled and caused

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severe skin burns and eye damage. If in eyes rinse with water for several minutes, if on skin remove contaminated clothing, rinse with water, if inhaled move to fresh air and call poison center immediately, and if swallowed rinse mouth, drink 1 to 2 glasses of water and contact the poison center immediately.

Interview with a MA on the SCU in the dining room on 03/16/22 at 12:25pm revealed:
-There were several residents that wandered into other residents' rooms and around the SCU.
-Resident #4 would try to eat anything in front of her, had tried to eat a napkin earlier today and had to be redirected.
-She required constant supervision and had been observed wandering in the SCU kitchen several months ago without supervision.

Interview with the Resident Care Coordinator (RCC) on 03/16/22 at 4:50pm revealed:
-Hazards should be secured in the SCU.
-She thought the bathroom cabinets had magnetic locks and had not realized that the cabinets were not secure.
-SCU staff were expected to inform her if there were any hazards and it was her responsibility to notify the maintenance director of any repairs or modifications that were needed.
-She was not aware that both kitchen doors were cracked open.
-Both kitchen doors should have been locked and secured.

Interview with the facility's primary care physician (PCP) on 03/17/22 at 3:14pm revealed:
-She was not aware that there were unsecured hazards on the SCU in resident rooms and the kitchen.
-She expected all hazards to be secured to

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D 079	Continued From page 5 prevent residents from harming themselves. Interview with the Administrator on 03/17/22 at 4:20pm revealed: -All hazards should be secured in the SCU to ensure residents safety. -The PCAs, MAs and RCC were expected to ensure hazardous items were secure.	D 079		
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: Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 5 sampled residents (#4) in accordance with their current diagnoses and assessed needs, resulting in the resident having 10 unwitnessed falls in a 12 week time-frame in which she sustained an injury from the second fall with a knot and bruise on her forehead and was seen by the local emergency department. The findings are: Review of the facility's fall management and interventions policy dated June 2018 revealed: -The goal of the fall policy was to manage risks of falls by improving the facility's awareness and interventional response to each resident identified at risk for falls.	D 270		

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-A fall risk assessment would be conducted at admission, readmission and after every fall.
-Residents would be evaluated for physical/medical issues, environmental factors, cognitive and sensory changes, physical therapy (PT), and occupational therapy (OT); and this would include communication with the primary care physician (PCP), staff, resident and family.
-There was a program for community awareness of residents at higher fall risks which included a rose sticker/card placed under the resident's name plaque by their room entrance door.
-Resident specific interventions would be listed in the personal care service and activities of daily living log.
-Management and staff in charge (SIC) would provide reminders to staff of at-risk residents during daily meetings.
-The facility would hold weekly falls management meetings with PT, OT, personal care aides (PCAs), medication aides (MAs), Resident Care Coordinator (RCC) and Administrator to review each resident identified as at risk, the effectiveness of current interventions, any additional falls and recommended changes in interventions.
-Care plans and would be updated when there was a change in risk factors or interventions.
-A resident who had two falls within 30 days was immediately included in the fall prevention program and the resident would come off the program if they had not had a fall in 60 days.
-Staff on all shifts were expected to check on residents proactively and regular for any unmet need, ensure call pendant is readily available and required interventions are in place.
-Resident interventions would be reviewed during the weekly fall management meeting.
-When a resident fell staff were expected to not move the resident, ask the resident if they have

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pain, observe the resident for any bleeding and /or body limbs in an unusual position.
-If the resident complained of pain, was bleeding or unconscious staff were expected to call 911 and do not attempt to move the resident.
-If the resident had a suspected injury to their head, neck and/or face staff were expected to call 911 and do not attempt to move the resident.
-If the resident was bleeding, staff were expected to provide basic first aid.
-Staff were expected to check vital signs, remain with the resident until emergency medical services (EMS) arrived, provide reassurance, notify the resident's physician and family or responsible party as soon as possible, and complete and incident and accident report and document the event in the residents medical record.
-The facility used a "Hot Box" system to ensure additional attention was given to residents who had a fall.
-When a resident was placed in the "Hot Box" system, the resident's chart was placed in a designated area to alert PCAs and MAs on each shift that the resident required additional attention and documentation.
-When a resident fell staff were expected provide documentation in the resident's chart for 3 days or long if directed.

Review of Resident #4's current FL-2 dated 02/23/22 revealed:
-Diagnoses included Alzheimer's and dementia.
-The resident was ambulatory and constantly disoriented.

Review of Resident #4's current care plan dated 03/16/22 revealed:
-The resident required extensive assistance with ambulation, transferring, bathing, and toileting

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daily.
-The resident had very limited vision.
-She was sometimes disoriented, had significant loss of her memory and had to be directed.
-The Licensed Health Professional Services (LHPS) tasks on her care plan for action plan and approach listed ambulation with two person assist and wheelchair as needed for weakness and instability.

Review of the LHPS dated 03/04/22 revealed:
-The resident required a wheelchair and two person assist.
-The resident had falls on 01/02/22, 01/16/22, 01/19/22, 02/03/22, 02/18/22 and 03/01/22.

Observation of the Special Care Unit (SCU) dining room on 03/16/22 at 12:11pm revealed:
-There were three residents sitting at a table.
-A MA was standing by Resident #4.
-The MA had to redirect Resident #4 five times because she attempted to try to stand up.
-Resident #4 was then observed grabbing the oxygen tubing that was resting on another residents' chest.

Review of an Incident and Accident Report dated 12/18/21 revealed:
-There was no time documented on the Incident and Accident Report.
-Resident #4 was found by a person care aide (PCA) in her room with a small knot and bruising on her forehead.
-A MA contacted emergency medical services (EMS) and the resident was transported to the emergency department for further evaluation.
-The resident returned to the facility on 12/18/21 at 11:00am, there were no new orders and the PCP was scheduled to follow up on 12/22/21.

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D 270	Continued From page 9 Review of Resident #4's progress notes revealed staff provided 15 to 30 minute checks on Resident #4 on 12/20/21 and 12/21/21. Review of a physician ordered dated 12/22/21 revealed Resident #4 was referred to physical therapy (PT) and occupational therapy (OT) to evaluate and treat. Interview with a MA on the SCU on 03/16/22 at 12:25pm revealed: -There were several residents that wandered into other residents' rooms and around the SCU. -Resident #4 would try to eat anything in front of her and required constant supervision. -Staff made rounds to check on residents every one to two hours; if a resident had a fall, they made checks on that resident every 30 minutes for three days. -Resident #4 had tried to eat a napkin earlier today and had to be redirected. -She required two person assist when she walked to ensure she did not fall. -She had been found on the floor of her bedroom several times in the past few months. Review of Resident #4's fall risk assessment dated 01/19/22 revealed: -The RCC completed the fall risk assessment, which was an initial assessment. -She scored 20 out of 39 points. -A score of 16-39 points indicated a resident was identified at a higher risk of falls. -The score was based on parameters and the resident's status; with a score for each parameter from zero to four. -Resident #4's mental status was scored at a 4; mental status was disoriented and frequently confused. -She had a score of 4 on history of falls; which	D 270		

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indicated that in the past 90 days she had 1-2 falls.
-She scored a 4 on the vision parameter; severely impaired/legally blind.
-She scored a one on the mobility parameter; ambulated without problem, using assistive device with one person assist.
-She scored a 4 on the diagnosis parameter; mid to late stage Alzheimer's disease/other dementia.
-She scored 2 on the medication parameter indicating she took 4-6 medications a day.
-There were no other fall risk assessments for Resident #4 except for the initial assessment date 01/19/22.

Review of Resident #4's Fall Risk Awareness and Interventions Notice revealed:
-On 12/09/21 the resident was placed in the fall program since she was a new admission.
-On 12/18/21 the resident was found sitting on her bed, appeared to have bruising on her head and required routine checks while in room resting.
-On 01/16/22 the resident was found sitting on the floor, staff to supervise resident to aide in prevention of walking unassisted, keep area free of clutter and ensure shoes are properly fitted.
-On 01/19/22 the resident was found sitting on the floor in front of a chair, interventions included to leave her bedroom door open while she was resting and continue to do routine checks.
-On 02/02/22 the resident was observed scooting across the floor.
-On 02/03/22 the resident was observed sitting on the floor; continue to supervise.
-On 02/08/22 the resident lost her balance and landed on her buttocks, aid when resident walked and continue to monitor when she was sitting.
-On 02/18/22 the resident was observed lying on the floor; continue to provide routine checks and keep room door open, if resident attempts to get

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up aid, take resident to an activity or provide a snack.
-On 02/23/22 the resident was observed sitting on the floor.
-On 03/01/22 the resident was observed lying on the floor on her back; do not leave resident unattended.
-On 03/13/22 the resident was observed sitting on the floor.

Review of Resident #4's primary care physician (PCP) note dated 02/23/22 revealed:
-The resident was seen at the request of facility staff due to difficulty with walking.
-She had an unwitnessed fall on 02/18/22 with increased difficulty walking and increased weakness.
-The resident would not benefit from physical therapy (PT) due to her severe memory loss.
-Staff were needing to borrow a wheelchair from time to time to ensure the residents safety.
-Her recommendations listed included resident being placed on fall preventions and ordering a wheelchair for the resident to decrease falls.

Review of Resident #4's PCP note dated 03/03/22 revealed:
-Staff had reported that the resident had numerous falls.
-She observed the resident sitting in a wheelchair during her visit.
-The residents muscle strength was decreased.

Interview with the RCC on 03/17/22 at 10:50am revealed:
-When a resident had a fall or significant change, they were placed in the hot box system.
-Staff were required to document on residents in the hot box system every shift for three days in the facility progress notes.

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D 270	Continued From page 12 -When a resident had a fall, staff were expected to check on the resident every 15 to 30 minutes for three days. Interview with the facility's PCP on 03/17/22 at 3:14pm revealed: -The resident's dementia had progressed and she had become very impulsive. -She had become more unstable with walking and her gait was staggered. -She ordered a wheelchair for the resident to decrease her fall risks adn to protect staff from injuries. She was concerned that the resident could have more falls if she was not provided the appropriate supervision. Interview with the Administrator on 03/17/22 at 4:20pm revealed: -The PCAs, MAs and the RCC were expected to ensure Resident #4's safety and provide proper supervision to prevent falls. -Staff were expected to follow the fall prevention program and to increase monitoring of Resident #4 every 15 to 30 minutes to ensure her safety. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	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 observations, interviews, and record	D 273		

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reviews the facility failed to ensure the acute health care needs were met for 1 of 5 sampled residents (#4) who had a physician's order for a wheelchair, had multiple falls and had not received a wheelchair.

The findings are:

Review of Resident #4's current FL-2 dated 02/23/22 revealed:
-Diagnoses included Alzheimer's and dementia.
-The resident was ambulatory and constantly disoriented.

Review of Resident #4's current care plan dated 03/16/22 revealed:
-The resident required extensive assistance with ambulation, transferring, bathing, and toileting daily.
-The resident had very limited vision.
-She was sometimes disoriented, had significant loss of her memory and had to be directed.
-The Licensed Health Professional Services (LHPS) tasks on her care plan for action plan and approach listed ambulation with two person assist and wheelchair as needed for weakness and instability.

Review of Resident #4's physician's order dated and signed by the primary care physician (PCP) on 02/23/22 revealed the PCP would send an order to her office to fax to the durable medical equipment (DME) company for a wheelchair due to the resident's need for assistance with difficulty in walking.

Review of a facsimile from the facility dated 03/01/22 revealed:
-The facility faxed a new order dated 03/01/22, insurance information and a demographic sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098006	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF WILSON	2045 WARD BOULEVARD, NW WILSON, NC 27893

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for Resident #4 to the DME company.
-The facility also faxed a copy of the original order from the PCP dated 02/23/22 to the DME company.

Review of a facsimile from the DME company dated 03/08/22 revealed the DME company requested documentation of Resident #4's needs for a wheelchair, her height and weight, and the attached the DME form signed by the PCP.

Review of a facsimile from the facility to the DME company dated 03/09/22 revealed the PCP completed a detailed order which included the Resident #4's height, weight, diagnostic code and length of need.

Review of a facsimile from the DME company dated 03/10/22 revealed:
-The DME received the PCP's order for Resident #4's wheelchair but the signature on the order did not meet the requirements of an electronic signature.
-The DME company also requested notes that rule out the use of a cane or walker for the resident to complete the order process.

Observation of Resident #4 on 03/16/22 at 4:43pm revealed:
-She was resting in her bed when a personal care aide (PCA) came in to see if she was ready for supper.
-There was not a wheelchair in her room.
-There were two wheelchair leg attachments at the end of her bed.

Interview with a PCA on 03/16/22 at 4:44pm revealed:
-She did not know if Resident #4 had a wheelchair or not.

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D 273	Continued From page 15 -The wheelchair leg rests belonged to another resident and needed to be in another room. -She had not seen Resident #4 in a wheelchair. Interview with the Resident Care Coordinator (RCC) for the SCU on 03/16/22 at 4:50pm revealed: -Resident #4's primary care physician (PCP) had ordered her a wheelchair on 02/23/22. -There was confusion with the durable medical equipment DME company sending faxed requests to the PCP's previous practice. -She faxed the wheelchair order a second time on 03/01/22 with additional information the DME company had requested. -She spoke with the PCP earlier today and the order for the wheelchair had been corrected. -The wheelchair had been ordered for the resident's instability when walking and as a fall precaution. -Staff were expected to provide the resident with two person assist when she was walking to prevent falls. -It was her responsibility to follow up with the durable medical equipment company and the PCP to prevent the delay in the resident receiving her wheelchair. Interview with the Resident Care Coordinator (RCC) for the Special Care Unit (SCU) on 03/16/22 at 4:43pm revealed: -The PCP was at the facility today and corrected the order for the wheelchair which was faxed to the DME company. -The wheelchair should be delivered to the facility by 03/18/22. -She should have contacted the DME company sooner to help coordinate any additional information needed to ensure Resident #4 received her wheelchair sooner.	D 273		

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D 273	Continued From page 16 Interview with the Resident #4's PCP on 03/17/22 at 3:14pm revealed: -She had become more unstable with walking and her gait was staggered. -The resident required two staff to assist her with walking and her knees would buckle at times. -She ordered a wheelchair for the resident to decrease her fall risks and to protect staff from injuries on 02/23/22 and again on 03/01/22. -She expected the facility to use a spare wheelchair until the resident's wheelchair was delivered by the DME company. -She was not aware that the facility had not provided the resident with a spare wheelchair. Interview with the Administrator on 03/17/22 at 4:20pm revealed: -She knew that there had been several attempts from the DME company to receive correct information required to complete the wheelchair order for the resident. -She expected Resident #4 to receive her wheelchair earlier due to her weakness and instability. -It was important for the resident to receive her wheelchair as soon as possible to prevent falls. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 273		