STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092141	A. BUILDING: _____ B. WING _____	R 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT MEMORY CARE COMMUNITY	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 and follow-up survey and complaint investigation on March 23, 2022 through March 24, 2022.	D 000	All items unsecured found during survey were immediately secured. Residents will have a locking box, cabinet, or closet in their apartments where personal products will be kept. Locks on the box, cabinet or closet will be locked, and staff or visitors will assist residents with accessing these items for personal care or by resident request. For those residents that request their personal products, staff will assist in unlocking and providing supplies to the resident, allow time for grooming and then re-secure those items in the locked area. Safe Haven Personal Products Letter will be distributed to the resident's primary contact and upon move in. All staff will be in serviced on community policy of securing potentially hazardous items in a Special care unit.	4/29/22
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 facility was free of obstructions and hazards as evidenced by personal care hygiene products being stored unlocked in 6 residents' rooms (C2, C5, C8, D2, D4, D7) and 4 oxygen canisters being stored in an unsecured manner on the floor in a resident room resulting in hazardous substances, objects, and oxygen canisters being unattended and accessible to the 28 residents residing in the special care unit (SCU). The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 38 special care unit (SCU) beds. Review of the facility's census report dated 03/23/22 revealed there were 28 residents currently in-house residing in the SCU.	D 079		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Agnes, Adm. | TITLE | (X6) DATE: 04/29/2022

Reviewed and Acknowledged
05/11/22 AV

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D 079	Continued From page 1 1. Review of the Memory Care Management Rounds Checklist dated 12/12/17 revealed: -At the top of the round's checklist, there were blank spaces for the name of the community, the date of the review, and reviewed by. -The following areas were listed for rounds the dining area, the common area, visual environment, sounds, the outdoor area, safety/security, and the resident rooms. -There were columns to indicate yes or no, proposed action, and dated completed. -For the resident rooms section, the management team member would verify when rounding the rooms were clean, well lit, and free of trip hazards, electrical cords, and carpet stains. -The additional areas the management team member would verify in residents' rooms were the lighting, the bathroom door was a contrasting color and/or clearly labeled, the room smelled good, chemicals were secured, and the resident's room was homelike and personalized. -The findings would be reviewed at morning stand up, and with the team so they became familiar with the standards. -There was a recommendation to go through the checklist on different shifts with the care team, so they are a part of maintaining the program in the community. Review of the facility's Environment Policy dated 09/02/21 revealed all potentially hazards items shall be kept in secure locations. Review of the facility's Personal Products Policy dated 09/02/21 revealed: -Residents would have a locking box, cabinet, or closet in their apartments where personal items would be kept. -Locks on the box, cabinet, or closet would be	D 079	The Memory Care Director or designee along with one additional manager or care staff member will evaluate the Memory Care neighborhood's compliance three times weekly utilizing the Management Rounds Checklist Once compliance is established rounds will be done weekly. Compliance rounds will be discussed in daily stand up meetings and quarterly quality assurance meetings. The evaluation will be done by the Memory Care Director or designee and one additional manager or care staff member physically walking the Memory Care areas to visually assess current compliance. The Management Rounds Checklist will be kept in the Memory Care Director's office in a binder organized by month.	

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D 079	Continued From page 2 locked, and staff or visitors would assist residents with accessing these items for personal care or by resident request. -For those residents that requested their personal products, staff would assist in unlocking and providing supplies to the resident and allow time for grooming and then re-secure those items in the locked area. -No chemicals, soaps, or cleaning supplies would be kept anywhere in the SCU. Review of the facility's Personal Products Letter Form dated 09/02/21 revealed: -At the beginning of the letter the community's address and the community name would be included. -The letter was addressed to the families and friends of the community. -The body of the letter included a small change in the process of securing all resident personal products including shampoos, mouthwash, lotions, razors, and other potentially harmful items in the SCU. -The National Poison Control Center told the community that many of the most common personal products can cause harm if improperly used or ingested. -Because of the potential hazards, the facility had reviewed their procedures and decided it was best to take this extra step to further ensure the safety and security of the residents. -The resident's personal care products would be maintained securely, and the residents would be assisted to access them at their request, or during their daily personal care routine. a. Observation of resident room D4 on 03/23/22 at 10:00am revealed: -The door to the resident's room was open and accessible to residents in the SCU.	D 079		

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D 079	Continued From page 3 -There were two 14-oz. cans of aerosol hair spray, two 8-oz. pump bottles of foaming hand soap, two 17-oz. bottles of body wash approximately 50% full, a 12-oz. bottle of shampoo, a 16.8-oz. bottle of body lotion, a 10-oz. bottle of shower gel with no top in place approximately 25% full, an 8-oz. tube of body cream with no top in place, an 8-oz. bottle of body mist with no top in place, an 8-oz. bottle of nourishing hair conditioner, a 4.6-oz. tube of toothpaste, an 8.2-oz. tube of toothpaste with no top in place approximately 50% full, a 3.4-oz. stick of women's deodorant, a 2-oz bottle of skin protectant, four 3-oz. bars of soap, a 2.6-oz. compact of perfumed dusting powder, a .44-oz. compact of pressed powder, and a 10-count of make-up remover cleansing towelettes on both sides of the resident's sink within her bathroom. Based on observations and interviews, it was determined the resident residing in resident room D4 was not interviewable. Observation of resident room D7 on 03/23/22 at 10:05am revealed: -The door to the resident's room was open and accessible to residents in the SCU. -There was a 12.8-oz. bottle of shampoo and conditioner on the resident's sink within the bathroom. -The shampoo and conditioner warning label indicated for external use only, if swallowed, get medical help or contact a Poison Control right away. -There was a 3-oz. bar of soap, an air freshener dispenser with an empty air freshener refill, 1 clear wine glass, and 1 electric razor with a cord. Based on observations and interviews, it was determined the resident residing in resident room	D 079		

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D 079	Continued From page 4 D7 was not interviewable. Observation of resident room D2 on 03/23/22 at 10:07am revealed: -The door to the resident's room was open and accessible to residents in the SCU. -On the resident's sink, there was a 3-ounce (oz.) bar of soap, an 18-oz. bottle of moisturizing skin relief lotion, and a 11-oz can of hairspray. -The hairspray label indicated danger: flammable, avoid heat, fire, flame, and smoking while spraying and until hair was fully dry, avoid spraying in eyes do not ingest inhaling contents could be harmful or fatal. Observation of hallway A on 03/24/22 from 8:30am-8:40am revealed a resident opened a door multiple times to an empty resident room. Based on observations and interviews, it was determined the resident residing in resident room D2 was not interviewable. b. Observation of resident room C2 on the C hall in the SCU on 03/23/22 at 10:09am revealed: -The door to the room was open and the resident was lying in his bed. -There were no staff in the resident's room or in the hall in view of the room. -There was an 8.8-ounce (oz.) spray can of heavy duty air freshener on the countertop beside the sink in the bathroom. -There were personal care products on the countertop beside the sink in the bathroom including: one 5-oz. can of shaving cream; three 3.4-oz. containers of antiperspirant/deodorant gel; one 5.7-oz. tube of toothpaste; one opened bar of soap; and an electric razor. -Warnings for the spray can of air freshener included: keep out of reach of children and pets;	D 079		

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D 079	Continued From page 5 do not spray toward the face; if eye contact occurs, rinse well with water. -Warnings for the shaving cream included: keep out of reach of children; contents under pressure; do not puncture or incinerate; do not heat. -Warnings for the deodorant/antiperspirant gel included: for external use only; do not use on broken skin; keep out of reach of children; if swallowed get medical help or contact a poison control center (PCC) right away. -Warnings for the toothpaste included: keep out of reach of children under 6 years of age; if more than used for brushing is accidentally swallowed get medical help or contact a PCC right away. -Warnings for the bar of soap included: for external use only; avoid contact with eyes; in case of eye contact flush with water; keep out of reach of children; if swallowed, get medical help or contact a PCC right away. Interview with the resident residing in room C2 on 03/23/22 at 10:09am revealed: -He used the personal care products in his bathroom. -He was not sure how long the personal care products had been in his bathroom. Observation of resident room C8 on the C hall in the SCU on 03/23/22 at 10:09am revealed: -The door to the room was open and the resident was lying in his bed. -There were no staff in the resident's room or in the hall in view of the room. -There were personal care products on the countertop beside the sink in the bathroom including: one 16-oz. bottle of body wash; one 2.7-oz. container of antiperspirant/deodorant; one 8.5-oz. bottle and one 1-liter bottle of antiseptic mouthwash; one 2.5-oz. bottle of body gel; and two 1.5-oz. tubes of toothpaste.	D 079		

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D 079	Continued From page 6 -There was a disposable razor on the countertop beside the sink and an electric razor on an open shelf in the corner of the bathroom. -Warnings for the body wash and body gel included: for external use only: avoid contact with eyes; irritating to the eyes. -Warnings for the antiperspirant/deodorant included: for external use only; do not use on broken skin; keep out of reach of children; if swallowed get medical help or contact a poison control center (PCC) right away. -Warnings for the mouthwashes included: keep out of reach of children under 12 years of age; if more than used for rinsing is accidentally swallowed get medical help or contact a PCC right away. -Warnings for the toothpaste included: keep out of reach of children under 6 years of age; if more than used for brushing is accidentally swallowed get medical help or contact a PCC right away. Based on observations and interviews, it was determined the resident residing in room C8 was not interviewable. Observation of resident room C5 on the C hall in the SCU on 03/23/22 at 10:09am revealed: -The door to the room was open and accessible to residents in the SCU. -There were no staff in the resident's room. -There was one 12.6-oz. bottle of shampoo on the countertop beside the sink in the bathroom. -Warnings for the shampoo included: for external use only; avoid contact with eyes; irritating to eyes. Based on observations and interviews, it was determined the resident residing in room C5 was not interviewable.	D 079		

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D 079	Continued From page 7 Interview with the Administrator on 03/23/22 at 12:22pm revealed: -There should be no personal care products left unlocked and unattended by staff in residents' rooms. -She would check the residents' rooms and remove any personal care items and have them locked in the spa room. Second observation of resident room C2 on the C hall in the SCU on 03/23/22 at 4:17pm revealed: -The door to the room was open and accessible to residents in the SCU. -There was still one opened bar of soap on the countertop beside the sink in the bathroom. Second observation of resident room C8 on the C hall in the SCU on 03/23/22 at 4:04pm revealed: -The door to the room was open and the resident was lying in his bed. -There were no staff in the resident's room or in the hall in view of the room. -There were still two 1.5-oz. tubes of toothpaste on the countertop beside the sink in the bathroom. -There was still an electric razor on an open shelf in the corner of the bathroom. -The 2.5-oz. bottle of body gel was on top of the bedside table beside the resident's bed. Second interview with the Administrator on 03/23/22 at 4:45pm revealed: -She and some other staff had removed personal care products in residents' rooms that morning on 03/23/22 when it was brought to her attention by surveyors. -She had removed personal care products from the rooms on the C hall and she must have overlooked the items that were still in resident rooms C2 and C8.	D 079		

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D 079	Continued From page 8 Interview with the Administrator on 03/23/22 at 12:22pm revealed: -A staff member, one of the department heads which included the Administrator or the Memory Care Director, completed "ingestible" rounds on a weekly basis along with the Memory Care Management Rounds Checklist. -The weekly rounds included each resident's room to be completed by one of the department heads to make sure resident personal hygiene products were put away. -She completed the last weekly round on Monday, 03/21/22. -Resident's personal care products were to be maintained securely in a portable containers with a lock in the locked facility's spa room. -Staff were responsible to assist residents with access to their personal care items at their request, or during their daily personal care routine. -It was a "rule" for resident's personal care products to be put away to prevent access from other residents. -The facility had residents that wandered in and out of residents' rooms. -All personal care products should be locked; this was a Memory Care Unit. 2. Observation of resident room B6 on 03/23/22 at 10:01am revealed: -There were two small and two large oxygen canisters on the floor in the room unsecured by the resident's closet approximately 10 feet inside the room. -The large canisters had gauges that indicated they were halfway full. The small canisters had no gauges affixed to them. Interview with the medication aide (MA) on	D 079	The oxygen therapy company is responsible for equipment set-up and on-going service in the resident's apartment. All oxygen tanks are to be kept in secure tank holders at all time. The memory care director or designee will be responsible for compliance by working with all oxygen therapy companies upon delivery of oxygen and observation management rounds.	4/29/22

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D 079	Continued From page 9 03/23/22 at 10:49am revealed: -There were four oxygen tanks on the floor unsecured. -He did not realize the tanks needed to be in a rack or stand. -MAs were responsible for administering oxygen. -He had been trained on oxygen administration but could not recall being trained on oxygen storage. -The oxygen tanks in B6 had been in the room for a long time and were not recently delivered. -The resident who resided in room B6 was disoriented and ambulatory. Interview with a personal care aide (PCA) on 03/23/22 at 10:52am revealed: -PCAs were not responsible for storage of oxygen tanks. -MAs were responsible for oxygen usage and storage. Interview with the Memory Care Director (MCD) on 03/23/22 at 10:54am revealed: -The four tanks were not secured. -The oxygen tanks needed to be in racks. Interview with the Administrator on 03/23/22 at 12:23pm revealed: -Oxygen canisters should be stored in racks. -Management should have seen the tanks needed racks or stands during management rounds done weekly. Telephone interview with a customer service representative at the oxygen supply company on 03/24/22 at 3:14pm revealed: -Oxygen tanks should be secured and put in a rack. -They deliver racks to facilities when they deliver oxygen canisters.	D 079	Unsecured oxygen tanks were immediately secured. Staff will be in-serviced for oxygen storage. The Memory Care Director or designee along with one additional manager or care staff member will evaluate the Memory Care neighborhood's compliance three times weekly utilizing the Management Rounds Checklist Once compliance is established rounds will be done weekly. Compliance rounds will be discussed in daily stand up meetings and quarterly quality assurance meetings. The evaluation will be done by the Memory Care Director or designee and one additional manager or care staff member physically walking the Memory Care areas to visually assess current compliance. The Management Rounds Checklist will be kept in the Memory Care Director's office in a binder organized by month.	4/29/22

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D 079	Continued From page 10 -They had last delivered oxygen for the resident in room B 6 on 01/31/22 and delivered a rack at that time.	D 079		
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 ensure referral and follow up following an appointment with an outside provider for 1 of 3 sampled residents (Resident #2) related to medication changes. The findings are: Review of Resident #2's current FL-2 dated 12/16/21 revealed: -Diagnoses included Parkinson's disease and dementia. -She was semi-ambulatory and intermittently disoriented. Review of Resident #2's primary care provider (PCP) progress note dated 12/16/21 revealed: -Resident #2 had been having shoulder pain. -The resident needed to see her neurologist. Review of Resident #2's record revealed no documentation that the resident had seen the Neurologist. Review of Resident #2's neurology progress note dated 02/17/22 revealed: -The front page was a fax cover sheet dated 03/24/22 after the surveyor's request.	D 273	All physician visits shall be documented in the resident's chart, including telehealth appointments. A telehealth tracking order form will be kept by the memory care director or designee daily in order to assure that all documentation including new orders are received in a timely manner. This tracking form will be maintained in the Memory care directors office.	4/29/22

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D 273	Continued From page 11 -The resident had a video visit with the Neurologist on 02/17/22 with her family member present. -The neurologist had increased Resident #2's Sinemet from 1 tablet to 1.5 tablets five times a day (used to treat tremors). Review of Resident #2's February and March 2022 medication administration records (MAR) revealed no documentation of an increase in Sinemet. Interview with the medication aide (MA) on 03/24/22 at 11:07am revealed: -The Memory Care Director (MCD) was responsible for obtaining and implementing any changes made when a resident went to a specialist appointment. -He was aware of Resident #2 having an appointment with the Neurologist but did not know of a medication change. Interview with Resident #2's family member on 03/24/22 at 11:43am revealed: -The family member had arranged for the video appointment. -She scheduled and facilitated the resident's appointments and the neurology appointment was the first date available for the call. -The Neurologist recommended the medication change due to the resident complaining of feeling weak and having a stiff walking style. -She had spoken with the MA and the MCD about the visit and had mentioned the Neurologist had adjusted her medications. Interview with the MCD on 03/24/22 at 3:04pm revealed: -She was aware of the neurology visit done by video call on the day of the appointment.	D 273		

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FALLS RIVER COURT MEMORY CARE COMMUNITY	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 12 -Resident #2's family member facilitated the video call with the neurologist and the MCD was not present. -She was unaware of the medication change order. -She would normally obtain progress notes when a resident goes to see an outside provider to ensure any changes were addressed. -She did not obtain the progress note because she had spoken with the family member and was under the impression there were no changes. -She had requested the progress note from the neurology visit that day after requested by the surveyor and it had not been requested prior. Interview with the Administrator on 03/24/22 at 3:08pm revealed the MCD was responsible to a resident visited an outside provider. Interview with the neurology practice Registered Nurse on 03/24/22 at 11:23 am revealed: -Resident #2 saw the Neurologist on 02/17/22. -There was a medication change ordered on that date. -The prescription was never sent to the facility. -There was no record the facility called to obtain the prescription for the change in medication.	D 273		