Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054006	A. BUILDING: _____ B. WING _____	R 03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 03/23/22 to 03/25/22.	D 000	See Attached	
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 A2 VIOLATION Based on interviews and record review the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#4) who sustained 7 unwitnessed falls from January 2022 to March 2022. The findings are: Review of the facility's Safety Check Guidelines dated September 2020 revealed: -Safety checks may be implemented by the Administrator or Resident Care Director (RCC) for a resident who sustains a fall plan for resident safety can be developed and implemented. -In their absence, safety checks will be implemented by the medication aide/supervisor (MA/S) and notification given to the Administrator and/or RCC. -Thirty minute or hourly visual safety checks may be implemented and will remain in place for 24 to 48 hours and/or until the resident is assessed by	D 270		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beverly H. Jones — TITLE: Administrator — (X6) DATE: 05/19/2022

Reviewed and Acknowledged
VC 06/01/2022

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the Administrator or RCC.
-The resident record will be documented on by the MA/S each shift.
-Safety checks may end at the discretion of the Administrator and/or RCC if there are no additional concerns after the resident assessment is completed.
-Staff are to visually check on the resident to ensure the resident is physically safe and comfortable; that any preestablished interventions are in place; the resident does not have an unmet need; and that the resident does not pose harm to themselves.
-A daily log for the resident will be initialed each time a safety check is complete and have a corresponding signature.

Review of the facility's Falls Management and Interventions policy dated September 2020 revealed:
-A fall risk assessment was to be performed on admission, readmission, after every fall, and/or at a minimum of quarterly or with a change in condition.
-A rose card was to be placed under the resident's room number plaque for residents who were high risk for falls.
-Resident specific interventions were to be added to the resident's personal care service (PCS) and activities of daily living (ADL) logs.
-During weekly Falls Management meetings, resident's at risk for falls were to be reviewed for effectiveness of current interventions, additional falls, and recommended change in intervention.
-An updated care plan with change in risk factors and/or interventions was to be documented.
-Updated PCS/ADL logs with change in risk factors and/or interventions was to be documented.

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D 270	Continued From page 2 Review of Resident #4's current FL-2 dated 01/03/22 revealed: -Diagnoses included stage 3 chronic kidney disease, failure to thrive, debility, deconditioning, and dementia. -The resident was constantly disoriented, semi-ambulatory with maximum staff assistance, hard of hearing, and had diminished sight. Review of Resident #4's current care plan dated 12/22/21 revealed: -The resident was forgetful and needed reminders. -The resident was independent with ambulation, toileting, and transfers. -The resident required limited staff assistance with bathing, grooming, and dressing. -There were no falls interventions documented. Review of Resident #4's Licensed Professional Health Support (LHPS) evaluation dated 02/10/22 revealed: -The resident did not require a device for mobility. -The resident complained of a fall on 01/23/22. Observation of Resident #4's room on 03/23/22 at 9:00am revealed: -There was a wheelchair located at the middle of the right side of the bed. -There was a rollator walker located on the right side towards the foot of the bed. -The resident was alert, lying in bed and had an abrasion on the top right side of his head. -There was no rose card under or on the resident's room number plaque. Review of Resident #4's local hospital emergency department (ED) visit note dated 03/24/22 revealed: -The resident was found by facility staff out of his	D 270		

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D 270	Continued From page 3 wheelchair, on the floor in blood, with head trauma and right shoulder pain. -The resident was unable to provide details of the injury because of a diagnosis of dementia. -The resident had significant left frontal and temporal abrasions with controlled bleeding. -The resident's neck had midline tenderness on the bone. -The resident's right shoulder had decreased range of motion and diffuse tenderness. -The resident was diagnosed with a fall, closed head injury, and an acute traumatic fall with cervical (C) spine fractures. -The resident had fractures of C-6 vertebral body fracture extending into the C-6 lamina and minimally displaced fracture of C-7 lateral mass. -The resident's condition was guarded. -The resident required trauma transfer level to a neurosurgeon at a higher-level facility for treatment. Review of Resident #4's local hospital's CT Scan report dated 03/24/22 revealed diagnoses included an acute oblique cervical 6 vertebral body fracture with displacement up to 3 to 4mm, left C6 laminar fracture, and a minimally displaced fracture of the left Cervical 7 lateral mass (fractures of the sixth and seventh neck bones). Review of Resident #4's incident and accident (I/A) report dated 03/23/22 revealed: -At 9:16pm, the resident was found on his bedroom floor by his bed. -Staff assisted the resident from the floor. -There were no injuries documented. -The report was signed by the RCC on 03/24/22. -There was no documentation of fall interventions put in place for the resident.	D 270		

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D 270	Continued From page 4 Review of Resident #4's progress note dated 03/23/22 at 9:42pm revealed: -Around 9:15pm, staff observed the resident on his bedroom floor. -The resident did not have injuries. -The resident reported he fell while trying to go to the bathroom. -Staff assisted the resident off the floor, to the wheelchair, and to the bathroom. -There was no documentation of fall interventions put in place for the resident. Interview with the MA on 03/24/22 at 3:30pm revealed: -On 03/23/22 during second shift, the PCA found Resident #4 on the floor beside his bed by. -She and the PCA assisted Resident #4 from the floor, placed him in the wheelchair, took him to the bathroom, then assisted the resident back to bed. -She moved Resident #4's wheelchair out of the way after placing the resident back to bed. -Resident #4 was not on increased supervision checks. -Resident #4 did not have fall interventions in place. -She was never told Resident #4 required increased staff supervision or fall interventions. -Resident #4 was supervised every two hours as a standard of care. Interview with a PCA on 03/24/22 at 4:15pm revealed: -At one time she thought a MA told her Resident #4 was on every 1-hour supervision checks. -She did not remember the date. -Resident #4 would fall when he got up to use the bathroom without calling for help. - On 03/23/22, during second shift, she found Resident #4 laying on the floor with his head	D 270		

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D 270	Continued From page 5 towards the foot of the bed trying to get up. -She left Resident #4 to get help and returned with the MA. -She and the MA picked up Resident #4 from the floor, gave him the walker, walked with him to the bathroom, then assisted the resident back to bed. -She turned on Resident #4's bathroom light, cracked the bathroom door, folded his wheelchair up, and placed his walker at his bedside because she knew he would get up on his own to go to the bathroom. -She did not know if she was ever told of specific fall interventions for Resident #4. -She checked on Resident #4 every 2 hours to see where he was and what he was doing. -The supervisory checks were not documented. -She knew Resident #4 tried to get up from the bed independently without calling for help and without using his walker. -She tried to check on Resident #4 more than every two hours when she was performing tasks on the 100 hall because he had a history of falling. Review of Resident #4's undated I/A report revealed: -Resident #4 sustained an unwitnessed fall. -The time was not documented. -The resident was found by staff on the floor in his bedroom. -There was no documentation of wounds or injuries. -Emergency Medical Services (EMS) was called and the resident was sent to the hospital. -The report was signed by the medication aide/supervisor (MA/S) on 03/24/22 at 5:00am. Review of Resident #4's progress note dated 03/24/22 at 6:00am revealed staff discovered the resident on the floor with blood on his face.	D 270		

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D 270	Continued From page 6 -The RCC was contacted and hospice was called. -The resident was evaluated by the hospice nurse. -The resident was transferred to the hospital. Telephone interview with a third MA on 03/25/22 at 11:15am revealed: -She worked third shift on 03/23/22. -The PCA reported Resident #4 was found on the floor in his room at approximately 4:00am. -She went to the room and found Resident #4 on the floor, near the foot of his bed. -The resident had blood on his face and appeared to have a cut on his forehead. -She requested the resident to stay in place and left the PCA to monitor the resident while she called the RCC at approximately 4:10am. -The RCC told her to call Resident #4's hospice nurse on call. -The MA contacted Resident #4's hospice nurse call line and left a message for the nurse on call at approximately 4:15am. -The hospice nurse evaluated Resident #4 at the facility. -Resident #4 was transported to the hospital by Emergency Medical Services (EMS). Review of Resident #4's I/A report dated 01/04/22 revealed: -At 9:00pm, the resident was found by staff on his bathroom floor. -The resident told staff he fell. -The resident did not sustain injuries. -The report was signed by the Resident Care Coordinator (RCC) on 01/05/22. -The report was signed by the Interim Administrator on 01/05/22. -There was no documentation of fall interventions put in place for the resident.	D 270		

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D 270	Continued From page 7 Review of Resident #4's progress note dated 01/04/22 at 9:46pm revealed: -The resident was "observed" on the bathroom floor without injuries. -The resident reported he fell. -The RCC and hospice were notified. -There was no documentation of fall interventions put in place for the resident. Interview with the MA/S on 03/23/22 at 3:30pm revealed: -On 01/04/22, the PCA found Resident #4 on his bathroom floor. -Resident #4 was admitted to hospice around that time. -Resident #4 was supervised every 2 hours as a standard of care. -Resident #4 was not on increased supervision. Review of Resident #4's I/A report dated 01/23/22 revealed: -At 2:00am, the resident was found by staff on the floor in his room. -Staff assisted the resident to stand and return to his bed. -The resident had bruising to his left hip. -The report was signed by the RCC on 01/24/22. -The report was signed by the Interim Administrator on 01/24/22. -There was no documentation of fall interventions put in place for the resident. Review of Resident #4's progress note dated 01/23/22 at 3:00am revealed: -The resident was observed on the floor without bleeding. -The resident had a bruise to his left hip. -Staff assisted the resident back to bed. -The RCC was notified and provider faxed. -There was no documentation of fall interventions	D 270		

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D 270	Continued From page 8 put in place for the resident. Review of Resident #4's I/A report dated 01/23/22 revealed: -At 4:00am, the resident was found on the floor in his room. -Staff assisted the resident to bed. -The resident had bruising to his forehead and arm. -The report was signed by the RCC on 01/24/22. -The report was signed by the Interim Administrator on 01/24/22. -There was no documentation of fall interventions put in place for the resident. Review of Resident #4's progress note dated 01/23/22 at 4:00am revealed: -The resident was observed on the floor. -The resident had bruising across his forehead and arm. -The RCC and the facility's contracted primary care provider (PCP) were notified. -There was no documentation of fall interventions put in place for the resident. Review of Resident #4's progress note dated 01/23/22 at 7:15am revealed: -Resident #4 had blood and scrapes to his forehead, scrapes and bruising to both arms and his left knee, and bruising to his left hip. Review of Resident #4's hospice visit note dated 01/23/22 revealed: -The on-call hospice nurse made an as needed visit to assess the resident for a fall. -Fall prevention issues identified were: the resident had impaired learning and physical debility. -The resident was a high risk for falls. -The MA was educated to increase supervision	D 270		

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D 270	Continued From page 9 for the resident and perform fall and safety precautions. -The timeframe for increased supervision was not specified. Telephone interview with the Director at the hospice agency on 03/24/22 at 12:35pm revealed: -On 01/23/22 at 7:12am, the facility called to report that Resident #4 had fallen at 1:00am and 4:00am and sustained multiple scrapes. -The on-call nurse made a facility visit on 01/23/22 and assessed Resident #4. -Resident #4 had injuries to his forehead, left elbow, left hip, and bilateral lower extremities. -On 01/23/22, staff were educated by the on-call nurse of the need to perform supervision checks on Resident #4 more than every 2 hours because he was a falls risk. Second interview with the RCC on 03/24/22 at 3:50pm revealed: -She tried to review Resident #4's hospice notes within 7 days of receipt. -She had not read anything in Resident #4's hospice notes that indicated to increase staff supervision for Resident #4. -Staff did not tell her Resident #4 needed increased supervision per the 01/23/22 hospice nurse visit note. -She did not remember Resident #4 falling twice on 01/23/22. -If she knew Resident #4 fell twice on 01/23/22 she would have instructed staff to supervise the resident every 1 hour. -She did not instruct staff to increase supervision for Resident #4 even though the resident was at a high risk for falls. Review of Resident #4's I/A report dated 03/09/22	D 270		

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D 270	Continued From page 10 revealed: -Resident #4 sustained an unwitnessed fall. -At 8:30am, staff heard a loud "bang" in the resident's room. -Staff entered the room to find the resident laying on the floor near his bathroom. -Resident #4 told the staff he fell. -The resident was assisted off the floor by staff. -The resident did not sustain injuries and denied pain. -Staff told the resident to use his call bell. -The report was signed by the RCC on 03/09/22. -The report was signed by the Interim Administrator on 03/09/22. -There was no documentation of fall interventions put in place for the resident. Review of Resident #4's progress note dated 03/09/22 at 10:30am revealed: -At 8:30am, staff heard a loud "bang" from the resident's room. -Staff found Resident #4 laying on the floor near his bathroom. -The resident reported he fell. -Staff assisted the resident from the floor. -The resident did not sustain injuries. -There was no documentation of fall interventions put in place for the resident. Interview with a MA/S on 03/23/22 at 3:30pm revealed: -Resident #4 had an unwitnessed fall on 03/09/22 and sustained a bump to his head. -He assisted staff to help Resident #4 from the floor. -He was not aware of any fall interventions in place for Resident #4. Telephone interview with Resident #4's hospice Registered Nurse (RN) on 03/23/22 at 3:30pm	D 270		

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D 270	Continued From page 11 revealed: -Resident #4 was a high falls risk because he was weak and would attempt to get up without calling for staff assistance. -The resident had a diagnosis of dementia and could not remember that he could not safely bear weight. Telephone interview with Resident #4's hospice RN on 03/24/22 at 9:42am revealed: -She documented in the resident's hospice visit notes for the facility to initiate fall precautions for the resident. -Resident #4 would often attempt to stand and staff needed to make sure the resident did not fall. -She told staff during each visit to make regular supervisory checks every two hours to ensure the resident was safe. -She expected the facility to follow their policy for supervising residents at a high risk for falls. Interview with the RCC on 03/24/22 at 10:05am revealed: -The facility held weekly meetings to discuss residents at risk for falls. -A Fall Risk Awareness and Intervention form was completed by the RCC and facility's in-house rehabilitation director for residents who were high risk for falls. -The Fall Risk Awareness and Intervention form was updated quarterly and with each resident fall to include hospice residents. -Resident #4 had fall interventions put in place on 05/12/20 which included staff to keep the resident's call bell within reach. -Currently she could only locate Resident #4's original 05/12/20 Fall Risk Awareness and Intervention form. -Resident #4 had more fall interventions put in	D 270		

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D 270	Continued From page 12 place by the facility but could not remember what they were or when they were initiated. -She would have to locate Resident #4's additional Fall Risk Awareness and Intervention forms. Review of Resident #4's Fall Risk Awareness and Interventions form dated 05/12/20 revealed: -The resident's fall risk interventions were: remind resident to use the call bell for assistance, keep the bathroom light on at night, and keep the resident's room and bathroom clean and free of clutter. -There was no documentation the resident was on the Rose Program Interview with the Administrator on 03/24/22 at 11:15am revealed: -Residents who sustained more than 2 falls a month were to be placed on the Rose Program. -The Rose Program consisted of the facility's in-house rehabilitation director (to determine the resident's fall intervention), PCA, RCC, and Administrator would meet weekly. -Residents who participated in the Rose Program would have a rose sticker placed on their room number plaque outside their room. -The rose sticker would alert staff that the resident was a falls risk. Review of a facility documented titled "Understanding the Rose Program" dated September 2020 revealed: -A resident was automatically placed on the Rose Program if they were a high risk for falls, upon admission to the facility, and readmission from a hospital or rehab stay. -A resident who has experienced 2 falls within the last 30 days is immediately included in the Rose Program.	D 270		

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D 270	Continued From page 13 -The resident may come off the program after his Fall Assessment score has decreased to a lower risk level due to an improvement in health or condition or had no falls in 60 days. -Interventions would be developed to help manage the resident's risk of falling. -The words "The Rose Program" will be written on the PCS/ADL log and highlighted in pink to reflect inclusion in The Rose Program. -All 3 shifts team members are expected to check on residents regularly for any unmet need, and to see that the resident is safe, has a call device ready, and that indicated interventions are in place. Review of Resident #4's Fall Risk Awareness and Interventions form dated 05/12/20 revealed there was no documentation the resident was on the Rose Program Second interview with the RCC on 03/24/22 at 3:50pm revealed: -The facility's supervision policy was to lay eyes on residents every 2 hours. -Occasionally a resident would be supervised every 1 hour if the resident was a high falls risk. -A high falls risk was considered a resident who had 2 falls within a 24-hour period. -Staff contacted the RCC when a resident fell. -The RCC or the Administrator notified staff when to place a resident on every 1-hour supervision for those residents who had more than 2 falls within a 24-hour period. -Resident #4 had not been on increased supervision. There was no reason why. -She reviewed I/A reports to ensure the forms were complete and appropriate persons notified. -Her signature on the I/A reports indicated she reviewed the reports.	D 270		

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D 270	Continued From page 14 Interview with the Interim Administrator on 03/24/22 at 4:50pm revealed she expected staff to follow the Safety Check Guidelines policy. Interview with a second PCA on 03/25/22 at 9:00am revealed: -Resident #4 did not have fall interventions in place. -Resident #4 was not on increased staff supervision. -She tried to look in at Resident #4 throughout the day when she was working on the resident's hall, but did not specify how often. -She never completed a safety checklist log for Resident #4. Second interview with the second MA on 03/25/22 at 9:40am revealed: -She was never directed to perform increased supervision checks on Resident #4. -She did not know what the Safety Check Guidelines were until the 03/24/22 in-service. Interview with the RCC on 03/25/22 at 9:50am revealed: -Interventions for residents who were on The Rose Program were documented on that resident's personal care sheet in the personal care sheet binder. -The MA and the PCAs were expected to look at and follow the interventions documented on that resident's personal care sheet. -The facility's policies were sent to her in February 2021. -She tried to read through the polices when she received them but was not able to read all of them due to the COVID-19 pandemic. -Staff were not trained on the Safety Check Guidelines check sheet until 03/24/22.	D 270		

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D 270	Continued From page 15 Interview with the facility's in-house rehabilitation director on 03/25/22 at 10:00am revealed: -She thought hospice provided Resident #4 with a walker and a wheelchair. -She told care staff to keep Resident #4's walker and wheelchair close to his bed for easy reach. -One week ago, she and maintenance staff rearranged Resident #4's room to decrease his falls risk. -Resident #4 was not in the Rose Program. Telephone interview with Resident #4's hospice RN on 03/25/22 at 2:15pm revealed: -She ordered a transfer chair for the resident on 01/25/22. -Hospice did not provide a walker for the resident because he was too unsteady for ambulation. -Resident #4 required hands on staff assistance for ambulation. Requests for Fall Risk Awareness and Intervention forms for Resident #4 on 03/24/22 at 10:15am and 03/25/22 at 10:30am were not provided by survey exit on 03/25/22. Based on observations, interviews and record reviews Resident #4 was not interviewable. Attempted telephone interview with Resident #4's family member on 03/23/22 at 3:26pm was unsuccessful. _____ The facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#4) who sustained 7 unwitnessed falls with 2 falls occurring less than 7 hours apart and the resident was transported to the emergency department and diagnosed a cervical 6 and cervical 7 fractures (neck fractures). This failure resulted in substantial risk	D 270		

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D 270	Continued From page 16 for serious physical harm, neglect, or death to the resident and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 25, 2022 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 24, 2022.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to respond immediately in the case of an accident or incident involving a resident to provide care and interventions according to the facility's policies and procedure for 1 of 5 sampled residents (#4) who had an unwitnessed fall with a head laceration and bleeding. The findings are:	D 271		

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D 271	Continued From page 17 Review of the facility's Emergencies and Incidents In the Event of a Medical Emergency Policy dated September 2020 revealed: -Contact Emergency Medical Services (EMS)/911 immediately when a resident has trauma such as significant bleeding, a traumatic fall, and/or excessive bleeding. -Step one, respond immediately. -Step two, A do not resuscitate (DNR) order does not allow staff to withhold care or basic first aid. -Step three, Contact Emergency Medical Services (EMS) by calling 911 if the resident appears to be in crisis. -Step six, call the Resident Care Coordinator (RCC) and/or Administrator. -Step eleven, notify the resident's Primary Care Provider (PCP). Review of the facility's Resident Emergencies and Incidents Falls policy dated September 2020 revealed: -Call 911 when a resident falls and complains of pain or is bleeding. -Call 911 when a resident falls and has a suspected injury to the head, neck, and/or face. Review of Resident #4's current FL-2 dated 01/03/22 revealed: -Diagnoses included failure to thrive, debility, deconditioning, and dementia. -The resident was constantly disoriented, semi-ambulatory with maximum staff assistance, hard of hearing, and had diminished sight. Review of Resident #4's undated incident and accident (I/A) report revealed: -The resident was found by staff on the floor in his bedroom. -The time was not documented.	D 271		

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D 271	Continued From page 18 -There was no documentation of injuries, bleeding, or resident complaint of pain. -The RCC was contacted. -The resident's hospice provider was called (the time was not documented). -EMS was called and the resident was sent to the hospital (the time was not documented). -The report was signed by the MA/S (medication aide/supervisor) on 03/24/22 at 5:00am. Review of Resident #4's local hospital emergency department (ED) visit summary dated 03/24/22 revealed: -The resident was found by facility staff out of his wheelchair, on the floor in blood, with head trauma and right shoulder pain. -The resident was unable to provide details of the injury because of dementia. -The resident had significant abrasions to the left front and side of head with bleeding. -The back of the resident's neck was painful. -The resident's right shoulder had limited movement and was painful. -The resident was diagnosed with a fall, closed head injury, and an acute traumatic fall with cervical (C) spine (neck) fractures. -The resident had Cervical 6 and Cervical 7 (the sixth and seventh bones of the neck) fractures. -The resident's condition was guarded. -The resident required transfer from the ED to another hospital that had neurosurgery (a surgeon who specializes in the nerves) available. Review of Resident #4's local hospital's CT scan report dated 03/24/22 revealed diagnoses included an acute oblique C-6 vertebral body fracture with displacement up to 3 to 4mm, left C-6 laminar fracture, and a minimally displaced fracture of the left C-7 lateral mass (fractures of the sixth and seventh neck bones).	D 271		

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D 271	Continued From page 19 Review of Resident #4's progress note dated 03/24/22 at 6:00am revealed: -Staff discovered the resident on the floor with blood on his face. -The RCC was contacted. -Hospice was called. -The resident was evaluated by the hospice nurse. -The hospice nurse sent the resident to the hospital -There was no documentation of staff calling 911 for EMS to transport Resident #4 to the hospital prior to the hospice nurse evaluating the resident. Telephone interview with a medication aide (MA) on 03/25/22 at 11:15am revealed: -She worked third shift on 03/23/22. -The personal care aide (PCA) reported to her Resident #4 was on the floor in his room at approximately 4:00am. -She went to the room and found Resident #4 on the floor, near the foot of his bed, attempting to get up on his own. -The resident had blood on his face and appeared to have a cut on his forehead. -She obtained the resident's vital signs including his blood pressure. -She was taught to keep the resident as still as possible if a head injury was suspected. -She requested the resident to stay in place and left the PCA to monitor the resident while she called the RCC at approximately 4:10am. -She called the RCC and told her Resident #4 was found on the floor in his room, had blood on his face and appeared to have a cut on his forehead. -The RCC told her to call Resident #4's on-call hospice nurse. -The MA contacted Resident #4's hospice nurse	D 271		

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call line and left a message for the nurse on call at approximately 4:15am.
-The hospice nurse returned her call at approximately 4:20am.
-The hospice nurse arrived at the facility at approximately 4:50am, cleaned the resident's face and instructed the MA to call 911 for emergency medical services.
-The ambulance arrived at the facility at approximately 5:10am.
-She was trained to first notify the RCC for instructions before calling 911 for all residents.
-She was not aware the facility had a policy to call 911 first when residents had a head injury or visible bleeding.

Interview with Resident #4's hospice nurse on 03/24/22 at 9:42am revealed:
-The resident sustained injuries from a fall early morning on 03/24/22.
-The facility called the hospice triage line to notify the hospice nurse.
-The on-call hospice nurse made a visit to assess the resident.
-Resident #4 was transferred to the hospital by EMS at 5:17am on 03/24/22.

Telephone interview with the on-call hospice nurse on 03/24/22 at 9:50am revealed:
-Facility staff called the nurse triage line on 03/24/22 at 4:06am and reported Resident #4 fell, hit his face, and was bleeding from his head.
-She called the facility at 4:11am and told the MA/S she was 30 minutes from the facility.
-When she arrived at the facility, Resident #4 was laying on the floor, had a head contusion, a 2.5 to 3-inch jagged laceration to his left forehead, and was bleeding.
-There was blood on Resident #4's bed, on the floor by the foot board, on the floor by the

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D 271	Continued From page 21 bathroom door inside the resident's room, and on the resident's walker that was against the wall across from the resident's bathroom. -She instructed staff to call 911 for transport Resident #4 to the emergency department for medical evaluation. -The MA/S did not tell her the severity of Resident #4's head wound when she returned the call to the facility. -She realized Resident #4 needed emergent care when she saw the size of the resident's head wound and the blood in his room. Interview with the Interim Administrator on 03/24/22 at 8:30am revealed: -An emergency was when a resident (including hospice residents) had an unwitnessed fall and sustained a head injury and was not acting as they normally did, or sustained a laceration. -It was the facility policy to send a resident to the ED if the resident hit their head or had evidence of hitting their head during a fall. -She expected staff to call 911 for EMS before calling hospice if the resident was bleeding. -Then staff were to call hospice after calling 911 for EMS to evaluate the hospice resident. Interview with the RCC on 03/24/22 at 10:05am revealed: -She expected the MA/S to call hospice if Resident #4 had a witnessed or unwitnessed fall, had a known or possible head injury, and/or any visible injuries. -Staff would know if Resident #4 hit their head or had a possible head injury if the resident was positioned with his head against an object or had visible head injuries. -Staff were not to call EMS for Resident #4 when he fell because the resident was on hospice services.	D 271		

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D 271	Continued From page 22 -Resident #4's hospice nurse would make a visit to evaluate him after he fell. Interview with the Administrator on 03/24/22 at 10:45am revealed: -His expectations for staff when residents sustained an unwitnessed fall was, "if in doubt, send them out". -The facility was ultimately responsible for Resident #4 regardless if the resident was on hospice services or not. -His expectations for staff responses to resident falls was based on the resident's cognition status. -If a resident was found on the floor by the bed, was confused, and did not know what happened he expected staff to contact 911 for EMS to transport the resident to the hospital. -Staff should have called 911 before calling hospice when Resident #4 was found on the floor by his bed on 03/24/22 because the resident was confused. A second interview with the Interim Administrator on 03/24/22 at 3:45pm revealed: -Resident #4 was still in the hospital as a result of the 03/24/22 fall. -Resident #4 was diagnosed with a cervical fracture and was being transferred to another hospital for medical care. Interview with a PCA on 03/25/22 at 9:15am revealed she was trained to notify the MA and stay with the resident until the MA arrived when a resident had a fall with injury, was unresponsive, or had an altered level of consciousness. Interview with a second MA/S on 03/25/22 at 9:40am revealed: -When a resident fell, she was supposed to look for injuries and/or bleeding and ask if they had	D 271		

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D 271	Continued From page 23 pain. -She was trained one year ago by the RCC, when a resident was bleeding, had wounds, and/or pain she was to call the RCC for guidance on what to do to make sure the right action was taken before calling 911 or hospice. -She had not seen nor was trained on the facility's Emergency Response Policy. A third interview with the Interim Administrator on 03/25/22 at 9:53am revealed: -An emergency was a resident fall with any injury such as a head laceration, swelling, pain, or bleeding. -She expected staff to call 911 immediately for any resident who experienced a fall with a visible injury. -She expected hospice to be called first if a resident sustained a fall and did not have visible injuries so hospice could evaluate and determine if emergency care was needed. -She expected staff to call 911 for EMS to evaluate Resident #4 on the morning of 03/24/22 instead of staff calling hospice because the resident sustained a fall and had visible injuries. -The Interim Administrator, RCC, and Regional nurse were responsible for training staff on how to respond to emergencies. Telephone interview with Resident #4's hospice Director on 03/25/22 at 10:36am revealed: -The on-call hospice nurse arrived at the facility on 03/24/22 at 4:51am and left at 5:25am. -She expected the facility to have first called 911 for EMS on the morning of 03/24/22 to transport Resident #4 to the hospital for a medical evaluation instead of calling hospice because Resident #4 had visible injuries. Based on observations, interviews, and record	D 271		

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D 271	Continued From page 24 reviews, Resident #4 was not interviewable. The facility failed to immediately respond to the emergent needs for Resident #4 who had an unwitnessed fall sustaining a 2.5 to 3-inch head laceration. There was blood to the resident's bed, on the floor by the foot board, on the floor outside the resident's bathroom door and on his walker located against the wall across from the resident's bathroom. Staff called the Resident Care Coordinator to ask guidance, then was instructed to call hospice instead of 911. The resident laid in the floor for 1 hour and 17 minutes before being transferred to the hospital by Emergency Medical Services where he was diagnosed with a closed head injury and traumatic displaced fractures of his neck which required transfer to neurosurgery at higher level of care hospital. The facility's failure to respond immediately was detrimental to the health and safety to the resident and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/03/21 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 9, 2022	D 271		
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 reviews, the facility failed to provide the acute	D 273		

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health care needs of 1 of 5 residents sampled (#4) regarding a primary care provider (PCP) referral for wounds to the left forearm and left knee and right elbow bruising, and a podiatry referral for long, thick, discolored, toenails with redness and pain to the toes.

The findings are:

Review of Resident #4's current FL-2 dated 01/03/22 revealed:
-Diagnoses included stage 3 chronic kidney disease, failure to thrive, debility, deconditioning, and dementia.
-The resident was constantly disoriented and semi-ambulatory with maximum staff assistance.
-The resident required staff assistance for bathing and dressing.

Review of Resident #4's current care plan dated 12/22/21 revealed:
-The resident was forgetful and needed reminders.
-The resident's skin was documented as normal except a growth to his nose with the skin bumpy and dry.
-The resident was independent with ambulation, toileting, and transfers.
-The resident required limited staff assistance with bathing, grooming, and dressing.

Review of Resident #4's Licensed Professional Health Support (LHPS) evaluation dated 02/10/22 revealed:
-The resident complained of a fall on 01/23/22.
-The resident's skin was warm, dry, and intact.

a. Observation of Resident #4 on 03/23/22 at 3:14pm revealed:
-There was a plum colored area to the left

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D 273	Continued From page 26 forearm approximately 5 inches long by 3 inches wide. -The discoloration faded from the outside to the inside of the forearm. -There was an open would approximately 1 inch long by 0.25-inch-wide in the center of the discoloration towards the outside of the forearm. -There was a wound approximately 2 inches in diameter to the outside lower left knee. -The wound was bright pink to light red in color which extended to the skin outside of the wound. -The skin around the perimeter of the wound was curled, dry, and scabbed. -There was area to the right elbow approximately 7 inches and semi-circumferential that was light plum colored and faded towards the perimeters. Interview with the personal care aide (PCA) on 03/23/22 at 3:10pm revealed: -She did not know Resident #4 had wounds to his left forearm, left knee, or a bruise to his right elbow until now, 03/23/22. -She documented wounds, bleeding, and bruising on the skin assessment sheets. -She would report wounds, bleeding, and bruising to the medication aide/supervisor (MA/S) when discovered. Interview with a MA/S on 03/23/22 at 4:10pm revealed: -Resident #4 sustained a a fall on 03/09/22 but she didn't know of any injuries during the fall. -She did not know how Resident #4 sustained wounds to the left forearm and left knee. -She did not know how Resident #4 sustained bruising to the right elbow. -Staff did not tell her Resident #4 had wounds to the left forearm and left knee or bruising to the right elbow. -She first saw Resident #4's left forearm and right	D 273		

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	HAL054006	A. BUILDING: _____ B. WING _____	R 03/25/2022

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D 273	Continued From page 27 elbow today, 03/23/22. -She did not look at the left knee wound. -The MA/S was to notify the resident's primary care provider (PCP), hospice provider, and Resident Care Coordinator (RCC) when wounds or bruising was discovered, and staff completed a skin assessment sheet. Interview with the RCC on 03/23/22 at 3:40pm revealed: -The PCAs documented wounds, redness, and bruising on the skin assessment sheets. -The PCAs were responsible for telling the MA/S or the MA if a resident had redness or wounds. -The MA/S was responsible for calling hospice to report Resident #4 had wounds and bruising. -She did not know Resident #4 had wounds to the left forearm, left knee, or bruising to the right elbow. Interview with the Interim Administrator on 03/23/22 at 3:45pm revealed: -The PCAs were to examine Resident #4 for blisters, redness, or wounds when providing personal care. -The PCAs were responsible for reporting to the MA/S if Resident #4 had wounds or redness when discovered. -The MA/S was responsible for reporting to the RCC if Resident #4's had wounds or redness. -The RCC called hospice and the resident's PCP to report Resident #4's wounds or redness. Review of Resident #4's skin assessment sheet dated 03/02/22 revealed: -There was documentation the resident had no open areas to the skin. -There was documentation the resident had old bruises; the location was not documented. -There were instructions to report to the MA/S	D 273		

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D 273	Continued From page 28 any unusual skin conditions such as bruises, skin tears, rashes, or open areas. Telephone interview with Resident #4's PCP on 03/23/22 at 4:00pm revealed: -She was not notified Resident #4 had wounds to his left forearm and left knee. -She was not notified Resident #4 had bruising to his right elbow. -She expected facility staff to notify her Resident #4 had wounds to his left forearm and knee and discoloration to the right elbow. -Resident #4 was weak and inactive and a minor injury could cause Resident #4 to have wounds and skin integrity issues. -Resident #4 was not at risk for infection due to the wounds. Interview with Resident #4's hospice nurse on 03/24/22 at 8:20am revealed: -Resident #4 had no wounds or bruising to the left arm, left knee, or right elbow when she last visited the resident on 03/18/22. -She expected facility staff notify hospice of the wounds to Resident #4's left forearm and left knee, and bruising to the right elbow. Refer to interview with the personal care aide (PCA) on 03/23/22 at 3:10pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/23/22 at 3:40pm, Refer to a second interview with the RCC on 03/23/22 at 3:50pm. Based on observations interviews, and record reviews, Resident #4 was not interviewable. b. Observation of Resident #4's left foot on	D 273		

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D 273	Continued From page 29 03/23/22 at 3:07pm revealed: -The first toenail was dark yellow to tan and the tip of the toenail was brown. -The first toenail was crusty, thick, grew upwards, and was nodular. -The second toenail was crusty, jagged, thick and dark yellow in color. -The third toenail was thick, dark yellow, crusty, grew upwards, was nodular, and was imbedded within the cuticle. -The fourth toenail was dark yellow to brown in color, thick, jagged, and curved towards the right into the second toe. -The nail at the base of the cuticle was gray. -The skin between the third and fourth toes were dark brown and crusty. -The fifth toenail was thick, dark yellow, grew up and was nodular. -The tip of the toenail closest to the fourth toe was brown. -The underside of the toenail towards the left was dark gray to black. -The skin to the left of the toenail was bright pink in color. -The resident flinched and reported pain when the personal care aide (PCA) touched the left fifth toe. Observation of Resident #4's right foot on 03/23/22 at 3:07pm revealed: -The first toenail was thick, dark yellow to brown in color, jagged, and grew up from the nail bed. -The resident flinched and reported pain when the PCA touched the right first toe. -The second toenail was jagged, dark yellow, and thick. -The third toenail was brown to dark yellow in color, thick, jagged, and grew past the tip of the toe towards the second toe. -The fourth toenail was dark yellow to light brown	D 273		

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D 273	Continued From page 30 in color, thick, jagged, and grew past the tip of the toe. Interview with the PCA on 03/23/22 at 3:10pm revealed: -She washed and applied lotion to Resident #4's feet when performing personal care. -She would only document painful toes/toenails on the skin assessment sheets. -She did not document long toenails on the skin assessment sheets. -Resident #4 had not complained of toe pain until today, 03/23/22 at 3:07pm. -If Resident #4 reported toe pain, she would have told the medication aide/supervisor (MA/S) or MA. -The beauty shop staff was responsible for nail care for the residents. Interview with a MA/S on 03/23/22 at 3:40pm revealed: -The PCAs were responsible for examining and washing resident's feet with every bath. -The PCAs were responsible for checking resident's toenails to see if they were long, thick or discolored. -The PCAs were responsible for documenting long, thick, or discolored toenails on the personal care sheets. -The PCAs were responsible for reporting long, thick, or discolored toenails to the MA/S. -The MA/S examined the resident's feet to determine if the resident needed to be referred to podiatry. -The MA/S called the Primary Care Provider (PCP) or hospice to request a podiatry referral. -The facility's beauty shop staff would trim the toenails of resident's if they were not a diabetic. -The PCA had not reported to him Resident #4's toenails were long, thick, or discolored.	D 273		

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D 273	Continued From page 31 Interview with the Resident Care Coordinator (RCC) on 03/23/22 at 3:40pm revealed: -The PCAs observed resident's feet with every bath and when putting socks on the resident's feet. -The PCAs were responsible for documenting long, discolored, thick toenails on the skin assessment sheets. -The PCAs were responsible for telling the MA/S or the MA if a resident had long, thick, discolored toenails. -The PCAs were responsible for telling the MA/S or the MA if a resident had redness to the toes. -The MA/S was responsible for calling hospice to report Resident #4 had redness or pain; or long, thick, discolored toenails. -Hospice would evaluate Resident #4 or refer the resident to podiatry. -Podiatry was at the facility three months ago. -She did not think Resident #4 saw podiatry at that time. Interview with the Interim Administrator on 03/23/22 at 3:45pm revealed: -The PCAs were responsible for examining Resident #4's toenails during every bath to see if the nails needed trimming, were long, or had blisters, redness, or wounds. -The PCAs were responsible for telling the MA/S if Resident #4 had discolored, thick, or long toenails; or redness. -The MA/S was responsible for telling the RCC if Resident #4's toenails were long, thick, or discolored; or if the toes were red. -The RCC was responsible for calling hospice and the facility's PCP to report Resident #4's toenails were long, thick, discolored, or red. -Even though Resident #4 was on hospice services, the resident still needed his feet examined by a provider.	D 273		

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D 273	Continued From page 32 Review of Resident #4's skin assessment sheet dated 03/02/22 revealed there was no documentation regarding the resident's feet or toenails. Telephone interview with the facility's PCP on 03/23/22 at 4:00pm revealed: -She examined Resident #4 on 02/23/22 and the resident's toenails were not long, thick, or discolored. -She expected staff to notify her that Resident #4's toenails were thick, jagged, discolored, long, and had redness to his toes even though he was on hospice services. -Facility staff did not notify her Resident #4's toenails were thick, jagged, discolored, and long or had redness to the right first toe and left fifth toe. -If facility staff notified her Resident #4's toenails were discolored, long, thick, and redness around the toes, she would have referred the resident to an outside podiatrist instead of waiting for a hospice or in-house podiatry visit. -Pain and redness to the skin around Resident #4's toenails could be a symptom of infection. -Resident #4's thick toenails could lead to an infection. Interview with Resident #4's hospice nurse on 03/24/22 at 8:20am revealed: -Hospice did not provide a PCA for Resident #4. -The facility was responsible for providing personal care to Resident #4. -She had not provided toenail care to Resident #4. -She last looked at Resident #4's toenails on 03/23/22. -She planned to attempt to file Resident #4's toenails and if could not, refer him to podiatry.	D 273		

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D 273	Continued From page 33 -She did not plan to attempt to cut Resident #4's toenails because they were to thick. -Resident #4's toenails had worsened since he had been on hospice in January 2022. -Resident #4 had no wounds or bruising to the left arm, left knee, or right elbow when she last visited him on 03/18/22. Refer to interview with the personal care aide (PCA) on 03/23/22 at 3:10pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/23/22 at 3:40pm, Refer to a second interview with the RCC on 03/23/22 at 3:50pm. Based on observations interviews, and record reviews, Resident #4 was not interviewable. _____ Interview with the personal care aide (PCA) on 03/23/22 at 3:10pm revealed skin assessment sheets were completed by the PCAs with every resident bath/shower. Interview with the Resident Care Coordinator (RCC) on 03/23/22 at 3:40pm revealed: -Residents were bathed three times a week and the PCAs were to complete a skin assessment sheet with every bath. -Hospice was available 24 hours a day, seven days a week. -Hospice would make an on-call visit to evaluate Resident #4 . A second interview with the RCC on 03/23/22 at 3:50pm revealed Resident #4 had one skin assessment sheet for March 2022.	D 273		

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D 282	Continued From page 34	D 282		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen was clean and protected from contamination related to food particles and a buildup of dirt and grease on the stove, hood vent, the floor of the walk-in refrigerator. The findings are: Observation of the kitchen on 03/24/22 at 8:37am revealed: -The stove had a buildup of grease with black and white food particles stuck on the surface. -The hood vent had a buildup of grease on the surface. -There were 2 large white storage bins that contained a white grainy substance that had black and brown dirt particles stuck on the surface. -The walk-in refrigerator had a strong unpleasant odor when the door of the refrigerator was opened. -There was a buildup of black dirt between the crevices of the floor of the walk-in refrigerator. -There was a buildup of food particles throughout the floor of the walk-in refrigerator. -There was a chicken leg that was black and	D 282		

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D 282	Continued From page 35 white underneath one of the racks in the walk-in refrigerator. -There was red liquid splattered on the walls of the walk-in refrigerator. Interview with the Dietary Manager on 03/24/22 at 9:27am revealed: -The kitchen staff were supposed to clean the entire kitchen daily. -The kitchen was not cleaned on 03/23/22. -She walked through the kitchen and walk-in refrigerator daily to make sure both were cleaned. -She had a daily cleaning schedule for the dietary aide and the cook to follow daily. -The cook and dietary aide were supposed to sign the daily cleaning schedule after they finished cleaning. -She did not know where the daily cleaning schedule for 03/20/22 to 03/27/22 was located. -She was only able to locate the signed daily cleaning schedule from 01/27/22. -She checked the daily cleaning schedule a few times a week. -She last checked the daily cleaning schedule 2 to 3 weeks ago. -There was a company that was supposed to clean the stove hood vent on 02/15/22. -The company did not come to the facility to clean the hood vent. -The stove hood vent cleaning company came to the facility every 3 months to clean the hood vent. -She tried to call the cleaning company but she was unable to speak to anyone about the missed cleaning on 02/15/22. -She did not remember when she called the hood vent cleaning company. -The dietary aide and the cook cleaned the hood vent a couple of weeks ago. Interview with the Administrator on 03/25/22 at	D 282		

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D 282	Continued From page 36 9:58am revealed: -The dietary aide and the cook were supposed to clean the kitchen nightly before the end of their shift. -The stove was supposed to be cleaned and wiped down daily. -The floors of the kitchen and walk-in refrigerator were supposed to be swept and mopped daily. -The walls of the walk-in refrigerator were supposed to be wiped and cleaned daily. -The Dietary Manager should have called the stove hood vent cleaning company on 02/16/22 to reschedule the cleaning. -She was not aware that the cleaning company did not come to the facility on 02/15/22. -She last walked through the kitchen about a week ago and scheduled a deep cleaning of the entire kitchen on 03/28/22, because the kitchen was not clean.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to food stored in the pantry that should have been refrigerated after opening and food stored in the	D 283		

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D 283	Continued From page 37 pantry that was expired. The findings are: Observation of the kitchen pantry on 03/24/22 at 8:37am revealed: -There was a was 16-ounce (oz) of shredded cheese in a zip-top bag with a best used by date of 12/10/21 located on the second shelf of a wired rack. -There was a 1-pound (lb) jar of grape-flavored jelly that was opened and stored on the bottom shelf of a wired rack with label instructions to refrigerator after opening. -There was a 1-gallon jug of marinade sauce that was opened and had 25% of the marinade left in the jug and had label instructions to refrigerate after opening. -There was an 8lb jug of salsa that was opened and had 25% of the salsa left in the jug and label instructions to refrigerate after opening. -There was a 4lb bottle of ready to use sweet and sour sauce that was opened and had 25% of the sauce left in the jug and label instructions to refrigerate after opening. -There were 2 one pound containers of a beef base in the walk-in refrigerator that expired on 11/23/21. Interview with the Dietary Manager on 03/24/22 at 9:27am revealed: -She checked for expired foods and refrigerated items when the food truck delivered food items on Wednesdays and Fridays. -She last cleaned the pantry and went through the items stored in the pantry on 03/23/22. -She looked for food that was opened and was required to be stored in the refrigerator and expired food. -The kitchen staff were supposed to store all food	D 283		

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D 283	Continued From page 38 items that were required to be refrigerated after opening. -She was not aware that there were food items that were required to be refrigerated after opening stored in the pantry. -She was not aware there was a 16oz bag of expired cheddar cheese stored in the pantry. -She was not aware there were 2 1lb containers of beef base stored in the walk-in refrigerator. Interview with the Administrator on 03/25/22 at 9:58am revealed: -The Dietary Manager was supposed to check for expired food and food that required refrigeration after opening in the pantry and walk-in refrigerator every Wednesday and Friday. -The Dietary Manager was supposed to throw away any food that was past its best by date. -She was not aware there was food that required to be refrigerated after opening stored in the pantry. -She was not aware there was a 16oz bag of shredded cheddar cheese past the best by stored in the pantry. -She was not aware there were 2 one pound containers of beef base past the best by date stored in the refrigerator.	D 283		
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:	D912		

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SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

(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
D912	Continued From page 39 Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and services. The findings are: 1. Based on interviews and record review the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#4) who sustained 7 unwitnessed falls from January 2022 to March 2022. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Services (Type A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to respond immediately in the case of an accident or incident involving a resident to provide care and interventions according to the facility's policies and procedure for 1 of 5 sampled residents (#4) who had an unwitnessed fall with a head laceration and bleeding. [Refer to Tag 271, 10A NCAC 13F .0901(c) Personal Care and Services (Type B Violation)].	D912		

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

Spring Arbor of Kinston
HAL-054-006
Lenoir County

It is the policy and standard practice of Spring Arbor of Kinston to comply with all North Carolina Adult Care rules and state regulations.

D270 - 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.

Plan of Correction

Resident #4 was in hospital during most of this survey. He returned to Spring Arbor on 3/28 and hospice services which had been in place for months prior to hospitalization were resumed. Safety Checks were implemented upon Resident #4's return. (Safety Check training was conducted for the team by Regional Director on 3/24.) One-on-one sitter service began on 3/29. Resident died on 3/30, pronounced by hospice.

Following this survey, Falls Assessments were reviewed and/or conducted if needed for all residents. These were completed under the guidance of the Regional Nurse.

The Rose Program was fully resumed under the leadership of the Interim Executive Director. Rose Program meetings are conducted weekly, with an interdisciplinary review of individual residents at risk. Appropriate Fall Management Interventions are developed and documented for each resident and new or updated information is communicated to team members.

Training was held on 4/5 for the team on the Rose Program, with focus on increased awareness of identifying those who are on the Rose Program and consistent follow through on providing the identified Interventions for individual residents. This training was conducted by the Regional Director.

Training was also held for the team on 4/7 about Hospice services and the appropriate communication with both Hospice and Spring Arbor leadership in the event of a hospice-resident fall or other incident. This training was conducted by the Regional Director and in collaboration with a Community Hospice RN.

Training was held on 3/23 by the Regional Director to address Spring Arbor's overall responsibility to the total care of every resident, and to discuss how every team member owns a piece of that responsibility in providing safe care for each resident.

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

Prevention of Re-occurrence

A schedule for weekly Rose Program meetings has been established and will be maintained ongoing. Falls management interventions are newly determined or updated as needed for each at-risk resident during this weekly meeting. These meetings are interdisciplinary, and include nursing, therapy, leadership, care staff, and other rotating team members as appropriate.

Staff are informed and/or reminded of specific falls management interventions by the Executive Director and on-site therapist during daily team and/or Stand-Up meetings.

Fall Risk Assessments will be completed for each new move-in, in addition to quarterly for each resident and following a fall. These will be done by the Resident Care Director, Cottage Care Coordinator, Executive Director or one of the on-site therapists. New assessments which identify "at risk" will be brought to Rose Program meeting for review and development of action plan.

Hot Box documentation of residents at higher risk for falls will be reviewed regularly by the Executive Director/designee, and changes to Care Plans and PCS logs will be made as needed. PCS logbooks will contain resident-specific falls interventions.

Spring Arbor's RN consultant and/or designee will continue to review resident care plans, orders and LHPS needs monthly and on an as-needed basis.

Monitoring Responsibility & Frequency

It is the responsibility of the Resident Care Director, Cottage Care Coordinator and/or Executive Director to review Hot Box Documentation and Shift-to-Shift reports daily to assure that changes in condition or concerns about increased fall risk are promptly addressed and communicated and brought to Rose Program meetings for discussion and development of interventions.

It is the responsibility of the Executive Director to assure that Rose Program meetings are conducted weekly. Each meeting will be documented, and all new or updated interventions will be included in PCS binders for easy staff reference.

The Regional Director and the Regional Nurse will audit Rose Program documentation and follow through at least twice a month x two months, then monthly x two months, and then quarterly thereafter during community visits.

Correction Completion Date: 4/22/2022

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

D271 - 10A NCAC 13F .0901 Personal Care and Supervision
(c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

Plan of Correction

Following this survey, re-education on *Responding to a Medical Emergency* was held for team members to be certain everyone fully understands their own and Spring Arbor's responsibility to respond immediately to a resident in the event of an incident or accident. This training also addressed how to work with Hospice in the event of a medical emergency of a resident receiving hospice services. This training was conducted by the Regional Director, Regional Nurse and Interim Executive Director on 3/24.

Prevention of Re-*occurrence*

Additional training was held for Medication Aides and Supervisors-in-Charge to review and reinforce responsibilities of the lead person each shift in the immediate response to any resident's medical emergency, including those on hospice services, followed by appropriate communications and documentation. This training was conducted by the Interim Executive Director on 4/13.

The review of each I/A Report by the Executive Director/designee by the next business day following an incident or accident will include an examination of timelines of actions and responses by staff, and further discussion and education with MT/SICs as may be needed to assure ongoing immediate responses to any resident's medical emergency.

The protocol for response to a medical emergency will be reviewed regularly with all team members by the Executive Director, Resident Care Director or Cottage Care Coordinator during monthly staff meetings.

Monitoring Responsibility & Frequency

The Executive Director will sign every I/A Report after reviewing the response timelines of the team to a medical emergency.

The Regional Director or Regional Nurse will randomly audit at least two I/A Reports and concurrent resident care note documentation during monthly community visits and will recommend or conduct additional training as needed.

Correction Completion Date: 4/13/2022

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

D273 – 10ANCAC 14F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents

Plan of Correction

Resident #4 was in hospital during the days of this survey. He returned to Spring Arbor on 3/28 and hospice services which had been in place for months prior to hospitalization were resumed. Wound dressing maintained per orders. Resident expired before podiatry services were able to be provided.

Following this survey, a review of resident charts and hospice notes was conducted to assure that all referral orders or recommendations had been followed through. All are in compliance. This effort was led by the Regional Nurse, the Interim Executive Director and the Cottage Care Coordinator.

The Regional Director and Interim Executive Director met with Community Hospice providers on 3/29 to discuss and agree to systems for improved communication and timely receipt of documentation in order that recommendations and orders be followed through in a timely manner moving forward.

Re-education was provided by Regional Director and Regional Nurse on 3/23 to all shifts on how and when to assess and report changes in skin condition to a Supervisor, Resident Care Director, Cottage Care Coordinator, Executive Director or Regional Nurse. The Care Plan Overview tool and PCS log documentation was also part of this retraining.

Prevention of Re-occurrence

New systems have been implemented between Hospice provider and community leadership which will improve communication and timely response to new recommendations and orders. This includes an Exit conversation between the Hospice Nurse or Executive Director/designee to assure communication and awareness of any changes, new orders, etc., related to a hospice service resident.

Consistent and proper use of the Skin Observation tool by team members will improve reporting and prompt assessment and treatment for skin or foot care needs.

It is the responsibility of the Supervisor-in-Charge to review each Skin Observation tool completed during a shift and to promptly report any changes or needs to the Resident Care Director, Cottage Care Coordinator, Executive Director or Regional Nurse.

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

Monitoring Responsibility & Frequency

The Resident Care Director, Cottage Care Coordinator and/or Executive Director will review all Skin Observation sheets that have been completed each week, to assure that all changes have been communicated and followed-up appropriately.

The Regional Nurse will randomly audit Skin Observation tool usage and follow through at least quarterly during community visits.

Correction Completion Date **4/15/2022**

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

D282 10A NCAC 13F .0904 Nutrition and Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.

Plan of Correction

A deep clean of the kitchen was completed while this survey was underway, with particular attention to the stove, hood vent and the floor of the walk-in refrigerator. This cleaning was performed under the guidance of the Food Service Director and Regional Director.

Retraining of the Food Service Director and Food Service team was conducted by the Regional Director on 3/23, with a review of specific cleaning protocols and schedules.

Prevention of Re-occurrence

The Food Service Director is responsible to follow and oversee the established systems and schedules in place for the team to maintain a kitchen that remains clean, orderly, and protected from contamination. In the absence of Food Service Director, it will be the responsibility of the Executive Director to oversee compliance to the established systems and schedules.

Monitoring Responsibility & Frequency

The Executive Director will visually inspect the status of kitchen cleanliness and orderliness on a daily basis x 2 weeks and then on a random basis at least weekly thereafter.

The Regional Director will inspect the kitchen for cleanliness and orderliness during each community visit.

Correction Completion Date: 4/4/2022

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

D283 10A NCAC 13F .0904 Nutrition and Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.

Plan of Correction

Immediately upon being made aware of this concern during survey, all food storage locations were inspected by the Food Service Director, Interim Executive Director and Regional Director. Foods past the expiration date and open food in the pantry which required refrigeration were discarded.

Retraining of the Food Service Director and Food Service team was conducted by the Regional Director on 3/23, with a review of specific storage and labeling requirements.

Prevention of Re-occurrence

All Food Service team members will receive initial and ongoing training by the Food Service Director on how to safely store all foods and beverages. In the absence of the Food Service Director, these training needs will be met by the Executive Director and the Regional Director.

The Food Service Director is responsible to follow all requirements for safe storage for foods and beverages. The Food Service Director will oversee team compliance with these requirements and will follow a schedule for checking and assuring that all food and beverages are stored safely and appropriately.

Monitoring Responsibility & Frequency

The Executive Director will visually inspect food storage systems in the kitchen daily x 2 weeks and then on a random basis at least weekly thereafter.

The Regional Director will inspect food storage systems in the kitchen during each community visit.

Correction Completion Date: 4/4/2022

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

D912 - 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.

Plan of Correction

Resident #4 was in hospital during the days of this survey. He returned to Spring Arbor on 3/28 and hospice services which had been in place for months prior to hospitalization were resumed. Safety Checks were implemented upon Resident #4's return. (Safety Check training was conducted for the team by Regional Director on 3/24.) One-on-one sitter service began on 3/29. Resident died on 3/30, pronounced by hospice.

Training and discussion on Resident Rights was conducted for team members on 3/29, 4/12, and 4/14, with focus on assuring that each resident receives the care and services that are adequate and appropriate for that resident, and which are in compliance with physician orders and with state and federal regulations. These trainings were conducted by the Regional Director.

Prevention of Re-occurrence

Ongoing review and reinforcement of Resident Rights will be addressed by the Executive Director at monthly staff meetings ongoing.

Colby Smith, Ombudsman, has been scheduled to conduct Resident Rights training for team members on May 27th at 2pm.

Spring Arbor will maintain updated Care Plans and will have systems in place to assure timely communication to the team of any changes in care needs or interventions for a specific resident.

Monitoring Responsibility & Frequency

The Resident Care Director, Cottage Care Coordinator and Executive Director will maintain an active Tracking Log to assure timely updates on Care Plans, LHPS and LOC assessments, family communications, etc., to assure that all current needs of each resident are being reviewed and met. The Executive Director will review the tracking log monthly to assure ongoing community compliance.

The Regional Nurse will audit the Tracking Log no less frequently than during each community visit.

Correction Completion Date 4/12/2022

PLAN OF CORRECTION for Annual, Follow-Up Survey completed March 25, 2022. (KXRH13)

Submitted by:

Beverly H. Jones/Administrator 05/19/2022

Name / Title **Date**