STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 completed a follow-up survey on June 1, 2022 to June 2, 2022.	{D 000}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure increased supervision to meet the needs 1 of 5 sampled residents (#1) who had a history of falls with injury and sustained 5 falls within 20 days after readmission to the facility. The finding are: Review of Resident #1's current FL-2 revealed: -The resident's level of care was on the assisted living (AL) unit. -The resident had diagnoses on unspecified hydronephrosis, vascular dementia, unsteadiness of her feet, and urinary tract infection. -The resident was intermittently disoriented and non-ambulatory to semi-ambulatory with a wheelchair. -The resident was incontinent of the bladder and	{D 270}	(see page 9 and 10) AVT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lineday Patton — TITLE: Executive Director — (X6) DATE: 7/5/22

Reviewed and Acknowledged — AVT 07.08.22

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{D 270}	Continued From page 1 bowel and required total care. Review of Resident #1 current care plan dated 05/10/22 revealed: -The resident required the use of a wheelchair. -The resident was sometimes disoriented, forgetful, and required reminders. -The resident required extensive assistance with toileting and bathing, and limited assistance with dressing, grooming, and transferring. Review of Resident #1's Licensed Health Profession Support (LHPS) evaluation dated 05/11/22 revealed: -The resident required assistance with ambulation and transferring to and from her wheelchair. -The resident was re-admitted back to the facility from a skilled nursing facility on 04/22/22 after she fell on 02/21/22 and sustained a femur fracture. -The resident sustained 3 falls since returning to the facility. -She required a one-person assistance with transfers. -She used a wheelchair to propel herself short distances, but required help for long distances, -She required assistance toileting. -She received physical therapy (PT) and occupational therapy (OT) to help increase her strength. -She was very social and enjoyed the company of others. Review of Resident #1's incident/accident (I/A) report dated 04/30/22 revealed: -The resident sustained an unwitnessed fall and was found on her bedroom floor, lying on her back, near the bed. -The resident stated she tried to transfer herself and fell.	{D 270}		

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{D 270}	Continued From page 2 -She denied pain and there were no visible injuries. -The resident was assisted to the restroom and back into her wheelchair. -The resident's primary care provider (PCP) and guardian were notified. Review of Resident #1's I/A report dated 05/04/22 revealed: -The resident sustained an unwitnessed fall and was found on her bedroom floor, lying on her back. -The resident stated she was trying to close her blinds and fell. -She denied pain and there were no visible injuries. -The resident was assisted into her wheelchair and reminded to use her call bell for assistance. -The resident's PCP and guardian were notified. Review of Resident #1's progress note dated 05/07/22 revealed: -The resident was found in her bedroom floor in front of her recliner with no visible injuries. -The resident was assisted up and was unsteady on her feet but did not complain of pain. -The residents guardian was notified. Review of Resident #1's I/A report dated 05/15/22 revealed: -The resident sustained an unwitnessed fall and was found on her bedroom floor, lying on her back near her bed. -The resident stated she was trying to get into bed and fell. -She denied pain and there were no visible injuries. -The resident was assisted to her bed and reminded to use her call bell for assistance. -The resident's PCP and guardian were notified.	{D 270}		

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{D 270}	Continued From page 3 Review of Resident #1's I/A report dated 05/19/22 revealed: -The resident sustained an unwitnessed fall and was found on her bedroom floor. -The resident stated she was trying to get up from her wheelchair and fell. -The resident was assisted back to her wheelchair. -The resident's PCP and guardian were notified. Review of Resident #1's progress note dated 05/20/22 revealed the resident was found in the bathroom on the toilet without assistance. Interview with Resident #1's family member on 06/01/22 at 9:56am revealed: -Resident #1 could no longer walk independently since she broke her hip in February 2022. -Resident #1 had begun sundowning (a neurological condition associated with increased confusion and restlessness related to dementia and Alzheimer's disease) in the afternoons and evening so she hired a private sitter to provide assistance and increased supervision to prevent her from falling. -Resident #1 forgets that she broke her hip and tried to walk independently sustaining several falls. -She was not sure if the facility was providing Resident #1 with increased supervision when there was not a private sitter with the resident but she knew facility staff checked on the resident every 2 hours. -She was not sure if facility staff were assisting Resident #1 to the restroom after dinner, and thought that may be reason the resident was falling in the evenings. Interview with Resident #1's private sitter on	{D 270}		

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{D 270}	Continued From page 4 06/01/22 at 08:15am revealed: -She began working as a private sitter for Resident #1 on 04/24/22. -She normally worked Monday through Friday from 8:00am to 4:30pm. -There was sometimes another private sitter that would come in the evenings to relieve her from 4:00pm-8:00pm. -She was there to ensure Resident #1 was not left alone for her safety and to prevent her from falling. -She assisted Resident #1 with toileting frequently, redirecting her as needed, and any other activity of daily living the resident needed assistance with. -Resident #1 was used to being independent and was sometimes disoriented and confused when she was tired. -Resident #1 had never fallen while she was working. Interview with a personal care aide (PCA) on 06/01/22 at 9:32am revealed: -Resident #1 did not remember that she was weaker and unsteady on her feet since she came back to the facility after breaking her hip. -Resident #1 required at least one person to assist her with all tasks. -Resident #1 liked to get up on her own, and when she tried to get up out of her wheelchair, she forgot to lock it before getting up and fell. -Resident #1 was sometimes disoriented and forgetful, but sometimes did not call for help because she did not want to have to bother the staff to assist her and often needed reminders to use her call bell. -Resident #1's family hired a private sitter, but they came on different days and times and were not always with the resident. -When there was no private sitter available, the	{D 270}		

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{D 270}	Continued From page 5 facility staff checked on the resident every 2 hours and sometimes more often because they knew she was a fall risk. -She had never been instructed to check on Resident #1 more often than every 2 hours that they provide supervision/safety checks; she was not sure why. -The staff tried to keep Resident #1 in the common areas and sometimes some of the other residents would try to look after her, but her last four falls occurred when the resident was in her room alone. Interview with a medication aide (MA) on 06/01/22 at 9:43am revealed: -Resident #1 required assistance with all tasks and liked to stay busy doing things and talking to other people. -She had several falls in the last month when she had been in her room alone. -She tried to check on Resident #1 more frequently than the standard 2 hours because she knew that the resident did not remember and would forget she could not walk and do things by herself anymore. -She had never been instructed to provide supervision/safety checks more frequently than every 2 hours and was unsure how often other staff checked in on the resident. -Resident #1 was a known fall risk and staff tried to keep her in the common areas as much as possible. -Increased supervision could have prevented Resident #1 from falling because the resident never fell when a private aide was on there to assist the resident. -Resident #1 only fell when she was alone and usually in the evenings. Interview with the Administrator on 06/01/22 at	{D 270}		

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{D 270}	Continued From page 6 8:40am revealed: -Before Resident #1 moved back to the facility on 04/22/22, she spoke with the resident's family several times due to the concern that the resident had multiple falls in the skilled nursing facility while she was recovering from a broken hip, from a fall, that occurred at this facility in February 2022. -Resident #1 wanted to be independent so the staff together to implement some interventions to try and prevent the resident from falling after she returned to the facility. -Interventions included placing the resident in a smaller room, pushing her bed against the wall, and installing halo bars for her to use to reposition herself, and employing a private sitter to be with Resident #1 Monday through Friday from 8:00am to 4:00pm as well as in the evenings if there was a sitter available. -If there was no private sitter available, the facility staff knew to keep a closer eye on the resident, but there had not been any formal increased supervision implemented for the resident. -She did not implement increased supervision for Resident #1 because she thought all the interventions she had put into place were sufficient to prevent her from falling. -Because the staff already knew the resident was a fall risk and they would try to keep the resident in the common areas as often as possible. -All residents were expected to receive safety/supervision checks every two hours and she did not increase Resident #1's safety/supervision checks because the daughter often came to visit as well. -There was no documentation of safety/supervision checks because the staff just knew to do them, and she really thought Resident #1's falls had been "spacing out" and improving.	{D 270}		

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{D 270}	Continued From page 7 Attempted interview with the primary care provider on 06/01/22 at 9:18am and 10:19am were unsuccessful.	{D 270}		

PLAN OF CORRECTION for Follow up survey completed on June 2, 2022.

Spring Arbor of Outer Banks
HAL-028-002

Dare County

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

D 270 - 10A NCAC 13F .0901(b) 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

Following this survey, the immediate safety needs of Resident #1 were addressed: added Safety Checks were implemented, the call bell was discussed with the resident, private aide, and family. Call bell positioned easily within reach and visible to resident. The PCP for Resident #1 was contacted to discuss that the interventions already in place were appropriate.

Team Member re- education on Safety Check Guidelines was conducted. In addition, key components of Rose Program Falls Management were reviewed with team members, as well as reminders about proper use of Hot Box. Re- education with all staff done on 6/2/22 and 6/3/22.

Resident #1 continued to be on Rose Program (Falls Management) and team was informed of safety checks and to continue ongoing interventions related to fall safety.

All interventions were continued until resident's discharge to Skilled Nursing with hospice/palliative care on June 29, 2022.

Prevention of Re-occurrence

The Resident Care Director and/or Executive Director will review the Shift-to-Shift report each day to identify new care concerns for any resident. Documentation for Hot Box residents will be reviewed at this same time.

Stand-up meetings each day will alert department heads and team members to individualized care concerns or challenges and any new related orders or interventions of which to be aware.

Weekly Rose Program meetings will review fall incidents and fall risk assessments from the prior week and will document collaborative discussion regarding appropriate interventions to be in place for an individual resident.

AVT

PLAN OF CORRECTION for Follow up survey completed on June 2, 2022.

Fall risk assessments will continue to be completed for each resident upon move in, after a fall, or with a change of condition.

Communication with the PCP will be maintained for residents with new fall risk considerations, to assure prompt response to a resident's needs

Monitoring Responsibility & Frequency

It is the responsibility of the Executive Director to assure that Rose Program meetings occur each week. In the absence of the Executive Director, the Resident Care Director or Designee will assume this responsibility.

The Regional Director and/or Regional Nurse will continue to audit Roses Program notes and interventions during each community visit quarterly.

Correction Completion Date: 6/3/2022

AVT

DQ.ID