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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on November 15, 2022 and November 16, 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 A TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) who had a diagnosis of Alzheimer's disease and who had a history of falls. The findings are: Review of the facility's falls policy dated September 2021 revealed: -The community would evaluate fall risk on admission and readmission and document the interventions according to the care needs and physician orders. -On admission or readmission, the resident would be evaluated by management for fall risk. -The resident would be evaluated after each fall,	D 270		

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and appropriate reports would be completed with documentation of each new intervention.
-When a fall or fall-related accident/incident occurred, a fall-related accident/incident report would be completed by the Resident Care Coordinator (RCC) or designee in the electronic Medication Administration Record (eMAR) at which time the facility's 72-hour fall management follow-up would be added in the eMAR.
-Vital signs and observations for any changes would be completed every shift by the medication aide (MA) along with documentation in a shift progress note.
-Within 24-48 hours of each fall, a manager would complete the post fall care plan evaluation for interventions.
-A new intervention must be added for each additional fall.
-The RCC or designee would add the fall risk banner to the face sheet in the eMAR.
-The RCC or designee would add the fall risk banner to the resident's face sheet in the eMAR and add the fall-risk emblem to the resident's door name plate.
-The RCC or designee would add intervention(s) to the orders in the eMAR.

Review of Resident #2's current FL2 dated 02/14/22 revealed:
-Diagnoses included Alzheimer's disease, atrial flutter, history of prostatic malignancy, history of lung cancer, and history of colon cancer.
-He was intermittently disoriented.
-His ambulatory status was semi-ambulatory with use of a wheelchair.
-He was incontinent of bladder and bowel.
-There was an order for a bed alarm to be used whenever the resident was in bed and to check function of the alarm every shift.

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Review of Resident #2's Rapid Geriatric Assessments dated 08/11/22 and 11/16/22 revealed:
-Resident #2 had a check box entry documenting that he either had a lot of difficulty walking across the room, used aides, or was unable to walk.
-Resident #2 had a check box entry documenting that he either had a lot of difficulty transferring himself from a chair or a bed, or was unable to transfer himself.
-Resident #2 had four or more falls in the last year.
-Resident #2's brief interview for mental status (BIMS) revealed he had a severe impairment.

Review of Resident #2's care plan dated 09/19/22 revealed:
-He was non-ambulatory and used a wheelchair.
-There was documentation that Resident #2 walked at times.
-He was always disoriented.
-He had significant memory loss and must be directed.
-He required extensive assistance with toileting, limited assistance with ambulation/locomotion, and limited assistance with transferring.

Review of Resident #2's licensed health professional support (LHPS) assessment dated 08/11/22 and 11/15/22 revealed LHPS tasks included ambulation using assistive devices that required physical assistance, and transferring semi-ambulatory or non-ambulatory residents.

Review of Resident #2's Special Care Unit (SCU) profile and care plan dated 10/03/22 revealed:
-Resident #2's behavior patterns were anxious and cooperative.
-He was incontinent and required staff for toileting needs and hygiene.

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-He used his wheelchair independently.
-He required limited assistance with transferring.
-His cognitive impairment was a level 3 which was described as: mid loss, handles most things, does not recognize others ownership, language is poor and responds to tone of voice, body language and facial expressions, limited use of tools and utensils, does things because they feel, taste, and look good - refuses if they do not. Can imitate but not aware of you as a person.

Review of Resident #2's physician order dated 03/22/22 revealed there was an order to discontinue the bed alarm; it was ineffective since Resident #2 kept removing it from the bed.

Review of Resident #2's hospice recertification form dated 09/28/22 revealed:
-Resident #2 had admitted to hospice services on 02/03/21.
-His life expectancy was less than 6 months.
-His primary diagnosis was severe protein-calorie malnutrition.
-There was documentation he transferred himself often but was unsafe; he did not remember to ask for help.

Observation of Resident #2 on 11/15/22 at 2:00pm revealed:
-He was sitting in his wheelchair in his room.
-His wheelchair was facing his bed with the back of the wheelchair to the bedroom entrance.
-There was a scoop mattress on the bed.
-The bed was in a low position to the floor.

Observation of Resident #2's room on 11/16/22 revealed:
-There was a star emblem on the wall above the room door.
-At 3:45pm, Resident #2 was in his room lying in

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bed.
-At 4:25pm, a personal care aide (PCA) walked past Resident #2's room without looking into the room to check on Resident #2.
-At 4:28pm, 43 minutes from the start of the observation, two PCAs walked into Resident #2's room.

a. Review of Resident #2's accident/incident report dated 09/19/22 revealed:
-At 10:40pm, Resident #2 had an unwitnessed fall in his room.
-Resident #2 was found lying on the floor on his left side on top of his pillow.
-There was no injury as a result of the fall.
-The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's Fall Risk Intervention Care Plan dated 09/19/22 revealed:
-There were no medical conditions or medications that were causal factors in the fall.
-There were no environmental factors such as poor lighting or clutter on floor as factors in the fall.
-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident.
-There was a care plan meeting on 09/20/22 to discuss planned interventions and educate regarding safety issues.
-Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR

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to alert staff that safety measures were required.

Review of Resident #2's September 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 09/21/22 on first, second or third shifts, and on 09/22/22 on second and third shifts.

Refer to interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to the interview with a second medication aide (MA) on 11/15/22 at 4:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with a fourth medication aide MA on 11/16/22 at 11:10am.

Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm.

b. Review of Resident #2's accident/incident report dated 09/19/22 revealed:
-At 11:21pm, Resident #2 had an unwitnessed fall in his room.
-Resident #2 was found lying on the floor on his left side.
-There was no injury as a result of the fall.
-The post-fall 72-hour vital signs and monitoring

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program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's Fall Risk Intervention Care Plan dated 09/20/22 revealed:
-There were no medical conditions or medications that were causal factors in the fall.
-There were no environmental factors such as poor lighting or clutter on floor as factors in the fall.
-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident.
-There was a care plan meeting on 09/20/22 to discuss planned interventions and educate regarding safety issues.
-Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required.

Review of Resident #2's September 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 09/21/22 on first, second or third shifts, and on 09/22/22 on second and third shifts.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to interview with a third medication aide (MA) on 11/16/22 at 9:45am.

Refer to the telephone interview with a fourth MA on 11/16/22 at 11:10am.

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Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm.

c. Review of Resident #2's accident/incident report dated 09/20/22 revealed:
-At 6:55am, Resident #2 had an unwitnessed fall in his room.
-Resident #2 was found lying on the floor on his left side.
-There was no injury as a result of the fall.
-The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's Fall Risk Intervention Care Plan dated 09/20/22 revealed:
-There were no medical conditions or medications that were causal factors in the fall.
-There were no environmental factors such as poor lighting or clutter on floor as factors in the fall.
-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident.
-There was a care plan meeting on 09/20/22 to

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discuss planned interventions and educate regarding safety issues.
-Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required.

Review of Resident #2's September 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 09/21/22 on first, second or third shifts, and on 09/22/22 on second and third shifts.

Review of Resident #2's hospice note dated 09/20/22 revealed:
-The nurse assessed Resident #2 following his fall earlier that morning.
-Resident #2 denied pain.
-She encouraged Resident #2 to call for help before getting up and to wait for someone to come assist him in an attempt to prevent future falls.

Telephone interview with a fourth medication aide (MA) on 11/16/22 at 11:10am revealed:
-She had completed incident/accident reports for Resident #2's fall on 09/20/22.
-She worked third shift.
-During the night, Resident #2 got up to try and walk to the bathroom which caused him to fall because he was not strong enough to walk.
-She had spoken with Resident #2's power of attorney (POA) regarding what else they could do to prevent him from falling but they could not think of anything.
-Both the personal care aides (PCAs) and MAs checked on Resident #2 every 30 minutes.
-Even when the PCAs brought Resident #2 to the bathroom, he still would stand up and try to walk afterward.
-For fall prevention interventions Resident #2 had

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a scoop mattress and they kept his bed in the lowest position to the floor.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with Resident #2's POA on 11/16/22 at 12:00pm.

Refer to the interview with a PCA on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm.

d. Review of Resident #2's accident/incident report dated 09/21/22 revealed:
-At 9:00pm, Resident #2 had an unwitnessed fall in his room.
-Resident #2 was found lying on his back next to his bed.
-There was no injury as a result of the fall.
-The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's September 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 09/22/22 on second and third shifts, or on 09/23/22 on first, second or third shift.

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Review of Resident #2's hospice note dated 09/22/22 revealed:
-The nurse was aware that Resident #2 had fallen the previous night.
-There was a safety intervention of applying a new scoop mattress to Resident #2's bed.
-Resident #2 was confused and told the nurse it was his first day there at the facility.
-Resident #2 denied having any pain.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to the interview with a second medication aide (MA) on 11/15/22 at 4:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED)on 11/16/22 at 4:40pm.

e. Review of Resident #2's accident/incident report dated 10/02/22 revealed:
-At 3:40pm, Resident #2 had an unwitnessed fall in his room.
-Resident #2 was found lying on his left side.
-There was no injury as a result of the fall.
-The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or

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change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's Fall Risk Intervention Care Plan dated 10/03/22 revealed:
-There were no medical conditions or medications that were causal factors in the fall.
-There were no environmental factors such as poor lighting or clutter on floor as factors in the fall.
-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that Resident #2 was receiving hospice services and all interventions possible were currently in place.
-There was a care plan meeting on 10/03/22 to discuss planned interventions and educate regarding safety issues.
-Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required.

Review of Resident #2's October 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 10/03/22 on third shift, or 10/05/22 on second shift.

Review of Resident #2's hospice note dated 10/04/22 revealed:
-The hospice social worker visited with Resident #2.
-She noted he had increased weakness because he was slouched down in his wheelchair.
-Resident #2 denied having pain.
-Resident #2 continued to be a high fall risk with poor safety awareness.

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D 270	Continued From page 12 -Resident #2 self-propelled himself in his wheelchair. Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm. Refer to the interview with a second medication aide (MA) on 11/15/22 at 4:15pm. Refer to interview with a third MA on 11/16/22 at 9:45am. Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm. Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm. Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm. f. Review of Resident #2's accident/incident report dated 10/09/22 revealed: -At 12:35am, Resident #2 had an unwitnessed fall in his room. -Resident #2 was found lying on the floor in his room. -Resident #2 had complained of having hip pain upon assessment post-fall. -The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR). Review of Resident #2's Fall Risk Intervention	D 270		

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WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

(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 270	Continued From page 13 Care Plan dated 10/09/22 revealed: -There were no medical conditions or medications that were causal factors in the fall. -There were no environmental factors such as poor lighting or clutter on floor as factors in the fall. -There were no safety-related factors such as lighting or call bells that contributed to the fall. -Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident. -There was no care plan meeting following this fall. -Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required. Review of Resident #2's October 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 10/10/22 on second and third shifts. Telephone interview with a fourth medication aide (MA) on 11/16/22 at 11:10am revealed: -She had completed incident/accident reports for Resident #2's fall on 10/09/22. -She worked third shift. -When Resident #2 fell on 10/09/22, he had initially told her that his hip hurt, but then denied pain right afterward; hospice evaluated him, and he did not need to go to the hospital. -During the night, Resident #2 got up to try and walk to the bathroom which caused him to fall because he was not strong enough to walk. -She had spoken with Resident #2's power of attorney (POA) regarding what else they could do to prevent him from falling but they could not think of anything.	D 270		

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D 270	Continued From page 14 -Both the personal care aides (PCAs) and medication aides (MAs) checked on Resident #2 every 30 minutes. -Even when the PCAs brought Resident #2 to the bathroom, he still would stand up and try to walk afterward. -For fall prevention interventions Resident #2 had a scoop mattress and they kept his bed in the lowest position to the floor. Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm. Refer to interview with a third MA on 11/16/22 at 9:45am. Refer to the telephone interview with Resident #2's POA on 11/16/22 at 12:00pm. Refer to the interview with a PCA on 11/16/22 at 3:25pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm. Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm. g. Review of Resident #2's accident/incident report dated 10/10/22 revealed: -At 10:30am Resident #2 had an unwitnessed fall in his room. -Resident #2 was found lying on the floor on his left side. -There was no injury as a result of the fall. -The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).	D 270		

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D 270	Continued From page 15 Review of Resident #2's Fall Risk Intervention Care Plan dated 10/10/22 revealed: -There were no medical conditions or medications that were causal factors in the fall. -There were no environmental factors such as poor lighting or clutter on floor as factors in the fall. -There were no safety-related factors such as lighting or call bells that contributed to the fall. -Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident. -There was a care plan meeting on 10/10/22 to discuss planned interventions and educate regarding safety issues. -Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required. Review of Resident #2's October 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 10/10/22 on third shift, or 10/12/22 on second and third shifts. Review of Resident #2's hospice clinical note dated 10/13/22 revealed: -The hospice nurse assessed Resident #2. -Resident #2 had two falls, on 10/09/22 and 10/10/22 since her last visit. -On 10/09/22 Resident #2 had reported some hip pain initially but upon her assessment there was no apparent injury. -Resident #2 continued to attempt to toilet himself and did not remember falling. -He had ongoing generalized weakness. Interview with a medication aide (MA) on 11/15/22	D 270		

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at 2:15pm revealed:
-She had completed the incident report from Resident #2's fall on 10/10/22.
-Resident #2 still thought he was able to get up and walk because of his Alzheimer's, but his body was too weak and that was the cause of his frequent falls.
-As a fall prevention intervention, Resident #2 was on increased supervision for 72 hours following a fall.
-The personal care aides (PCA) and MAs worked together to check on every resident every 30 minutes.
-During the 30 minute checks, staff would encourage Resident #2 to use the restroom because even if he said he did not have to go, sometimes he actually did.
-Even if Resident #2 was agreeable to toileting during the 30 minute check, he still sometimes would try to transfer himself from his wheelchair to the bed, or from his wheelchair to the toilet, which would cause him to fall.
-The MAs were not responsible for completing care plans or implementing fall prevention interventions, but the Resident Care Coordinator (RCC) was.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to the interview with a second MA on 11/15/22 at 4:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

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D 270	Continued From page 17 Refer to the interview with a PCA on 11/16/22 at 3:25pm. Refer to the interview with the RCC on 11/16/22 at 3:30pm. Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm. h. Review of Resident #2's accident/incident report dated 10/13/22 revealed: -At 4:00pm Resident #2 had an unwitnessed fall in his room. -Resident #2 was found lying on his bathroom floor. -There was no injury as a result of the fall. -The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR). Review of Resident #2's Fall Risk Intervention Care Plan dated 10/14/22 revealed: -There were no medical conditions or medications that were causal factors in the fall. -There were no environmental factors such as poor lighting or clutter on floor as factors in the fall. -There were no safety-related factors such as lighting or call bells that contributed to the fall. -Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident. -There was no care plan meeting following this fall. -Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR	D 270		

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to alert staff that safety measures were required.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to the interview with a second medication aide (MA) on 11/15/22 at 4:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm.

i. Review of Resident #2's accident/incident report dated 11/10/22 revealed:
-At 10:00pm Resident #2 had an unwitnessed fall in his room.
-Resident #2 was found lying on the floor on his right side.
-There were abrasions to his right toe and his right elbow; first aid was applied.
-The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's Fall Risk Intervention Care Plan dated 11/11/22 revealed:

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-There were no medical conditions or medications that were causal factors in the fall.
-There were no environmental factors such as poor lighting or clutter on floor as factors in the fall.
-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #2 was cognitively impaired and there were no new interventions implemented with documentation that all interventions possible were in place for this hospice resident.
-There was no care plan meeting following this fall.
-Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required.

Review of Resident #2's November 2022 eMAR revealed there was no post-fall 72-hour vital signs documented on 11/12/22 on first and second shifts, or 11/13/22 on second shift.

Interview with a fifth medication aide (MA) on 11/16/22 at 5:40pm revealed:
-She had completed the incident/accident report for Resident #2's fall on 11/10/22.
-She thought the reason Resident #2 fell was because his wheelchair sat him up too straight and he either fell out of the chair, or when he stood up his feet slipped.
-Resident #2 often attempted to transfer himself out of his wheelchair or out of his bed which caused him to fall.
-Staff checked on him every 30 minutes but they did not document it because there was no place to document and no expectation that they document the 30-minute checks.
-Resident #2 was on increased supervision for the 72 hours following one of his falls which

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included vital signs every shift and monitoring for a change in condition or injury each shift.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm.

j. Review of Resident #2's accident/incident report dated 11/14/22 revealed:
-At 4:33pm Resident #2 had a fall in his room.
-Resident #2 was found lying on the floor on his left side.
-Resident #2 had a bloody nose, with bruising to the left of his face within 30 minutes of the fall.
-The post-fall 72-hour vital signs and monitoring program to monitor for bruising, pain, injury, or change in mental status was activated on the electronic Medication Administration Record (eMAR).

Review of Resident #2's Fall Risk Intervention Care Plan dated 11/15/22 revealed:
-There were no medical conditions or medications that were causal factors in the fall.
-There were no environmental factors such as

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poor lighting or clutter on floor as factors in the fall.
-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #2 was cognitively impaired.
-Increased supervision was the documented fall prevention intervention.
-There was a care plan meeting on 11/15/22 to discuss planned interventions and educate regarding safety issues.
-Per the falls policy, Resident #2's safety awareness emblem was in place on his door and the fall risk banner was on his profile in the eMAR to alert staff that safety measures were required.

Refer to the interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm.

Refer to the interview with a second medication aide (MA) on 11/15/22 at 4:15pm.

Refer to interview with a third MA on 11/16/22 at 9:45am.

Refer to the telephone interview with Resident #2's power of attorney (POA) on 11/16/22 at 12:00pm.

Refer to the interview with a personal care aide (PCA) on 11/16/22 at 3:25pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm.

Refer to the interview with the Executive Director (ED) on 11/16/22 at 4:40pm.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 11/16/22 at 2:50pm was unsuccessful.

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D 270	Continued From page 22 Based on record review and attempted interview, it was determined Resident #2 was non-interviewable. _____ Interview with Resident #2's hospice nurse on 11/15/22 at 3:15pm revealed: -The fall prevention intervention that Resident #2 had in place was having a scoop mattress on his bed to keep him safe. -Resident #2 had a pressure sensor alarm on his bed, but he kept throwing it on the floor and breaking it, so the bed alarm had been discontinued. -He also had a floor mat at one point, but the floor mat was discontinued because it was a trip hazard for the resident. -Resident #2 usually fell from his wheelchair because he impulsively would get up to go to the bathroom and was not strong enough to walk more than a couple of steps at a time. -He never remembered to lock the brakes on his wheelchair so sometimes he would fall from the wheelchair rolling out from under him. -To prevent Resident #2 from falling, he would need one-to-one supervision or a sitter to stay with him at all times. -She, along with facility staff, and Resident #2's power of attorney (POA) had discussed the option of getting a sitter for him, but the cost was too high to pursue that option. -They had also discussed having the personal care aides (PCAs) toilet Resident #2 more frequently than every two hours, but if he did not have to go at that moment, he would continue to stand up and try to walk to the bathroom once the staff left his room. -She did not know what else the staff could do to prevent Resident #2 from falling because of his dementia, impulsivity, and lack of safety	D 270		

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awareness.
-They did not recommend physical therapy for strengthening for residents who were on hospice.
-Physical therapy could do a safety evaluation for Resident #2, but it would not be effective because Resident #2 was unable to remember any new safety measures the physical therapist would teach him.

Interview with a second medication aide (MA) on 11/15/22 at 4:15pm revealed:
-She had completed the incident/accident reports from Resident #2's falls on 09/19/22 (at 10:40pm), 09/21/22, 10/02/22, 10/13/22, and 11/14/22.
-She had erroneously documented that the fall on 11/14/22 was witnessed, but it had been unwitnessed.
-Whenever she asked Resident #2 what caused him to fall, he usually claimed that he slipped and fell out of his wheelchair.
-Resident #2 would get up on his own without calling for help to use the bathroom.
-The only fall prevention intervention that she was aware of for Resident #2 was his scoop mattress.
-Resident #2's POA brought him a pair of grippy house slippers to try to prevent his feet from slipping but she could not remember when he received the slippers and they did not seem to be effective.
-Resident #2 had an alarm on his bed at one point, but they removed it a couple of months prior because he broke it.
-Resident #2 usually spent time in the activity room where staff were able to monitor him, but when he was in his room, the PCAs usually checked on him hourly.
-They did not complete 30-minute checks for Resident #2 and even if they did, it would not keep Resident #2 from falling.

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-Staff always kept Resident #2's room door open so that they could peek in on him every time they walked past his room, and his room was on the hall with the most foot traffic.

Interview with a third MA on 11/16/22 at 9:45am revealed:
-Resident #2 tried to do everything for himself which caused him to fall.
-He slid down in his wheelchair a lot and tried to transfer himself which resulted in him sliding to the floor.
-To prevent Resident #2 from falling, all staff were responsible for ensuring his bed was in the lowest position.
-The PCAs and MAs checked on Resident #2 every 30 minutes and toileted him every two hours just like they did for all the residents at the facility.
-Only one resident had 30-minute checks on their eMAR, and she did not know why Resident #2 did not have 30-minute checks on his electronic medication administration record (eMAR).
-After a fall, a resident was placed on increased supervision which meant each shift would document vital signs and do an assessment on the resident for 72 hours following the fall.

Telephone interview with a fourth MA on 11/16/22 at 11:10am revealed:
-She had completed incident/accident reports for Resident #2's falls on 09/19/22 (at 11:21pm), 09/20/22 and 10/09/22.
-She worked third shift.
-When Resident #2 fell on 10/09/22, he had initially told her that his hip hurt, but then denied pain right afterward; hospice evaluated him, and he did not need to go to the hospital.
-During the night, Resident #2 got up to try and walk to the bathroom which caused him to fall

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because he was not strong enough to walk.
-She had spoken with Resident #2's POA regarding what else they could do to prevent him from falling but they could not think of anything.
-Both the PCAs and MAs checked on Resident #2 every 30 minutes.
-Even when the PCAs brought Resident #2 to the bathroom, he still would stand up and try to walk afterward.
-For fall prevention interventions Resident #2 had a scoop mattress and they kept his bed in the lowest position to the floor.

Telephone interview with Resident #2's POA on 11/16/22 at 12:00pm revealed:
-Resident #2 forgot that he was no longer safe to walk on his own, and he fell a lot because he tried to transfer himself.
-He had a floor mat at one point, but it seemed to make the room more dangerous for him because he still attempted to transfer himself even though the wheelchair was further away from the bed with the mat in place.
-His bed alarm had been discontinued because he kept disabling it.
-She had brought in a body pillow for him with the intention of him sleeping further from the edge of his bed, but he kept throwing the pillow off the bed.
-Resident #2 had a scoop mattress, but she did not know of any other fall prevention measures in place.
-She was told that the staff checked on Resident #2 every 30 minutes.
-The RCC had brought up transferring Resident #2 to a skilled nursing facility (SNF,) but she did not want him to move to another facility.
-She thought Resident #2 would have just as many falls at a SNF because he was impulsive about standing up when staff were not around,

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and she would not be able to pay for him to have one-on-one supervision at a SNF either.
-Resident #2 was familiar with his current facility because he had been living there so long and she did not feel it would be in his best interest to move him somewhere else.

Interview with a PCA on 11/16/22 at 3:25pm revealed:
-He usually worked second shift.
-Fall prevention measures in place for Resident #2 included changing out his socks for grippy house slippers, sitting up straight in his wheelchair if they saw him slouching down in it, and doing 30-minute checks on him.
-PCAs did not document their 30 minute checks on the residents because it was a general expectation that they did the 30 minute checks already.
-They offered to help Resident #2 to the bathroom every hour.

Interview with the Resident Care Coordinator (RCC) on 11/16/22 at 3:30pm revealed:
-The facility's policy was that the PCAs were expected to do a visual check on all the residents every 30 minutes, and toilet all the residents every 2 hours.
-The fall prevention interventions they had tried for Resident #2 included a bed alarm that he pulled the wire out of, a lowered hospital bed, and a scoop mattress.
-In Resident #2's mind, he was still able to walk but he could not safely do so.
-Resident #2 did not remember to lock the brakes on his wheelchair which contributed to his falls.
-If staff locked Resident #2's wheelchair brakes, Resident #2 was able to transfer himself with limited staff assistance, but when he fell, he needed the assistance of two staff to help him off

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the floor.
-Whenever a resident fell, it auto-populated the 72-hour vital sign and every shift assessment entries on the eMAR.
-Increased supervision meant to monitor the resident for a change in mental status or any new injury or bruising for 72 hours after a fall.
-They had not implement 15-minute checks on any of the residents.

Interview with the Executive Director (ED) on 11/16/22 at 4:40pm revealed:
-All residents needed to be visualized every 30 minutes and toileted every two hours.
-There was no increased supervision for any resident where the supervision was more frequent than every 30 minutes.
-The 30-minute checks were not a fall prevention intervention because that was the expectation of all staff to complete for all residents.
-There was no written policy documenting the expectation that staff visualized each resident every half hour and complete toileting rounds every two hours because that was just part of their new employee training.
-They did not add a new fall prevention intervention after each fall that Resident #2 had because aside from always having one-on-one supervision, they had exhausted all the fall prevention measures.

Interview with the corporate nurse on 11/16/22 at 5:00pm revealed:
-His role was primarily to complete resident assessments and do staff training.
-He had sat in on a care plan meeting with Resident #2's POA before and nobody knew what else could be done to prevent him from falling because he attempted to self-transfer so frequently.

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D 270	Continued From page 28 -He did a fall risk assessment on Resident #2 the day prior, on 11/15/22 and the initial fall risk assessment he did for Resident #2 was in August 2022. -Resident #2 was a high risk for falls; he did not re-assess him after each fall.	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 11 residents (#6 and #7) observed during the medication passes on 11/15/22 and 11/16/22 including errors with a potassium supplement (#6) and a thyroid medication (#7). The findings are: The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am medication pass on 11/16//22. 1. Review of Resident #6's current FL2 dated 10/17/22 revealed: -Diagnoses included Alzheimer's dementia,	D 358		

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hypertension and shortness of breath.
-There was an order for potassium chloride (a supplement to increase potassium levels) 20 milliequivalents (mEq) once daily.

Review of the "common oral dosage forms that should not be crushed list " provided by the contracted pharmacy provider revealed potassium chloride 20mEq tablets should not be crushed or chewed.

Review of Resident #6's standing orders dated 08/02/22 revealed an order for all medications may be given by mouth/or crushed (CHECK DO NOT CRUSH LIST) and placed in applesauce or pudding unless otherwise noted.

Observation of the medication pass for Resident #6 on 11/16/22 revealed:
-At 8:21am, the morning medication aide (MA) removed one medication packet labeled for morning, 11/16/22, containing 4 oral medications from the weekly supply sent by the contracted pharmacy.
-The MA placed 3 tablets, including one potassium chloride 20mEq, in a plastic pouch and crushed the medications.
-She emptied the plastic pouch in a plastic souffle cup, added one teaspoonful of vanilla pudding to the powder, and mixed the contents of the souffle cup and the pudding.
-At 8:25am, the MA administered 2 one-half teaspoonful servings of the pudding containing Resident #6's crushed potassium chloride 20mEq along with 4 ounces of water.

Review of Resident #6's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for potassium chloride

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20mEq take on tablet daily, scheduled for administration at 9:00am daily.
-Potassium chloride 20mEq was documented as administered on 11/16/22 at 8:28am.

Observation of medication on hand for administration on 11/16/22 at 9:00am revealed Resident #6 had 4 days of medications packets labeled for morning, and night medications, including potassium chloride 20mEq in the morning medication packets.

Interview with the morning MA on 11/16/22 at 11:29am revealed:
-She was aware potassium chloride 20mEq tablets should not be crushed.
-She was nervous during the medication pass and overlooked pulling the potassium chloride 20mEq out of the plastic pouch before crushing Resident #6's tablets.
-She did not know if the facility had a Do Not Crush list available for the MAs to reference because she had not seen one in the 4 months she had been on the medication cart.
-Routinely, she would have pulled the potassium chloride 20mEq from the medications to be crushed and administered it separately.

Telephone interview with a pharmacist at the contracted pharmacy on 11/16/22 at 12:57am revealed:
-Potassium chloride 20mEq tablets should not be crushed and administered in applesauce or pudding.
-The contracted pharmacy's medication packing system did not generate Do Not Crush auxiliary warning labels to alert MAs when a medication should not be crushed.
-The facility should have a reference sheet for medications that were not to be crushed.

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-There was no indicator on record to alert pharmacy staff for Resident #6 having her medications crushed.
-The pharmacist could review residents' medications for crushing and make recommendations to change the dosage form or substitute a different medication for medications that should not be crushed if the facility requested.

Interview with the Resident Care Coordinator (RCC) on 11/16/22 at 1:40pm revealed:
-The morning MA was very nervous during the medication pass and overlooked not crushing Resident #6's potassium chloride 20mEq.
-She had affixed a Do Not Crush list to the top of each medication cart several months prior.
-The MAs complained the list was getting wet from the water pitcher and dirty.
-She taped a copy of the Do Not Crush list to the bottom of the 2nd drawer of the medication carts.
-She assumed the lead MAs had informed all MAs of the location of the Do Not Crush list for medications.
-The MAs should review each medication before crushing the medication and consult the Do Not Crush list if there was a question concerning if a medication was to be crushed.
-The MAs should consult the RCC for additional concerns regarding if a medication should or could be crushed.

Interview with the Administrator on 11/16/22 at 4:45pm revealed:
-The RCC was responsible to ensure medications were administered as ordered.
-The RCC was responsible to ensure MAs had access to a list of medications not to be crushed when administered.
-The MA should reference or consult the Do Not

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D 358	Continued From page 32 Crush list prior to crushing medications. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's primary care provider (PCP) on 11/16/22 at 2:50pm was unsuccessful. 2. Review of Resident #7's current FL2 dated 05/16/22 revealed diagnoses included Alzheimer's disease and hypothyroidism. Review of Resident #7's signed physician orders dated 10/17/22 revealed there was an order for levothyroxine 50 micrograms (mcg) one tablet every morning. (Levothyroxine 50mcg is a thyroid supplement used to treat hypothyroidism.) Observation of the medication pass for Resident #7 on 11/16/22 revealed: -At 8:49am, the morning medication aide (MA) removed one medication packet labeled for morning, 11/17/22, containing 4 oral medications and one medication packet labeled for morning, 11/17/22, containing one levothyroxine 50mcg from the weekly supply of Resident #7's medications sent by the contracted pharmacy. -The MA placed 2 tablets, including one, levothyroxine 50mcg in a plastic pouch and crushed the medications. -She emptied the plastic pouch in a plastic souffle cup, added one teaspoonful of applesauce to the powder, and mixed the contents of the souffle cup and the applesauce. -At 8:52am, the MA administered the applesauce containing the crushed levothyroxine 50mcg to Resident #7.	D 358		

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Observation of Resident #7's medications on hand for administration on 11/16/22 at 8:51 revealed:
-There was one medication packet labeled 11/16/22 for morning administration containing 4 oral medications.
-There was no medication packet labeled 11/16/22 for morning administration containing one levothyroxine 50mcg.

Interview with the morning medication aide (MA) on 11/16/22 at 8:55am revealed:
-When she was removing Resident #7's morning medications from the weekly supply sent from the contracted pharmacy, the medication containers labeled for morning on 11/16/22 and 11/17/22 broke loose from the weekly supply.
-She would staple the medication packet labeled 11/16/22 back to the weekly supply.

Review of Resident #7's November 2022 electronic Medication Administration Record (eMAR) revealed there was an entry for levothyroxine 50mcg one tablet every morning, scheduled for administration at 6:00am daily.

Review of Resident #7's November 2022 detailed eMAR used to document the exact time a medication was documented revealed:
-Levothyroxine 50mcg was documented as administered on 11/16/22 at 5:39am.
-There were 3 medications documented as administered at 8:49am.
-There was no subsequent time of administration documented on 11/16/22.

Second interview with the morning MA on 11/16/22 at 10:33am revealed:
-She was nervous during the medication pass.
-She did not routinely administer Resident #7's

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levothyroxine 50 mcg but did today because it was still in the medication cart and she administered by the label for morning not by the date.
-She pulled 11/16/22 and 11/17/22 medications off the weekly medication supply by accident.
-She used the 2 medications packets dated 11/17/22 to administer Resident #7's morning medications at 8:49am and documented administration on the November 2022 eMAR.
-She did not realize Resident #7's levothyroxine 50mcg had been administered by the night shift MA at 5:39am until there was no levothyroxine 50mcg dated 11/16/22 on hand to staple back to Resident #7's weekly medications card.
-Resident #7 received a second dose of levothyroxine 50mcg at 8:49am along with other medications scheduled for 9:00am.
-She would notify the Resident Care Coordinator (RCC) immediately.

Telephone interview with a night shift MA on 11/16/22 at 10:54am revealed:
-There were 2 MAs administering medications due at 6:00am on 11/16/22.
-The residents' early morning medications were routinely administered in the medication room located in the waiting area for the dining halls (resident were brought to the waiting area in the morning until the dining halls were opened for meals).
-She did not administer Resident #7's levothyroxine 50mcg but was certain Resident #7 was in the medication room and received her 11/16/22 levothyroxine 50mcg from the second night-shift MA around 5:30am.

Interview with the RCC on 11/16/22 at 1:25pm revealed:
-The detailed eMAR for Resident #7 documented

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Resident #7 received levothyroxine 50mcg at 5:39am by the night shift MA.
-There was no levothyroxine 50mcg dated 11/16/22 still available on hand for administration for Resident #7.
-She was not able to reach the night shift MA that documented administration of Resident #7's levothyroxine 50mcg on 11/16/22 at 5:39am but felt certain the medication was administered as documented.
-The morning MA verified she administered Resident #7's levothyroxine 50mcg at 8:49am along with the other medications labeled for 11/17/22 and scheduled for 9:00am because it was available.
-The RCC had notified Resident #7's primary care provider (PCP) and was instructed by the PCP to hold the levothyroxine 50mcg on 11/17/22. (The facility was to send an order to hold levothyroxine 50mcg on 11/17/22 via fax and she would sign the order.)
-She would complete an medication error form for Resident #7 receiving duplicate levothyroxine 50mcg on 11/16/22.

Interview with the Administrator on 11/16/22 at 4:45pm revealed:
-The RCC was responsible to ensure medications were administered as ordered.
-The RCC was responsible to ensure PCP notification for medications not administered as ordered.
-The morning MA was responsible to ensure the correct days of residents' medications were removed from the weekly supply sent by the contracted pharmacy and consult the RCC if there were questions regarding medication administration.

Based on observations, interviews, and record

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D 358	Continued From page 36 reviews, it was determined Resident #6 was not interviewable. Attempted telephone interview with the second night shift MA working on 11/15/22 to 11/16/22 shift on 11/16/22 at 10:59am was unsuccessful. Attempted telephone interview with Resident #6's PCP on 11/16/22 at 2:50pm was unsuccessful.	D 358		