Revised via Email 12/22/22

PRINTED: 11/22/2022
FORM APPROVED

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
	HAL041072	A. BUILDING: _____ B. WING _____	R 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on November 15, 2022 and November 16, 2022.	D 000	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of correction is prepared solely as a matter of compliance with the law.**	
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	**10A NCAC 13F. 0901(b) Personal Care and Supervision** **Community ED and MCC have completed an evaluation assessment of all residents for fall risk and interventions were implemented as needed per physician order and evaluation. Staff was educated on the use of fall interventions as ordered to prevent falls.** **Community Executive Director, RCC and Area Clinical Director will review weekly stand-up, At-Risk notes to ensure the use of interventions such as but not limited to: fall mat, scoop mattress, body/chair or bed alarm, fall risk emblem, two hour checks, one hour checks, 30 minute checks, PT/OT referral and recommendation have been put in place** **Regional Director of Operations and/or Area Clinical Director will review incident report and interventions weekly and PRN** **Community will assure staff provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms** **Residents whom have noted falls between evaluations will be re-evaluated after each fall and new interventions**	11/21/2022 11/21/2022 11/21/2022 11/21/2022

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See page 2 for Rest of page
HMP

			implemented, documented with 72 hour fall management documentation in Matrixcare system. MCC, LSIC and/or ED will assure that any residents with noted at risk for falls will have Fall risk emblems in place and are noted as Fall Risk on Matrix Care banner of resident face sheet.	

Reviewed & Acknowledged
HRD 12/22/22

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D 270	Continued From page 1 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.	D 270		

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D 270	Continued From page 2 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.	D 270		

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D 270	Continued From page 3 -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	D 270		

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D 270	Continued From page 4 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	D 270		

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D 270	Continued From page 5 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	D 270		

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D 270	Continued From page 6 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.	D 270		

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D 270	Continued From page 7 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	D 270		

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D 270	Continued From page 8 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	D 270		

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D 270	Continued From page 9 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.	D 270		

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D 270	Continued From page 10 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	D 270		

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D 270	Continued From page 11 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.	D 270		

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: _____ B. WING _____	R 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

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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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D 270	Continued From page 16 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.	D 270		

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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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D 270	Continued From page 18 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:	D 270		

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D 270	Continued From page 19 -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	D 270		