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	HAL030008	A. BUILDING: _____ B. WING _____	R 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF MOCKSVILLE	150 KEN DWIGGINS DRIVE MOCKSVILLE, NC 27028

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{D 000}	Initial Comments The Adult Care Licensure Section and Davie County Department of Social Services conducted a follow-up survey 01/10/23 through 01/11/23.	{D 000}	Responses to the cited deficiencies does not constitute admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared soley as a matter of compliance with State 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: Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) who had a history of falls. The findings are: Review of the facility's falls policy on 01/10/23 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, 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	D 270	Staff shall attend training on facilities' new falls program, to include admitting and current needs of the resident by 2/10/2023. Care Coordinator to ensure resident's care plans are updated to reflect current needs of each resident, and proper risk notifications are posted for each resident as they occur. Care Coordinator/Executive Director to review falls daily to ensure notification and 72 hour follow up in place. Each intervention, specific to the incident, will be recorded on the Post Fall report, completed with the Incident Report. Monthly At Risk/Falls Meeting will be held by ED/CC and Home Health/Therapy Group to evaluate and place additional interventions if possible, including proper signage.	

Reviewed and Acknowledged 02/10/23 KHH

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D 270	Continued From page 1 Health Record (eHR) at which time the facility's 72-hour fall management follow-up would be added in the eHR. -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 eHR. -The RCC or designee would add the fall risk banner to the resident's face sheet in the eHR 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 eHR. Review of Resident #4's current FL2 dated 11/09/22 revealed: -Diagnoses included cerebral ischemic attack, unspecified osteoarthritis, repeated falls, hypertension, cerebral infraction, hemiplegia and hemiparesis. -She was intermittently disoriented. -Her ambulatory status was semi-ambulatory with use of a cane and wheel chair. -She was continent of bladder and bowel. -She needed help with verbal communication. Review of Resident #4's care plan dated 11/15/22 revealed: -She was ambulatory with the use of an aide or device, wheelchair or cane. -There was documentation that Resident #4 had limited range of motion. -She had adequate memory.	D 270		

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D 270	Continued From page 2 -She required limited assistance with transfers and ambulation. Review of Resident #4's licensed health professional support (LHPS) assessment dated 11/09/22 revealed LHPS tasks included ambulation using assistive devices that required physical assistance, and transferring semi-ambulatory or non-ambulatory residents. Observation of Resident #4 on 01/10/23 at 9:15am revealed: -She was sitting in her recliner chair in her room. -Her recliner chair was right beside her bathroom. -Her call light was on the arm of her recliner chair. Observation of Resident #4's room on 01/11/23 at 9:45am revealed there were no posted signs or symbols in the room or on the door indicating she was a Fall Risk. a. Review of Resident #4's accident/incident report dated 12/29/22 revealed: -At 2:33am, Resident #4 had an unwitnessed fall in her room. -There was an injury as a result of the fall; her back had a red mark on it. -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 12/29/22 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.	D 270		

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D 270	Continued From page 3	D 270		

-There were no safety-related factors such as lighting or call bells that contributed to the fall.
-Resident #4 was cognitively impaired and there were no new interventions implemented with documentation.
-There was a care plan meeting on 12/29/22 to discuss planned interventions and educate regarding safety issues.
-Resident #4 was educated on using the emergency call system.

Review of Resident #4's December 2022 eMAR revealed there was post-fall 72-hour vital signs documented on 12/19/22 on first, second and third shifts, and on 12/20/22 on first, second and third shifts.

Refer to the interview with a medication aide (MA) on 01/10/23 at 3:00pm.

Refer to the interview with a second MA on 01/10/23 at 3:05pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 01/11/23 at 9:20am.

Refer to the interview with Resident #4's primary care provider (PCP) on 01/11/23 at 10:20am.

Refer to the telephone interview with a third MA on 01/11/23 at 10:40am.

Refer to the telephone interview with a personal care aide (PCA) on 01/11/23 at 1:50pm.

Refer to the telephone interview with Resident #4's responsible party on 01/11/23 at 11:30am.

Refer to the interview with the facility's Administrator on 01/11/23 at 11:50am.

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D 270	Continued From page 4 b. Review of Resident #4's accident/incident report dated 01/03/23 revealed: -At 1:33am, Resident #4 had an unwitnessed fall in her room. -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 01/03/23 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 #4 was cognitively impaired and there were no new interventions implemented with documentation. -There was a care plan meeting on 01/03/23 to discuss planned interventions and educate regarding safety issues. -Resident #4 was educated on using the emergency call system. -Per the falls policy, Resident #4's safety awareness emblem was not in place on her door and the fall risk banner was not in her profile in the eMAR to alert staff that safety measures were required. Review of Resident #2's January 2023 eMAR revealed there was post-fall 72-hour vital signs documented on 01/03/23 on first, second or third shifts, and on 01/03/23 on first, second and third shifts.	D 270		

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D 270	Continued From page 5 Refer to interview with a medication aide (MA) on 01/10/23 at 3:00pm. Refer to interview with a second MA on 01/10/23 at 3:05pm. Refer to interview with the Resident Care Coordinator (RCC) on 01/11/23 at 9:20am. Refer to interview with Resident #4's primary care provider (PCP) on 01/11/23 at 10:20am. Refer to telephone interview with a third MA on 01/11/23 at 10:40am. Refer to telephone interview with a personal care aide (PCA) on 01/11/23 at 1:50pm. Refer to telephone interview with Resident #4's responsible party on 01/11/23 at 11:30am. Refer to interview with the facility's Administrator on 01/11/23 at 11:50am. --- Interview with a medication aide (MA) on 01/10/23 at 3:00pm revealed: -She was aware of Resident #4's falls. -Resident #4 was very independent and did not like to call for help. -Resident #4 had been told to use her call bell for assistance. -Staff checked on all the residents every 2 hours. -Staff would check on Resident #4 more often because of the falls, but they did not document frequent checks and had not been told to document frequent checks. Interview with a second MA on 01/10/23 at	D 270		

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D 270	Continued From page 6 3:05pm revealed: -She was aware of Resident #4's falls. -Resident #4 was very independent and did not like to call for help. -Resident #4 had been told to use her call bell for assistance. -Staff checked on all the residents every 2 hours. -Staff checked on Resident #4 more often because of the falls but they were not scheduled checks and they did not document the additional checks. -A wheelchair had been put in Resident #4's room to help her with mobility. Interview with the Resident Care Coordinator (RCC) on 01/11/23 at 9:20am revealed: -Staff, including the MA and personal care aides (PCAs), all reminded Resident #4 to use her call light when she needed to transfer or ambulate. -Resident #4 had also received a new pair of house shoes with grippy soles to try and prevent falls, but she did not choose to wear them often. -Resident #4's cognition was intact but due to her medical diagnoses she was unable to communicate well and did not talk much. -Resident #4 had physical therapy (PT) ordered for her in the past but she often refused to participate. -Placing a fall risk emblem on the door frame was a new program the facility was putting in place in the next week. -Once the fall risk emblem was on Resident #4's door frame, the intention would be to have staff check on her every time they walk past her room. -Staff on all shifts routinely check on all the residents every two hours. -As far as she knew, Resident #4 had never been on increased supervision checks. Interview with Resident #4's primary care provider	D 270		

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(PCP) on 01/11/23 at 10:20am revealed:
-He had ordered PT for Resident #4 three times along with also trying occupational therapy (OT) and speech therapy (ST).
-After Resident #4's fall on 01/03/23 he referred her back to PT, but she had to wait a certain number of days from when she had last been discharged from PT for her insurance to cover it.
-To try and reduce the number of falls or prevent Resident #4 from falling, he had also tried titrating down one her high fall risk medications, but the resident did not tolerate it, so he had to increase the dose back up.
-It seemed lately that Resident #4's falls were happening more on the night shift due to her waking up and trying to get up to go to the bathroom too fast without calling for help.
-He felt that Resident #4 was lucid enough to remember to use the call light for help with transfers, she just chose not to.
-He did not know what other fall prevention interventions the facility could implement to help prevent Resident #4 from falling.

Telephone interview with a third MA on 01/11/23 at 10:40am revealed:
-She primarily worked second shift.
-The MAs and PCAs checked on all the residents every two hours.
-Resident #4 never used her call light.
-She thought Resident #4 fell from getting off balance due to her weak side that was residual from her stroke.
-The fall prevention interventions in place for Resident #4 were PT, reminders to use her call light, and frequent checks from staff.
-The frequent checks were not ordered or care planned, just something the staff all did because they knew Resident #4 had frequent falls.
-She thought there was no fall risk emblem on

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Resident #4's door per the fall risk care plan because it was a violation of the resident's privacy.
-Resident #4 went through periods of time where she would fall often and then periods of time where she would have no falls for months.
-Resident #4 was very independent and liked to do things for herself.

Telephone interview with a PCA on 01/11/23 at 1:50pm revealed:
-He was a PCA on the night shift.
-They looked in on all the residents every two hours.
-Resident #4 used her call light for help occasionally, if she did not think she would be able to make it to the bathroom on her own.
-He was working during one of Resident #4's recent falls and he thought her feet had gotten crossed when she was coming out of the bathroom, causing her to trip.
-He was not aware of Resident #4 ever being injured as a result of her falls.
-Resident #4 was not on increased supervision.
-The PCAs knew which residents were fall risks by the fall emblem in their charting system.

Telephone interview with Resident #4's responsible party on 01/11/23 at 11:30am revealed:
-He was aware of the falls Resident #4 had been having.
-He had encouraged Resident #4 to use the call light in the past, but she liked her independence and chose not to use it.
-He thought the facility had discussed increased supervision with him for Resident #4 in the past, but it was his preference for her to use the call light and not depend on staff to check on her.
-He thought the facility was doing everything they

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D 270	Continued From page 9 could to try to prevent Resident #4 from falling. Interview with the facility's Administrator on 01/11/23 at 11:50am revealed: -She was aware that Resident #4 had falls. -She expected the staff to check on all the residents every two hours. -The staff were constantly reminding Resident #4 to use her call light before transferring and ambulating, but she was very independent and did not like help from the staff. -They had tried PT as a fall prevention intervention, but Resident #4 refused it a lot. -Resident #4 had a fall risk banner in her electronic medication administration record (eMAR) which alerted the MAs that she was a fall risk. -They were in the process of implementing emblems to the door frames of the residents who were fall risks. -They had not discussed doing increased supervision for Resident #4. -She expected a new fall prevention intervention to be implemented after each fall, and for the intervention to be relation to the cause of the fall to try and prevent it from happening again.	D 270		