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
	HAL011005	A. BUILDING: _____ B. WING _____	R 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHER'S FAIRVIEW REST HOME	3016 CANE CREEK ROAD FAIRVIEW, NC 28730

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and a complaint investigation from 07/20/23 through 07/21/23.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 resident rights (Resident #4) were maintained related to the residents television remote control being removed from the resident's room. The findings are: Review of Resident #4's current FL2 dated 03/28/23 revealed diagnoses included Alzheimer's disease and dementia. Interview with Resident #4 during the initial tour on 07/20/23 at 8:46am revealed: -Someone had taken one of those "things" out of her room. -"They" took "it" out of her room and now she had to "walk" to get the item. -She indicated she would like to be able to hear sound from her television. Observation in Resident #4's room on 07/20/23 at 8:48am revealed: -There was a television on the right side of the room. -There was a picture on the screen of the	D 338		

LSB Reviewed and acknowledged 08/25/23

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D 338	Continued From page 1 television, but there was no sound. -There were two remote controls on a table directly adjacent to the resident's chair. -The volume on the television was not muted nor could it be adjusted using the remote controls. Telephone interview with Resident #4's family member on 07/20/23 at 4:05pm revealed: -She visited Resident #4 on 07/18/23 at 4:15pm. -When she arrived, Resident #4's television was off. -There was one remote in the room, which controlled the power to the television. -She powered the television on. -There was no sound coming from the television. -She searched for the second remote but was unable to find it. -The volume and channel selection remote was not in the room. -A medication aide (MA) came by the room and she asked her where the other remote control was for the television. -The MA told her staff had been instructed to take the remote out of Resident #4's room. -The MA told her Resident #4 would have to walk down to the desk and ask for the remote when she wanted it. -She was "upset" staff removed the remote and Resident #4 did not have any sound on the television "even during the day." -Resident #4 had a diagnosis of Alzheimer's disease and was unable to remember to go to the desk to ask for the return of the remote control. -Resident #4 had called her on 07/16/23 and started crying, saying she could not "be here anymore." -She did not understand at the time why Resident #4 had been so upset, until she visited and then she knew it was probably because she was sitting there with no sound on her television.	D 338		

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D 338	Continued From page 2 -She called the Resident Care Coordinator (RCC) on 07/18/23 and left a voicemail communicating her concerns about the remote being taken from Resident #4. -She felt there were better ways staff could have addressed the problem rather than to take the remote control. -The RCC returned her call the next day (07/19/23). -The RCC told her the remote had been returned to Resident #4 and staff had been instructed not to take it out of the room again. -The RCC stated staff were instructed to ask Resident #4 to turn the volume down on the television when it disturbed other residents. Interview with a personal care aide (PCA) on 07/20/23 at 11:55am revealed: -The item Resident #4 was referring to being removed from her room was her television remote control which controlled the volume and channel selection. -Staff had been instructed by the Administrator to remove the remote control from Resident #4's room after the resident went to sleep in the evenings for "about a week." -Staff were instructed by the Administrator to return the remote control to Resident #4's room at 8:00am the next day. -Resident #4 would fall asleep with the remote in her hand and accidentally turn the volume up on the television disturbing other residents. -Resident #4 was not hard of hearing and listened to her television at a reasonable level during the daytime. -The television remote control was returned to Resident #4's room on Tuesday (07/18/23) and had not been removed again. -The sound on Resident #4's television was not working when she came in to work the morning of	D 338		

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D 338	Continued From page 3 07/20/23. -She and a MA had tried to adjust the sound on the television the morning of 07/20/23, but they were unsuccessful. -The MA told her the volume had not worked on the television since 07/19/23. -The MA tried to restore the sound on the television on 07/19/23, but was unsuccessful. Interview with a MA on 07/20/23 at 2:12pm revealed: -She was instructed by the Administrator on 07/14/23 to start removing Resident #4's volume and channel selection remote from the room in the evenings when Resident #4 went to sleep and then return the remote in the mornings the following day by 8:00am. -The Administrator had asked her to let the other staff know to take the remote at night when Resident #4 went to sleep and give it back in the mornings at 8:00am. -She removed the remote for the first time from Resident #4's room when Resident #4 was ready to go to bed at 7:00pm on 07/14/23. -On Tuesday (07/18/23), Resident #4's family member visited and was "upset" the remote control was not in the room. -She was told by the RCC to return the remote to Resident #4's room and to stop removing it from the room. Interview with a second MA on 07/20/23 at 4:35pm revealed: -Resident #4's remote control was at the desk when her shift started on 07/17/23 at 6:30am. -When the Administrator came in on 07/17/23, she asked the Administrator who the remote control belonged to. -The Administrator told her the remote belonged to Resident #4.	D 338		

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D 338	Continued From page 4 -The Administrator said if Resident #4 asked for the remote or came up to the desk to get the remote to give it back to her. -She did not know why Resident #4's remote control was at the desk. Interview with the RCC on 07/21/23 at 8:05am revealed: -An MA called her on 07/18/23 and said a family member was upset the remote control had been taken from Resident #4's room. -She told the MA to give the remote control back to Resident #4. -Resident #4 would not know to walk to the desk and ask for the remote when she wanted it. -Staff had been instructed to the take the remote back to Resident #4 in the mornings, however she did not think the staff were taking the remote back to Resident #4. -Staff made her aware on 07/19/23 the volume was set to 100 on Resident #4's television and it was not muted, but there was still no sound coming from the television. -She and the staff thought the sound was broken on the television. Interview with the Administrator on 07/21/23 at 8:45am revealed: -One resident complained the volume level of Resident #4's television at night was preventing them from being able to sleep. -Staff verified they had found the volume on Resident #4's television to be very loud on two occasions at night. -She instructed staff to take Resident #4's television remote control at night after the resident went to sleep starting 07/14/23. -She instructed staff to return the remote to Resident #4's the next day at 8:00am while the resident was at breakfast.	D 338		

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D 338	Continued From page 5 -She did not tell staff Resident #4 would need to walk to the desk and ask for the remote to get it back. -She knew Resident #4 was not able to ask for the remote back due to her diagnosis. -She did not know why staff had not returned the remote control in the mornings as she had instructed. -"Maybe" it was not communicated to all of the staff what was expected. -Normally, staff communicated resident changes during the shift to shift report or there was a shift to shift communication book. -Either staff failed to make an entry in the communication book about removing and returning Resident #4's television remote or staff failed to see the entry in the communication book. -She had asked a MA to be responsible to communicate her instructions concerning Resident #4's remote control to the other staff.	D 338	This deficiency has been corrected by moving resident in room 8 that complained of not being able to sleep due to resident #4's tv volume to room 6 on July 28, 2023. Prior to the July 28 move, 2nd & 3rd shift monitored resident #4's tv volume. Staff will monitor tv volumes closer during hours residents would be sleeping.	7/28/23
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and	D 454		

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D 454	Continued From page 6 (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews the facility failed to ensure the notification of the responsible party of 1 of 1 sampled Resident (#3) within 48 hours of falls without injury. The findings are: Review of Resident #3's current FL2 dated 03/14/23 revealed: -Diagnoses included osteoarthritis, history of stroke, and dementia. -Resident #3 was semi ambulatory and used a walker for ambulation. -Resident #3 was intermittently disoriented. Observation of Resident #3 during the initial tour on 07/20/23 at 8:50am revealed: -Resident #3 was lying on the edge of his bed. -Resident #3's head was on his pillow, but the pillow was partially hanging off the side of the bed. Interview with Resident #3 on 07/20/23 at 8:50am revealed: -He had slid out of the bed onto the floor several times.	D 454		

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D 454	Continued From page 7 -On some occasions he had rolled out of bed onto the floor. Review of nurse's progress notes for Resident #3 dated 05/01/23 through 06/30/23 revealed: -A fall without injury occurred on 05/05/23 but the responsible party (RP) was not notified. -A fall without injury occurred on 05/18/23 but the RP was not notified. -A fall without injury occurred on 06/04/23 but the RP was not notified. -A fall without injury occurred on 06/07/23 but the RP was not notified. -A fall without injury occurred on 06/09/23 but the RP was not notified. Review of the Incident/Accident (I/A) reports for Resident #3 from 05/01/23 to 06/30/23 revealed: -Each IA report had a notation that indicated the time the family member was notified and who was spoken to about the incident that occurred. -On 05/05/23 the time family was notified, and the person spoken to were blank on the I/A report. -On 05/18/23 there was no I/A report completed for the fall that occurred. -On 06/04/23 the time family was notified, and the person spoken to were blank on the I/A report. -On 06/07/23 the time family was notified, and the person spoken to were blank on the I/A report. -On 06/09/23 the time family was notified, and the person spoken to were blank on the I/A report. Interview with a medication aide (MA) on 07/20/23 at 11:45am revealed: -Resident #3 had multiple episodes of sliding out of his bed onto the floor. -She did not consider sliding out of bed onto the floor a fall for Resident #3. -She was unsure if staff always contact the RP when a fall without injury occurred.	D 454		

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D 454	Continued From page 8 Interview with the Resident Care Coordinator (RCC) on 07/20/23 at 12:30pm revealed: -The facility had no written policies and procedures for staff to follow related to resident falls. -The MAs just had training for IA Reports and Fall Prevention on 05/05/23. -The MA on duty when a resident fell should always completed an incident/accident report and a progress note. -The MA on duty when a resident fell should also contact the RP and the primary care provider (PCP) whether an injury occurred or not. Telephone interview with a MA on 07/20/23 at 2:11pm revealed: -She worked as a 3rd shift MA. -If a resident fell during her shift without injury, she did not call the RP in the middle of the night. -She reported to the oncoming 1st shift staff regarding any falls that occurred and directed them to call the RP. -She would leave a message for the PCP via text. -She never followed up to verify contact with the PCP was made per her direction. Telephone interview with the RP on 07/20/23 at 4:24pm revealed: -Resident #3 has had multiple falls and will continue to have falls. -Resident #3 often slid out of bed onto the floor due to his weakness and forgetfulness. -The RP did not keep record of how often staff called her regarding Resident #3's falls since he had so many. Telephone interview with the PCP on 07/20/23 at 4:11pm revealed: -Resident #3 was a known fall risk prior to being	D 454		

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D 454	Continued From page 9 accepted as a resident in the facility. -Many of Resident #3's falls were from sitting on the side of the bed and sliding onto the floor or rolling out of bed onto the floor. -She had not kept track of the number of falls Resident #3 had as she was contacted by the facility staff. Interview with the Administrator on 07/20/23 at 3:18pm revealed: -All the MAs were trained on what to do if a resident had a fall. -If a resident fell and was uninjured, the MA was supposed to complete an I/A report, complete a progress note, and notify the RP and PCP. -She was unaware the MAs were not notifying the RP about each of Resident #3's falls.	D 454	Staff has been instructed about filling out incident/accident reports completely, documenting in charts and notifying resident's responsible person/family about injuries, falls or illness whether medical attention was needed or not. RCC has written up policies and procedures to be followed on this. RCC will be monitoring this as well as the Med Techs. making sure of documentation and notifying of RP's/families. RCC will be monitoring this weekly.	7/28/23