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
	HAL025040	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMORY CAR	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 21, 2024 and February 22, 2024.	D 000		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;	D 255		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lara Williams | TITLE: Senior General Manager | (X6) DATE: 3/18/2024

Reviewed and Acknowledged MW 03/20/24

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D 255	Continued From page 1 (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete an assessment and care plan for 1 of 5 sampled residents (#1) with significant change in mobility with repeated falls. The findings are: Review of Resident #1's current FL-2 dated 07/03/23 revealed: -Diagnoses included dementia, hallucinations, and wandering. -The resident's level of care was memory care. -The resident was documented as constantly disoriented. -The resident was documented as ambulatory with a walker. -The resident required assistance with bathing and dressing. Review of the Resident Register for Resident #1 revealed: -The resident was admitted to the facility on 12/31/18. -The resident was forgetful.	D 255	10A NCAC 13F .0801(c)(1) Resident Assessment Reviewed Reporting and documenting a Change in Condition in Care Team Meeting: All Staff are responsible for reporting events and any change in condition seen for a resident to the Supervisor In Charge (SIC)/Memory Care Coordinator/Nurse/General Manager. The Memory Care Coordinator/Nurse or Designee will assess reported change/needs, document and update the Care Plan as required. Staff training will be conducted to review this Rule and the communities policy and procedures on reporting, documenting and updating a Resident Assessment and Care Plan when it is determined that the resident has had a significant Change in Condition. Included in the training will be the required 10 day timeframe and the listed conditions in the Rule 10A NCAC 13F .0801(c)(1) (A) - (M) to determine a significant change.	The date of correction for this deficiency will not exceed 4/7/24 Completed 3/8/24 Training Scheduled 3/22 & 3/29/24

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D 255	Continued From page 2 Review of an undated Fall Assessment for Resident #1 revealed: -Under Medical History/Problems, the box for incontinence was selected with the comment of "urgency". -Under the please provide of further explanation for each of the boxes checked above: Resident has some urge incontinence and staff manages with pull-ups. -Under the Interventions for Medical History/Problems: Will monitor for changes and notify medical doctor (MD) if he has any issues. Review of Resident #1's Service Plan assessment dated 11/10/23 revealed: -In the Evaluation section under the Fall Potential Evaluation Score, the score was 12. -A Fall Potential Evaluation score was defined as a score between 10 and 26, Resident #1 was a high potential for falls. -The Goal for Resident #1 was listed as "Resident will maintain and/or maximize current level of functioning with fall potential". -Under the Action tab for Devices/Transfer & Ambulation Assistance, walker was listed. -Under the Action tab for Activity of Daily Living (ADL) tab, none apply was listed. -Under the Action Tab for outside Consults tab, none applied was listed. -Under the Action tab for Environmental Room/Hazards, none applied was listed. -Under the Action tab for drug Regimen Review, none applied was listed. -Under the Action tab for Vision/Hearing tab, none applied was listed. -The resident required supervision with toileting, eating, ambulation, personal hygiene, and transferring. -The resident required limited assistance with bathing, dressing, and grooming.	D 255		

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D 255	Continued From page 3 -There was no documentation Resident #1 used a wheelchair for mobility. Review of Resident #1's 6 accident/incident reports for falls dated 12/01/23 through 01/25/24 revealed: -On 12/01/23, Resident #1 was found by staff laying on his back, after they entered his bathroom and found the bathroom sink running and going over into the floor which, paramedics were called and said Resident #1 seemed ok and he was not transported to the hospital, the fall was unwitnessed. -On 12/23/23, Resident #1 was sitting on the floor by the laundry room, his walker was by the bathroom, the fall was unwitnessed. -On 01/05/24, Resident #1 was found lying on his left side in the doorway by staff with no injury, the fall was unwitnessed. -On 01/10/24, Resident #1 was found sitting on the floor outside of his room in the doorway, the fall was unwitnessed. -On 01/18/24, Resident #1 was found in his room, lying on his back halfway on the fall mat that was kept by his bed, the fall was unwitnessed. -On 01/25/24, Resident #1 required an Emergency Department (ED) visit after he was found lying on his back on his bathroom floor with a knot on the back of his head. Review of Resident #1's progress notes dated between 12/01/23 through 02/01/24 revealed: -On 12/27/23, Resident #1 had no issues from his fall but appeared to be confused and kept wandering the hallway -On 12/28/23, Resident #1 still had an unsteady gait. -On 12/29/23, Resident #1 used a wheelchair to ambulate today, he had a hard time bearing weight and ambulating independently or via his	D 255		

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rolling walker.
-On 01/05/24, Resident #1 was continued to be very confused and had unsteady gait, he has been re-directed to sit down or use his walker.
-On 01/06/24 at 2:26pm Resident #1 was unsteady on his feet and needed lots of supervision.
-On 01/06/24 at 9:38pm, Resident #1 tried to get out of wheelchair.
-On 01/07/24, Resident #1 was very unsteady on his feet and had trouble ambulating.
-On 01/15/24 at 1:28pm, Resident #1 ambulated with wheelchair due to unsteady gait, staff had to give frequent reminders about being unable to ambulate independently with his walker.
-On 01/15/24 at 8:50pm, Resident #1 still had an unsteady gait.
-On 01/16/24, Resident #1 remained stable but very weak and could only transfer with staff assistance,

Observations of Resident #1 on 02/22/24 at 10:22am revealed he was in the common activity area,seated in a wheelchair with a chair alarm attached.

Review of Resident #1's Service Plan assessment dated 02/09/24 revealed:
-In the Evaluation section under the Fall Potential Evaluation Score, the score was 11.
-A Fall Potential Evaluation score was defined as a score between 10 and 26, Resident was a high potential for falls.
-The Goal for Resident #1 was listed as "Resident will maintain and/or maximize current level of functioning with fall potential".
-Under the Action tab for Devices/Transfer & Ambulation Assistance, wheelchair was documented.
-Under the Action tab for Activity of Daily Living

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D 255	Continued From page 5 (ADL) tab, none applied was documented. -Under the Action Tab for outside Consults tab, currently on hospice was documented. -Under the Action tab for Environmental Room/Hazards, none applied was documented. -Under the Action tab for drug Regimen Review, none applied was documented. -Under the Action tab for Vision/Hearing tab, none applied was listed. -Resident may require prompts/cues for mobility/ambulation or escorting and/or reminders/encouragement to utilize assistive devices to and from meals, activities and/or common areas and may require hands on assistance by staff. -Resident will be prompted/cued for transfers and position change. Interview with the 7am-3pm medication aide (MA) on 02/22/24 at 9:30am revealed: -She thought Resident #1 had increased falls starting in November or December 2023. -Resident #1 now had a bed alarm, chair alarm, a fall mat, a wheelchair and received hospice. -The residents' service plan was in the ADL binder and included interventions. Interview with the hospice nurse on 02/22/24 at 10:42am: -Resident #1 was admitted to hospice services on 02/02/24 due to repeated falls and diagnoses of hypertension, heart disease, Alzheimer's Disease and dementia. -Hospice provided skilled nursing, personal care aide and social work services to Resident #1. -Resident #1 had a chair alarm, bed alarm, hospital bed, wheelchair and fall mat in place. -She was not aware of any falls for Resident #1 since he was admitted to hospice services on 02/02/24.	D 255		

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D 255	Continued From page 6 Interview with Resident #1's responsible party on 02/22/24 at 2:25pm. -The staff always let him know when the resident had falls or other issues. -He was aware that Resident #1 had frequent falls. -Resident #1 forgot that he had difficulty ambulating and would try to get up without assistance. -Resident #1 used a walker and wheelchair for ambulation. -Resident #1 needed frequent reminders not to get up unassisted. Interview with the Memory Care Coordinator (MCC) on 02/22/24 at 11:30am revealed: -She had met with the Administrator in December 2023 about Resident #1's falls but had no documentation of the meeting. -She thought she had requested a wheelchair for Resident #1 in late December 2023 but could not remember for sure. -She requested a fall mat for Resident #1 after the 01/05/24 fall. -She requested a bed alarm and chair alarm for Resident #1 after the 01/25/24 fall. -Resident #1 saw his PCP on 01/29/24 and a bed and chair alarm were ordered for him as well as a neurology referral. -Hospice was ordered for Resident #1 on 01/31/24 due to increasing weakness and the resident seemed more "antsy and confused". -She felt Resident #1's walking ability worsened in late December 2023 and was certain she had requested a wheelchair for him then but could not find documentation of the wheelchair request until 01/09/24. -She had not documented fall interventions on Resident #1's electronic progress notes and had	D 255		

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D 255	Continued From page 7 not added interventions to Resident#1's 11/10/23 service plan. -She did not update Resident #1's service plan until 02/09/24. -Resident #1 had no further falls since 01/25/24. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care & Supervision]	D 255		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#1) who had seven 6 falls in a 9 week period with a hospital emergency department (ED) visit for a head injury. The findings are: Review of the facility Event Management Policy revealed: -The policy last review date was 05/01/18. -Under the Policy Purpose Tab, a pattern of unsteadiness and falls may indicate an emerging	D 270	10A NCAC 13F .0901(b) Personal Care and Supervision Resident #1's Care Plan was updated to reflect fall interventions and the addition of support from Hospice Services after the 1/5/24 fall. The Memory Care Coordinator and Nurse were retraining in assessing changes in condition and immediate interventions as needed to be implemented for all residents as required. The Memory Care Coordinator/Nurse and General Manager have been trained by the Regional Health Services Director and given guidelines to follow on appropriate interventions to support residents with incident and accidents (Event Management). The Memory Care Coordinator/Nurse/General Manager were trained by the Regional Health Services Director on Alert Charting, required timeframes and timely documentation. The Memory Care Coordinator/Nurse and General Manager will review Incident/Accident Reports weekly in addition to the monthly Event Management Audit to assess any previously unforeseen resident changes/needs within timeframes as required.	The date of correction for this deficiency will not exceed 4/7/24 Completed 2.29.24 Completed 2.29.24 Weekly starting 3/8/2024

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D 270	Continued From page 8 health concern for the resident. -For this reason, and to help ensure the safety of our residents, all falls must be reported to the Physician and responsible party, and a documented investigation completed. -All residents must be evaluated for risk for falls, and steps taken to reduce the risk. -The goal was to work with the care team and the resident/family to address the fall risk with the appropriate approaches early on. -Approaches need to be manageable for the resident/family and the care team to be effective. -Under the follow-up tab, Update the service plan with the date of the fall. -If the fall indicates a change of condition, review and/or update the Service Plan including fall prevention approaches as appropriate. -Complete a progress note or document on the incident report indication whether the fall indicates a change of condition, and why it does or doesn't appear to be a result of abuse or neglect. -Under the Fall Risk Evaluation and Service Planning Tab, Fall risk evaluation, all residents would be evaluated at move-in to identify residents who may be at risk for falls. -Residents identified at risk for falls should have interventions put in place to decrease risk. -Under the Fall History and Actions recommended tab, If a resident falls or continues to have falls even with preventative approaches, review those approaches and modify them where appropriate. -In some cases, we may need to include additional support to supplement our services. -That may include Physical Therapy, adaptive equipment, home health, sitters, etc. -The nature of the falls should be reviewed. -We should consider whether the resident was appropriate for our community with the services and support available.	D 270		

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D 270	Continued From page 9 1. Review of Resident #1's current FL-2 dated 07/03/23 revealed: -Diagnoses included dementia, hallucinations, and wandering. -The resident's level of care was memory care. -The resident was documented as constantly disoriented. -The resident was documented as ambulatory with a walker. -The resident required assistance with bathing and dressing. Review of the Resident Register for Resident #1 revealed: -The resident was admitted to the facility on 12/31/18. -The resident was forgetful. Review of an undated Fall Assessment for Resident #1 revealed: -Under Medical History/Problems, the box for incontinence was selected with the comment of "urgency". -Under the please provide of further explanation for each of the boxes checked above: Resident has some urge incontinence and staff manages with pull-ups. -Under the Interventions for Medical History/Problems: Will monitor for changes and notify medical doctor (MD) if he has any issues, Review of Resident #1's Service Plan assessment dated 11/10/23 revealed: -In the Evaluation section under the Fall Potential Evaluation Score, the score was 12. -A Fall Potential Evaluation score was defined as a score between 10 and 26, Resident #1 was a high potential for falls. -The Goal for Resident #1 was listed as	D 270		

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"Resident will maintain and/or maximize current level of functioning with fall potential".
-Under the Action tab for Devices/Transfer & Ambulation Assistance, walker was listed.
-Under the Action tab for Activity of Daily Living (ADL) tab, none apply was listed.
-Under the Action Tab for outside Consults tab, none applied was listed.
-Under the Action tab for Environmental Room/Hazards, none applied was listed.
-Under the Action tab for drug Regimen Review, none applied was listed.
-Under the Action tab for Vision/Hearing tab, none applied was listed.
.-The resident required supervision with toileting, eating, ambulation, personal hygiene, and transferring.
-The resident required limited assistance with bathing, dressing, and grooming.
-There were no interventions for falls prevention documented.

a. Review of Resident #1's electronic accident/incident (A/I) report dated 12/01/23 revealed:
-The incident time was 1:15am.
-Incident Type: Fall-no injury.
-Description: Staff went into Resident #1's room to check on him and found the bathroom sink in his room was running and going over into the floor which was filled with water. Resident #1 was laying on the floor on his back. Paramedics were called and said Resident #1 seemed "ok" and to keep an eye on him and report to the doctor.
-Location was documented as bedroom.
-Injury/Concerns-no injuries or concerns.
-The resident's mental status prior to the incident was documented as "usual".
-Assistive device was documented as walker.
-Appearance of the resident when found was

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documented as laying on his back.
-He was able to get up independently.
-Emergency Medical Services (EMS) was called, Resident #1 was not taken to the hospital.
-Under the response tab, Alert charting was initiated, the resident's family was notified, and the resident's primary care provider (PCP) was notified via fax.
-The Memory Care Coordinator (MCC) and Administrator were notified.

Review of Resident #1's electronic progress notes entered 12/01/23 through 12/04/23 revealed:
-On 12/01/23 at 2:41pm, the resident was doing better, no complaints of pain.
-On 12/01/23 at 8:03pm, no issues, ambulating great,
-On 12/02/23 at 1:16am, the resident was resting quietly.
-On 12/02/23 at 1:23pm, no issues or complaints of pain or discomfort this shift.
-There were no Alert Charting notes documented on 12/02/23 for the 3-11pm shift.
-There were no Alert Charting notes documented on 12/03/23 for the 11pm-7am.
-On 12/03/23 at 1:16pm, no issues or complaints of pain or discomfort this, eating and drinking well.
-There were no Alert Charting Notes documented on 12/04/23 for the 11pm-7am shift, the 7am-3pm shift or the 3pm-11pm shift.
-There were no fall risk interventions documented for Resident #1.

Interview with the MCC on 02/22/24 at 2:32pm revealed:
-Resident #1's PCP was notified of the 12/01/23 fall via fax.
-There were no fall interventions put in place for

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D 270	Continued From page 12 Resident #1. b. Review of Resident #1's A/I report dated 12/23/23 revealed: -The incident time was documented as 4:17pm. -The resident was sitting on the floor by the laundry room, his walker was by the bathroom. -The resident's mental status prior to the incident was documented as "usual". -The resident was sitting when found. -The resident said he sat down on the floor. -The resident's prior activity was documented as toileting. -There was no injury. -EMS was not called. -His vital signs were documented as blood pressure (BP) 141/80, pulse (P) 82, respirations (R)18 and temperature (T) 98.3*. -The fall was unwitnessed. -The was no documentation that the Administrator, family, and PCP were notified. -There was nothing documented under the Conclusions & Actions section. Review of Resident #1's electronic progress notes entered 12/24/23 through 12/26/23 revealed: -On 12/24/23 at 6:14am, he slept quietly through the shift. -There were no Alert Charting notes documented on 12/24/23 for the 7am-3pm shift or the 3pm-11pm shift. -There were no Alert Charting notes documented on 12/25/23 for the 11PM-7am shift or the 7am-3pm shift. -On 12/25/23 at 8:09pm, there was an entry, no issues from the fall. -There no Alert Charting notes documented on 12/26/23 for the 11pm-7am shift, or the 7am-3pm shift.	D 270		

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D 270	Continued From page 13 -There was an entry on 12/26/23 at 8:41pm, no signs of any issues. -There were no fall risk interventions documented. Interview with the MCC on 02/22/24 at 11:30am and 2:32pm revealed: - Resident #1 was monitored every 2 hours. -The medication aide working on 12/23/23 was new to the facility and did not give the A/I report to her. -She was notified of Resident #1's fall on 12/23/23 via telephone text message since it was on the weekend. -She forgot to ask about the A/I report when she returned to work. -She did not think the PCP was notified of this fall. -No fall interventions were put in place for Resident #1. c. Review of Resident #1's electronic A/I report dated 01/05/24 revealed: -The time of incident was documented as 2:45am. -The resident was found in the doorway on the floor by staff with no injury. -Activity prior to the incident was documented as resident was getting out of bed. -The resident's mental status prior to the incident was documented as "usual". -Assistive device was documented as walker. -The resident was laying on his left side. -EMS was not called. -Resident #1's vital signs were documented as BP 147/91, P 68, R 18, T 96.8 F. -Under the response tab, Alert charting was initiated, the resident's family was notified, and the resident's PCP was notified via fax. -The MCC and Administrator were notified.	D 270		

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D 270	Continued From page 14 -Under the Action Plan tab, N/A (Not Applicable) at this time was documented for Review Services Provided (update service plan and re-evaluate if applicable). Review of Resident #1's electronic progress notes from 01/05/24 through 01/08/24 revealed: -On 01/05/24 at 3:20pm, no complaints of pain or discomfort this shift, the PCP was faxed about the resident's fall. -On 01/05/24 at 8:51pm, the resident was very confused, resident had been re-directed all day and had a very unsteady gait. -On 01/05/24 at 8:53pm, the resident continued to be very confused and had an unsteady gait, the resident had been re-directed to sit down or use his walker. -On 01/06/24 at 6:17am, the resident was very unsteady on his feet and needed lots of supervision. -On 01/06/24 at 2:26pm, the resident had been sitting down most of the shift but no issues. -On 01/06/24 at 9:38pm, the resident tried to get out of his wheelchair. -On 01/06/24 at 9:40pm, the resident showed no signs of issues from the fall. -On 01/07/24 at 7:54am, the resident slept quietly through the shift. -On 01/07/24 at 11:37am, the resident had no issues. -On 01/07/24 at 11:38am, the resident was adjusting from the prior incident. -On 01/07/24 at 9:42pm, the resident was still very unsteady on his feet and had trouble ambulating. -On 01/08/24 at 5:35am, the resident was assisted to the restroom, then he went back to sleep with no further incident. Interview with the MCC on 02/22/24 at 11:30am	D 270		

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and 2:32pm revealed:
-Resident #1 was monitored every 2 hours.
-A fall mat and a wheelchair were requested for Resident #1 after his fall on 01/05/24.
-She faxed the orders for the wheelchair and fall mat on 01/05/24 and received the signed orders back from the PCP on 01/09/24.
-She did not request an order for more frequent monitoring for Resident #1 and she did not implement increased monitoring.

d. Review of Resident #1's A/I report dated 01/10/24 revealed:
-The incident time was documented as 6:30am.
-The resident was found sitting on the floor outside of his room in the doorway.
-The location of the incident was documented as the doorway to his room.
-There were no visible injuries.
-Activity prior to the fall was documented as unknown.
-Mental status prior to the incident was documented as "usual".
-Assistive device was documented as walker.
-Use of assistive device was documented as "has but not used".
-Appearance of Resident when found was documented as sitting and oriented per baseline.
-EMS was not called.
-Follow up actions were documented as; the resident was assisted up with no complaints of discomfort.
-His vital signs were documented as BP 166/67, P 65, R 17, T 98.6.
-Under the Notification tab, the MCC was notified, the PCP was notified via fax and the resident's responsible party was notified via phone.
-Under the Conclusions and Actions tab, the resident's progress note was updated, the PCP was notified via fax and Alert Charting was

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initiated.
-There were no other interventions documented.

Review of Resident #1's electronic progress notes dated 01/10/24 through 01/12/24 revealed:
-There were no Alert Charting notes documented on 01/10/24 for the 7am - 3pm shift.
-On 01/10/24 at 10:59pm, there was entry labeled Incident, the resident was found on the floor in his bedroom.
-There were no other Alert Charting notes documented on 01/10/24 for the 3pm-11pm shift.
-There were no Alert Charting notes documented on 01/11/24 for the 11pm-7am shift.
-On 01/11/24 at 3:05pm, Covid 19 precautions continued, fluids encouraged through shift.
-There were no Alert Charting notes documented on 01/12/24 for the 11pm-7am shift.
-On 01/12/24 at 2:51pm, vital signs were stable with no fever, no complaints of pain or discomfort, will continue to monitor and pass on to next shift.
-On 01/12/24 at 8:17, vital signs stable and the resident ate 100% of his dinner, fluids were pushed.
-There were no fall risk interventions documented.

Interview with the MCC on 02/22/24 at 11:30am and 2:32pm revealed:
-Resident #1 was monitored every 2 hours.
-On 01/10/24, she was waiting on the fall mat for Resident #1.
-She had sent a request for the wheelchair and fall mat to the PCP, but the PCP did not get the signed order back to her until 01/09/24.
-She did not request an order for more frequent monitoring for Resident #1 and she did not implement increased monitoring.

e. Review of Resident #1's 01/18/24 electronic A/I

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report dated 01/18/24 revealed:
-The incident time was documented as 11:45pm.
-The incident description was documented as: Staff walked in the resident's room and found him on the floor on his back, he was laying halfway on the fall mat that was kept by his bed,
-Activity prior to the incident was documented as getting in or out of bed.
-Mental status prior to the Incident was documented as "usual".
-Assistive devices was documented as walker.
-Use of assistive devices was documented as unknown.
-Appearance of the resident when found was documented as laying on back.
-EMS was not called.
-His vital signs were documented as BP 188/70, P 70, R 20, T 98.2 F.
-Under the Conclusions and Actions tab, it was documented that Alert Charting was initiated, the PCP was notified via fax and the residents responsible party was notified.
-Under the Action Plan tab, N/A was documented for Review Service Provided (updates service plan and re-evaluate if applicable).

Review of Resident #1's electronic progress notes revealed there were no Alert Charting Notes documented for 01/18/24, 01/19/24 or 01/20/24 and there were no fall interventions documented or increased supervision documented.

Interview with the MCC on 01/18/24 at 11:30am and 2:42pm revealed:
-Resident #1 had received the fall mat.
-Resident #1 had Covid 19 during this time and was weaker than usual.
-They had not received the wheelchair for Resident #1 from the medical equipment provider

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yet but he was able to use a wheel chair that had been donated to the facility.
-She did not request an order for more frequent monitoring for Resident #1 and she did not implement increased monitoring.

f. Review of Resident #1's 01/25/24 electronic A/I report dated 01/25/24 revealed:
-The incident time was documented as 10:30pm.
-The incident description was documented as "walked in room and resident was on the bathroom floor".
-Injury was documented as wound type: bumped head, concerns: knot on back of head.
-Activity prior was documented as walking.
-Mental status was documented as "usual".
-Assistive device was documented as wheelchair.
-Use of assistive device was documented as "used".
-Appearance of resident when found was documented as laying on back.
-EMS was called at 11:00pm.
-The resident was taken to the emergency department (ED).
-There was documentation, the PCP was notified via fax.
-There was documentation, the resident's responsible party was contacted via phone.
-There resident was not admitted to the hospital.
-Under the Notification tab, there was documentation, the MCC was notified, the PCP was notified via fax and the resident's responsible party was notified via phone.
-Under the Conclusions and Actions tab, it was documented that Alert Charting was initiated, the PCP was notified via fax and the residents responsible party was notified.

Review of Resident #1's ED after visit summary revealed:

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-Resident #1 was seen for an unwitnessed fall.
-Resident #1's was diagnosed with a closed head injury.
-Resident #1 was to follow up with his PCP in 2-3 days.

Review of Resident #1's electronic progress notes from 01/25/24 through 01/28/24 revealed:
-There were no Alert Charting notes documented on 01/25/24.
-There were no Alert Charting notes documented on 01/26/24.
-On 01/27/24 at 1:41am, the resident rested quietly.
-On 01/27/24 at 1:12pm, the resident had no complaints of pain or discomfort this shift.
-On 01/27/24 at 7:19pm, the resident had no complaints of discomfort this shift.
-There were no Alert Charting notes documented on 01/28/24 for the 11pm-7am shift.
-On 01/28/24 at 1:14pm, the resident had no complaints of pain or discomfort this shift.
-on 01/28/24 at 7:08pm, the resident had no complaints of pain or discomfort this evening, the resident ate 50% at dinner and drank plenty of fluids, he at all snacks offered.

Observation of Resident #1's room on 02/22/24 at 7:11am there was a bed alarm and a fall mat was folded beneath the resident's bed.

Observation of Resident #1 on 02/22/24 at 10:22am revealed he was in the common activity area, seated in a wheelchair with a chair alarm attached.

Review of Resident #1's Service Plan assessment dated 02/09/24 revealed:
-In the Evaluation section under the Fall Potential Evaluation Score, the score was 11.

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-A Fall Potential Evaluation score was defined as a score between 10 and 26, Resident was a high potential for falls,
-The Goal for Resident #1 was listed as "Resident will maintain and/or maximize current level of functioning with fall potential",
-Under the Action tab for Devices/Transfer & Ambulation Assistance, wheelchair was documented.
-Under the Action tab for Activity of Daily Living (ADL) tab, none apply was documented.
-Under the Action Tab for outside Consults tab, currently on hospice was documented.
-Under the Action tab for Environmental Room/Hazards, none apply was documented.
-Under the Action tab for drug Regimen Review, none apply was documented.
-Under the Action tab for Vision/Hearing tab, none apply was listed.
-Resident may require prompts/cues for mobility/ambulation or escorting and/or reminders/encouragement to utilize assistive devices to and from meals, activities and/or common areas and may require hands on assistance by staff.
-Resident will be prompted/cued for transfers and position change.

Interview with a PCA on 02/21/24 at 11:55am:
-The residents were checked every 2 hours by the PCAs or the MAs.
-The PCAs documented once per shift on each resident on the ADL sheets kept in the ADL binder.
-A copy of each resident's service plan was kept in the ADL binder.

Interview with the 7am-3pm MA on 02/22/24 at 9:30am revealed:
-The residents were checked every 2 hours by

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either the PCAs or the MAs.
-The PCAs documented resident care once per shift on the ADL sheets in the ADL binder.
-If a resident had a fall, she would check them out for injuries.
-If they hit their head or had visible bleeding, injury or complained of pain, EMS was called and they were sent to the ED.
-The MA completed an A/I report for each resident fall and it was then sent to the MCC for review.
-The MA or the MCC notified the provider via fax and notified the resident's responsible party by phone.
-After a resident fell, the MAs were to initiate Alert Charting, which involved entering a progress note on the resident's condition once each shift for 72 hours.
-If a resident required monitoring more frequently than every 2 hours, an order had to come from the PCP.
-She thought interventions were put into place after a resident had 3 falls by the MCC.
-She thought Resident #1 had increased falls starting in November or December 2023.
-Resident #1 now had a bed alarm, chair alarm that were ordered by the PCP, a fall mat, a wheelchair and received hospice.
-If a resident had interventions put into place, this was communicated verbally to staff at shift change.
-The MCC communicated with the MAs and the MAs communicated with the PCAs.
-The residents' service plan was in the ADL binder and included interventions.

Interview with the 11pm-7am MA on 02/22/24 at 7:11am revealed:
-The residents were checked every 2 hours by either the PCAs or the MAs.

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D 270	Continued From page 22 -After Resident #1's falls he would check on him about every 30 minutes. -He would make sure Resident#1's fall mat was in place if he was in bed and his bed alarm was in place. -If Resident #1 was awake during the night shift, he tried to make sure he kept him in the common area so he could keep an eye on him. Interview with the hospice nurse on 02/22/24 at 10:42am: -Resident #1 was admitted to hospice services on 02/02/24 due to repeated falls and diagnoses of hypertension, heart disease, Alzheimer's Disease and dementia. -Hospice provided skilled nursing, personal care aide and social work services to Resident #1. -Resident #1 had a chair alarm, bed alarm, hospital bed, wheelchair and fall mat in place. -She was not aware of any falls for Resident #1 since he was admitted to hospice services on 02/02/24. Interview with Resident #1's responsible party on 02/22/24 at 2:25pm. -The staff always let him know when the resident had falls or other issues. -He was aware that Resident #1 had frequent falls. -Resident #1 forgot that he had difficulty ambulating and would try to get up without assistance. -Resident #1 used a walker and wheelchair for ambulation. -Resident #1 needed frequent reminders not to get up unassisted. Interview with the MCC on 02/22/24 at 11:30am revealed: -The residents were checked every 2 hours by	D 270		

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either the personal care aide (PCA) or the medication aide (MA).
-When a resident fell, the resident was checked by the MA to determine if there were injuries.
-If a resident hit their head, EMS was contacted and they were sent to the ED.
-After a fall, Alert Charting was implemented which consisted of the MA documenting an electronic progress note on the resident's condition each shift for 72 hours.
-Monitoring of residents more frequently than every 2 hours required an order from the PCP.
-She considered 2-3 falls in a 30-day period would be considered frequent falls.
-She met monthly with the Administrator and the nurse to discuss who was at risk for frequent falls.
-She had met with the Administrator in December 2023 about Resident #1's falls but had no documentation of the meeting.
-She described examples of fall interventions to be the use of walkers, wheelchairs, bed and chair alarms and/or referral to physical therapy.
-Any interventions should be documented in the electronic progress notes and added to the service plan.
-She thought she had requested a wheelchair for Resident #1 in late December 2023 but could not remember for sure.
-She requested a fall mat for Resident #1 after the 01/05/24 fall.
-She requested a bed alarm and chair alarm for Resident #1 after the 01/25/24 fall.
-Resident #1 saw his PCP on 01/29/24 and a bed and chair alarm were ordered for him as well as a neurology referral.
-Hospice was ordered for Resident #1 on 01/31/24 due to increasing weakness and the resident seemed more "antsy and confused".
-She felt Resident #1's walking ability worsened in

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TRUEWOOD BY MERRILL, NEW BERN MEMORY CAR	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 270	Continued From page 24 late December 2023 and was certain she had requested a wheelchair for him then but could not find documentation of the wheelchair request until 01/09/24. -She had not documented fall interventions on Resident #1's electronic progress notes and had not added interventions to Resident#1's 11/10/23 service plan. -She did not update Resident #1's service plan until 02/09/24. -Resident #1 had no further falls since 01/25/24. Second Interview with the MCC on 02/22/24 at 2:32pm revealed: -The residents' service plans were updated quarterly or when there was a change in the resident's condition. -The service plan was kept in the activity of daily living (ADL) binder for all staff to review. -The PCAs and MAs were to review the ADL binder daily for each resident daily for any new interventions put in place. -New Interventions were also communicated verbally between staff at shift change. -She had requested interventions for Resident #1 such as the fall mat, wheelchair and chair and bed alarms. -Resident #1's service plan was updated on 02/09/24 but should have been updated sooner to reflect his change in condition and frequent falls. -It never occurred to her to request the PCP to increase monitoring for Resident #1 more often than every 2 hours after each fall. Interview with the Administrator on 02/22/24 at 3:10pm revealed: -The residents were to be monitored every 2 hours by the PCAs and/or MAs. -After a resident fell, they were evaluated by the MA for injuries and were sent to ED if needed.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025040	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 25 -An A/I report was completed, -The resident's PCP was notified by fax and the responsible party was notified by phone. -Alert Charting was initiated, the MA entered a progress note on the resident's condition each shift for 72 hours. -Increased resident monitoring more than every 2 hours had to be ordered by the PCP. -The MCC completed a level of care service plan quarterly and when there is a change in the resident's status. -She knew Resident #1 had some falls but was not aware that he had 6 falls since 12/01/23. -She had met with the MCC about Resident #1 in late December 2023 and thought a wheelchair and fall mat had been ordered at that time. -A chair and bed alarm, and hospice had been ordered for Resident #1 after the last fall on 01/25/24. -Resident #1's service plan should have been updated prior to 02/09/24 to reflect interventions put into place and the change in Resident #1's condition. -Staff should have reached out to Resident #1's PCP for further recommendations for fall interventions. Attempted telephone interview with Resident #1's PCP on 02/22/24 at 12:37pm and 2:46pm were unsuccessful. _____ The facility failed to provide adequate supervision for 1 of 3 sampled residents (#1), who was identified as a fall risk and had 6 falls in a 2-month period which resulted in an ED visit for a closed head injury. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 26 accordance with G.S. 131D-34 on 02/22/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 07, 2024.	D 270		