STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 and the Dare County Department of Social Services conducted an annual and follow up survey from April 17, 2024 to April 18, 2024.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 8 exit doors were equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to 4 residents residing on the Assisted Living (AL) unit who were disoriented and/or had a history of wandering and a resident who was memory impaired, was ambulatory and intermittently disoriented. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 102	D 067		

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D 067	Continued From page 1	D 067		

beds of which 74 were on the assisted living (AL) side of the facility.

Review of the facility's AL census on 04/17/24 revealed there were 52 residents residing on the AL side of the facility.

Review of Resident #1's current FL-2 dated 04/25/23 revealed:
-Diagnoses included dementia and atrial fibrillation.
-He was ambulatory and was intermittently disoriented.

Review of Resident #4's current FL-2 dated 07/12/23 revealed:
-Diagnoses included memory impairment.
-The resident was ambulatory and intermittently disoriented.

Review of a resident's FL-2 dated 03/05/24 revealed:
-Diagnoses included dementia.
-The resident displayed wandering behaviors.

Review of a resident's FL-2 dated 10/10/23 revealed:
-Diagnoses included dementia.
-The resident displayed wandering behaviors.
-The resident was interminably disoriented.

Observations made on 04/17/24 from 9:33am to 9:57am revealed:
-There was an exit door at the end of a hallway near resident room 308.
-The door was not locked.
-Survey staff opened and closed the exit door two times at 9:33am, no alarm was heard at the exit door.
-A second survey staff was located near the door

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 067	Continued From page 2	D 067		

alarm control panel which was located on the wall to the left of the facility's front reception desk.
-When the exit door near resident room 308 was opened an alarm was heard at the front reception desk for 30 seconds and then the alarm stopped.
-Staff members were observed standing at the front reception desk when the exit door near resident room 308 was opened.
-The Administrator, receptionist, and Business Office Manager (BOM) were observed at the front reception desk.
-The Administrator, receptionist and BOM did not look at the door alarm control panel near the front reception desk to see where the alarm notification was located or leave the front reception desk.
-Facility staff responded to the alarm at 9:57am, 24 minutes after the door was opened.

Interview with a personal care aide (PCA) on 04/17/24 at 9:55am revealed:
-All staff had a pager to notify them when an exit door was opened.
-She accidentally left her pager in the medication storage room.
-She went to the medication storage room to retrieve her pager.
-There was a notification on her pager with "305 Door and Door Alarm."
-When an exit door was opened there was an alarm that continued until the exit door was checked and reset.
-When an exit door was opened staff had a notification on their pager of the exit door location and a notification there was a door alarm.

Interview with a PCA on 04/17/24 at 9:00am revealed:
-There were exit doors on each of the facility's three hallways, in the activity room and dining room.

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D 067	Continued From page 3 -The doors were equipped with door alarms because there were 4 residents who displayed wandering behaviors on the AL unit. -Resident #1 displayed wandering behaviors in the past year. -When the exit door was opened the alarm activated at the control panel and to the staff's pagers. -The pagers indicated the location of the opened door. -Staff responded to the page and checked the door and surrounding areas. -Once staff determined there were no resident safety issues they would clear the alarm by pressing a button on the wall located next to the exit door. -The exit door had a self-release lock and automatically unlocked if the interior door handle was pushed down. -Residents were checked on every 2 hours and the residents who had wandering behaviors were checked on every hour. -If an exit door alarm was activated, she checked the surrounding areas and checked the residents who were at risk for wandering. Observations made on 04/17/24 at 5:03pm revealed: -An exit door in the facility's main dining room was not locked. -Survey staff opened and closed the door two times, no audible alarm sounded. -A second survey staff was located near the door alarm control panel which was located at the facility's front reception desk. -There was no audible alarm sound at the front reception desk area and the alarm panel did not turn on to show an exit door had been opened. Interview with the Administrator on 04/17/24 at	D 067		

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SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 067	Continued From page 4 5:05pm revealed: -She was aware the exit door in the dining room was not equipped with an alarm. -She was not sure why the door did not have an alarm. -She did not realize it was required to have an alarm on that door because it had not had an alarm since she started working at the facility over a year ago. -The exit door located in the in the facility's main dining room had not been equipped with an alarm since she had worked at the facility. -Housekeeping staff locked the dining room up each night after cleaning the dinner meal service. Interview with the Maintenance Director on 04/17/24 at 5:20pm revealed a temporary chime alarm had been installed on both of the exit doors. Interview with the Administrator on 04/18/24 at 8:34am revealed: -After further inspection of the door alarm on the exit door near room 308 she found the door alarm was malfunctioning. -The door alarm was supposed to sound and page staff continuously until staff clear the alarm from the system. -On 04/18/24 The door alarm near room 308 was not continuously sounding and was shutting off and that was why staff had not responded to the alarm on 04/18/24 at 9:33am when the surveyor opened and closed the door. -The Maintenance Director was in the process of repairing the door alarm on the exit door near 308 and was making arrangements for the exit door in the dining room to be added to the alarm paging system. Second interview with the Administrator on	D 067		

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	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 067	Continued From page 5 04/18/24 at 2:00pm revealed: -The facility had four residents living in Assisted Living who could be disoriented at times and/or had histories of wandering or exit seeking behaviors but none of the residents were currently displaying exit seeking type behaviors. -All residents had the right to go outside of the building and walk or sit on the front porch. -If residents were leaving the property they were supposed to sign out in the book at the front desk. -If a resident that had episodes of disorientation or wandering behaviors wanted to go outside staff were to provide stand by assist supervision until the resident came back in the building. -Staff provided additional supervision by responding to the exit door alarms via their paged alerts. -Staff were to check the area to ensure the residents were safe prior to clearing the door alarm pager. -Temporary audible chime alarms were installed on the exit door in the dining room and on the exit door near room 308. Interview with the Maintenance Director on 04/18/24 at 2:55pm revealed: -He completed a call light and door alarm audit once a month. -The most recent alarm audit was on 03/25/24 and all alarms were working. -The door in the main dining room did not have an alarm because the facility's previous Administrator had the alarm removed so that staff could exit the facility to take out the trash. -The door alarm near room 308 had been repaired. -The door in the facility's main dining was temporality equipped with a chime alarm and the part to have the exit door connected to the	D 067		

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D 067	Continued From page 6 facility's main alarm system would arrive in approximately 2 days. Third interview with the Administrator on 04/18/24 at 5:04pm revealed there was no policy related to exit door alarms. Observations of exit door near room 308 on 04/18/24 at 12:55pm revealed. -The alarm panel located at the reception desk was activated and sounded continuously when the exit door was opened. -Staff members responded in under 2 minutes. Observations of the exit door in the facility's main dining room on 04/18/24 at 3:07pm revealed: -The exit door alarmed with an audible door chime when the door was opened, and staff responded in under 1 minute.	D 067		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5) including a medication used to treat diabetes.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 358	Continued From page 7 The findings are: Review of Resident #5's current FL-2 dated 5/11/23 revealed: -Diagnoses included Type II diabetes. -There was a physician's order for Lantus solostar 100 units/ml, 18 units to be administered by injection each night at bedtime. -There were no parameters or instructions to hold medication for low blood glucose levels. Review of Resident #5's physician order dated 11/01/23 revealed: -Lantus solostar 100 units/ml, 20 units to be administered by injection each night at bedtime. -There were no parameters or instructions to hold medication for low blood glucose levels. Review of Resident #5's electronic medication administration record (eMAR) for February 2024 revealed: -There was a computerized entry for Lantus solostar 100 units/ml, inject 20 units each night at bedtime and scheduled for 8:00pm. -There were no parameters or instructions to hold medication for low blood glucose levels. -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 02/02/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was 96. -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 02/09/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was 86. -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 02/10/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 358	Continued From page 8	D 358		

administered because the medication was on hold.
-There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 02/18/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was 101.
-There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 02/20/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was 68.
-Lantus solostar 100 units/ml, 20 units was not administered 5 of 29 scheduled doses for blood glucose levels ranging from 68 to 101.

Review of Resident #5's eMAR for March 2024 revealed:
-There was a computerized entry for Lantus solostar 100 units/ml, inject 20 units each night at bedtime and scheduled for 8:00pm.
-There were no parameters or instructions to hold medication for low blood glucose levels.
-There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 03/01/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was low.
-There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 03/06/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was low.
-There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 03/11/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the medication was on hold.

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	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 358	Continued From page 9 -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 03/14/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was 82. -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 03/16/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was low. -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 03/29/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was checked twice and the reading was low. -Lantus solostar 100 units/ml, 20 units was not administered 6 of 31 scheduled doses for blood glucose levels ranging from 82 to 107. Review of Resident #5's eMAR for April 2024 revealed: -There was a computerized entry for Lantus solostar 100 units/ml, inject 20 units each night at bedtime and scheduled for 8:00pm. -There were no parameters or instructions to hold medication for low blood glucose levels. -There was documentation Lantus solostar 100 units/ml, 20 units was not administered on 04/13/24 with an exception note that the Lantus solostar 100 units/ml, 20 units was not administered because the blood glucose was 108. -Lantus solostar 100 units/ml, 20 units was not administered 1 of 16 scheduled doses. Interview with Resident #5 on 04/17/24 at 3:40pm revealed: -His blood glucose level was checked four times each day.	D 358		

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	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 358	Continued From page 10	D 358		

-He could not say how his blood glucose levels normally ranged.
-He did not know if his medication was ever held for low glucose levels.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 04/18/24 at 1:55pm revealed:
-Resident #5 was prescribed Lantus solostar 100 units/ml, inject 20 units each night at bedtime and scheduled for 8:00pm.
-There were no parameters with instructions to hold for any reason.
-Lantus solostar was a long-acting insulin that did not cause low blood glucose levels the way a short acting insulin did.
-Lantus solostar was used to stablize blood glucose levels.
-Staff should not hold Lantus solostar and should administer the medication as prescribed.
-No medication should be held without a physician's order to do so.
-It was important to administer the medication as prescribed so the physician would know how to adjust medications.

Interview with a medication aide (MA) on 04/18/24 at 3:20pm revealed:
-She had held Resident #5's Lantus solostar for low blood glucose levels.
-Low blood glucose readings were 70 or lower but she held it in March for a reading of 107.
-She did not contact Resident #5's PCP to obtain an order to hold the medication.
-She held the medication because she was told by other supervisors that it should be held.
-She was aware a physicians order was needed to hold a medication.
-She should have verified there was an order in place before holding Resident #5's Lantus

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 358	Continued From page 11 solostar. Interview with the Administrator on 04/18/24 at 10:17am revealed: -There were no parameters in place or a physician's order to hold Resident #5's Lantus solostar. -MA's had called her when Resident #5's blood glucose was low and she told them to hold his insulin including the Lantus solostar; low blood glucose was 70 or less. -She did not obtain an order to hold the Lantus when she gave the instructions to hold the medication. -She was aware a physician's order was needed to hold a medication. -She was a Registered Nurse (RN) and thought she was being safe. Attempted telephone interview with Resident #5's primary care provider (PCP) on 04/18/24 at 10:34am was unsuccessful.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by:	D 451		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 12	D 451		

Based on interviews and record reviews, the facility failed to notify the local Department of Social Services for 3 of 5 sampled residents (#5, #3,#1) following falls with injuries that requred evaluation at the local hospital emergency room which included broken ribs (#5), a contusion to the head (#3) and a laceration to the head that required stitches (#1).

The findins are:

1.Review of Resident #5's current FL-2 dated 5/11/23 revealed:
-Diagnoses included Type II diabetes, coronary artery disease and congestive heart failure.
-He was ambulatory.
-There was no information regarding orientation status.

Review of an after visit summary from the local hospital emergency department (ED) dated 12/11/23 revealed:
-Resident was seen for an accidental fall.
-He was diagnosed with closed fracture of multiple ribs on the right side.

Review of Resident #5's nursing note dated 12/11/23 at 5:00pm revealed:
- Resident #5 reported that he fell a few days prior.
-There was a large bruise on his right side over the ribs.
-Resident reported the pain was increasing and had vomited.
-Emergency Management System (EMS) was called and he was transported to the local hospital for evaluation.

Review of a second nursing note dated 12/11/23 at 10:25pm revealed Resident #5 returned to the

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	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 451	Continued From page 13	D 451		

facility from the local hospital with multiple rib fractures on the right side with no new medication orders.

Interview with Resident #5 on 04/17/24 at 3:40pm revealed:
-He fell out of bed and fractured his ribs when he fell on the trash can beside his bed.
-He could not remember when he fell but it had been "a few months" prior.

Interview with a medication aide (MA) on 04/18/24 at 2:26pm revealed:
-She noticed a bruise on Resident #5's right side while administering medication to him.
-Resident #5 reported he fell a couple of days prior.
-He reported that he was in pain and she sent him out to the local emergency department for evaluation where he was diagnosed with rib fractures.
-She did not complete an A/I report but she did notify the family of the incident and his being sent to the hospital for evaluation.
-When a resident falls, she was suppose to complete an A/I report, notify the family and the Resident Care Director (RCD).
-The RCD was present when Resident #5 was sent out for evaluation.

Interview with the Resident Care Director (RCD) on 04/18/24 at 10:25am revealed:
-She and the Administrator were resposible for notifying the local Department of Social Services (DSS) of incidents that included fracture.
-She could not say why DSS was not notified for Resident #5.

Interview with the Department of Social Services (DSS) Adult Home Specialist (AHS) on 04/18/24

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	HAL028002	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

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D 451	Continued From page 14	D 451		

at 9:08am revealed there had been no notification Resident #5 had rib fractures related to a fall on 12/11/23.

Interview with the Administrator on 04/17/24 at 3:25pm revealed:
-She remembered hearing that Resident #5 had complained of rib pain but did not remember hearing about a fall.
-There was no accident/incident (A/I) report completed for the incident on 12/11/24.
-One should have been completed if he reported the fall on 12/11/24 even if he said he fell days before.
-There was no notification made to the local Department of Social Services for the incident.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 04/18/24 at 10:34am was unsuccessful.

Refer to interview with the the Resident Care Director (RCD) on 04/18/24 at 10:25am.

Refer to interiview with the Department of Social Services (DSS) Adult Home Specialist (AHS) on 04/18/24 at 9:08am.

2. Review of Resident #3's current care plan dated 01/04/24 revealed:
-Diagnosis included Alzheimer's dementia.
-She was ambulatory.
-She was constantly disoriented.

Review of Resident #3's aftervisit summary from the local hospital emergency department (ED) dated 03/10/24 revealed:
-She was seen for an accidental fall.
-She was diagnosed with a contusion to the head.

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D 451	Continued From page 15	D 451		

Review of Resident #3's resident record revealed there was no nursing note for the date of 03/10/24.

Interview with a local Department of Social Services (DSS) caseworker on 04/18/24 at 9:08am revealed there was no notification of Resident #3's fall and ED evaluation for the fall on 03/10/24.

Interview with the Administrator on 04/18/24 revealed:
-There was no Accident/Incident Report for Resident #3's fall on 03/04/24.
-The DSS was not notified of Resident #3 being sent to the local ED for evaluation following the fall.
-It was the responsibility of the RCD and the Memory Care Director to notify the local DSS of incidents if bones were broken.
-She was not aware DSS was required to be notified of incidents that included evaluation by the local ED or anything more that first aid.

Based on observations, record reviews and interviews with staff, it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #5's primary care povider (PCP) on 04/18/24 at 10:34am was unsuccessful.

Refer to interview with the the Resident Care Director (RCD) on 04/18/24 at 10:25am.

Refer to interiview with the Department of Social Services (DSS) Adult Home Specialist (AHS) on 04/18/24 at 9:08am.

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D 451	Continued From page 16	D 451		

3. Review of Resident #1's current FL-2 dated 04/25/23 revealed:
-Diagnoses included dementia and atrial fibrillation.
-He was ambulatory and was intermittently disoriented.

Review of Resident #1's nursing note dated 12/02/23 at 8:45am revealed:
-Staff documented Resident #1 fell near the facility's entryway and his head was "bleeding profusely".
-Staff called Emergency Management System (EMS) and the resident was transported to the hospital for evaluation.

Review of an after-visit summary from the local hospital emergency department (ED) dated 12/02/23 revealed:
-Resident #1 was seen for an accidental fall and was diagnosed with a laceration of the scalp and laceration of the left index finger.
-Resident #1 received sutures to his head and left index finger and was discharged back to the Assisted Living Facility.

Interview with a local Department of Social Services (DSS) Adult Home Specialist (AHS) on 04/18/24 at 9:08am revealed the DSS office had not received any incident reports for Resident #1's fall on 12/02/23.

Interview with the Resident Care Director (RCD) on 04/18/24 at 2:15pm revealed:
-She and the Administrator were responsible for notifying the local Department of Social Services (DSS) of incidents that included serious injuries such as fractures.
-She could not recall if she had reported Resident #1's fall with injury to the local DSS office

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D 451	Continued From page 17	D 451		

because she was not aware that all incidents and accidents in which a resident required medical treatment or evaluation, beyond first aide, needed to be reported.

Interview with the Administrator on 04/18/24 at 2:00pm revealed:
-Resident #1's fall on 12/02/23 had not been reported to the local DSS office because she was not aware that all incidents and accidents in which a resident required medical treatment or evaluation, beyond first aide, needed to be reported.
-She thought only incidents with serious injury, such as fractures, needed to be reported.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/24 at 9:31am was unsuccessful.

Refer to interview with the the Resident Care Director (RCD) on 04/18/24 at 10:25am.

Refer to interview with the Department of Social Services (DSS) Adult Home Specialist (AHS) on 04/18/24 at 9:08am.

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Interview with the Resident Care Director (RCD) on 04/18/24 at 10:25am revealed she was not aware Department of Social Services (DSS) needed to be notified of incidents that required evaluation by the local ED including surtures.

Interview with a local Department of Social Services (DSS) Adult Home Specialist (AHS) on 04/18/24 at 9:08am revealed the DSS office had not received any incident reports from the facility from 06/29/23 through 03/04/24.