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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey from February 12, 2025 to February 14, 2025.	D 000		
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 2 of 5 sampled residents based on the resident's assessed needs and current symptoms resulting in one resident having 13 falls in 7 months (#3) and one resident having 4 falls in a 2 month period (#5). The findings are: Review of the facility's Fall Management Policy updated 10/21/24 revealed: -Purpose, to promote safety and preserve mobility by reducing the risks of falls and fall related injuries, to utilize a comprehensive approach in the identification of a resident's physical and cognitive risk factors that may contribute to the incidence of falls. -Under the heading of Fall Assessment Tool, an	D 270		

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D 270	Continued From page 1 initial comprehensive assessment is conducted at admission, which includes the identification of risk factors, key components of a multi-factor assessment include fall history, mental status, mobility, orthostatic hypotension, medications, and visual impairments. -The Fall Assessment is completed by gathering specific information regarding history and risk factors from residents, family members, caregivers, and other health professionals. -The Fall Risk Assessment is completed as follows on admission, every 6 months, when there is a change in condition or for safety precautions, and when a resident has two or more falls, unrelated to a transient health condition (i.e. urinary tract infection, flu, upper respiratory infections, etc.) in a 1-month period. -Each fall must be investigated and analyzed to determine possible causative factors, and the effectiveness of safety measures implemented to minimize falls. -A fall is evaluated in accordance with the following indicators, situation, contributing factors, safety measures/devices, and medications. -All resident falls are reported to the resident's primary care provider (PCP) for review and any recommendations they may have. -Interventions are to be documented on the residents' Individualized Service Plan as well as communicated to appropriate care givers. -The Fall Intervention Check List/Plan is a tool that is available to identify contributing factors and monitors progress towards goals regarding resident safety and mobility. -If the Fall Intervention Check List/Plan tool is used, it will become part of the "Incident Report Log-Individual Resident" binder assisting in the on-going process of review and follow-up. -The Fall Interview Check List/Plan is a tool to assist in the revision of the Individualized plan for	D 270		

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residents with falls when there are any changes to interventions and/or goals defined for each specific resident following a fall.
-The Fall Intervention Check List/Plan will be used as a tool for review during the bi-monthly Comprehensive Resident Review meeting.

Review of the facility's Hot Box Charting protocol dated 08/27/20 revealed:
-Document on each shift until the Director of Clinical Services (DCS)/Designee indicates that a resident should no longer be included in the Hot box.
-Please enter a resident into the Hot Box for care concerns, some examples of concerns/issues are change in health, behaviors, cognitive status, to be determined by the DCS/Designee (increased confusion, decreased appetite).
-Be specific regarding the change and any interventions until the DCS/Designee removes the resident from Hot Box charting.
-Residents beginning anti biotic therapy, document vital signs and any adverse reactions (notify DCS/Designee) for the duration of treatment.
-Falls, describe the fall, appearance of any redness or bruising and any changes in condition or complaints noted for at least 3 days.
-Admission/Return from hospital, document time returned and vital signs upon return, document for at least 3 days regarding the reason they were in and any change in status.
-Skin impairments, skin tears, etc., document size, color, shape and presence of dressing if required, note response to treatment and report any adverse reactions to the DCS/Designee, document until the wound is healed or as determined by the DCS/Designees.
-The Hot Box charting form included columns for the date, resident's room number, the resident's

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name, reason for placing chart in the Hot Box, initials of the team member placing chart in the Hot Box, date removed from the Hot box and DCS/Designees "initials."

1. Review of Resident #3's current FL-2 dated 09/05/24 revealed:
-Diagnoses include neuropathy, heart block, and diabetes.
-The resident was semi-ambulatory.
-There was no documentation on the resident's use of assistive devices.
-There was no documentation of the resident's orientation status.

Review of Resident #3's care plan dated 01/26/25 revealed:
-The resident was reassessed on 01/26/25 and his care plan was updated.
-The resident's initial care plan was completed on 10/09/23.
-The resident resided in an assisted living facility.
-The resident required extensive assistance with toileting.
-The resident required limited assistance with ambulation and bathing.
-The resident required supervision with grooming.
-The resident had limited ability with his ambulation and used a walker for short distances, and a wheelchair for long distances.
-The resident's orientation was sometimes disoriented.
-The resident's memory was sometimes forgetful.

Review of Resident #3's Licensed Health Professional Support (LHPS) services dated 10/09/24 revealed:
-The resident ambulated with an assistive device that required physical assistance.
-Staff should continue to monitor for falls and

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report any new falls to the resident's primary care provider (PCP).

Review of Resident #3's LHPS dated 01/23/25 revealed:
-The resident ambulated with an assistive device that required physical assistance
-The resident was observed sitting in a chair in his room with his rollator within reach.
-The resident was becoming forgetful.
-The resident had a fall on 01/10/25 with no injury.
-The resident was receiving hospice services.
-Staff should continue to monitor for falls and report any new falls to the resident's PCP and hospice nurse.

Observation of Resident #3's room on 02/13/25 at 3:40pm revealed there was a fall mat beside his bed.

a. Review of Resident #3's Accident/Incident (A/I) report dated 08/30/24 at 12:23pm revealed:
-The incidence classification was documented as an unwitnessed fall.
-The resident was found on his knees in the living area entrance of his room.
-The resident stated he was getting ready to come to the dining room, lost his balance, and eased to the floor on his knees.
-The resident's vital signs were documented as blood pressure was 147/77, pulse was 66, respirations were 20, and his temperature was 97.3.
-Staff questioned the resident about his pain level.
-He was not transported to the hospital.
-There was documentation that his PCP was notified via phone on 08/30/24 at 12:23pm.
-There was documentation that his responsible

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party (RP) was notified via phone on 08/30/24 at 12:23pm.
-There was documentation that the Resident Care Coordinator (RCC) was notified via phone on 08/30/24 at 12:23pm.
-The resident did not sustain any injuries and did not require outside medical care.
-There was documentation that range of motion (ROM) was performed and the resident was able to move his arms and legs.
-The A/I report was created by the RCC on 08/30/24 at 12:23pm.

Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 08/30/24 to 09/02/24.

Review of electronic progress notes for Resident #3 dated 08/30/24 revealed:
-There was an entry by the RCC at 12:30pm that Resident #3 had a fall, there were no injuries, and all parties were notified.
-There was an entry by a medication aide (MA) at 9:15pm that Resident #3 had no falls and no complaint of pain.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident #3 dated 08/31/24 revealed:
-There was an entry by a MA at 7:00am that the resident had no issues regarding his fall on 08/30/24.
-There was an entry by a MA at 3:15pm that the resident had no issues regarding his fall on 08/30/24 and no complaint of pain or discomfort.
-There was an entry by a MA at 9:15pm that Resident #3 had no falls during the shift and did not complain of pain or discomfort.
-There was an entry by a MA at 10:45pm that

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revealed no issues regarding his fall on 08/30/24.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident #3 dated 09/01/24 revealed:
-There was an entry by a MA at 1:45pm that there were no issues regarding the residents' fall on 08/30/24.
-There was no chart note for the 3:00pm to 11:00pm shift.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident #3 dated 09/02/24 revealed:
-There was an entry by a MA at 12:15am that the resident received a skin tear on his right knee while staff was transferring him to his wheelchair.
-There was an entry by a MA at 1:45pm that the resident had no issues regarding his skin tear.
-There was an entry by a MA at 6:00pm that the resident was doing well, no pain or discomfort from his skin tear.
-There was an entry by a MA at 9:30pm that the resident had no falls during the shift and no complaint of pain from the skin tear on his right knee.
-There was an entry by a MA at 10:45pm that the resident was naked in another resident's room during rounding, staff changed the resident and sat him in a chair in the other resident's room because the resident refused to return to his room.

Review of Resident #3's Fall Risk Assessment dated 09/02/24 revealed:
-Instructions: Assess the resident status in the nine clinical condition parameters listed below by assigning the corresponding score which best

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D 270	Continued From page 7 describes the resident's current status. Add the column of numbers to obtain the total score. If the score is 10 or greater, the resident may be considered at HIGH RISK for potential falls. Update the Care Plan to reduce the potential of a fall and/or severity of fall related injury with individualized interventions for the prevention of falls. -Under the Mental Status/ Cognition heading, "mild confusion but has no safety awareness concerns" was selected for a score of 1. -Under the Mobility/Continence heading, "impaired mobility may use an assistive device and continent, may use incontinent supplies successfully" was selected for a score of 2. -Under the Gait Balance heading, "requires use of assistive device, unsteady balance noted while standing/unable to stand without hands on balancing assistance, and unsteady balance noted while walking/unable to walk without hands on assistance" was selected for a score of 3. -Under the Visual Status heading, "adequate with or without glasses" was selected for a score of 0. -Under the Fall History (past 6 months), "four plus falls in the past 6 months" was selected for a score of 4. -Under the Medication Usage heading," takes 3 or more" was selected for a score of 4. -Under the Other Considerations heading, "none present" was selected for a score of 0. -Under the Predisposing Diseases/Conditions heading, "1-3 present" was selected for a score of 2. -Under the Total Score, 16 was documented. -A total score of 10 or higher may represent a high risk for falls requiring interventions to prevent falls on the resident's care, yes was selected. -The Fall Risk Assessment dated 09/02/24 was completed by the RCC.	D 270		

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D 270	Continued From page 8 b. Review of Resident #3's A/I report dated 10/27/24 at 5:30pm revealed: -The incidence classification was documented as fall without injury. -The resident was found on the floor in another resident's room. -The resident reported he did not know how he fell. -The resident's vital signs were documented as blood pressure 168/72 and his pulse was 71. -Staff questioned the resident about his pain level. -He was not transported to the hospital. -There was documentation that his PCP was notified via phone on 10/27/24 at 5:30pm. -There was documentation that his RP was notified via phone on 10/27/24 at 5:30pm. -There was documentation that the RCC was notified via phone on 10/27/24 at 5:30pm. -The resident did not sustain any injuries and did not require outside medical care. -There was documentation that ROM was not performed. -The A/I report was created by the RCC on 10/27/24 at 5:30pm. Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 10/27/24 to 10/30/24. Review of electronic progress notes for Resident #3 dated 10/28/24 revealed: -There was an entry by a MA at 2:45pm that the resident came to the dining room for meals. -There was an entry by a MA at 9:45pm that the resident had no falls during the shift and had no complaints of pain or discomfort. -There was no chart note for the 11:00pm to 7:00am shift.	D 270		

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D 270	Continued From page 9 Review of electronic progress notes for Resident #3 dated 10/29/24 revealed: -There was an entry by a personal care aide (PCA) at 7:15am that the resident reported he did not feel well, vital signs and blood sugar were within normal range and declined to go to the local emergency department. -There was an entry by a MA at 9:30am that second shift staff reported that the resident did not feel well overnight, the resident was weak and lethargic, and the PCP was notified about the resident's change in condition. -There was an entry by a MA at 10:30am that the resident's PCP sent an order to collect a urine specimen for a possible urinary tract infection (UTI). -There was an entry by the RCC at 3:15pm that the resident was still not feeling well, staff were waiting for the urinalysis from the resident's PCP. -There was an entry by a MA at 10:15pm that the resident had no falls, came to eat dinner and seemed more alert. -There was no chart note for the 11:00pm to 7:00am shift. Review of electronic progress notes for Resident #3 dated 10/30/24 revealed: -There was an entry by a MA at 7:00am that the resident slept well through the night, no signs of confusion, and the resident stated he felt okay. -There was an entry by a MA at 2:15pm that a urine specimen was collected from the resident. -There was an entry by a MA at 2:45pm that the resident slept most of the day and staff were waiting for the resident's specimen to be picked up. -There was no chart note for the 3:00pm to 11:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift.	D 270		

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D 270	Continued From page 10 c. Review of Resident #3's A/I report dated 11/29/24 at 10:45am revealed: -The incidence classification was documented as fall without injury. -The resident was found on the floor between his wheelchair and his bed. -The resident reported that he did not fall, that he wanted to lay on the floor. -The resident's vital signs were documented as blood pressure 146/69 and his pulse was 64. -He was not transported to the hospital. -There was documentation that his PCP was notified via phone on 11/29/24 at 10:45am. -There was documentation that his RP was notified via phone on 11/29/24 at 10:45am. -There was documentation that a supervisor was notified via phone on 11/29/24 at 10:45am. -The resident did not sustain any injuries and did not require outside medical care. -There was documentation that ROM was not performed. -The A/I report was created by a MA on 11/29/24 at 10:45am. Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 11/29/24 to 12/02/24. Review of electronic progress notes for Resident #3 dated 11/29/24 revealed: -There was an entry by a MA at 10:45am that the resident was found lying on the floor in between his wheelchair and his bed, the resident stated that he did not fall, he just decided to lay on the floor. -There was an entry by a MA at 10:15pm that the resident had no complaint of pain. d. Review of Resident #3's A/I report dated	D 270		

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11/29/24 at 11:47pm revealed:
-The incidence classification was documented as a fall without injury.
-The resident was found on his bathroom floor.
-The resident stated that he fell when he was trying to walk to the bathroom.
-The resident's vital signs were documented as blood pressure was 126/60, pulse was 76, and his temperature was 97.7.
-Staff questioned the resident about his pain level.
-He was not transported to the hospital.
-There was documentation that his PCP was notified via phone on 11/29/24 at 11:47pm.
-There was documentation that his RP was notified via phone on 11/29/24 at 11:47pm.
-There was documentation that the RCC was not notified.
-The resident did not sustain any injuries and did not require outside medical care.
-There was documentation that ROM was normal.
-The A/I report was created by a MA on 11/29/24 at 11:47pm.

Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 11/29/24 to 12/02/24.

Review of an electronic progress note for Resident #3 dated 11/29/24 revealed there was an entry by a MA at 11:45pm that the resident was found on his bathroom floor, the resident denied injury and there were no apparent injuries.

Review of electronic progress notes for Resident #3 dated 11/30/24 revealed:
-There was an entry by a MA at 3:15pm that the resident was provided with incontinent care, was observed leaving his room holding on to the side

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rails without his wheelchair, and staff assisted the resident to his wheelchair and brought him to the front living room.
-There was an entry by a MA at 10:15pm that the resident had no falls and no complaint of pain.
-There was no chart note for the 7:00am to 3:00pm shift.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident #3 dated 12/01/24 revealed:
-There was an entry by a MA at 6:45am that the resident dressed himself and had no complaint of pain.
-There was an entry by a MA at 9:15pm that the resident had no complaint of pain and no falls.
-There was no chart note for the 7:00am to 3:00pm shift.

Review of electronic progress notes for Resident #3 on 12/02/24 revealed:
-There was an entry by a MA at 6:30am that the resident had a good night and no complaint of pain from his fall.
-There was an entry by a MA at 2:15pm that the resident had no falls and no complaints.
-There was an entry by a MA at 9:15pm that the resident had moments of confusion, was easily redirected, and had no complaint of pain.

Review of Resident #3's resident record, A/I reports, and electronic progress notes revealed the resident had two falls on 11/29/24.

e. Review of Resident #3's A/I report dated 12/05/24 at 6:46am revealed:
-The incidence classification was documented as a fall without injury.
-The resident was found on the floor by his bed.

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-The resident stated that he slid from his bed to the floor.
-The resident's vital signs were not taken.
-Staff questioned the resident about his pain level.
-He was not transported to the hospital.
-There was documentation that his PCP was not notified.
-There was documentation that his RP was not notified.
-There was documentation that the RCC was notified on 12/05/24 at 6:46am.
-The resident did not sustain any injuries and did not require outside medical care.
-There was documentation that ROM was normal.
-The A/I report was created by a MA on 12/05/24 at 6:46am.

Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 12/05/24 to 12/08/24.

Review of electronic progress notes for Resident #3 dated 12/05/24 revealed:
-There was an entry by a MA at 6:45am that the resident reported he slid down to the floor from his bed.
-There was an entry by a MA at 2:15pm that the resident had no complaints of pain.
-There was an entry by a MA at 9:45pm that the resident had no falls and no complaint of pain.

Review of electronic progress notes for Resident #3 dated 12/06/24 revealed:
-There was an entry by a MA at 6:45am that the resident was bathed and dressed.
-There was no chart note for the 7:00am to 3:00pm shift.
-There was no chart note for the 3:00pm to

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D 270	Continued From page 14 11:00pm shift. f. Review of Resident #3's A/I report dated 12/06/24 at 10:51am revealed: -The incidence classification was documented as a fall without injury. -The resident was found on the floor by a housekeeper. -The resident stated that he was trying to get out of bed without his walker or wheelchair, fell and hit his head on the edge of the bed. -The resident's vital signs were documented as blood pressure 165/78, pulse 63, respirations 20, and temperature was 97.6. -Staff questioned the resident about his pain level and he rated his pain at 6 (the Numeric Rating Pain Scale is used to ask individuals to rate their pain from 0 to 10, 0 means no pain, and 10 means the worst possible pain). -The resident was transported to the local emergency department (ED). -There was documentation that his PCP was notified on 12/06/24 at 10:51am. -There was documentation that his RP was notified on 12/06/24 at 10:51am. -There was documentation that the RCC was notified on 12/06/24 at 10:51am. -There was documentation that the local Department of Social Services (DSS) was notified on 12/09/24 at 12:29pm. -There was documentation that the RCC was notified on 12/05/24 at 6:46am. -The A/I report was created by a MA on 12/06/24 at 10:51am. Review of Resident #3's discharge summary from the hospital dated 12/09/24 revealed: -Resident #3 was at the local hospital from 12/06/24 to 12/09/24. -The resident was diagnosed with generalized	D 270		

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weakness, recurrent falls, and a urinary tract infection (UTI).
-The resident reported that he attempted to put his shoes on, he fell over and did not pass out.
-The resident had a follow up appointment with his cardiologist scheduled for 03/05/25.

Review of an electronic progress note for Resident #3 on 12/06/24 at 3:00pm revealed the resident had to be sent to the local emergency department due to a fall, he was found on the floor and reported he hit his head on the edge of the bed.

Review of an electronic progress note for Resident #3 on 12/08/24 at 9:15pm revealed the resident was still in the hospital, a family member called staff and reported that he had a UTI.

Review of an electronic progress note for Resident #3 on 12/09/24 at 2:45pm revealed the resident returned to the facility.

Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 12/10/24 to 12/13/24.

Review of electronic progress notes for Resident #3 on 12/10/24 revealed:
-There was an entry by a MA at 2:45pm that the resident was confused and rolled around in his wheelchair looking for his car.
-There was an entry by a MA at 9:45pm that the resident had been confused and yelled at staff, he eventually laid down to rest in the facility living room.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident

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D 270	Continued From page 16 #3 on 12/11/24 revealed: -There was an entry by a MA at 3:45am that the resident wanted to sleep on the couch in the lobby, staff would continue to monitor throughout the remainder of the morning. -There was an entry by a MA at 3:00pm that the resident slept most of the day and there were no issues. -There was no chart note for the 3:00pm to 11:00pm shift. Review of electronic progress notes for Resident #3 on 12/12/24 revealed: -There was an entry by a MA at 9:45pm that the resident had no falls and no complaint of pain. -There was no chart note for the 7:00am to 3:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift. Review of electronic progress notes for Resident #3 on 12/13/24 revealed: -There was no chart note for the 7:00am to 3:00pm shift. -There was no chart note for the 3:00pm to 11:00pm shift. -There was no chart note for the 11:00pm shift to 7:00am shift. Review of Resident #3's Fall Risk Assessment dated 12/09/24 revealed: -Instructions: Assess the resident status in the nine clinical condition parameters listed below by assigning the corresponding score which best describes the resident's current status. Add the column of numbers to obtain the total score. If the score is 10 or greater, the resident may be considered at HIGH RISK for potential falls. Update the Care Plan to reduce the potential of a fall and/or severity of fall related injury with	D 270		

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individualized interventions for the prevention of falls.
-Under the Mental Status/ Cognition heading, "mild confusion but has no safety awareness concerns" was selected for a score of 1.
-Under the Mobility/Continence heading, "impaired mobility may use an assistive device and continent, may use incontinent supplies successfully" was selected for a score of 2.
-Under the Gait Balance heading, "requires use of assistive device, unsteady balance noted while standing/unable to stand without hands on balancing assistance, and unsteady balance noted while walking/unable to walk without hands on assistance" was selected for a score of 3.
-Under the Visual Status heading, "adequate with or without glasses" was selected for a score of 0.
-Under the Fall History (past 6 months), "2 plus falls in the past 3 months" was selected for a score of 6.
-Under the Medication Usage heading," takes 3 or more" was selected for a score of 4.
-Under the Other Considerations heading, "none present" was selected for a score of 0.
-Under the Predisposing Diseases/Conditions heading, "1-3 present" was selected for a score of 2.
-Under the Total Score, 18 was documented.
-A total score of 10 or higher may represent a high risk for falls requiring interventions to prevent falls on the resident's care, yes was selected.
-The Fall Risk Assessment dated 12/09/24 was completed by the RCC.

Review of a signed physician order dated 12/12/24 revealed there was an order to refer Resident #3 to hospice.

Review of Resident #3's hospice care plan revealed the resident was admitted to hospice

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D 270	Continued From page 18 services on 12/16/24 with a diagnosis of cerebral infarction (cerebral infarction is a type of stroke). g. Review of Resident #3's A/I report dated 01/10/25 at 2:23am revealed: -The incidence classification was documented as a fall without injury. -The resident was found sitting in his doorway on the floor. -The resident stated that he sat down, he was not hurt, and he was trying to sneak out of the facility. -The resident's vital signs were not documented. -There was documentation that his PCP was notified on 01/10/25 at 2:23am. -There was documentation that his RP was notified on 01/10/25 at 2:23am. -There was documentation that the RCC was notified on 01/10/25 at 7:14am when she arrived at work. -There was documentation that ROM was normal. -The A/I report was created by a MA on 01/10/25 at 2:23am. Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 01/10/25 to 01/13/25. Review of electronic progress notes for Resident #3 on 01/10/25 revealed: -There was an entry by a MA at 2:15am that the resident was found sitting in his doorway, the resident stated he sat down, was trying to sneak out of the facility, and staff brought the resident to the front of the building to keep him safe. -There was an entry by a MA at 7:00am that the resident had been up all night, packed up his room, was very agitated, the MA left a message for the hospice nurse. -There was an entry by a MA at 7:15am that the	D 270		

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hospice nurse called and was going to contact the hospice physician to have him visit the resident.
-There was an entry by a MA at 2:45pm that the resident had been vomiting and there were no issues from his fall.

h. Review of Resident #3's A/I report dated 01/10/25 at 9:46pm revealed:
-The incidence classification was documented as a fall without injury.
-The resident was found on the floor on two different occasions during the same shift.
-The first time the resident was found was before dinner; the resident was found sitting on the floor at the foot of his bed.
-Staff assisted the resident back to his wheelchair, the resident denied any complaint of pain.
-Staff escorted the resident to the front lobby near the dining room to prevent further falls.
-The resident wheeled himself back to his room and was found in the same area on the floor at the foot of his bed.
-The resident denied any complaint of pain.
-The resident's vital signs were documented as blood pressure 135/68, pulse 72, respirations 18, and temperature was 97.7.
-There was no documentation that his PCP was notified.
-There was documentation that his RP was notified on 01/10/25 at 9:46pm.
-There was documentation that the resident's hospice nurse was notified at 01/10/25 at 9:46pm and would visit the resident tomorrow.
-There was documentation that the RCC was notified on 01/10/25 at 9:46pm.
-There was documentation that ROM was not completed.
-The A/I report was created by a MA on 01/10/25

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D 270	Continued From page 20 at 9:46pm. Review of the Hot Box Protocol sheets revealed Resident #3 should be charted on every shift from 01/10/25 to 01/13/25. Review of electronic progress notes for Resident #3 on 01/10/25 revealed: -There was an entry by a MA at 10:30pm that the resident had 2 falls during the shift, the hospice nurse was called and would visit the resident later tonight. -There was no chart note for the 7:00am to 3:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift. i. Review of Resident #3's A/I report dated 01/11/25 at 6:51am revealed: -The incidence classification was documented as a fall without injury. -The resident was found on the floor beside his bed when staff were making their rounds. -The resident was not able to state how he got on the floor. -Staff assisted the resident back to bed. -Staff observed bruising to the resident's small right toe, and the resident stated that it hurt. -The resident's vital signs were documented as blood pressure 139/73, pulse 78, respirations 18, and temperature was 97.4. -The resident was not transported to the hospital and no first aid was provided. -There was documentation that the resident's hospice nurse was contacted on 01/11/25 at 6:51am. -Staff expressed concern to the hospice nurse that the resident had a UTI. -The hospice nurse explained since the resident was on hospice they usually did not complete a	D 270		

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urinalysis but ordered the resident antibiotics.
-There was documentation that his PCP was notified on 01/11/25 at 6:51am.
-There was documentation that his RP was notified on 01/11/25 at 6:51am.
-There was documentation that the RCC was notified on 01/11/25 at 6:51am.
-There was documentation that ROM was not completed.
-The A/I report was created by a MA on 01/11/25 at 6:51am.

There were no Hot Box charting sheets provided with dates beyond 01/15/25.

Review of electronic progress notes for Resident #3 on 01/11/25 revealed:
-There was an entry by a MA at 6:45am that the resident was found sitting on the floor by staff and denied complaint of pain.
-There was an entry by a MA at 1:45pm that the resident was seen by the hospice nurse who assessed his falls and would contact the hospice physician for Ativan as needed to help with the resident's agitation (Ativan is used to treat anxiety).
-There was an entry by a MA at 3:00pm that the resident had no injuries from his recent fall.
-There was an entry by a MA at 10:15pm that the resident had no falls during the shift, no signs of confusion, or agitation, and the facility received a new order for Lorazepam 0.5mg as needed for anxiety (Lorazepam is the generic name for Ativan).

Review of a hospice note for Resident #3 dated 01/11/25 at 10:00am revealed:
-The resident was observed sitting on the floor next to his bed.
-The resident had no injuries.

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D 270	Continued From page 22 -The resident required feeding assistance which was a decline for the resident. -The hospice nurse discussed the resident's recent falls with the hospice physician, and the physician ordered Lorazepam 0.5mg every four hours as needed. -The resident should continue his antibiotic for a UTI. Review of electronic progress notes for Resident #3 on 01/11/25 revealed: -There was an entry by a MA at 6:45am that the resident was found sitting on the floor by staff and denied complaint of pain. -There was an entry by a MA at 1:45pm that the resident was seen by the hospice nurse who assessed his falls and would contact the hospice physician for Ativan as needed to help with the resident's agitation (Ativan is used to treat anxiety). -There was an entry by a MA at 3:00pm that the resident had no injuries from his recent fall. -There was an entry by a MA at 10:15pm that the resident had no falls during the shift, no signs of confusion, or agitation, and the facility received a new order for Lorazepam 0.5mg as needed for anxiety (Lorazepam is the generic name for Ativan). Review of a hospice note for Resident #3 dated 01/11/25 at 10:00am revealed: -The resident was observed sitting on the floor next to his bed. -The resident had no injuries. -The resident required feeding assistance which was a decline for the resident. -The hospice nurse discussed the resident's recent falls with the hospice physician, and the physician ordered Lorazepam 0.5mg every four hours as needed.	D 270		

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D 270	Continued From page 23 -The resident should continue his antibiotic for a UTI. Review of electronic progress notes for Resident #3 on 01/12/25 revealed: -There was an entry by a MA at 6:45am that the resident slept well through the night, no signs of confusion or agitation. -There was an entry by a MA at 2:00pm that the resident had a good day, vitals were within normal range. -There was an entry by a MA at 10:15pm that the resident had no falls and vitals were noted. Review of electronic progress notes for Resident #3 on 01/13/25 revealed: -There was an entry by a MA at 2:45pm that the resident had no complaints and no issues. -There was no chart note for the 7:00am shift to the 3:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift. Review of Resident #3's Fall Risk Assessment dated 01/13/25 revealed: -Instructions: Assess the resident status in the nine clinical condition parameters listed below by assigning the corresponding score which best describes the resident's current status. Add the column of numbers to obtain the total score. If the score is 10 or greater, the resident may be considered at HIGH RISK for potential falls. Update the Care Plan to reduce the potential of a fall and/or severity of fall related injury with individualized interventions for the prevention of falls. -Under the Mental Status/ Cognition heading, "moderate confusion; has some safety awareness concerns, needs occasional reminders to use assistive device or call for	D 270		

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assistance as needed," was selected for as score of 2.
-Under the Mobility/Continence heading, "impaired mobility may use an assistive device and continent, may use incontinent supplies successfully" was selected for a score of 2.
-Under the Gait Balance heading, "requires use of assistive device, unsteady balance noted while standing/unable to stand without hands on balancing assistance, and unsteady balance noted while walking/unable to walk without hands on assistance" was selected for a score of 3.
-Under the Visual Status heading, "adequate with or without glasses" was selected for a score of 0.
-Under the Fall History (past 6 months), "2 plus falls in the past 3 months" was selected for a score of 6.
-Under the Medication Usage heading," takes 3 or more" was selected for a score of 4.
-Under the Other Considerations heading, "1-2 for recent hospital stay in the last four weeks, the resident is showing signs of fatigue/restlessness, is easily over stimulated by excessive noise, misplaces items easily, and wanders about the community with no real purpose," was selected for a score of 2.
-Under the Predisposing Diseases/Conditions heading, "1-3 present" was selected for a score of 2.
-Under the Total Score, 21 was documented.
-A total score of 10 or higher may represent a high risk for falls requiring interventions to prevent falls on the resident's care, yes was selected.
-The Fall Risk Assessment dated 01/13/25 was completed by the RCC.

j. Review of Resident #3's A/I report dated 01/16/25 at 11:32am revealed:
-The incidence classification was documented as a fall without injury.

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-The resident was found on the floor of the facility living room.
-The resident stated he decided to lay down and take a nap.
-The resident's vital signs were not documented.
-There was documentation that the resident was not questioned about his pain.
-There was documentation that his PCP was notified on 01/16/25 at 11:32am.
-There was documentation that his RP was notified on 01/16/25 at 11:32am.
-There was documentation that the RCC was notified on 01/16/25 at 11:32am.
-There was documentation that ROM was not completed.
-There was no documentation that ROM was completed.
-The A/I report was created by a MA on 01/16/25 at 11:32am.

There were no Hot Box charting sheets provided with dates beyond 01/15/25.

Review of electronic progress notes for Resident #3 on 01/16/25 revealed:
-There was an entry by a MA at 11:30am that the resident was found on the floor in the corner of the living room on his stomach, the resident reported he decided to lay down in the floor, the MA contacted the hospice nurse who would assess the resident today (01/16/25).
-There was an entry by a MA at 12:45pm that the resident completed his antibiotics.
-There was an entry by a MA at 9:30pm that the resident did not have any falls and had no complaint of pain.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident

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D 270	Continued From page 26 #3 on 01/17/25 revealed: -There was an entry by a MA at 7:00am that the resident had a good day. -There was an entry by a MA at 9:15pm that the resident did not have any falls and no complaint of pain. -There was no chart note for the 11:00pm to 7:00am shift. Review of electronic progress notes for Resident #3 on 01/18/25 revealed: -There was an entry by a MA at 2:30pm that the resident had no falls during the shift and no complaint of pain. -There was no chart note for the 7:00am to 3:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift. k. Review of Resident #3's A/I report dated 01/18/25 at 9:45pm revealed: -The incidence classification was documented as a fall without injury. -The resident had an unwitnessed fall when he attempted to transfer into his roommate's bed. -The resident's roommate called for assistance and made staff aware of the fall. -The resident stated he was trying to go to bed. -The resident complained of mild pain to his right knee but refused to be sent to the local ED. -The resident's vital signs were documented as blood pressure 150/78, pulse 74, respirations 20, and temperature was 97.3. -There was documentation that ROM was not completed. -He was not transported to the hospital. -There was documentation that his PCP was notified on 01/18/25 at 10:55pm. -There was documentation that his RP was notified on 01/18/25 at 9:55pm.	D 270		

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D 270	Continued From page 27 -There was documentation that the RCC was notified on 01/18/25 at 10:00pm. -There was no documentation that the hospice nurse was notified. -The A/I report was created by a RCC on 02/14/25 at 1:55pm. Review of electronic progress notes for Resident #3 on 01/18/25 revealed: -There was an entry by a MA at 9:45pm that the resident had an unwitnessed fall when trying to transfer to his roommate's bed. -There was no chart note for the 7:00am to 3:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift. Review of electronic progress notes for Resident #3 on 01/19/25 revealed: -There was an entry by a MA at 7:00am that the resident rested well last night and had no complaints of pain from his fall the previous day. -There was an entry by a MA at 2:45pm that the resident had a good day and no complaints of pain from his fall. -There was an entry by a MA at 10:30pm that the resident had a good day, no complaints of pain from his fall. Review of electronic progress notes for Resident #3 on 01/20/25 revealed: -There was an entry by a MA at 10:15pm revealed the resident had no complaint of pain and did not have any falls during this shift. -There was no chart note for the 7:00am to 3:00pm shift. -There was no chart note for the 11:00pm to 7:00am shift. Review of a hospice note for Resident #3 dated	D 270		

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D 270	Continued From page 28 01/25/25 revealed: -The resident had normal vital signs and no complaint of pain. -The resident had not had recent falls. -Staff should call hospice with any questions or concerns. There were no Hot Box charting sheets provided with dates beyond 01/15/25. I. Review of Resident #3's A/I report dated 01/31/25 at 11:01pm revealed: -The incidence classification was documented as a fall without injury. -The resident was found on the floor beside his bed lying on his back. -The resident stated he rolled off the bed. -The resident's vital signs were documented as blood pressure 130/59, pulse 74, respirations 16, and temperature was 98.1. -Staff questioned the resident about his pain level. -He was not transported to the hospital. -There was documentation that ROM was completed, the resident was able to move all extremities without any complaints. -There was documentation that his hospice nurse was notified on 01/31/25 at 11:20pm. -There was documentation that his RP was notified on 01/31/25 at 11:25pm -There was documentation that the RCC was notified on 01/31/25 at 11:28pm. -The A/I report was created by a MA on 01/31/25 at 11:15pm. Review of electronic progress notes for Resident #3 on 01/31/25 revealed: -There was an entry by a MA at 11:30pm that the resident was found on the floor beside his bed, he reported that he did not hit his head, was not hurt,	D 270		

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the resident reported he rolled out of bed, and the hospice nurse was notified.
-There was an entry by a MA at 11:45pm that the hospice nurse called the facility and reported she would visit the resident on Sunday 02/01/25 to assess his fall.
-There was no chart note for 7:00am to 3:00pm shift.
-There was no chart note for 3:00pm to 11:00pm shift.

Review of electronic progress notes for Resident #3 on 02/01/25 revealed:
-There was an entry by a MA at 6:30am that a PCA reported the resident was lethargic, coughing, had generalized weakness and the hospice agency was made aware of the resident's change in condition.
-There was an entry by a MA at 10:30am that the hospice nurse saw Resident #3, he was doing better, a hospice nurse would visit the resident tomorrow, and "may have something viral going around the facility."
-There was an entry by a MA at 3:00pm that the resident reported he was not feeling better, he felt weak, lethargic and was coughing.
-There was an entry by a MA at 9:45pm that the resident stayed in bed throughout the day, staff brought dinner to his room, but he refused, and the resident still appeared to be weak but had no fever.

Review of electronic progress notes for Resident #3 on 02/02/25 revealed:
-There was an entry by a MA at 7:15am that the resident had a sore throat and a temperature of 98.3 degrees.
-There was an entry by a MA at 9:30pm that the resident reported he felt a little better than yesterday, he did not have a fever.

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-There was an entry by a MA at 9:45pm that hospice was notified that the resident was not feeling well, the hospice nurse came to visit the resident and the resident had been monitored.
-There was no chart note for the 11:00pm to 7:00am shift.

There were no Hot Box charting sheets provided with dates beyond 01/15/25.

m. Review of Resident #3's A/I report dated 02/03/25 at 11:16pm revealed:
-The incidence classification was documented as a fall without injury.
-The resident was found on the floor beside his bed.
-The resident stated he did not know how he fell, but he did not hit his head.
-The resident's vital signs were documented as blood pressure 143/78, pulse 73, respirations 16, and temperature was 97.4.
-There was documentation that the staff did not question the resident about his pain.
-He was not transported to the hospital.
-There was documentation that ROM was completed, the resident was able to move all extremities without any concerns.
-There was documentation that his hospice nurse was notified on 02/03/25 at 11:16pm.
-There was documentation that his RP was notified on 02/03/25 at 11:16pm.
-There was documentation that the RCC was notified on 02/03/25 at 11:16pm.
-The A/I report was created by an MA on 02/03/25 at 11:16pm.

Review of electronic progress notes for Resident #3 on 02/03/25 revealed:
-There was an entry by a MA at 11:15pm that the resident was found on the floor on his fall mat

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face down, the resident did not know what happened, the MA notified the hospice nurse and the RCC.
-There was no chart note for the 7:00am to 3:00pm shift.
-There was no chart note for the 3:00pm to 11:00pm shift.

Review of electronic progress notes for Resident #3 on 02/04/25 revealed:
-There was an entry by a MA at 9:15am that the hospice nurse visited the resident on 02/03/25 and the hospice nurse planned to complete an order with the hospice physician for a wedge for Resident #3.
-There was an entry by a MA at 2:45pm that he resident had a fall last night and he was not feeling well.
-There was an entry by a MA at 3:00pm that the resident had felt weak but had no complaints after his fall.
-There was an entry by a MA at 9:30pm that the resident had no falls, was administered cough medicine for his cough, and they would continue to monitor for any changes.
-There was no chart note for the 11:00pm to 7:00am shift.

Review of electronic progress notes for Resident #3 on 02/05/25 revealed:
-There was an entry by a MA at 6:45am that the resident had a cough and reported he did not feel well.
-There was an entry by a MA at 11:00pm that the resident had no issues, and staff would continue to monitor.
-There was no chart note for the 7:00am to 3:00pm shift.
-There was no chart note for the 3:00pm to 11:00pm shift.

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D 270	Continued From page 32 There were no Hot Box charting sheets provided with dates beyond 01/15/25. Interview with a PCA on 02/13/25 at 10:50am revealed: -Resident #3 had a difficult time remembering he was supposed to use his wheelchair and tried to walk independently often. -Resident #3 had frequent falls, he often sat down on the floor or slid onto the floor if he felt like taking a nap. -When a resident returned from the hospital or had a fall the RCC or MAs notified PCAs that the resident was on increased checks. -Residents were checked every two hours, if they needed supervision or just returned from the hospital, they may need checks every hour or every 30 minutes. -When a resident returned from the hospital or had a fall PCAs were expected to check on residents every 30 minutes for a few days. -She was not aware of anywhere that the PCAs were required to document how often they checked on a resident, she only reported her increased checks to the MA on duty. Interview with a MA on 02/14/25 at 10:28am revealed: -When a resident had a fall, the MA checked the resident's vital signs and checked for any injury. -When a resident hit their head, they contacted emergency medical services (EMS) so the resident could be evaluated at the hospital. -When a resident fell on her shift, she was responsible for reporting to the oncoming MA that the resident had a fall. -MAs and PCAs usually checked on residents every two hours. -When a resident had an injury, the MAs and	D 270		

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PCAs checked on the resident every hour instead of every two hours.
-The MAs used a hot box system that triggered staff to check on a resident at least once every hour for 72 hours when a resident had a fall or returned to the facility from the hospital.
-The RCC usually initiated the Hot Box protocol.

Interview with a second MA on 02/14/25 at 3:41pm revealed:
-She thought that Resident #3 was checked every two hours, she was not aware of increased checks for Resident #3.
-It did not matter how often staff checked on Resident #3 "it did not matter; he does what he wants to do whenever he wants to."
-She had not been instructed to check on Resident #3 every hour or every 30 minutes to prevent additional falls.
-Staff did try to keep the resident in the front lobby near the medication room to decrease his falls.
-MAs and PCAs checked on all residents every two hours.
-When a resident had a fall, it varied on whether or not the resident was checked on more frequently than every two hours.
-The RCC usually notified staff when a resident needed more frequent checks.
-Sometimes a resident had a "fluke or an accidental fall," and these residents continued to be checked on every two hours.
-If a resident continued to have falls, she would notify the resident's PCP or the hospice nurse if the resident was on hospice.
-The Administrator or RCC would notify MAs if a resident was on increased checks.

Interview with the RCC on 02/14/25 at 4:36pm revealed:
-Staff tried to check on Resident #3 every hour

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due to frequent falls.
-Staff would sometimes bring the resident in his wheelchair to the lobby so staff could watch him more frequently.
-The resident had a fall mat beside his bed, but she could not recall the date the PCP ordered the fall mat.
-She would add a resident to the Hot Box list when a resident had a fall, however if she was not at the facility when an incident occurred the MA on duty could add the resident to the Hot Box list for increased monitoring.
-When a resident was placed on the Hot Box list, MAs were expected to document at least one time each shift for three days.

Interview with the Administrator on 02/14/25 at 4:03pm revealed:
-MAs and PCAs on all shifts were expected to check on residents every two hours to ensure the residents' safety.
-MAs and PCAs should check on residents every two hours to ensure they have access to their call bell.
-A fall mat had been provided for Resident #3 to ensure he was not injured if he slid out of his bed.
-She and the RCC had not spoken with the resident's family to see if they could hire a private sitter to help decrease his falls.
-When staff realized that a resident's frequent falls continued, staff were expected to increase the resident's check to once every hour.
-Staff were expected to document when they checked on the resident in the facility progress notes.
-The facility staff did not provide one on one supervision for residents.
-The RCC could determine whether a resident needed increased checks.
-When a resident returned from the hospital or

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D 270	Continued From page 35 fell, staff added that resident to the "Hot Box" list. -When a resident was added to the Hot Box list, MAs were expected to document on the resident every shift. Attempted telephone interview with Resident #3's primary care provider (PCP) on 02/14/25 at 1:45pm was unsuccessful. 2. Review of Resident #5's current FL-2 dated 05/17/24 revealed diagnoses included chronic pain, generalized anxiety disorder, other amnesia, and tremor. Review of Resident #5's annual Personal Care Physician Authorization and Care Plan revealed: -The reassessment date was 07/30/24. -Under social/mental health history, the resident was not real social, she spoke if spoken to, did not attend many activities and liked to be alone. -She had no problem with ambulation/locomotion. -"No problems" was documented for upper extremities. -Orientation was documented as normal and memory was documented as adequate. -Activities of daily living (ADLs) were documented with a performance code of zero indicating "independent" for bathing, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring. -The reassessment was completed by the Resident Care Coordinator (RCC).	D 270		

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D 270	Continued From page 36 -The Personal Care Physician Authorization and Care Plan was signed by Resident #5's primary care physician (PCP) on 08/09/24. a. Review of Resident #5's accident/injury (A/I) report dated 12/15/24 at 10:58am revealed: -The incidence classification was documented as fall-without injury. -The resident had an unwitnessed fall in the resident's bathroom. -The resident was found on the floor half out of her shower. -The resident stated she was trying to reach down for her shampoo and lost her balance and her foot slipped. -Her vital signs were documented as blood pressure was 128/56, pulse was 69, and her temperature was 97.5. -She was questioned about her pain level and her pain level was documented as 0 on a scale of 0 to 10 (with zero being no pain and 10 being the worst pain). -She was not transported to the hospital. -There was documentation that her PCP was notified via fax on 12/15/24 at 10:58am. -There was documentation that her responsible party (RP) was notified via phone on 12/15/24 at 10:58am. -There was documentation that the RCC was notified via phone on 12/15/24 at 10:58am. -The resident did not sustain any injuries and did not require outside medical care. -There was documentation that range of motion was not performed. -There was documentation that no medications were passed in the 12 hours prior to 12/15/24 at 10:58am. -The A/I report was created by a medication aide (MA) on 12/15/24 at 10:58am.	D 270		

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D 270	Continued From page 37 Review of the Hot Box Protocol sheets provided from 12/10/24 to 01/15/25 revealed Resident #4 was not listed on the Hot Box charting lists. Review of Resident #5's electronic progress notes dated 12/15/24 revealed: -There was an entry by a MA at 2:45pm, the resident had a fall today, she stated that she was trying to get her shampoo in the shower, when her foot slipped, she was not hurt and had no injuries, her RP was called, and the PCP was notified. -There was an entry by a MA at 8:45pm, the resident had no falls during the shift and did not complain of pain or discomfort. Review of Resident #5's electronic progress notes dated 12/16/24 revealed: -There was no chart note for the 11:00pm to 7:00am shift. -There was no chart note for the 7:00am to 3:00pm shift. -There was an entry by a MA at 10:15pm, the resident had no falls during the shift and did not complain of any pain or discomfort. Review of Resident #5's electronic progress notes entered by the MA dated 12/17/24 revealed: -There was an entry by a MA at 6:45am, the resident rested throughout the night without any issues or concerns. -There was an entry by a MA at 2:30pm, the resident walked around today, not having problems, came out for lunch. b. Review of Resident #5's A/I report dated 12/17/24 at 9:51pm revealed: -The incidence classification was documented as fall-without injury.	D 270		

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-The resident had an unwitnessed fall outside.
-The resident fell outside on her bottom.
-The resident stated she was trying to step on a bug and lost her balance.
-Her vital signs were documented as blood pressure was 128/85, pulse was 82, respirations were 18, and her temperature was 98.0.
-She was not questioned about her pain level.
-She was not transported to the hospital.
-There was documentation that her PCP was not notified.
-There was documentation that her RP was notified via phone on 12/17/24 at 9:10pm
-There was documentation that the RCC was notified via phone on 12/17/24 at 9:30pm.
-The resident did not sustain any injuries and did not require outside medical care.
-There was documentation that range of motion was performed and the resident moved her arms and legs without any issues.
-There was documentation that no medications were passed in the 12 hours prior to 12/17/24 at 9:51pm.
-The A/I report was created by a MA on 12/17/24 at 9:51pm.

Review of the Hot Box Protocol sheets provided from 12/10/24 to 01/15/25 revealed Resident #4 was not listed on the Hot Box charting lists.

Review of Resident #5's electronic progress notes dated 12/18/24 revealed:
-There was no chart note for the 11:00pm to 7:00am shift.
-There was an entry by the RCC at 3:16pm, the resident had an accidental fall on 12/15/24 at 10:58am.
-There was an entry by the RCC at 3:22pm, accidental fall on 12/17/24 at 9:51pm.
-There was an entry by a MA at 10:00pm, the

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resident had no falls during the shift and did not complain of pain or discomfort.

Review of Resident #5's electronic progress notes dated 12/19/24 revealed:
-There was no chart note for the 11:00pm to 7:00am shift.
-There was no chart note for the 7:00am to 3:00pm shift.
-There was an entry by a MA at 10:45am, the resident had no issues during the shift, the resident had no complaints of pain.

There were no electronic progress notes provided for Resident #5 for 12/20/24 or 12/21/24, the next electronic progress note was 01/02/25 at 12:00pm.

Review of Resident #5's Fall Risk Assessment dated 12/18/24 revealed:
-Instructions: Assess the resident status in the nine clinical condition parameters listed below by assigning the corresponding score which best describes the resident's current status. Add the column of numbers to obtain the total score. If the score is 10 or greater, the resident may be considered at HIGH RISK for potential falls. Update the Care Plan to reduce the potential of a fall and/or severity of fall related injury with individualized interventions for the prevention of falls.
-Under the Mental Status/ Cognition heading, "mild confusion but has no safety awareness concerns" was selected for a score of 1.
-Under the Mobility/Continence heading, "impaired mobility-may use an assistive device and continent, may use incontinent supplies successfully" was selected for a score of 2.
-Under the Gait Balance heading, "gait/balance normal" was selected for a score of 0.

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D 270	Continued From page 40 -Under the Visual Status heading, "adequate with or without glasses" was selected for a score of 0. -Under the Fall History (past 6 months), "1-3 falls in the past 6 months" was selected for a score of 2. -Under the Medication Usage heading," takes 3 or more" was selected for a score of 4. -Under the Other Considerations heading, "none present" was selected for a score of 0. -Under the Predisposing Diseases/Conditions heading, "1-3 present" was selected for a score of 2. -Under the Total Score, 11 was documented and resident will be assessed for physical therapy (PT)/occupational therapy (OT). -A total score of 10 or higher may represent a high risk for falls requiring interventions to prevent falls on the resident's care, Yes was selected. -The 12/18/24 Fall Risk Assessment was completed by the RCC. c. Review of Resident #5's hospital discharge summary dated 01/06/25 revealed: -The resident was admitted on 01/02/25 and discharged on 01/06/25 with a diagnosis of colitis (colitis is an inflammatory reaction in the colon, often autoimmune or infectious). -She needed an outpatient colonoscopy with her primary gastroenterology. -She was to continue folate (a type of vitamin b) therapy, Augmentin (Augmentin is an antibiotic) for another 5 days along with lactobacillus (a probiotic). Review of the Hot Box Protocol sheets provided from 12/10/24 to 01/15/25 revealed Resident #4 was not listed on the Hot Box charting lists. Review of Resident #5's electronic progress notes dated 01/06/25 revealed:	D 270		

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-There was an entry by an MA at 9:45pm, the resident returned to the facility via the RP's vehicle at approximately 4:30pm, the resident needed assistance exiting the vehicle and help getting into her bed, the resident's RP provided incontinence briefs for the resident, and she did need assistance getting to and from the bathroom until she was able to regain her strength.

Review of Resident #5's electronic progress notes dated 01/07/25 revealed:
-There was an entry by the RCC at 6:30am.
-The resident slept all night, did not awake during nightly checks, and staff continued to monitor the resident.

d. Review of Resident #5's A/I report dated 01/07/25 at 12:32pm revealed:
-The incidence classification was documented as fall without injury.
-The resident had an unwitnessed fall in her bathroom.
-The resident stated that she was trying to use the bathroom without assistance when she went to sit on the toilet she slipped and fell.
-Her vital signs were documented as not taken.
-She was questioned about her pain level and her pain level was documented as 7 on a scale of 0 to 10.
-She was transported to the emergency department (ED) by emergency medical services (EMS).
-There was documentation that her PCP was notified on 01/07/25 at 12:32pm.
-There was documentation that her RP was notified on 01/07/25 at 12:32pm.
-There was documentation that the RCC was notified on 01/07/25 at 12:32pm.
-There was documentation that the county Department of Social Services (DSS) was notified

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on 01/07/25 at 1:11pm.
-There was documentation that the resident did not sustain injury and did not require outside medical care.
-There was documentation that range of motion was not performed.
-There was documentation that no medications were passed in the 12 hours prior to 01/07/25 at 12:32pm.
-The A/I report was created by a MA on 01/07/25 at 12:32pm.

Review of Resident #5's electronic progress notes dated 01/07/25 revealed:
-There was an entry by a MA at 2:00pm, the resident had a fall and had to be sent out to the ED.
-There was an entry by the RCC at 5:01pm, the resident had an accidental fall.

Review of Resident #5's hospital discharge summary dated 01/16/25 revealed:
-The resident was admitted on 01/07/25 discharged on 01/16/25 with a diagnosis of accidental fall.
-The problem based hospital course list included hypokalemia (low levels of potassium in the blood, elevated alanine aminotransferase (ALT, an enzyme found primarily in the liver), elevated aspartate aminotransferase (AST, an enzyme found primarily in the liver, but also in the heart, muscles and kidneys), chronic back pain, thrombocytopenia (a low number of platelets in the blood) and hypertension.

There were no Hot Box charting sheets provided with dates beyond 01/15/25.

Review of Resident #5's electronic progress notes dated 01/16/25 revealed:

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D 270	Continued From page 43 -There was an entry by a MA at 9:15pm, the resident returned from the hospital today at 4:10pm, she was a little weak and needed stand by assistance for ambulating and using the bedside commode, she was alert and oriented x 3, she ate 25% of her dinner, the resident was excited about being home and was now in bed resting, vitals noted. Review of Resident #5's electronic progress notes dated 01/17/25 revealed: -There was an entry by a MA at 6:45am, the resident rested well through the night, she was asleep every time staff checked in with her. -There was an entry by a MA at 2:30pm, the resident was okay, she came out for lunch and stated that she was glad to be back and had no problems at that time, -There was an entry by a MA at 9:15pm, the resident seemed to be feeling better as she came down to dinner and went outside on the porch to smoke, the resident needed stand-by assistance with all activities of daily living (ADLs), the resident was monitored throughout the shift for safety and had not complained of any pain/discomfort; her RP brought food and assisted the resident with putting on night clothes, no other concerns voiced. Review of Resident #5's electronic progress notes dated 01/18/25 revealed: -There was no chart note for the 11:00pm to 7:00am shift. -There was an entry by the MA at 2:30pm, the resident was happy to be back in the facility, she appeared much stronger than she was when she left the facility to go in the hospital. -There was no chart note for the 3:00pm to 11:00pm shift.	D 270		

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D 270	Continued From page 44 Review of Resident #5's electronic progress notes dated 01/19/25 revealed: -There was no chart note for the 11:00pm to 7:00am shift. -There was an entry by a MA at 2:45pm, the resident did not come out of her room today, she barely ate (only just a banana), she took her morning medications at 1:00pm today, the resident seemed very lethargic today. -There was no chart note for the 3:00pm to 11:00pm shift. There were no electronic progress notes provided for Resident #5 for 01/20/25. Review of Resident #5's Fall Risk Assessment dated 01/16/25 revealed: -Instructions: Assess the resident status in the nine clinical condition parameters listed below by assigning the corresponding score which best describes the resident's current status. Add the column of numbers to obtain the total score. If the score is 10 or greater, the resident may be considered at HIGH RISK for potential falls. Update the Care Plan to reduce the potential of a fall and/or severity of fall related injury with individualized interventions for the prevention of falls. -Under the Mental Status/ Cognition heading, "alert, oriented, reliable safety awareness" was selected for a score of zero. -Under the Mobility/Continence heading, "impaired mobility-may use an assistive device and continent, may use incontinent supplies" successfully was selected for a score of 2. -Under the Gait Balance heading, "requires use of assistive devices" was selected for a score of 1. -Under the Visual Status heading, "adequate with or without glasses" was selected for a score of 0. -Under the Fall History (past 6 months), "1-3 falls	D 270		

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in the past 6 months" was selected for a score of 2.
-Under the Medication Usage heading," takes 3 or more" was selected for a score of 4.
-Under the Other Considerations heading, "none present" was selected for a score of 0.
-Under the Predisposing Diseases/Conditions heading, "1-3 present" was selected for a score of 2.
-Under the Total Score, 11 was documented and the resident has an order for PT and OT.
-A total score of 10 or higher may represent a high risk for falls requiring interventions to prevent falls on the resident's care, Yes was selected.
-The 01/16/25 Fall Risk Assessment was completed by the RCC.

Review of Resident #5's Personal Care Physician Authorization and Care Plan revealed:
-The reassessment date was 01/16/25 due to significant change.
-Under social/mental health history, the resident is not real social, she will talk if spoken to, does not attend many activities and likes to be alone.
-"Ambulatory with aide or devices" was documented for ambulation/locomotion.
-"No problems" was documented for upper extremities.
-Orientation was documented as "oriented" and memory was documented as "adequate".
-Activities of daily living (ADLs) were documented with a performance code of zero indicating "independent" for eating, a performance code of 1 indicating supervision for toileting, a performance code of 2 indicating limited assistance with ambulation/locomotion, a performance code of 3, indicating extensive assistance with bathing, a performance code of three indicating extensive assistance with dressing, a performance code of 2, indicating limited assistance with

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grooming/personal hygiene, and a performance code of 2, indicating limited assistance with transferring.
-The Personal Care Physician Authorization and Care Plan was signed by Resident #5's PCP on 02/13/25.

e. Review of Resident #5's A/I report dated 01/23/25 at 2:50pm revealed:
-The incident classification was documented as fall without injury.
-The resident had an unwitnessed fall in her room.
-The resident's RP called and stated the resident called her and said she had fallen trying to lay down on her bed, staff went in and found the resident lying on her side.
-The resident stated that she was trying to lay down and take a nap and she had been doing it herself from time to time.
-Her vital signs were documented as blood pressure was 144/72, pulse was 80, respirations were 22, and temperature was 97.5.
-She was questioned about her pain level and her pain level was documented as 5 out of 0 to 10.
-She was not transported to the hospital.
-Her PCP was notified via fax on 01/23/25 at 2:50pm.
-Her RP called and reported the fall to the facility.
-The Administrator was in the facility and notified at the time of the incident.
-The resident did not sustain any injuries.
-There was documentation range of motion was performed and the resident was able to move her arms and legs as usual.
-There was documentation no medications were passed 12 hours prior to 01/23/25 at 2:50pm.
-The A/I report was created by the RCC on 01/23/25 at 2:50pm.

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D 270	Continued From page 47 There were no Hot Box charting sheets provided with dates beyond 01/15/25. Review of Resident #5's electronic progress notes dated 01/23/25 revealed there was an entry by the MA at 10:30pm, the resident had a good day, she ate her dinner in her room with her sitter, no complaints of pain or discomfort from her previous fall. Review of Resident #5's electronic progress notes dated 01/24/25 revealed: -There was no chart note for the 11:00pm to 7:00am shift. -There was an entry by the RCC at 2:45pm, the resident had a fall on 01/23/25 near the end of the shift, the resident did not have any visible injuries and stated she was okay. -There was an entry by the MA at 3:15pm, there has not been any issues with the resident today, she had a sitter earlier this morning, staff offered to bring her down to lunch but she refused, she ate a bowl of broth per her request. -There was no chart note after 3:15pm on 01/24/25. Review of Resident #5's electronic progress notes dated 01/25/25 revealed: -There was an entry by the MA at 7:15am, the resident had a good night, no complaints or concerns at this time. -There was no chart note from the 7:00am to 3:00pm shift after the 7:15am entry. -There was an entry by the MA at 10:15pm, the resident had a private sitter from 3:00pm to 5:00pm, the resident was a one person assist with all ADLs, the resident had no falls during the shift and no complaints of pain or discomfort. Review of Resident #5's electronic progress	D 270		

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notes dated 01/26/25 revealed:
-There was no chart note for the 11:00pm to 7:00am shift.
-There was an entry by the RCC at 10:10am, the resident had an accidental fall on 01/23/25 at 2:50pm.
-There was an entry by the MA at 3:15pm, the resident was still somewhat weak, she did come out for lunch today.
-There was an entry by the MA at 9:15pm, the resident had no falls during the shift and did not complain of pain or discomfort, the resident did not eat dinner in the dining room and drank an ensure in her room, her sitter came for about an hour and sat with the resident, the resident remained a one person assist with all ADLs.

There was no Fall Risk Assessment provided for Resident #5 after her 01/23/25 fall.

Review of a rehabilitation referral form dated 02/10/25 for Resident #5 revealed:
-The reason for the referral request was PT and OT evaluation and treatment to maximize independence in the community by participating in gait training, activities of daily living and endurance training.
-PT evaluation and treatment were requested.
-OT evaluation and treatment were requested.
-The rehabilitation referral form was signed by Resident #5's PCP on 02/10/25.

Interview with Resident #5 on 02/13/25 at 1:08pm revealed:
-She has been admitted to the hospital a couple times since the first of the year due to stomach problems.
-She has had some falls in the past related to her being weak from being in the hospital.
-She recently had a colonoscopy and had some

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polyps removed.
-She went to the bathroom on her own and pretty much took care of herself.
-Her RP hired a sitter that came for a few hours a day either in the mornings or in the afternoons.
-Staff checked on her frequently.
-She felt she was slowly getting her strength back.

Interview with a personal care aide (PCA) on 02/14/25 at 2:45pm revealed:
-The residents were checked every 2 hours for assistance with ADLs and incontinence checks.
-Sometimes a resident required more frequent checks, if they were new to the facility, had a fall or had recently returned from the hospital.
-If a resident needed to be checked more than every two hours, it would either appear on her daily tasks on the computer or the MA would let her know at shift change.
-In the past Resident #5 had been pretty independent but since she returned from her last hospitalization she required more assistance and had to be reminded to use her call bell.

Interview with a MA on 02/13/25 at 10:36am revealed:
-The residents were checked every 2 hours by the PCAs and the MAs.
-If a resident had a fall, the MA was notified and assessed the resident for any injuries.
-If a resident hit their head or had an injury, they were sent to the ED, unless they received hospice services, if a resident was under hospice, the hospice nurse was contacted prior to sending the resident out.
-Any time a resident had a fall, returned from the hospital or was prescribed antibiotics, they were placed on the Hot Box charting list.
-Hot box charting, meant the MA made a

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progress note on the resident every shift for 72 hours.
-If a resident was prescribed antibiotics, the MA did a progress note on the resident each shift for as long as they were on the antibiotic.
-She thought the PCAs could make progress notes but mainly the MAs did the progress notes.

Interview with a second MA on 02/14/25 at 3:43pm revealed:
-The residents were checked every 2 hours by the PCAs and the MAs.
-Some residents were checked every hour if they had a fall, were not feeling well, or if they had returned from the hospital or ED.
-There was not anywhere that they documented more frequently than every 2-hour checks, they just did it.
-Resident #5 had been mainly independent and did everything for herself prior to her last hospital visit.
-She now required some assistance with toileting and ADLs.
-Resident #5 was reminded to call for help when she needed to use the restroom.
-A resident was placed on the hot box charting list after a fall,return from the hospital or when taking antibiotics.
-Hot box charting meant the MA should make a progress note on the resident each shift for 3 days.

Interview with the RCC on 02/14/25 at 4:36pm revealed:
-The residents were checked every 2 hours by staff.
-If a resident had a fall, prescribed antibiotics or returned from the hospital stay, they were placed on the hot box charting list.
-Hot box charting meant the MA should make a

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progress note on the resident each shift for at least 3 days.
-There should not be gaps or omissions of progress notes for residents on the hot box list.
-She did fall risk assessments on the residents when upon admission, every 6 months and when there was a change in condition such as increased weakness.
-She was responsible for implementing and documenting any fall interventions for the residents.
-Resident #5 had previously been independent but after her last hospitalization, she was weaker and required more assistance.
-She updated Resident #5's care plan after she returned from the hospital on 01/16/25 to reflect the additional needed assistance.
-PT and OT had been ordered for Resident #5 after her last fall.
-If a resident was on the hot box charting list, she expected the MAs to make a progress note each shift until the resident was removed from the hot box to reflect their condition.

Interview with the Administrator on 02/14/25 at 4:15pm revealed:
-Staff checked on the residents every 2 hours for assistance with ADLs, toileting and to see if they needed anything.
-When a resident had frequent falls, staff were expected to increase resident checks to every hour.
-The facility did not have a policy to document hourly checks.
-The RCC could implement fall interventions for the residents if needed, such as increased monitoring.
-Resident #5 had been independent in the past but had a decline since her last hospitalization and now had a sitter a few hours a day provided

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D 270	Continued From page 52 by her RP. -Staff did not provide one on one supervision for the residents. -Resident #5 knew she was to use her call bell to call for assistance but would not and tried to do things for herself. -Resident #5's care plan had been updated after her last hospitalization to reflect her need for increased assistance. -The facility also used the hot box charting system if a resident had a fall, returned from the hospital or was prescribed an antibiotic. -When a resident was placed on the hot box charting list, the MAs were to document a progress note concerning their condition on each shift for at least 3 days. -There should not be any omissions or gaps in the progress notes if a resident was on the hot box charting list. Attempted telephone interview with Resident #5's RP on 02/14/25 at 1:34pm was unsuccessful. Attempted telephone interview with Resident #5's PCP on 02/14/25 at 2:52pm was unsuccessful. _____ The facility failed to ensure supervision of 2 of 5 sampled residents (#3, #5) both identified as a high fall risk, one that had 13 falls in a 7 month period plus two falls in a 24 hour period,with one causing a hospitalization (#3), and a resident having 4 falls and with one causing a hospitalization with documented increased weakness in a 2 month period (#5). These failures were detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 02/14/25 for	D 270		

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D 270	Continued From page 53 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 31, 2025. -	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#4) related to failing to inform	D 273		

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a primary care provider (PCP) of a 14% weight loss in one month.

The findings are:

Review of the facility's Resident Weight Policy dated 10/21/24 revealed:
-A resident's weight can provide basic information about a person's health condition.
-At a minimum, a resident's weight should be taken at least monthly, or as applicable per state regulations, unless ordered more frequently by the resident's physician/healthcare provider.
-Resident weights may be taken by anyone that has been trained, or as per state regulations.
-Resident weights should be taken upon move-in and routinely monitored at least monthly thereafter, or as directed per physician/healthcare provider.
-Monthly weights should be recorded.
-If a resident's weight is ordered to be performed more frequently by the resident's physician/healthcare provider, those results will be found on the electronic medication administration record (eMAR) for review.
-When weighing the resident, the following guidelines should be followed, the resident should be weighed in a manner that provides privacy and respect, the same type of scale should be used each time the resident is weighed, the scale should be on a firm, flat surface, preferably not on carpet, the scale should be calibrated, per manufacturer's guideline, prior to each weight that is obtained and not moved from calibration, residents should be weighed at the same time of day when possible, residents should be weighed in the same type of clothing and footwear each when possible.
-If a resident has a 5% or greater loss of their weight in 1 month or a 10% or greater weight loss

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in 6 months, re-weigh for verification.
-If the re-weigh amount continues to reflect a 5% or greater weight loss in 1 month or 10% or greater weight loss in 6 months, the results will be reported to the community clinical team.
-The resident's physician/healthcare provider will be notified of a 5% or 10% weight loss unless directed per orders, with documentation completed reflecting the notification.
-The physician/healthcare provider instructions/orders will be carried out accordingly.
-The clinical team may institute simple interventions to promote stabilization, or weight gain.
-Examples of simple interventions that may be instituted are, weekly weights until weight is stable with no overall loss, for 4 weeks or there is a 5% gain in 4 weeks, observation of the resident during mealtime identifying any contributing factors, i.e., chewing/swallowing difficulties, poor fitting dentures, mouth pain, inability to sit for long periods of time, etc., if not counter indicated by resident condition, may offer larger portions, higher calorie foods/snack, increased protein intake, frequent smaller meals, or request an order for a nutritional supplement.

Review of Resident #4's current FL-2 dated 09/09/24 revealed diagnoses included chronic systolic (congestive) heart failure, hypertension, hyperlipidemia, hypothyroidism, gastro-esophageal reflux disease, iron deficiency anemia, pulmonary fibrosis, and typical atrial flutter.

Review of Resident #4's signed physicians order sheet dated 08/05/24 revealed there was an order for monthly vital signs.

Review of Resident #4's signed physicians order

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sheet dated 02/12/25 revealed there was an order for monthly vital signs.

Review of Resident #4's signed diet order dated 07/15/24 revealed she was to receive a no added salt diet.

Review of Resident #4's December 2024 eMAR revealed:
-There was an entry to obtain monthly vital signs, scheduled for the first shift on the third day of the month.
-Resident #4's weight was documented as 121.4 lbs. on 12/03/24.

Review of Resident #4's January 2025 eMAR revealed:
-There was an entry to obtain monthly vital signs, scheduled for the 1st shift on the third day of the month.
-Resident #4's weight was documented as 123 lbs. on 01/03/25.

Review of Resident #4's February 2025 eMAR revealed:
-There was an entry for monthly vital signs, scheduled for the 1st shift on the third day of the month.
-Resident #4's weight was documented as 105.8 lbs. on 02/03/25.

Review of Resident #4's electronic progress notes provided by the facility for the dates of 12/01/24 through 02/12/25 revealed there was no documentation of primary care provider (PCP) notification of the resident's weight change from 123 lbs. on 01/03/25 to 105.8 lbs. on 02/03/25 reflecting a 17.2 lbs. weight loss (14% weight loss).

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Interview with Resident #4 on 02/13/25 at 1:55pm revealed:
-She was recently hospitalized for congestive heart failure and blood pressure issues.
-She knew she had a recent weight loss, she thought she previously weighed around 112 lbs. and now weighed 107 lbs.
-She had never been a big eater.

Telephone interview with the Registered Nurse (RN) with Resident #4's hospice provider on 02/14/25 at 2:19pm revealed:
-She was filling in for the RN that usually saw Resident #4.
-Resident #4 started hospice services on 02/07/25 for a diagnosis of congestive heart failure.
-She did not see documentation of notification of Resident #4's previous and current weight.
-A change in weight from 123 lbs. to 105.8 lbs. in one month was a significant weight loss.
-She would expect hospice to have been notified of Resident #4's weight loss as the weight loss could indicate failure to thrive.

Telephone interview with the RN from Resident #4's PCP office on 02/14/25 at 2:28pm revealed:
-The resident's last visit to the office was 10/03/24.
-They received a request to order hospice services for Resident #4 on 02/07/25.
-She had no other documentation of contact regarding Resident #4 for February 2025 aside from the request for hospice services on 02/07/25.

Interview with a personal care aide (PCA) on 02/14/25 at 3:43pm revealed:
-She had never weighed a resident.
-She thought the medication aides (MAs)

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D 273	Continued From page 58 weighed the residents. Interview with the MA on 02/14/25 at 3:48pm revealed: -She weighed the residents when it popped up on the eMAR. -She never compared the resident's current weight with the previous months' weight unless a PCP or a family member asked. -She was not sure who reviewed the residents' monthly weights. -She could usually tell if a resident had lost weight or gained weight by looking at them. -She knew Resident #4 had been hospitalized recently and possibly had lost some weight. Interview with the Resident Care Coordinator (RCC) on 02/14/25 at 4:36pm revealed: -The MAs weighed the residents when it popped up on the eMAR. -She was responsible for reviewing the residents' monthly weights. -She notified a resident's PCP if there was a 5-pound weight loss or gain. -It was important to compare the residents' weight, if there was a weight gain, it could be caused by fluid build up such as congestive heart failure and if there was a weight loss, it could be due to illness such as flu. -If a resident had weight loss, she tried to observe them in the dining room as well. -She ran a monthly report to compare the residents' weight mid-month around the 15th. -She had not run her monthly report for February yet, so she was not aware that Resident #4 had a significant weight loss. -Resident #4 should be re-weighed to make sure the current weight was accurate and if the current weight was accurate, it should be reported to her PCP.	D 273		

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D 273	Continued From page 59 -She knew Resident #4 had been eating less and was recently hospitalized for congestive heart failure. Interview with the Administrator on 02/14/25 at 4:15pm revealed: -The MAs were not required to compare a resident's current weight to the previous month. -The RCC ran a monthly report and compared the residents' current weight to the previous month's weight. -If there was a significant weight gain or loss, she would expect the resident to be re-weighed to verify the weight was accurate and the PCP notified of the weight change. -A weight loss or gain of 5% or greater was to be reported to the resident's PCP. -A 5% weight gain could indicate possibly congestive heart failure, and a 5% weight loss could indicate malnutrition.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#2) related to daily blood pressure checks.	D 276		

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D 276	Continued From page 60 The findings are: Review of Resident #2's current FL-2 dated 08/30/24 revealed: -Diagnoses included hypertension. -There was an order to check the resident's blood pressure weekly. Review of a signed physician order for Resident #2 dated 09/17/24 revealed there was an order to check the resident's blood pressure one time a week and to notify the primary care provider (PCP) if the resident's blood pressure was less than 90/50 or greater than 160/100. Review of a signed physician order for Resident #2 dated 12/30/24 revealed there was an order to check the resident's blood pressure once a day for the next week; 12/30/24 to 01/05/25. Review of a signed physician order for Resident #2 dated 02/04/25 revealed there was an order to document the resident's blood pressure daily and to notify the PCP if the resident's systolic blood pressure was greater than 160 (Systolic blood pressure refers to the pressure in a person's arteries when the heart beats, a normal systolic blood pressure is less than 120). Review of a visit note from Resident #2's PCP dated 02/04/25 revealed: -The visit on 02/04/25 was her initial visit with the resident and she completed a history and physical. -The PCP documented that the resident's blood pressure had been fluctuating, with instances of high blood pressure readings. -The PCP was considering an increase in the residents' high blood pressure medication due to	D 276		

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instances of high blood pressure.
-The PCP documented that the resident's blood pressure would be monitored daily, and she would adjust medication as necessary.

Review of Resident #2's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain the resident's weekly blood pressure and to notify the resident's PCP if her blood pressure was less than 90/50 or greater than 160/100.
-There was no documentation that the residents' blood pressure was checked on 12/30/24.
-Resident #2 had a blood pressure of 204/74 on 12/07/24.
-The resident had a blood pressure of 163/77 on 12/10/24.
-The resident had a blood pressure of 181/79 on 12/17/24.
-The resident had a blood pressure of 187/77 on 12/31/24.

Review of electronic progress notes for Resident #2 revealed there was no documentation that the resident's PCP was notified when the resident's blood pressure was greater than 160/100 on 12/07/24, 12/10/24, 12/17/24, or 12/31/24.

Review of communication logs from the facility to the PCP revealed there was no documentation that the resident's PCP was notified when the resident's blood pressure was greater than 160/100 on 12/07/24, 12/10/24, 12/17/24, or 12/31/24.

Review of Resident #2's January 2025 eMAR revealed:
-There was an entry to obtain the resident's weekly blood pressure and to notify the resident's

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D 276	Continued From page 62 PCP if her blood pressure was less than 90/50 or greater than 160/100. -There was no documentation that the resident's blood pressure was checked on 01/01/25, 01/02/25, 01/03/25, or 01/05/25 daily as ordered. -Resident #2 had a blood pressure of 164/70 on 01/11/25. -The resident had a blood pressure of 176/80 on 01/14/25. -The resident had a blood pressure of 180/84 on 01/18/25. Review of electronic progress notes for Resident #2 revealed there was no documentation that the resident's PCP was notified when the resident's blood pressure was greater than 160/100 on 01/11/25, 01/14/25, or 01/18/25. Review of communication logs from the facility to the PCP revealed there was no documentation that the resident's PCP was notified when the resident's blood pressure was greater than 160/100 on 01/11/25, 01/14/25, or 01/18/25. Review of Resident #2's February 2025 eMAR revealed: -There was an entry to obtain the resident's weekly blood pressure and to notify the resident's PCP if her blood pressure was less than 90/50 or greater than 160/100. -There was an entry to obtain the resident's blood pressure daily and to notify the resident's PCP if her blood pressure was less than 90/50 or greater than 160. -Resident #2 had a blood pressure of 177/82 on 02/01/25. -The resident had a blood pressure of 176/80 on 02/04/25. -The resident had a blood pressure of 170/80 on 02/05/25.	D 276		

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D 276	Continued From page 63 -The resident had a blood pressure of 163/69 on 02/09/25. Review of electronic progress notes for Resident #2 revealed there was no documentation that the resident's PCP was notified when the resident's blood pressure was greater than 160/100 on 02/01/25, 02/04/25, 02/05/25, or 02/09/25. Review of communication logs from the facility to the PCP revealed there was no documentation that the resident's PCP was notified when the resident's blood pressure was greater than 160/100 on 02/01/25, 02/04/25, 02/05/25, or 02/09/25. Interview with a medication aide (MA) on 02/13/25 at 3:30pm revealed: -When a PCP had parameters for a resident's blood pressure MAs were supposed to notify the PCP per their orders. -She was not sure why there was no documentation that Resident #2's PCP was notified when her systolic blood pressure was over 160. -Resident #2 was at an increased risk of a stroke or heart attack when her systolic blood pressure was over 160. -When MAs had communication with a resident's PCP the MAs documented in the electronic progress notes and if they faxed a communication report to the PCP, a copy of the fax with confirmation should be printed and left for the Resident Care Coordinator (RCC). Interview with a second MA on 02/14/25 at 10:25am revealed: -Resident #2's PCP had orders for staff to notify her if the resident's systolic blood pressure was over 160.	D 276		

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D 276	Continued From page 64 -When the resident's systolic blood pressure was over 160, MAs were expected to notify the resident's PCP. -She thought Resident #2's PCP had ordered that the resident's blood pressure be checked once a week. -She was not aware that there was an order to check the resident's blood pressure one time a day. -She thought she had documented each time the resident's systolic blood pressure was over 160 in the electronic progress notes. -She was not sure why she forgot to document that she notified the resident's PCP when her systolic blood pressure was over 160. -She thought she had texted the RCC when the resident's systolic blood pressure was over 160 but could not remember. -Resident #2 was at risk of a stroke, falling due to dizziness, and at risk of a heart attack when her blood pressure was too high. Interview with the RCC on 02/14/25 at 4:36pm revealed: -She was aware that Resident #2 had a history of high blood pressure. -Resident #2 was seen by a new PCP at the beginning of February 2025. -The PCP increased the residents blood pressure checks from once a week to once a day to monitor her blood pressure readings. -MAs were required and expected to follow PCP orders for residents. -The MAs were expected to document that they notified the resident's PCP when her blood pressure was outside of parameters in the electronic progress notes. -The MAs placed Resident #2 at risk of a heart attack or stroke when they failed to notify her PCP that her blood pressure was too high based	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074047	A. BUILDING: _____ B. WING _____	R 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVION OF GREENVILLE	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 276	Continued From page 65 on the parameters the PCP ordered. Interview with the Administrator on 02/14/25 at 4:03pm revealed: -She expected MAs to follow PCP orders. -She was not aware that Resident #2's PCP was not notified on several occasions per the PCP order if the resident's blood pressure was over 160/100. -Staff should have notified the resident's PCP to help ensure the resident received appropriate care for her high blood pressure. -The PCP may want to change the resident's medication or may want the resident to have an appointment. -The resident was at risk of a stroke when her blood pressure was uncontrolled. Telephone interview with Resident #2's PCP on 02/14/25 at 1:56pm revealed: -She became Resident #2's PCP on 02/04/25. -The resident had a history of high blood pressure. -She ordered the residents' blood pressure be checked daily to help her determine how to adjust the resident's medication to manage her high blood pressure. -She had not been notified by facility staff in February 2025 that the resident's blood pressure was over 160/100. -She expected the MAs and RCC to follow her orders and to notify her when the resident's blood pressure was too high. -She needed to be notified when the resident's blood pressure was too high because she may need to change the resident's medication. -When Resident #2 had a blood pressure of 160/100 or higher it placed the resident at an increased risk of increased dizziness, suffering a stroke or heart attack.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074047	A. BUILDING: _____ B. WING _____	R 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 276	Continued From page 66 Attempted telephone interview with Resident #2's previous PCP on 02/14/25 at 2:52pm was unsuccessful.	D 276		