STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054071	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The adult care licensure section conducted a follow up survey on April 15-16, 2025. Refer to event ID KMYP12.	D 000	It is the policy and standard practice of Spring Arbor of Kinston to comply with all North Carolina Adult Care rules and state regulations.	
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime service consisted of non-disposable place settings. The findings are: Observations during the Special Care Unit (SCU) breakfast meal on 04/16/25 between 7:30am and 8:15am revealed: -The tables were set up with place settings that consisted of a napkin, non-disposable fork and spoon, non-disposable plate, coffee mug, 1 Styrofoam cup of water, 1 Styrofoam cup of milk and 1 Styrofoam cup of juice. -There were 11 residents present for the meal. -The meal included eggs, grits, sausage or	D 286	Plan of Correction: ED immediately ordered service ware needed for community on 04/16/2025. Dinnerware arrived and was put into service on 04/18/2025—04/21/2025. Team members were in-serviced on 04/16/2025 by the Food Service Director (FSD) on what table service should include for residents: napkin, non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. FSD and Director of Quality Education Nurse conducted a Skills Fair 05/01/25 and reeducated team members on essential supplies required for individual place settings in the dining rooms and with room service.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Daugherty — TITLE: Executive Director — (X6) DATE: 05/14/2025

Reviewed and acknowledged on June 2, 2025 Joyce Johnston

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D 286	Continued From page 1 bacon, cooked apples and toast. -The cooked apples were served in Styrofoam bowls. Observation during the Assisted Living (AL) breakfast that was delivered to Resident #3's room on 04/16/25 at 8:47am revealed: -Resident #3's breakfast was served on a disposal plate. -Resident #3's coffee was served in a disposal cup with a lid. -Resident #3's water was served in a disposal cup with a lid. -Resident #3's disposal utensils included a disposable fork, spoon, and knife. Interview with the medication aide (MA) on 04/16/25 at 8:50am and 11:30am revealed: -She had worked at the facility for three weeks. -She delivered Resident #3's breakfast to his room. -This was the first time that she had delivered a meal to a resident's room. -She did not know why the meal was served using disposable place settings. Interview with a SCU personal care aide (PCA) on 04/16/25 at 10:45am revealed: -She put the drinks in the Styrofoam cups for the residents on the SCU because non disposable cups were not sent from the kitchen. -Drinks served in Styrofoam cups on the SCU started 2 weeks ago because there were no more glass cups. -She was unsure what happened to the cups. -All the cups came from the main kitchen. -She asked the Dietary Manager (DM) about cups and was told they did not have any more. -Prior to 2 weeks ago, they had all glass cups on the SCU.	D 286	Prevention of Re-occurrence: All team members were trained and reeducated on proper, required table service for residents and to report to the FSD and/or Executive Director (ED)any items necessary for table service for all meals in the dining rooms. Monitoring Responsibility & Frequency: The Food Service Director/ED and/or department head designee will monitor meals to ensure proper table service items are available and in use in the dining room and for meals that are delivered in the room daily for 1 month and weekly for 2 months. The Director of Quality & Education Nurse and/or Regional Director of Operations will monitor during their on-site visits to the community to ensure compliance with table service standards as well. Correction Completion Date: 05/05/2025	05/05/2025

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D 286	Continued From page 2 -The kitchen staff alternate between non disposable bowls and Styrofoam bowls, but she did not know why. -They received 3 or 4 new residents on the SCU in the past 2 weeks which could have affected the number of available cups and bowls. -She knew SCU residents probably liked to have glassware. -There were 13 residents in the SCU and only 10 cups, which was not enough to serve all the beverages. Interview with a dietary aide (DA) on 04/16/25 at 10:03am revealed: -Glasses were used for tea, water and juice in the assisted living dining room. -The SCU staff fixed the drinks for the special care unit residents; she did not. -The Cook fixed the plates; she did not. -Residents on the AL side that ate in their rooms had been served on Styrofoam plates since she started 2 years ago (2023). -She was unsure why residents that ate in their rooms were served on Styrofoam plates. -She knew residents that ate in the dining room were supposed to have non disposable place settings, but she did not know that applied to the trays that were taken to the residence rooms. -Residents should have been served on China because they deserve it. Interview with the Cook on 04/16/25 at 10:11am revealed: -Residents that ate in their rooms were served on disposable place settings because half of the non-disposable silverware and plates were not returned to the kitchen. -Residents that ate in their rooms had been served in disposable place settings since she started in June of 2024.	D 286		

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D 286	Continued From page 3 -Residents that ate in the AL dining room were served in non-disposable place settings. -She was not sure who made the decision for residents eating in their rooms to be served using disposable place settings. -She did not have anything to do with what cups drinks were served in on the SCU. -The drinks for the SCU were transported in pitchers and the SCU staff poured the drinks into the cups. -The night staff prepared the breakfast fruit for the next morning, and they put the fruit in the Styrofoam bowls. -They did not have enough bowls for all residents in the facility. -They had approximately 43 bowls. -The DM was made aware of the bowl shortage last week and would be ordering more bowls. Interview with the DM on 04/16/25 at 10:16am revealed: -She had always been trained to send Styrofoam plates to the residents that ate in their rooms. -She was trained by the previous DM. -She was not sure why Styrofoam plates were used for residents that ate in their rooms. -Dietary staff plated the fruit in Styrofoam bowls for the SCU. -She did not know why the fruit was served in Styrofoam bowls. -She went to the SCU yesterday and observed all Styrofoam cups being used. -The cups in the SCU were cracked and broken and that was why they were using Styrofoam cups. -She knew the SCU needed cups but did not know they needed all new cups; she thought they only needed a few more cups. -She obtained more cups for the SCU about 3 weeks ago and was unsure what happened to	D 286		

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D 286	Continued From page 4 those cups. -She was not aware of the state regulation regarding the use of non-disposable place settings for all residents. -The use of disposable place settings made the residents feel like they did not care. -The SCU residents needed routine and should be served using the same place settings all the time. -SCU residents did not need Styrofoam cups because they could crush or bite the Styrofoam cups. -She had to get approval from the Administrator to order more cups and bowls. -She planned to order a case of 50 tall cups, a case of 50 short cups and no less than 60 bowls. -She planned to order more cups and bowls today (04/16/25). Interview with the Special Care Unit Coordinator (SCC) on 04/16/25 at 10:51am revealed: -She noticed the drinks being served in the non-disposable cups. -Sometimes the fruit and dessert were served in disposable bowls and other times in non-disposable bowls. -New cups were ordered because the old ones were thrown out due to tea stains. -She was unsure what date new cups were ordered. -There were still enough cups for tea but not enough for milk and juice as well. -She was not aware of the state regulation regarding non-disposable place settings for all residents. -Residents paid a lot of money to reside at the facility and they should have the best of the best. -Residents on the SCU could eat or bite into the Styrofoam cup or bowl. -Residents being served using Styrofoam cups	D 286		

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D 286	Continued From page 5 posed a dignity issue. Interview with the Resident Care Director (RCD) on 04/16/25 at 12:35pm revealed: -Disposable place settings were used only when there was COVID or isolation in place. -She saw disposable place settings being used this morning (04/16/25) during breakfast meal service on the AL side. -She saw disposable trays and Styrofoam cups being used. -She was not aware Styrofoam cups and bowls were used on the SCU this morning (04/16/25) for breakfast meal service. -She did not know why disposable place settings were used on the AL side or in SCU. -Dietary staff were responsible for making sure disposable place settings were not used. -All staff should have been responsible for making sure disposable place settings were not used. -MAs and PCAs were present during meals. -She did not know if staff were aware that disposable place settings could not be used. -She was concerned that the policy was not being followed regarding non-disposable place settings Interview with the Administrator on 04/16/25 at 1:05pm revealed: -She was aware of the state regulation regarding non-disposable place settings for all residents. -She was aware residents that ate in their rooms on the AL side were served on disposable plates. -The residents that ate in their rooms on the AL side were served on disposable plates because the food was plated that way. -She was not aware the fruit on the SCU was served in disposable bowls. -They had bowls but not enough cups. -She ordered cups for the SCU as well as dome	D 286		

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D 286	Continued From page 6 covers for plates to use for residents that eat in their room. -She was not aware the SCU residents were served beverages in Styrofoam cups. -She was not sure how long Styrofoam cups and disposable plates had been used. -Glass cups were available in the main dining room, but they were not being used in the SCU because SCU staff felt Styrofoam cups were safer. -Non-disposable place settings pose a dignity issue unless being used due to COVID, norovirus or some other similar reason. -There was no reason for disposable place settings to be used at the time. -It was the responsibility of all staff to make sure non-disposable place settings were used. -Dietary staff were responsible for making sure there were enough non-disposable place settings and notifying her if there was not. -She was responsible for overseeing all staff responsibilities.	D 286		
D 364	10A NCAC 13F .1004 (g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 1 of 5 residents (#6) observed including medications used to treat gastroesophageal reflux disease, allergy	D 364	Plan of Correction: Immediately upon these findings by the survey team, a prompt Med Tech meeting was held on 04/16/25 by the Resident Care Director (RCD) to address the findings and reeducation began of New Order processes and follow through with delivery of medications. Subsequent Med Tech meetings were conducted by the RCD and Director of Quality & Education Nurse on:	

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D 364	Continued From page 7 symptoms, and iron deficiency. The findings are: Review of the Administration of Medications policy dated 09/20 revealed that medications must be administered within one hour before or after the time ordered. Review of Resident #6's current FL-2 dated 04/08/25 revealed diagnoses included Alzheimer's disease, depression, hyperlipidemia, anxiety, hypertension, gastroesophageal reflux disease, and irritable bowel. Review of Resident #6's current physician order sheet dated 04/08/25 revealed: -There was an order for Pantoprazole Sodium DR 40mg to be administered twice daily (Pantoprazole Sodium DR is used for treating gastroesophageal reflux disease). -There was an order for Fluticasone Prop 50mcg spray to be administered twice daily (Fluticasone Prop spray is used to treat allergy symptoms). -There was an order for Ferrous Sulfate 325mg to be administered twice daily (Ferrous Sulfate is used to treat iron deficiency). Observation of the medication aide (MA) on 04/15/25 at 9:30am revealed the MA walked into Resident #6's room and administered her morning medications. Review of Resident #6's April 2025 eMAR revealed: -Pantoprazole Sodium DR 40mg was documented as administered at 8:00am on 04/15/25. -Fluticasone Prop 50mcg spray was documented as administered at 8:00am on 04/15/25.	D 364	4/21/25 (Topics: Med Cart audit, shift to shift reports, How/When to complete an Incident Report, EHR documentation—Alert charting) 4/22/25 Med Tech In-Service (Topic: Diabetic training) with another Diabetic Training scheduled for 5/8/25 with Pharmacist. 5/1/25 Skills Fair (Topics: Documentation, Vital Signs, Incident Reporting & Hand Hygiene) 5/8/25 Med Tech In-Service (Topics: New Order tracking process, pending orders, Med Cart audit, EHR (electronic health record) documentation, Alert charting) Prevention of Re-occurrence: RCD and/or designee will monitor/observe medication passes to ensure medications are administered within the scheduled time.	

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D 364	Continued From page 8 -Ferrous Sulfate 325mg was documented as administered at 8:00am on 04/15/25. Interview with the MA on 04/15/25 at 9:40am revealed: -She had worked as an MA at the facility for one month. -She knew that she was late administering medications. -She had not notified anyone that the medications were administered late. -She did not document in their eMAR system that the medications were administered late. -She was not trained on what to do if medications were administered late. Interview with the Resident Care Director (RCD) on 04/15/25 at 9:50am revealed: -She had worked as the RCD at the facility for one year. -She did not know that the morning medications were administered late. -The MA had been trained to notify her when medications were administered late. -The MA or herself should notify the primary care provider (PCP) that the medications were administered late. -It should have been documented in the eMAR that the medications were administered late. Interview with the Administrator on 04/15/25 at 10:00am revealed: -She had worked as the Administrator at the facility for 3 weeks. -She did not know that the morning medications were administered late. -The RCD should have been notified that the medications were administered late. -The PCP should be notified that the medications were administered late.	D 364	Monitoring Responsibility & Frequency: Weekly Med Tech training/In-Services will be conducted by the RCD and/or Director of Quality & Education Nurse for 3 months and monthly thereafter to include continued education with medication administration. RCD and Director of Quality of Education will monitor/observe medication passes weekly for 1 month and monthly for 2 months to ensure compliance with medication administration times. Correction Completion Date: 05/08/2025	05/08/2025

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D 364	Continued From page 9 -The medications should be administered following the facility policy. -Medications could be administered one hour prior and one hour after scheduled administration time. Attempter telephone interview with Resident #6's PCP on 04/16/25 at 8:45am was unsuccessful.	D 364		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure incident and accident reports involving emergency room (ER) evaluations after a fall for 3 of 5 sampled residents (2, 3, #4) were sent to the Department of Social Services (DSS) within 48 hours of the event. The findings are: Review of the facility's Policy for Incident and Accident Reports dated September 2020 revealed:	D 451	Plan of Correction: Executive Director (ED) emailed County DSS incident report. Prevention of Re-occurrence: ED and/or designee will be responsible for notifying the county department of social services of any accident or incident that results in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. ED and/or designee will email a copy of the incident report to County DSS. The Director of Quality & Education Nurse and/or Regional Director of Operations will monitor weekly for 3 months then monthly on-going to ensure incident reports are reported to County DSS timely.	

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D 451	Continued From page 10 -The Incident and Accident Report was to be completed with all requested information whenever an incident or accident occurred or was alleged to have occurred. -The Resident Care Director or Cottage Care Director and Executive Director would review and sign each Incident and Accident report and would oversee implementation of follow-up actions as indicated. -The Executive Director or designee would notify the Regional Director and Director of Quality and Education as soon as possible of all serious incidents or allegations as per Divisional Communication Guidelines: missing resident, unexpected death, fall with injury/ 911 (resident, team, visitor) abuse or neglect, suspected or verified, behavioral episode resulting in 911 call, other serious incident or allegation. -An incident or accident resulting in death or requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aid should be reported to the appropriate regulatory authority in compliance with state regulations. -The Executive Director would investigate and evaluate the incident or accident and document any appropriate follow-up and preventative actions. -A copy of each serious Incident and Accident Report or allegation as identified in #3 would be sent to the Regional Director and Director of Quality and Education by next business day. -Incident and Accident Reports were to be filed in a secure location. These reports were not to be filed in the residents' chart or records. -All Incident and Accident Reports would be maintained by the community for a period of 10 years. 1. Review of Resident #2's current FL-2 dated	D 451	Monitoring Responsibility & Frequency: ED and/or designee will continuously monitor all incident reports that involve injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. ED and/or designee will email a copy of the incident report to County DSS. The Director of Quality & Education Nurse and/or Regional Director of Operations will monitor monthly for 3 months to ensure incident reports are reported to County DSS timely. Correction Completion Date: 4/17/2025	

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D 451	Continued From page 11 11/18/24 revealed diagnoses included dementia, age related cognitive decline, repeated falls, unsteadiness in feet, other abnormalities of gait or mobility, unilateral primary osteoarthritis right knee, respiratory disorder and solitary pulmonary nodule. Review of Resident #2's After Visit Summary dated 02/13/25 revealed: -The resident was seen in the emergency room (ER) for a fall. -The diagnoses were fall, head injury and bleeding in brain. -There was attached information regarding subdural hematoma and closed head injury. Review of Resident #2's incident and accident report dated 02/13/25 revealed: -A witnessed fall occurred. -The incident time was 9:00am. -The reported date and time was 02/13/25 at 9:30am. -Staff reported that the resident tripped over her feet while walking and fell. -The resident landed on her face and an open area above her right eye was bleeding. -There was a scratch on her right arm from elbow down to forearm and also a bruise on the left ankle. -The Special Care Coordinator (SCC) was present. -Emergency Medical Services (EMS) was called that the Power of Attorney (POA) was notified. -Resident was sent out for a check-up. -The concern was the resident had bleeding above the right eye on her brow area, a scratch on her elbow downward to wrist, and a bruise on the left ankle. -The treatment provided was the wound was cleaned and 911 was called.	D 451		

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D 451	Continued From page 12 -The action taken was EMS was called, first aid was administered, vitals were measured, and staff assisted the resident. -Under the heading of "Action Item", was EMS/911 called, Notify Divisional of Management, Notify Family Member, Notify Licensure Agency, Notify Physician. The Resident Care Director's name was beside each item under the heading "Modified By". "Date Modified" was 02/20/25 at 11:37am. -The report was closed on 02/22/25 at 6:05pm by the Administrator at that time. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's responsible party on 04/16/25 at 1:44pm was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 04/16/25 at 3:59pm and 4:05pm were unsuccessful. Refer to interview with a medication aide (MA) on 04/16/25 at 1:51pm. Refer to interview with the Adult Home Specialist (AHS) on 04/16/25 at 12:47pm. Refer to interview with the Special Care Coordinator (SCC) on 04/16/25 at 10:51am. Refer to interview with the Resident Care Director (RCD) on 04/16/25 at 12:35pm. Refer to interview with the Administrator on 04/16/25 at 1:05pm.	D 451		

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	HAL054071	A. BUILDING: _____ B. WING _____	R 04/16/2025

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D 451	Continued From page 13 Refer to interview with the Regional Director of Operations on 04/16/25 at 1:23pm. 2. Review of Resident #3's current FL-2 dated 03/27/25 revealed diagnoses included dementia, altered mental status, hyperglycemia, hyperkalemia, chronic foley, and age-related debility. Review of Resident #3's incident and accident report dated 03/03/25 revealed: -The resident had an unwitnessed fall at 8:00am. -Resident #3 was found on the floor in his room. -Resident #3's toenail came off and he was sent to the hospital. -Emergency Medical Services (EMS) was called. -The incident report was closed on 03/10/25 at 11:24am by the Regional Director of Operations (RDO) who was the interim Executive Director (ED). Interview with the Adult Home Specialist (AHS) on 04/16/25 at 1:05pm revealed she had received Resident #3's incident/accident report on 03/10/25. Interview with the Regional Director of Operations (RDO) on 04/16/25 at 1:25pm revealed: -He sent the incident/accident report on 03/10/25 to the Department of Social Services (DSS). -He knew that the incident/accident report was sent to DSS late. -He knew that the incident/accident report should be sent to DSS within 24 hours. Refer to interview with a medication aide (MA) on 04/16/25 at 1:51pm. Refer to interview with the Adult Home Specialist (AHS) on 04/16/25 at 12:47pm.	D 451		

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D 451	Continued From page 14 Refer to interview with the Special Care Coordinator (SCC) on 04/16/25 at 10:51am. Refer to interview with the Resident Care Director (RCD) on 04/16/25 at 12:35pm. Refer to interview with the Administrator on 04/16/25 at 1:05pm. Refer to interview with the Regional Director of Operations on 04/16/25 at 1:23pm. 3. Review of Resident #4's current FL-2 dated 03/27/25 revealed diagnoses included Dementia, congestive heart failure hypokalemia, atrial fibrillation, hypertension gastroesophageal reflux, and normocytic anemia. Review of Resident #4's incident and accident report dated 02/13/25 revealed: -The resident had an unwitnessed fall at 1:30am. -Resident #3 was found on the floor in his room. -Resident #3's injuries were not documented. -Emergency Medical Services (EMS) was called. -The incident report was closed on 02/18/25 at 8:55pm by the previous Executive Director (ED). Interview with the Adult Home Specialist on 04/16/25 at 1:05pm revealed she had not received an Incident/Accident report on Resident #4. Interview with the Regional Director of Operations (RDO) on 04/16/25 at 1:25pm revealed he did not know that Resident #4's incident/accident report was not sent to Department of Social Services (DSS). Refer to interview with a medication aide (MA) on	D 451		

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D 451	Continued From page 15 04/16/25 at 1:51pm. Refer to interview with the Adult Home Specialist (AHS) on 04/16/25 at 12:47pm. Refer to interview with the Special Care Coordinator (SCC) on 04/16/25 at 10:51am. Refer to interview with the Resident Care Director (RCD) on 04/16/25 at 12:35pm. Refer to interview with the Administrator on 04/16/25 at 1:05pm. Refer to interview with the Regional Director of Operations on 04/16/25 at 1:23pm. Interview with a medication aide (MA) on 04/16/25 at 1:51pm revealed: -When a resident falls, they determine whether the fall was witnessed or unwitnessed and whether or not the resident hit their head. -Residents were automatically sent out to the emergency room (ER) if they hit their head or if the fall was unwitnessed because it was unknown if the resident hit their head. -The Power of Attorney (POA) was notified of the fall. -An incident report was started and everyone contacted was documented. -Someone always remained with the resident after the fall. -Vitals were taken by the MA or personal care aide (PCA) right after the incident. -The primary care provider (PCP) was notified after the incident. -The Special Care Coordinator (SCC), Resident Care Director (RCD), and Administrator were notified immediately. -Vital signs and important information was shared	D 451		

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D 451	Continued From page 16 with Emergency Medical Services (EMS) when they arrived. -She thought the Department of Social Services (DSS) should be notified if there was abuse or if DSS was the POA but did not know for sure when DSS should be notified of Incident and Accident Reports. -She thought the Administrator was responsible for DSS notification of Incident and Accident Reports. Interview with the Adult Home Specialist (AHS) on 04/16/25 at 12:47pm revealed: -The facility was supposed to send Incident and Accident reports to the Department of Social Services (DSS) within 48 hours of the incident if the resident was sent out to the emergency room (ER). -The facility emailed Incident and Accident reports to her and she responded via e-mail letting them know the report was received. -She filed the incident and accident reports in a folder under the facility's name on the computer. -She also printed the Incident and Accident reports and filed them in a physical record in her office. -She did not receive an Incident and Accident report for Resident #2 for the 2/13/25 fall. Interview with the Special Care Coordinator (SCC) on 04/16/25 at 10:5am revealed: -After a resident fell and vitals were done, a PCA stayed with the resident while EMS was called. -The Administrator, RCD, PCP and POA were notified of the fall. -An Incident and Accident Report was completed. -DSS was notified if the resident had a head injury, broken bone or suffered abuse or neglect. -The Administrator was responsible for notifying the DSS of the incident.	D 451		

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D 451	Continued From page 17 -The Administrator was notified immediately of the falls. -She did not know the timeframe in which an Incident and Accident report needed to be reported to DSS. Interview with the Resident Care Director (RCD) on 04/16/25 at 12:35pm revealed: -After a fall, the MA assessed the resident and completed a full set of vital signs. -The RCD and Administrator were informed of the fall, whether there was injury or no injury, and whether or not the resident hit their head. -If the fall was unwitnessed or there was an injury, the resident was sent out to the emergency room (ER). -If there was no injury, Alert Charting was done, and the resident was monitored for 3 days. -The PCP and responsible party were notified, and an Incident and Accident report was completed. -When a new Incident and Accident report was entered into the system, she was notified via e-mail. -The Regional Nurse also received notification of new incident reports via email. -She reviewed the Incident and Accident report, and the Administrator approved the report. -The Administrator was responsible for sending the report to anyone that was supposed to receive it. -She did not know what reports were supposed to be sent to DSS. Interview with the Administrator on 04/16/25 at 1:05pm revealed: -After a fall, she expected staff to follow the policy when providing care to the residents. -The responsible party was notified, first aid was provided, and EMS was called.	D 451		

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D 451	Continued From page 18 -If more than first aid was needed, she was responsible for sending the notification to DSS within 48 hours. -The MA started the incident report. -The RCD and Administrator reviewed the incident report. -If any actions needed to be added to the Incident and Accident Report, the Regional RN did that. -The Regional RN reviewed all Incident and Accident reports before they were sent to DSS. -She was not aware of the two 02/13/25 Incident and Accident report was not sent to DSS. -She did not become the Administrator until 03/24/25. -The Regional Director of Operations was the acting Administrator between the time she became Administrator and the time the previous Administrator left. Interview with the Regional Director of Operations on 04/16/25 at 1:23pm revealed: -The MA or Supervisor wrote the Incident and Accident Reports after a fall and logged it into the electronic health record. -The Administrator and the RCD were made aware via telephone or text message by the MA depending on the severity of the fall. -If the resident was sent out to the hospital, they had 48 hours to get the Incident and Accident Report approved, document follow up and get the report sent to DSS. -The Administrator was responsible for getting the Incident and Accident report to DSS. -He was employed at the facility on 2/11/25 but was not there every day. -The previous Administrator was still employed at that time. -He was not aware the 02/13/25 Incident and Accident report for Resident #2 was not sent to DSS.	D 451		

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D 451	Continued From page 19 -The Incident and Accident report for Resident #2 should have been sent to DSS within 48 hours by the Administrator. -The Incident and Accident Report had to be printed and faxed to DSS.	D 451		