Adult Care Home Corrective Action Report (CAR)

I. Facility Name: **Champions Assisted Living** County: New Hanover
Address: 1007 Porters Neck Road Wilmington, NC 28411 License Number: HAL-065-020
II. Date(s) of Visit(s): 03/07/25, 03/19/25, 03/27/25, 04/02/25, 04/16/25, 04/23/25, 04/30/25, and 05/06/25 Purpose of Visit(s): Complaint Investigation

Instructions to the Provider ***(please read carefully)*****:** Exit/Report Date: **May 6, 2025**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0703 Rule/Statutory Reference: Tuberculosis Test, Medical Examination, and Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs. This Rule is not met as evidenced by: ***Based on interviews and record reviews, the facility failed to clarify information on an FL-2 to determine if the facility could meet the needs for 1 of 8 sampled residents (#8), as the resident's FL-2 at admission documented the resident's level of care as skilled nursing facility.*** Level of Non-Compliance: STANDARD DEFICIENCY The findings are:	[X] POC Accepted JL, SWS RA, BSW *DSS Initials* Champions Assisted Living acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions with quality of care of residents. The plan of correction is submitted as a written assertion of compliance. Responses to the stated deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Champions Assisted Living reserves the right to refute and incorporates by reference any rebuttal of deficiencies that it submits through informal dispute resolution, formal appeal and/or other administrative or legal procedures.	

Review of Resident #8's current FL-2 dated 07/27/24 revealed: -Diagnoses included advancing dementia, risk for falls, and aphasia. -The resident was intermittently disoriented, wandered, and injurious to others. -The resident was semi-ambulatory. -The resident was incontinent of bladder. -The resident required assistance with bathing and dressing. -The resident's recommended level of care was documented as skilled nursing facility (SNF). Review of Resident #8's Resident Register revealed an admission date of 08/05/24. Review of Resident #8's record on 04/02/25 revealed no clarification for SNF level of care documented on the FL-2 dated 07/27/24. Telephone interview with a nurse of Resident #8's former Primary Care Provider (PCP) on 04/01/25 at 4:25pm revealed: -The FL-2 on file for the resident was dated 06/27/24 with a level of care being documented as SNF. -There was a portal message on 06/19/24 that the resident's responsible party (RP) left that indicated the resident was transitioning to memory care at the facility's community and a blank FL-2 was sent for completion. -On 07/10/24, the facility's Administrator called looking for the resident's FL-2 form which was needed for admission. -On 07/11/24, there was a note that the FL-2 was faxed to the facility. -She did not see a copy of the FL-2 dated 07/27/24 for the resident. Interview with the Special Care Coordinator (SCC) on 04/02/25 at 11:38am revealed: -The Admission Coordinator was responsible for making sure the resident's paperwork was completed with the required information upon admission. -The Administrator or one of the facility nurses would be responsible for clarifying any orders on the FL-2 that were not clear upon admission. -She reviewed the FL-2's and orders for residents admitted to the memory care unit. -She had not noticed Resident #8's level of care was documented	Current resident's FL2s were audited to ensure accuracy. FL2's for residents admitting to facility to be reviewed by Administrator or Clinical Director to ensure no clarifications are needed. If clarifications are needed the physician or physician extender is to be contacted to ensure that the facility can meet the resident's needs.	5/13/25

as SNF on the FL-2 dated 07/27/24.
-Resident #8's SNF level of care should have been clarified as the facility was not a SNF.

Interview with the Clinical Director on 04/02/25 at 3:37pm revealed:
-One of the facility nurses would be responsible for clarifying any orders on the FL-2 that were not clear upon admission.
-She was not aware Resident #8's level of care was documented as SNF on the FL-2 dated 07/27/24.
-The SNF level of care should have been clarified by completing a new FL-2 with the appropriate level of care to be Adult Care Home/memory care.
-One of the facility nurses would have been responsible for completing a new FL-2 with the appropriate level of care and getting the FL-2 signed by the PCP.

Telephone interview with Resident #8's RP on 04/17/25 at 10:14am revealed she was not aware Resident #8's FL-2 dated 07/27/24 had SNF as the recommended level of care.

Telephone interview with Resident #8's current PCP on 04/17/25 at 12:03pm revealed:
-One of the facility nurses would usually call to get an order clarified if needed.
-The FL-2 was reviewed by the PCP during the first visit when the resident is seen as a new patient.
-There was no documentation the facility had called to get the level of care clarified from SNF to memory care/adult care home.
-The level of care should have been addressed and corrected.

Second interview with the SCC on 04/23/25 at 11:48am revealed she got Resident #8's FL-2 updated and clarified with memory care being the recommended level of care on 04/02/25 once the Adult Home Specialist brought the resident's level of care to her attention on 04/02/25.

Interview with the Administrator on 04/23/25 at 2:40pm revealed:
-She was not aware Resident #8's FL-2 dated 06/27/24 had SNF as the recommended level of care.
-A nurse or the SCC would have been responsible for reviewing Resident #8's FL-2 upon admission and getting any orders clarified

as needed. -Resident #8's level of care should have been clarified and changed from SNF to Adult Care Home/memory care.		
Rule/Statute Number: 10A NCAC 13F .0901	☒ POC Accepted JL, SWS RA, BSW DSS Initials	
Rule/Statutory Reference: 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 A2 VIOLATION ***Based on interviews and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 8 sampled residents (#2,#8) sampled who had multiple falls, including falls with head injuries and rib fractures requiring visits to the emergency room for further evaluation.***	Resident #8 was provided with 24 sitters on 4/21/25 and resident #2 has a planned discharged to a higher level of care on 5/27/25	
Level of Non-Compliance: TYPE A2 VIOLATION		
The findings are: Review of the facility's fall precautions dated 11/07/23 revealed: -All residents will be assessed for fall risks within 72 hours of admission and quarterly thereafter. -The purpose of the policy was to identify residents with the potential for falls to attempt to prevent falls. -The Clinical Director or the Social Worker will conduct a risk assessment for falls after admission and thereafter. -A Fall Risk Worksheet will be used. -A score of 5 or above should be considered at risk for falls. -Fall Risk will be initiated on the Activity of Daily Living (ADL) Sheet and Face Sheet. -If the resident was ambulatory, non-skid footwear should be encouraged. -Referrals may be made to appropriate therapy disciplines on a case by case basis. -Residents who experience more than 2 falls in a 30 day period will be considered "High Fall Risk." -Residents who are a "High Fall Risk" will have a Fall Risk	Revised fall risk assessment was put in place on 4/3/25 and has since been used as a more robust and comprehensive assessment to determine fall risk. Daily review of falls implemented with focus of post fall intervention and effectiveness. Monthly falls prevention education sessions to be provided to residents monthly by Functional Pathways staff. Bi-annual functional assessments to be initiated by Functional Pathways staff to assess baseline and possible decline as well as need for potential therapy services to attempt to prevent falls. Falls meetings to be held weekly, monthly, and quarterly to discuss interventions, effectiveness, and trends amongst falls.	4/3/25 5/7/25 6/5/25 6/5/25 4/8/25

assessment completed after the second fall and each subsequent fall. -Residents who are "High Fall Risk" will have a visual indicator placed on the face sheet banner. -Assessments to prevent falls should be an ongoing process, with all staff observing and reporting concerns with regular meetings to determine effectiveness of program. Review of the facility's Resident Care Assessment scoring tool revealed: -A score of 1-11 points was a Level 1 (Supervisor-Mild Care) . -A score of 11.5-21.5 points was a Level 2 (Limited Assistance-Moderate Care). -A score of 22-30 points was a Level 3 (Extensive Assistance-Heavy Care). -A score of 20.5-35 points was a Level 4 (Enhanced Care). -A score of 35.5 points was Totally Dependent-Unable to care for which indicates discharge. 1. Review of Resident #2's current FL-2 dated 11/12/24 revealed: -Diagnoses included dementia, dry eye syndrome of bilateral lacrimal glands, nail disorder, ischemic optic neuropathy, corneal of right eye, hemorrhoids, and urinary tract infection. -The resident was intermittently disoriented. -The resident was ambulatory. -The resident was continent of bowel and bladder. -The resident required assistance with bathing. -The resident's recommended level of care was documented as memory care. Review of Resident #2's Resident Register revealed an admission date of 05/19/19. Review of Resident #2's Fall Risk Worksheet dated 08/16/24 revealed: -The resident ambulated independently with a cane. -The resident was confused. -The resident had history of falls due to previous falls in the past year. -The resident scored 11 which indicated the resident was at risk for falls. -The worksheet was completed by the social worker (SW).	Resident Falls and Falls Risk Policies to be brought to QA Committee for review and revision as deemed appropriate. Residents who have experienced 2+ falls in a month will have an invitation for care plan meeting sent to family member to discuss current interventions and potential next steps. Residents who have experienced 2+ falls in a month will have 3050R care plan updated to reflect fall risks and interventions that are in place and/or may be effective. Residents who fall frequently and have ineffective interventions will be reviewed for discharge by interdisciplinary team. If family member or responsible party is not agreeable to safety interventions or need for discharge, a 30-day notice will be issued.	5/20/25 6/5/25 6/5/25 6/5/25 6/5/25

Review of Resident #2's care plan dated 11/12/24 revealed:
-The resident walked independently with a cane.
-The resident was forgetful and needed reminders.
-The resident required limited assistance with toileting, bathing, dressing, and grooming.
-The resident was independent with transferring.
-The care plan did not address falls or interventions.

Review of Resident #2's level of care assessment dated 02/04/25 revealed:
-The reason for the assessment was the 90-day review.
-There were no recent medical problems or concerns indicated.
-The resident ambulated with the assistance of a walker.
-The resident required intermittent supervision (cueing, guidance) and/or physical assistance for difficult maneuvers with transfers.
-The resident required daily supervision for safety, encouragement, or minor physical assistance with toileting.
-The resident was intermittently disoriented and had wandering behaviors.
-The resident had 1-2 falls in the last quarter.
-There was no documentation related to fall interventions.
-The resident scored 19 and was a Level 2, which meant the resident required limited assistance/moderate care.

Review of Resident #2's current care plan dated 02/24/25 revealed:
-The reason for this care plan was documented as the 90-day review.
-The resident was intermittently disoriented and had prior history of wandering in a non-secured environment.
-The resident ambulated with assistance of a walker.
-The resident required intermittent supervision (cueing/guidance) and or/or physical assistance for difficult maneuvers.
-The resident required daily supervision for safety or encouragement or minor physical assistance.
-The resident had 3-4 falls in the last quarter.
-There was no documentation related to fall interventions.
-The resident scored 21 and was a Level 3, which meant the resident required extensive assistance.

Review of Resident #2's progress notes revealed:
-On 10/24/24 at 10:49am, staff documented the resident was observed lying on the floor in the hallway that morning; the

resident was walking to breakfast when the resident's shoes she was wearing broke; the resident had no signs of injuries and denied pain or discomfort; the resident refused multiple times for vitals to be checked; the resident's shoes were changed to sneakers; staff would encourage the resident to continue to wear sneakers instead of sandals.
-On 10/27/24 at 8:15pm, the staff documented the resident returned to the facility from the hospital via EMS with diagnoses of fall and laceration of scalp; the resident needed a follow up appointment in 7 days for suture removal; the resident received no new order and would continue to monitor.
-On 11/04/24 at 2:16pm, staff documented 2 sutures were removed from the left side of the head just above the resident's ear.
-On 11/29/24 at 1:18pm, staff documented the resident was walking from the dining room when she lost balance and fell landing on her bottom; the resident had no signs or symptoms of injury and was able to stand with assistance; staff would encourage the resident to use a walker instead of a cane to help with balance.
-On 12/05/24 at 10:24pm, staff documented the resident was found on the floor in her bathroom around 5:30pm with her pants hallway down; staff reported the resident was trying to get up on her knees; there were no injuries noted.

Review of a Fall Incident Report for Resident #2 dated 10/27/24 revealed:
-The resident had an unwitnessed fall in her room on 10/27/24 at 2:30pm.
-Staff discovered the resident with blood dripping from her head.
-The resident exhibited pain or complained of pain on the left side of her head.
-The injury to the left side of her head was documented as a laceration.
-The resident was taken to the emergency room (ER).
-The resident's diagnosis was a fall with laceration of scalp which resulted in 2 staples being placed.
-The primary care provider (PCP) was notified.
-The interventions for immediate measures taken were: first aid, rest, a completed environmental assessment, and emergency medical services (EMS) called.
-The interventions were documented as effective with no description documented.

-Hourly rounding was initiated on 10/27/24 for 24 hours.
-The resident was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall from 10/27/24-10/30/24.
-The Falls Prevention Program was initiated.

Review of Resident #2's ER encounter report dated 10/27/24 revealed:
-The resident was seen for an unwitnessed fall.
-The resident fell and hit the left side of her head and sustained a small laceration above the left ear.
-The resident suffered approximately 0.5cm superficial linear laceration located on the parietal scalp.
-The final impression was fall and left parietal scalp laceration.

Review of Resident #2's Fall Risk Worksheet dated 11/18/24 revealed:
-The resident ambulated independently with a cane.
-The resident was confused.
-The resident had history of falls due to previous falls in the past year.
-The resident scored 13 which indicated the resident was at risk for falls.
-The worksheet was completed by the Special Care Coordinator (SCC).

Review of Resident #2's Fall Risk Worksheet dated 02/07/25 revealed:
-The resident ambulated independently with a walker.
-The resident was confused.
-The resident had history of falls due to previous falls in the past year.
-The resident scored 13 which indicated the resident was at risk for falls.
-The worksheet was completed by the SCC.

Review of a Fall Incident Report for Resident #2 dated 02/08/25 revealed:
-The resident had an unwitnessed fall in her room on 02/08/25 at 7:00am.
-The resident indicated she fell when getting out of bed.
-Staff discovered the resident with a ½ inch laceration to the back

of her head.
-The resident received first aid and was not sent out for evaluation.
-The PCP was notified.
-The interventions for immediate measures taken were: first aid, increase lighting in resident room, call light within reach, education provided to ask for assistance/use call light, completed environmental assessment, and increased monitoring.
-The interventions were documented as somewhat effective with no description documented.
-Hourly rounding was initiated on 02/11/25 for 24 hours.
-The resident was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall from 02/11/25-02/14/25.
-The Falls Prevention Program was initiated.

Review of Resident #2's progress notes revealed:
-On 02/08/25 at 6:40am, the staff documented the resident had a bloody spot on the back of her head and was observed sitting on the couch in the common area; the resident was assessed, and it was noted to have approximately a 1-inch laceration to back mid top of head with dried blood in the center; the resident stated she was getting out of bed and lost balance and was able to get up; the resident did not have any complaints of pain, discomfort, swelling, discoloration, or active bleeding noted; the resident denied pain upon touching of the area, headache, or blurred vision; staff would continue to monitor and would send out for severe changes; family and physician notified.
-On 02/20/25 at 6:21am, staff documented when doing rounds for toileting, the resident was observed to have blood on the left side face while lying in bed; the resident was sent out for observation.
-On 02/20/25 at 11:14am, staff documented the resident returned to the facility via EMS at 9:00am; she had a laceration on the left side of her face that had been glued; she also had a dime size area on the back of her head that did not require treatment; the resident's left eye and check area were swollen and bruised; the resident did not remember where or how she fell.

Review of a Fall Incident Report for Resident #2 dated 02/20/25 revealed:
-The resident had an unwitnessed fall in her bathroom on 02/20/25 at 4:45pm.
-Staff discovered the resident in bed with blood on the right side of

her face.
-The location of injury was documented as left side of face with an abrasion and bruising.
-The resident was taken to the ER for further evaluation.
-The resident returned to the facility with diagnosis of fall, with face laceration/contusion.
-The PCP was notified.
-The interventions for immediate measures taken were: first aid, rest, increase lighting in resident room, call light within reach, a completed environmental assessment, emergency medical services called, and increased monitoring.
-The interventions were documented as effective with no description documented.
-Hourly rounding was initiated on 02/20/25 for 24 hours
-The resident was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall from 02/20/25-02/23/25.
-The Falls Prevention Program was initiated.

Review Resident #2's ER encounter report dated 02/20/25 revealed:
-The resident was seen for an unwitnessed fall with noted pain to the left temple.
-The resident was found by staff to be in her bed with dried blood to the left temple.
-The resident believed she fell out of bed but was unclear if she had passed out.
-The resident sustained left facial subcutaneous (below the skin but above the muscle) and soft tissue strain with a small (bruising around the eye) periorbital contusion.
-The resident received 4 sutures due to a 3 cm laceration to the left temple.
-The final impression was fall, facial laceration, and contusion to face.

Review of an order from Resident #2's PCP dated 02/25/25 revealed:
-There was a referral for evaluation and treatment for physical therapy (PT), occupational therapy (OT), and speech therapy(ST).
-The associated diagnoses included physical deconditioning, frequent falls, and cognitive decline.

Review of Resident #2's record revealed:
-There were no Fall Risk Worksheets completed after the residents' falls on 11/21/24, 11/29/24, 12/05/24, and 12/07/24 according to incident reports for the same dates.
-There were no attempts to get PT from October 2024 until 02/25/25.

Interview with a medication aide (MA) on 03/19/25 at 11:43am revealed:
-Resident #2 was total care and required assistance with all activities of daily living (ADL's).
-Resident #2 was a fall risk as she had had several over the last several months with some that resulted in an injury that required to resident to be sent out to the ER for evaluation.
-Resident #2 was known to sit on the floor as if she had fallen.
-The personal care aides (PCAs) were responsible for checking on residents hourly for 72 hours after each fall according to protocol.
-After 72 hours residents were checked on every 2 hours, which meant physically seeing the residents.
-She was not aware of any other interventions for Resident #2 related to her falls.

Interview with a PCA on 03/19/25 at 12:01pm revealed:
-Resident #2 was total care and used a walker to ambulate.
-Resident #2 was confused and had recently moved to special care due to cognitive decline.
-Resident #2 was a fall risk but would sit on the floor at times as if she had fallen.
-Resident #2 would need assistance getting up if she fell.
-She was not sure if Resident #2 had any injuries related to her falls.
-Most of the memory care residents sat in the common area and could be supervised.
-She tried to check on residents every 30 minutes when she worked, but the facility's policy was for residents to be checked on every 2 hours, which meant physically seeing the residents.
-She was not aware of any interventions for Resident #2 related to her falls.

Interview with a second PCA on 03/19/25 at 1:45pm revealed:
-Resident #2 required assistance with toileting, bathing, and dressing.

-Resident #2 used a walker to assist with ambulation.
-Resident #2 had 2 falls in the last 3 months.
-She had not been informed that Resident #2 was a fall risk and had no concerns.
-Residents were checked every 2 hours for toileting needs.
-Increased supervision would come from management if needed.

Interview with a third PCA on 03/27/25 at 11:09am revealed:
-Resident #2 was total care, but often did not wait for assistance.
-Resident #2 had "a lot" of falls over the last several months.
-She had hit her head due to a fall and had to be sent to hospital.
-Resident #2 would need assistance to get up from a fall.
-Resident #2 started PT about two weeks ago.
-Residents were checked on every 2 hours unless they had a fall then they would be checked on every 30 minutes or every hour for 3 days, which depended on the order.
-She was not aware what the facility's fall policy was but knew if a resident fell 3 times in a week they would be evaluated for rehabilitation for 1 week.
-She had not been instructed that Resident #2 had any fall interventions.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Telephone interview with Resident #2's Responsible Party (RP) on 04/02/25 at 12:25pm revealed:
-The resident had several falls while at the facility with injuries such skin tears and she hit her head.
-He did not discuss any interventions with the facility related to the residents' falls.
-He did not have any concerns about the resident's care but depended on the facility to evaluate the resident's medical needs.

Telephone interview with the nurse at Resident #2's PCP office on 04/02/25 at 9:27am revealed:
-Resident #2 used a cane for ambulation and required stand by assistance when ambulating.
-The resident was a "fall risk" and fell often at the facility as the facility would call or send a fax related to the resident's falls.

Interview with the first shift (7:00am-3:00pm) Nurse Supervisor on

04/02/25 at 1:50pm revealed:
-Resident #2 was recently moved to special care unit from the assisted living.
-Resident #2 used a cane and fell "a lot" and had to be reminded to use cane.
-Resident #2 often wore sandals that she felt contributed to her falls.

Interview with the SCC on 04/02/25 at 11:38am revealed:
-Resident #2 required assistance with dressing.
-Resident #2 had been using a cane but currently used a walker.
-Resident #2 shuffled her feet when walking.
-Resident #2 was wearing sandals that were causing her to fall, but now she was wearing sneakers.

Interview with the Clinical Director on 04/02/25 at 3:37pm revealed Resident #2 was a fall risk and had falls that required the resident to be sent out for further evaluation.

Interview with the Administrator on 04/23/25 at 2:40pm revealed:
-Resident #2 required assistance with dressing.
-Resident #2 was at risk for falls and has had frequent falls.
-Resident #2 went from using a cane to a standard walker and has stopped wearing sandals to help decrease falls.
-She was not aware the SCC had not completed the Fall Risk Assessments for Resident #2 after each fall and subsequent fall after the resident had 2 falls within 30 days as expected.
-Resident #2 was not on any increased supervision related to falls.

Refer to interview with the SCC on 04/02/25 at 11:38am.

Refer to interview with the first shift (7:00am-3:00pm) Nurse Supervisor on 04/02/25 at 1:50pm.

Refer to interview with the Clinical Director on 04/02/25 at 3:37pm.

Refer to interview with the Administrator on 04/23/25 at 2:40pm.

2. Review of Resident #8's current FL-2 on 03/27/25 dated 07/27/24 revealed:
-Diagnoses included advancing dementia, risk for falls, and aphasia.

-The resident was intermittently disoriented, wandered, and injurious to others.
-The resident was semi-ambulatory.
-The resident was incontinent of bladder.
-The resident required assistance with bathing and dressing.
-The resident's recommended level of care was documented as skilled nursing facility (SNF).

Review of Resident #8's Resident Register revealed an admission date of 08/05/24.

Review of Resident #8's Resident Care Assessment for pre-admission dated 06/18/24 revealed:
-The resident used a walker and required intermittent supervision (cueing, observation) with walking and may require human assistance for difficult parts of walking outdoors.
-The resident required moderate assistance with dressing and needed verbal encouragement to complete dressing.
-The resident required assistance with bathing.
-The resident required intermittent supervision (cueing, guidance) and /or physical assistance with transfers.
-The resident was incontinent with bladder and required constant supervision and/or physical assistance with toileting.
-The resident had 1-2 falls in the last quarter.
-The resident was constantly disoriented and had history of wandering in non-secured environment.
-The resident scored 22 and was a Level 3, which meant the resident required extensive assistance to heavy care.

Review of Resident #8's care plan dated 11/12/24 revealed:
-The care plan was completed due to a significant change, but there was no documentation what the significant change was.
-The resident ambulated with a rollator.
-The resident had daily incontinence of bowel and bladder.
-The resident was always disoriented with significant memory loss and needed to be directed.
-The resident had a history of mental illness, wandered, resisted care, was injurious to others, and was verbally and physically abusive.
-The resident was totally dependent with toileting needs.
-The resident required limited assistance with transferring and ambulation/locomotion.

Review of Resident #8's level of care assessment dated 02/04/25 revealed:
-The reason for the assessment was the 90-day review.
-The resident ambulated with the assistance of a walker.
-The resident was dependent on staff for all toileting needs.
-The resident required intermittent supervision (cueing, guidance) and/or physical assistance for difficult maneuvers with transfers.
-The resident had 5 plus falls in the last quarter.
-The resident was constantly disoriented and wandered.
-The resident was uncooperative, had unpredictable behaviors, strong reaction to frustrations, and was unable to be redirected and needed to be escorted to meals and activities.
-The resident scored 32 and was a level 4, which meant the resident required enhanced care.

Review of Resident #8's current care plan dated 02/10/25 revealed:
-The resident used a rollator.
-The resident required intermittent supervision when walking and may require human assistance for difficult parts of walking outdoors.
-The resident was dependent on staff for all toileting needs.
-The resident had moderate confusion/forgetfulness with some predictable behavior.
-The resident was constantly disoriented and had a history of wandering in a non-secured environment.
-The resident had 5 plus falls in the last quarter.
-The resident scored 31 and was a level 4, which meant the resident required enhanced care with discharge indicated as the level.

Review of a Fall Incident Report for Resident #8 dated 11/13/24 revealed:
-The resident had an unwitnessed fall in the day room at 8:09pm.
-Staff found the resident lying on the floor on his left side.
-The injury was a quarter size abrasion to the left side of the forehead with swelling.
-It was documented the primary care provider (PCP) was notified by note in the physician book.
-The interventions/immediate measures taken were adaptive equipment, first aid, rest, call light within reach, complete environmental assessment, and increased monitoring.
-The interventions were somewhat effective with no description

documented.
-The resident was not sent out for further evaluation.
-The Falls Prevention Program was initiated.

Review of a Fall Incident Report for Resident #8 dated 11/26/24 revealed:
-The resident had a witnessed fall in the day room at 1:25pm.
-The resident tripped over another resident's walker and fell on his back.
-The resident's injury was to the mid center of back.
-It was documented the PCP was notified by note in book.
-The interventions/immediate measures taken were ensure resident is using appropriate eyewear, bring to supervised area for closer observation, proper fitting footwear/non-skid socks, complete environmental assessment, call EMS, and increased monitoring.
-The interventions were effective with no description documented.
-The resident was sent out for further evaluation.
-Hourly monitoring was initiated on 11/26/24-11/26/24.
-The Falls Prevention Program was initiated.

Review Resident #8's emergency room (ER) encounter report dated 11/26/24 revealed:
-The resident tripped over a walker, fell backwards, striking his back and head.
-The resident had complaints of backpain.
-The final impression was a fall.

Review of Resident #8's Fall Risk Worksheet dated 12/03/24 revealed:
-The resident had Parkinson's.
-The resident ambulated with a rollator with limited mobility.
-The resident was confused.
-The resident had a history of falls due to previous falls in the past year.
-The resident scored 18, which indicated the resident was at risk for falls.
-The worksheet was completed by the Special Care Coordinator (SCC).

Review of a Fall Incident Report for Resident #8 dated 01/12/25 revealed:

-The resident had an unwitnessed fall in the resident's room at 11:30am.
-The resident was found on the floor in his room.
-There was no injury documented.
-It was documented that the PCP was notified by note in book.
-The interventions/immediate measures taken were to ensure resident was using appropriate eyewear, bring to supervised area for closer observation, complete environmental assessment, and increased monitoring.
-The interventions were effective with no description documented.
-The resident was sent out for further evaluation with diagnosis of cough, respiratory syncytial virus infection (RSV), and injury of head.
-Hourly monitoring was initiated on 01/12/25-01/13/25.
-The resident was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall from 01/12/25-01/15/25.

Review Resident #8's ER encounter report dated 01/12/25 revealed:
-The resident was seen for a cough.
-The resident's family indicated the resident had a history of Parkinson's disease and dementia.
-When staff went to check on the resident for his coughing, he was found on the floor with complaints of head pain.
-The final impression was acute cough, decreased energy, respiratory syncytial virus infection (RSV), and injury of head.

Review of Resident #8's Fall Risk Worksheet dated 03/04/25 revealed:
-The resident ambulated independently with a rollator and shuffled feet.
-The resident was confused.
-The resident had a history of falls due to previous falls in the past year.
-The resident scored 14, which indicated the resident was at risk for falls.
-The worksheet was completed by the SCC.

Review of a Fall Incident Report for Resident #8 dated 03/26/25 revealed:
-The resident had an unwitnessed fall outside on facility grounds at

2:00pm.
-Staff discovered the resident lying on the ground on his left side.
-The resident had a skin tear on his right finger.
-It was documented that the PCP was notified by note in book.
-The interventions/immediate measures taken: first aid, ensure resident is using appropriate eyewear, bring resident to supervised area for closer observation, proper fitting footwear/non-skid socks, family increasing sitter times, complete environmental assessment, and increased monitoring.
-The interventions were effective with no description documented.
-The resident was sent out for further evaluation with diagnosis of rib fracture.
-Hourly monitoring was initiated on 03/26/25-03/27/25.
-The resident was to be monitored for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall from 03/26/25-03/29/25.

Review of Resident #8's ER encounter report dated 03/26/25 revealed:
-The resident's chief complaint was an unwitnessed fall, as the resident fell outside hitting his head.
-It was noted that the resident was supposed to use a walker but did not use it.
-The resident had multiple falls over the course of a week.
-The facility called emergency medical services (EMS) as the resident asked to be sent out for evaluation.
-The resident had some internal rotation on his right leg.
-An impression showed fractures right posterolateral 9^{th}-11^{th} ribs, nondisplaced, minimally displaced, and mildly displaced.
-The final impression was a closed fracture of multiple ribs of right side, fall, and pulmonary nodules.

Review of Resident #8's progress notes from the resident's PCP from 10/02/24- 04/09/25 revealed:
-The resident was seen multiple times related to follow ups related to a fall.
-The resident was documented to have weakness using a walker to ambulate.
-The resident had weakness due to Parkinson's.
-The resident was ambulating with a walker alone.
-The resident was ambulating without a walker and not easily redirected.

-The resident was to be encouraged to use a walker.
-The resident needed supportive 24 hour care.

Review of Resident #8's record revealed an order dated 03/13/25 for physical therapy (PT) and occupational therapy (OT) to evaluate and treat.

Review of Resident #8's progress notes from 10/01/24 to 04/23/25 revealed:
-On 10/01/24 at 1:48pm, staff documented that the resident was observed walking up and down the hallway without a rollator several times; staff continued to remind the resident that he needed to have his rollator with him at all times; the resident was very restless and would not sit down for long periods of time; staff would continue to monitor.
-On 10/09/24 at 8:31am, staff documented the resident was found lying on his left side in the dayroom bathroom; he reported no pain and that he did not hit head; he had a minor skin tear on his left arm.
-On 10/16/24 at 3:42pm, staff documented the resident fell on his bottom in the dayroom; the resident had a skin tear on his left arm with no other injuries.
-On 10/19/24 at 9:00am, staff documented the resident was found sitting on the floor in his room. Resident was assessed and no injuries noted. Will continue to monitor for any changes in condition.
-On 10/19/24 at 10:30am, staff documented the resident was found sitting on the floor in his room; he was assessed and no new injuries noted; staff would continue to monitor for any changes in condition.
-On 10/19/24 at 10:41am, staff documented the resident was found sitting on the floor in his room; he had no socks and no shoes; the resident had a red area on his back from where he was leaning against his rollator; he was reminded that he should have his shoes on at all times while walking; staff would continue to monitor.
-On 10/22/24 at 1:53pm, staff documented the resident was very agitated and anxious; staff had to remind the resident several times to keep his rollator with him; staff would continue to monitor.
-On 10/26/24 at 6:09pm, staff documented the resident was found by staff sitting on the dining room floor with his back against the

door; no injuries were noted and staff would continue to monitor for any change in condition.
-On 11/03/24 at 12:56pm, staff documented resident lost his balance and fell in the dining room.
-On 11/04/24 at 11:45am, staff documented the resident continued to walk the halls and refused to use his rollator; staff would continue to keep a close watch on the resident and continue to encourage him to use his rollator.
-On 11/04/24 at 8:21pm, staff documented the resident was found walking around in his room without his walker.
-On 11/06/24 at 12:59pm, staff documented the resident was seen by PCP for a follow up from his fall; he complained of some of some left side rib pain; mobile x-ray was called and order placed for a left side rib x-ray, which showed no acute fracture of dislocation.
-On 11/07/24 at 2:51pm, staff documented the resident was ambulating without his rollator; staff would continue to encourage the resident to use his rollator.
-On 11/10/24 at 5:28pm, staff documented the resident was found sitting on the floor in the hallway.
-On 11/12/24 at 2:07pm, staff documented a care plan meeting was held with the resident's family; there was no documentation falls were discussed during this meeting.
-On 11/13/24 at 9:35pm, staff documented an unwitnessed fall; the resident was lying on his left side; he did not have walker with him; the resident obtained a quarter size swelling on the left side of his forehead, no cut or redness noted; ice was applied for 20 minutes; a message was left for family member; the PCP was notified.
-On 11/14/24 at 8:52pm, staff documented the resident fell in bedroom at 7:15pm; he had been put to bed but got up and fell.
-On 11/20/24 at 2:51pm, staff documented the resident was observed lying on the floor twice within an hour; he had no apparent injuries; he continued to pace up and down the halls leaving his rollator; staff would continue to remind the resident to keep rollator with him at all times.
-On 11/21/24 at 1:26pm, staff documented an email was sent to the resident's family member to follow up on things discussed at the last care plan meeting which included a sitter and an appointment with a neurologist.
-On 11/24/24 at 10:30am, staff documented the resident was observed sitting on the floor in the living room; he stated he was

trying to stand up and his rollator slid out from under him; there were no apparent injuries; staff would remind the resident that he should not sit on his rollator.
-On 11/26/24 at 1:25pm, staff documented the resident tripped over another resident's walker and fell on his back.
-On 11/26/24 at 3:20pm, staff documented the resident lying on supine on the floor with knees bent and head raised; the resident reported back pain; the nurse noted a skin tear on his left arm and palm with redness to mid center of back; the resident was tearful and wanted to go to the hospital; staff reported the resident did not hit his head.
-On 11/26/24 at 7:28pm, staff documented the resident returned from the hospital; discharge instructions stated nothing was found with head or spine.
-On 12/04/24 at 1:51pm, staff documented the resident was observed lying on the floor in the living room after breakfast; the resident did not know what had happened; no apparent injuries were noted; the resident was reminded to keep his rollator with him at all times.
-On 12/16/24 at 1:05pm, staff documented the resident was observed on his hands and knees in the living room; the resident's walker was in front of him; he could not recall what had happened; no apparent injuries were noted; staff would continue to encourage the resident to walk slower and continue to use a rollator.
-On 12/18/24 at 1:21pm, staff documented resident was observed lying on the floor in the living room; he stated he lost his balance and fell back landing on his bottom; no apparent injuries were noted and staff would continue to encourage resident to use a rollator.
-On 01/13/25 at 10:05am, staff documented the resident was found sitting on floor near his table; staff assisted the resident with putting his socks and shoes back on and placed his rollator near him; staff would continue to monitor.
-On 02/04/25 at 2:05pm, staff documented the resident was observed walking backwards with his rollator; the resident knocked over a walker that was behind him and tripped over it; he landed on his buttocks and complained of lower back pain on left side; he was assessed and given Tylenol (used to treat mild to moderate pain); staff would continue to monitor.
-On 02/07/25 at 2:16pm, staff documented the resident was observed laying on the floor in the common room; he was not able

to state what had happened; no apparent injuries were noted and staff would continue to monitor.
-On 02/08/25 at 10:03pm, staff documented the resident was witnessed trying to turn around to grab his rollator and lost his balance and sat on the floor; no injuries were noted.
-On 02/11/25 at 1:32pm, staff documented the resident was observed sitting on the floor; no injuries were noted and staff would continue to monitor.
-On 02/17/25, at 12:53pm staff documented the resident was observed sitting on the floor by his chair in the dining room; he stated that he was trying to get up out of chair when he tripped; no injuries were noted and staff would continue to monitor.
-On 02/18/25 at 1:02pm, staff documented the resident was observed sitting on the floor in the hallway after lunch; the resident was confused and not able to explain what had happened; he had a skin tear on his left shin.
-On 02/24/25 at 12:08pm, staff documented the resident was observed on his hands and knees in another resident's room; he was not wearing any shoes and did not have his rollator; staff would continue to encourage resident to keep his shoes on while up and walking around as well as keeping his rollator with him at all times.
-On 03/09/25 at 10:51am, staff documented the resident fell when he started walking sideways.
-On 03/09/25 at 5:11pm, staff documented the resident took a fall, falling to the side losing balance; he was able to verbalize some frustration about the morning incident and stated, "I always do that."
-On 03/18/25 at 1:41pm, staff documented the resident was observed sitting on the living room floor; the resident was trying to turn around and got his foot caught on his rollator and tripped; the resident would be starting PT and OT; staff would continue to monitor.
-On 03/24/25 at 9:12pm, staff observed the resident on his knees in his room; he did not remember how he got on his knees; he had a skin tear on his right elbow and first aid was administered.
-On 03/26/25 at 2:48pm, staff documented the resident was outside and fell and was not sure what had happened or if resident had hit his head; the resident was observed lying on his right side on the ground with his right arm behind his back; there was some blood on the ground where his right pinky had a small gash; he was able to sit up and be placed in a wheelchair; the resident cried and

complained about his right side; the resident was leaning to the right and wanted to go to the hospital.
-On 04/03/25 at 12:40pm, staff documented the resident would now be on continuous hourly checks between the hours of 9:00pm and 10:00am to ensure safety while he was unaccompanied by a private sitter starting 04/03/25.
-On 04/04/25 at 1:38pm, the resident had a new fall risk assessment completed using the new assessment tool; the resident has had several falls in the last quarter; the resident now had sitters from 10:00am-8:00pm and on 1 hour checks outside of those time frames; the resident transitioned from a rollator to a standard walker with signage on it to increase chances of appropriate usage; a care plan meeting was scheduled for 04/07/25.
-On 04/08/25 at 8:21am, staff documented a care plan meeting was held with the resident's family; the number of falls the resident has had and his new cancer diagnosis was discussed; the family wanted a hospice consultation; the family agreed to increase the number of hours for the resident's sitter; the resident would now have a sitter from 7:00am-8:30pm daily; the Administrator explained that the resident still may need to be moved to a SNF; the family was very reluctant to separate the resident from his family member who resided at facility and shared a room with the resident.
-On 04/17/25 at 12:06pm, staff documented the resident's family member was contacted via email to request increase with sitter hours due to the resident having another fall; staff would continue to monitor.
-On 04/20/25 at 12:39am, staff documented the resident was found sitting on the floor by his chair in his sitting area; he was assessed and stood with the assistance of 2 staff members; he was assisted to bed; hourly checks were in place for resident as well.
-On 04/21/25 at 10:27am, staff documented they spoke with the resident's family member regarding an email; the family member agreed due to the resident having 2 falls during the night that increasing the sitter was a good idea.

Interview with a medication aide (MA) on 03/27/25 at 11:55am revealed:
-Resident #8 required assistance with toileting, dressing, and bathing.
-Resident #8 fell a lot and often tripped over his rollator because it

was too big.
-Resident #8 had an unwitnessed fall on 03/26/25 as he was found lying on his right side and was sent out to be evaluated due to the resident crying and asking to be sent out.
-The expectation was for resident to be monitored by the MA or personal care aide (PCA) hourly for 24 hours and charted on for 72 hours after each fall.
-Most of the time the memory care residents were kept in common areas so they could be supervised, as there was usually a staff member in the common areas at all times.
-Resident #8 had a private sitter usually during second shift for supervision needs, which was the only on-going intervention she was aware of for the resident.

Interview with a PCA on 03/27/25 at 11:09am revealed:
-Resident #8 required assistance with toileting, dressing, and bathing.
-Resident #8 used a walker for ambulation.
-Resident #8 had an unwitnessed fall yesterday while in the courtyard and was sent out as he complained of pain after being found lying on his right side.
-She could not count the number of times Resident #8 has fallen since being admitted.
-Resident #8 had a sitter who came in the evenings.
-Residents were checked every 2 hours unless they had a fall then they would be checked on every 30 minutes or every hour for 3 days, which depended on the order.
-She was not aware of any interventions for Resident #8 as the resident was not on increased supervision due to his numerous falls.
-She was not aware what the facility's fall policy was but knew if a resident fell 3 times in a week they would be evaluated for rehabilitation for 1 week.

Interview with a second MA on 04/02/25 at 12:45pm revealed:
-Resident #8 was a fall risk as he has had so many falls, she could not count.
-Resident #8 had to be sent out for falls due to head injuries and rib fracture.
-Resident #8 used a walker for ambulation but often had to be reminded to keep the walker with him as he would walk without it.
-Resident #8's gait was unsteady at times.

-Resident #8 had a private sitter who usually came in the evening.
-Resident #8 was monitored hourly or every 2 hours after a fall, which was determined by the nurse.
-She did not know who it was determined if Resident #8 was to be checked on hourly or every 2 hours after a fall.
-She was not aware of any interventions in place for Resident #8 other than his private sitter.

Interview with the first shift (7:00am-3:00pm) Nurse Supervisor on 04/02/25 at 1:50pm revealed:
-Resident #8 was a fall risk as he has had a lot of falls since admission.
-She knew Resident #8 had a private sitter, but she was not aware of any other interventions in place to decrease falls.

Interview with the second shift (3:00pm-11:00pm) Nurse Supervisor on 04/02/25 at 2:56pm revealed:
-Resident #8 required assistance with toileting.
-Resident #8 was a "high" fall risk as he has had multiple falls since admission.
-Resident #8 has had a private sitter for several months from 2:30pm-8:30pm and increased from 10:30am-8:30pm due to increase in falls.
-Resident #8 had a rollator but was not using a regular walker for ambulation.
-Resident #8 started PT about 2 weeks ago due to falls.
-Resident #8 was not on increased supervision and was checked every 2 hours, which was standard.
-She was not aware of the facility's written fall policy.

Interview with the SCC on 04/02/25 at 11:38am revealed:
-Resident #8 required assistance with dressing and toileting.
-Due to Resident #8's Parkinson's Disease his gait was "horrible," as he would just freeze and couldn't move when walking.
-Resident #8 also shuffled his feet when walking.
-Resident #8 recently got a regular walker as the rollator he had was too wide which caused the resident to trip a lot.
-Resident #8 was started on hourly checks a few days ago.
-She acknowledged that she had not completed the fall risk assessments for Resident #8 related to his falls according to the facility's policy.

Second interview with the SCC on 04/23/25 at 11:48am revealed:
-The facility held a care plan meeting the earlier part of the month and discussed Resident #8's falls.
-Resident #8's Responsible Party (RP)agreed to increase the resident's private sitter to 24 hours, which started on 04/23/25.
-Resident #8 probably could have been transferred to a skilled nursing facility several months ago due to his falls and decline physically and cognitively.
-The family chose to hire private sitters to help monitor Resident #8's falls and supervision as they wanted to keep the resident at the facility with his family member.

Interview with the Clinical Director on 04/02/25 at 3:37pm revealed:
-Resident #8 was a fall risk and had falls that required the resident to be sent out for further evaluation.
-She has expressed her concern that Resident #8 needed a higher level of care due to the number of falls he has had since admission, but that was not her decision as it was up to the Administrator to decide when the facility could no longer meet the residents' needs.

Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.

Telephone interview with Resident #8's RP on 04/17/25 at 10:14am revealed:
-Resident #8's gait was unsteady due to Parkinson's Disease.
-Resident #8 had fallen a lot at the facility which was a concern.
-She and other family members visited the resident 3 to 4 times a week at different times.
-She often found the resident without his walker when she visited, as he needed reminders to use his walker.
-When she asked staff about him not having his walker, they would not know where it was and would have to look for it.
-Often times the PCAs are observed sitting in the common rooms talking or on their phones when the residents were not even in the common areas, and on the halls observing the residents.
-She spoke to a nurse about staff being on their phones after Resident #8's last fall and the nurse agreed staff where on their phones too much with "drove her crazy."
-It was common to see a resident walking around the unit with

their forehead bandaged due to a fall.
-After a care plan meeting several months ago, she hired a sitter due to the resident's falls, as it was discussed that the resident's level of care was bordering a score of 35, which was SNF.
-The private sitter first started coming at 2:30pm to 8:30pm due to the falls occurring after lunch or around shift change.
-After Resident #8's 03/26/25 fall she did not feel confident in the resident's care and changed the time to 10:00am to 8:30pm.
-A care plan meeting was held on 04/07/25, at which time she was told the resident's level of care score was 34, and the private sitter was increased to 7:00am to 8:30pm.
-There had been some discussion for several months with facility staff that the resident's walker was too large, as the resident needed a walker that had some weight to it to keep him from picking it up and carrying it.
-It took her talking to a therapist after the resident started PT in March to get a weighed walker, which had helped.
-When there are 20 residents in a room and most had an assisted device, all the assistive devices were too large and created a tripping hazard.
-She felt like putting the residents in a common room was an easier way for staff to supervise the residents.
-She felt the PCAs did not understand that the residents needed assistance and direction as they would often just tell a resident the bathroom was down the hall, not fully understanding the residents' cognitive issues and that the resident may need to be taken to the bathroom.
-Other than her providing a private sitter, the only intervention she was told was that the staff would check on the resident every 2 hours for supervision due to his falls.

Telephone interview with Resident #8's PCP on 04/16/25 at 3:52pm revealed:
-Resident #8 had dementia which affected his cognition and Parkinson's Disease.
-Resident #8 was a fall risk, which was related to the Parkinson's Disease.
-She expected the facility to follow their protocols for falls to ensure supervision.

Second telephone interview with Resident #8's PCP on 05/06/25 at 9:41am was unsuccessful.

Telephone interview with the Medical Assistant who worked with Resident #8's PCP on 05/06/25 at 9:41am revealed when she reads supportive 24 hour care, it meant Resident #8 had some physical limitations or dementia that would require someone to be with him 24 hours a day and that the resident was total care.

Interview with the Administrator on 04/23/25 at 2:40pm revealed:
-Resident #8 currently had a private sitter 24 hours daily to monitor supervision due to falls.
-Resident #8 had recently gotten a new walker that was weighted so the resident could not pick up the walker.
-She was not aware the SCC had not completed the Fall Risk Assessments for Resident #8 after each fall and subsequent fall after the resident had 2 falls within 30 days according to the facility's policy.
-Resident #8's level of care was to the point the facility was considering discharging the resident to a SNF.
-Prior to hourly checks that started prior to the 24 hour sitter Resident #8 was on the standard 2 hour checks.

Refer to interview with the SCC on 04/02/25 at 11:38am.

Refer to interview with the first shift (7:00am-3:00pm) Nurse Supervisor on 04/02/25 at 1:50pm.

Refer to interview with the Clinical Director on 04/02/25 at 3:37pm.

Refer to interview with the Administrator on 04/23/25at 2:40pm.

Interview with the SCC on 04/02/25 at 11:38am revealed:
-Residents were monitored hourly for 24 hours and charted on for 72 hours after each fall, then they were monitored every 2 hours.
-The Fall Prevention Program on the incident report meant the interventions were addressed on the incident report.
-She was responsible for completing the Fall Risk Assessments for memory care, which were completed every 3 months.
-If a resident scored a 5 or more on the Fall Risk Assessment they were considered "at risk" for falls.
-She was not aware if a resident fell 2 times in a 30 day period they were considered "high fall risk" and that a fall risk assessment

needed to be completed after the second fall and each subsequent fall, as she thought it was 3 falls in 30 days.
-She was not aware of what the facility's fall policy was exactly, but the goal was to protect the residents from harm.

Interview with the first shift (7:00am-3:00pm) Nurse Supervisor on 04/02/25 at 1:50pm revealed:
-The facility had weekly meetings with the Administrator and management staff where falls were discussed as well as if interventions needed to be implemented.
-Special care residents were monitored every 2 hours, but she was not sure if the checks were documented.
-Any increased supervision and interventions were determined based on case-by-case situation.
-She had not seen the fall risk assessments the facility used to assess resident's falls.
-She was not aware of the facility's fall policy but that did not mean the facility did not have one.

Interview with the Clinical Director on 04/02/25 at 3:37pm revealed:
-The MAs were responsible for completing the Fall Incident Report at which time they were to check interventions on the form to be implemented.
-The MAs documented on the Fall Incident Report whether the interventions were effective or not effective.
-She could not answer how the MAs determined if the interventions were effective if they were checked in real time when the form was completed and not monitored over time.
-When she closed the Fall Incident Report, she made sure the physician and family had been notified, orders were implemented if needed, and interventions were in place.
-The facility did implement interventions, but she didn't know what else could be done to keep residents from falling.
-The facility's Administrator and management staff met every Monday to discuss resident care needs such as falls and to come up with interventions if needed.
-Residents were monitored hourly and charted on for 72 hours after each fall.
-After the 24 hours, resident went back to being monitored every 2 hours by the MAs and PCAs.

Interview with the Administrator on 04/23/25 at 2:40pm revealed:
-The Residents were monitored hourly for 24 hours and charted on for 72 hours after each fall.
-After the 24 hours residents went back to be monitored every 2 hours.
-The MAs were responsible for completing the Fall Incident Report and checking the interventions that were to be implemented for the resident.
-The MAs could also document if the interventions were effective or not.
-The Fall Incident Report was usually closed by a nurse, which meant the incident was closed after the 72 hours acute charting, at which time the nurse could also note if the interventions were effective or not.
-When closing out the Fall Incident Report, the nurse should be looking to see if the interventions were effective.
-The facility did not document specifically about the interventions being observed as being effective.
-The Fall Risk Assessments had been completed by the social worker at admission and quarterly thereafter, but within the last 60 days were being completed by the social worker, nursing staff, or MCC.
-There was no difference in the care residents received when considered "at risk" or "high risk" as "high risk only meant a resident had 2 or more falls within 30 days and would need a fall risk assessment completed after the second fall and each subsequent fall.
-She typically did not review the Fall Risk Assessments.
-The facility's fall policy dated 11/07/23 was the current policy the facility went by.

The facility failed to ensure supervision of Resident #2 who sustained 10 falls in 4 months as 5 of the 10 falls were unwitnessed and that resulted in lacerations to the head and face resulting in Resident #2 being sent out to the hospital for further evaluation of a 0.5cm superficial linear laceration of the scalp, facial laceration, and 4 sutures due to a 3cm laceration to the left temple. Resident #8 sustained incidents of being found on the floor over a 6 month period resulting in injuries that resulted in Resident #8 being sent out to the hospital for further evaluation for a head injury and rib fractures. The failure resulted in risk of physical harm and constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/02/25 for this violation, which was amended on 04/03/25. **CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 5, 2025.**		
Rule/Statute Number: 10A NCAC 13F .0902	☒ POC Accepted JL, SWS RA, BSW *DSS Initials*	
Rule/Statutory Reference: 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 interviews and record reviews, the facility failed to ensure physician notification and referral and follow up for 1 of 8 sampled residents (#2) who fell and hit their head.***		
Level of Non-Compliance: STANDARD DEFICIENCY		
The findings are: Review of the facility's policy and procedures related to falls dated 06/18/21 revealed: -Residents who fall were not to be moved until accessed by a licensed nurse, unless the resident can get up without assistance, to protect a possible injury. -A licensed nurse or Supervisor-In-Charge (SIC) was to be called immediately to evaluate the condition of the resident. -The evaluation is to include: reassure the resident and determine if resident has pain or location of pain; range of motion of affected joint(s)-this is not to be done if resident shows signs of discomfort on movement; a resident who cannot communicate verbally must be watched closely for signs of pain; take blood pressure, pulse, and respiration after the assessment; based on assessment, the nurse decides whether to move the resident. -If the decision was not to move the resident, the following should be done: make resident as comfortable as possible; call attending physician to notify and get instructions; prepare to call ambulance and transport to hospital of physician's choice; notify family/responsible party; and complete incident report form. -If the decision was to move the resident, the following should be done: return to bed/chair in a safe manner; call attending	Updated contact information was sent to all outside physicians to ensure correct contact information is available beginning on 4/3/25. Clinical Director or designee is to call providers daily until they have reached a live person at the office for further direction on resident care needs if applicable. Residents experiencing head injuries or change of status post fall are to be sent to hospital for further monitoring if their primary care physician cannot be reached for further orders.	4/3/25 5/27/25 5/26/25

physician; notify family/responsible party; complete incident report form.
-Residents were to be monitored post fall hourly for 24 hours and are to be charted on daily for 72 hours.

Review of Resident #2's current FL-2 dated 11/12/24 revealed:
-Diagnoses included dementia, dry eye syndrome of bilateral lacrimal glands, nail disorder, ischemic optic neuropathy, corneal of right eye, hemorrhoids, and urinary tract infection.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident was continent of bowel and bladder.
-The resident required assistance with bathing.
-The resident's recommended level of care was documented as memory care.

Review of Resident #2's Resident Register revealed an admission date of 05/19/19.

Review of a Fall Incident Report for Resident #2 dated 01/09/25 revealed:
-The resident fell in the hallway at 10:50am.
-The resident lost her balance and hit head on the door.
-The resident complained of pain to back and left elbow.
-The resident had a skin tear on back.
-The resident was not sent out for further evaluation.
-A voicemail was left for the resident's primary care provider (PCP).

Review of a note from Resident #2's PCP dated 01/09/25 at 12:26pm revealed:
-The facility's Clinical Director reported that the resident fell on 01/09/25, at which time the resident hit her head on the left side.
-The resident complained of left elbow pain and had a small skin tear on back.
-The Clinical Director wanted to know if the resident needed an appointment to be evaluated.
-A call was returned to the facility, and a message was left that the resident did need to be seen and to call back to schedule an appointment.

Review of Resident #2's record revealed no documentation of a follow up appointment with the resident's PCP related to the

resident's fall on 01/09/25 when the resident hit her head.

Review of a Fall Incident Report for Resident #2 dated 02/08/25 revealed:
-The resident had an unwitnessed fall in her room at 7:00am.
-The resident stated she fell getting off bed.
-The resident suffered a ½ inch laceration to the back top of head.
-The resident was not sent out for further evaluation.
-The PCP was notified at 7:54am.

Review of Resident #2's progress noted dated 02/08/25 revealed:
-Staff reported the resident had a bloody spot on the back of her head.
-The resident was assessed and had approximately a 1 inch laceration to the back mid top of head with dried blood in the center.
-The resident stated she lost balance when getting out of bed.
-The resident denied pain upon touch to the area.
-The resident had a headache and blurred vision in good eye.
-The facility will continue to monitor and send resident out for severe changes.
-The family and PCP were notified.
-The progress noted was completed by the 7:00am-3:00pm Nurse Supervisor

Interview with the Clinical Director on 04/23/25/25 at 1:12pm revealed:
-The PCP would be notified of a fall with a head injury and to see if the resident needed to be evaluated.
-If the PCP called back and left a message, the message would have been checked by a nurse or Administrator as the message could have gone to one of several phones and then sent to the transportation person.
-She did not recall calling Resident #2's PCP on 01/09/25 and leaving a message about the resident's fall on 01/09/25.
-The transportation person would be responsible for documenting any appointment for a resident in the resident's progress notes.
-There should be a progress note with documentation of any conversation with a PCP.

Interview with the 7:00am-3:00pm Nurse Supervisor on 04/02/25 at 1:50pm revealed:

-She called Resident #2's PCP on 02/08/25 and left a message about the resident's fall on 02/08/25.
-She later stated that she called Resident #2's PCP and spoke to the on-call person regarding the resident's fall on 02/08/25.
-She then indicated that the on call person indicated the resident did not need any follow up evaluation if she was not showing any symptoms or distress from the fall.
-Telephone calls to the PCP were to be documented in the progress notes but for some reason she did not document the telephone call and instructions on 02/08/25 related to the resident's fall.

Telephone interview with a nurse with Resident #2's PCP on 04/02/25 at 9:27am revealed:
-The resident was a fall risk and had fallen often at the facility.
-The facility called the office or would send a fax regarding the residents' falls.
-The resident used a cane and required stand by assistance with ambulation, her gait was "wobbly" and "unsteady."
-The office received a voicemail on 01/09/25 the resident had fell hitting head, had left elbow pain, and a skin tear on her back.
-The PCP's office called the facility back at on 01/09/25 at 12:30 and left a voicemail that the resident needed to be evaluated due to fall and an appointment needed to be made.
-The PCP's office did not receive notification of the resident's fall on 02/08/25 and would have expected notification due to the resident hitting her head.
-Anytime someone hit their head there needed to be follow up their PCP or by going to emergency room for further evaluation.
-She would have expected follow up evaluations for Resident #2 due to falls on 01/09/25 and 02/08/25 where the resident hit her head.

Interview with the Administrator on 04/23/25 at 2:40pm revealed:
-She would expect the PCP to be called for notification of a fall with a head injury.
-If the PCP calls facility back to leave a message it could have gone to 1 of several different phone numbers.
-If the Clinical Director left a message for Resident #2's PCP she would have expected her to follow up with the PCP if she had not heard from the PCP after leaving a message.
-She would expect any communication and/or attempts with the PCP to be documented as a progress note for that resident.

IV. Delivered Via:	Hand Delivered	Date: 05/08/25
DSS Signature:	Janella Lee, SWS Regina Anderson, BSW	Return to DSS By: 05/29/25

V. CAR Received by:	Administrator/Designee (print name): Jessica Hivner, RN
	Signature: Jessica Hivner, RN Date: 5/8/25
	Title: Clinical Director

VI. Plan of Correction Submitted by:	Administrator (print name): Caitlin Flockhart
	Signature: Caitlin Flockhart Date: 5/29/25

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☒ *POC Accepted*	By: Regina Anderson, BSW	Date: 05/29/25
Comments:	Janella Lee, SWS	

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*