Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	C 04/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover Department of Social Service conducted an annual survey and complaint investigation from 04/05/17-04/06/17 and 04/11/17-04/12/17. The New Hanover Department of Social Services initiated the complaint investigation on 03/20/17.	D 000	**D189 – 10ANCAC 13F.0604(e)(2)(A-E) Personal Care and Other Staffing** • Measures put in place to correct alleged deficient practice – Dietary person was on the SCU effective 4/7/17 to assist with meal service set-up and breakdown • Measures put in place to prevent further occurrence - Dietary liaison responsibilities were developed and implemented on 4/10/17 to assist with meal service set-up and breakdown Education provided to NA's, PCA's, MA's on mealtime service responsibilities/duties and added to assignment sheet implemented 5/11/17. • FSD, DSCU (Director of Special Care Unit) and/or designee will observe one meal per day to ensure food services are performed at the optimal level • Completion date – 5/17/17	5/17/17
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of	D 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE M A Wood TITLE ED (X6) DATE 5.11.2017

POC reviewed/accepted

J. J. 5/12/17

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D 189	Continued From page 1 residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure Nurse Aides (NAs), Personal Care Aides (PCAs), and Medication Aides (MAs) were not routinely assigned to perform food service duties. The findings are: Observation of the special care unit (SCU) on 04/05/17 from 3:55pm-5:25pm revealed: -There were two Nurse Aides (NAs) and one Medication Aide (MA) on duty. -Fifteen residents were observed on the SCU. -A NA was observed placing dishes and eating utensils on the dining tables from 3:55pm-4:15pm. -At 3:56pm, a second NA came into the dining area with Resident #2 and asked the NA who was setting the tables to "watch" Resident #2. The NA responded "let her walk, with only two people we can't keep her with us all the time." -At 4:12pm, the second NA was in the hallway	D 189		

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D 189	Continued From page 2 near the nurses' office/common living area assisting Resident #2 with ambulation while also attempting to re-direct two other residents at the same time; the other NA on duty was still in the dining area setting the tables. -Between 4:17pm-4:44pm, the two NAs and one MA were assisting residents into the dining area. -At 4:30pm, dietary staff delivered food to the SCU. -At 4:33pm, the Director of the Special Care Unit (DSCU) came into the dining area and began to serve beverages. -At 4:36pm, Resident #2's meal was served; she was not served a beverage until 4:44pm and she had already eaten half of her sandwich and 3 strawberries. -At 4:39pm, a NA asked the DSCU if she needed to wear an apron and the DSCU replied "it's for when you are serving food." -At 4:40pm, the MA was still brining residents into the dining area and the NAs and DSCU were serving beverages and meals to residents. -At 4:46pm, the MA was serving beverages to residents. At 4:53pm, a resident was served a plate containing a sloppy joe sandwich, corn, and french fries. At 5:02pm the NA acknowledged the resident should have had water and tea after it was brought to her attention that the resident had not been served beverages. The resident was served a glass of water and a glass of tea at 5:03pm by the NA. -As the residents ate, the NAs and MA asked if residents wanted seconds and refilled beverages. -As the residents finished eating and left the dining area, the NAs and MA removed the dirty dishes and cleaned the tables. Interview with a Dietary Aide on 04/05/17 at 5:25pm revealed:	D 189		

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D 189	Continued From page 3 -Dietary staff brought the food up to the SCU before each meal. -The SCU staff on duty served the food to the residents in the SCU. -At the conclusion of meals, SCU staff cleared off the dishes and food and placed the dirty linen in a bag. -Dietary staff went back to the SCU to pick up the dirty dishes, food, and linen after the meal was completed. Interview with the Food Service Director (FSD) on 04/06/17 at 7:45am revealed: -Meal service in the Assisted Living Dining room was done "restaurant style" which meant residents ordered from the menu and were served by dietary staff. -Meal service in the SCU room was done "butler style" which meant the SCU staff showed the residents the available menu choices (that were already plated) at meals and served the food to the residents in accordance with their choice. -Food for SCU unit meals was prepared and plated in the kitchen and taken up to the SCU by dietary staff and dropped off. -Dietary staff went back to the SCU to pick up dishes after meals. -The tables were cleaned by SCU staff. -"Sometimes" a Dietary Aide would clean and sanitize the tables, depending on "whoever gets to it first." Observation on of the SCU on 04/06/17 from 8:00am-8:44am revealed: -The FSD was serving beverages and food to residents. -The two NA staff on duty assisted the FSD in serving the residents their meal. -Resident #2 was assisted to eat breakfast by the Resident Service Director/Registered Nurse	D 189		

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D 189	Continued From page 4 (RSD/RN). -At 8:44am, the NAs were clearing and cleaning the tables as the residents finished eating and left the dining room. Observation of the SCU on 04/06/17 at 11:40am revealed: -There were nine residents seated in dining room. -A NA was serving beverages and plating food. Confidential interviews with staff working in the SCU revealed: -"Nobody comes up here from dietary to help" at meals. -Staff were "shocked" to see dietary staff and other (nursing) staff providing meal assistance during the survey because that was not the normal procedure. -Dietary staff brought the food and dropped it off then came back and picked it up. -SCU floor staff (NAs and MAs) served residents their meals. -The NAs had to set the dining tables, serve the food, and clean the tables while also trying to provide personal care to the residents every day. -Without interruptions, it took at least 10 to 15 minutes to set the table. -The NAs and MAs swept and/or mopped the dining area floors when housekeeping staff was not on duty. -The NAs and MAs "disinfected" the tables and put fresh flowers out on the table if flowers were available. -Some MAs did not help the NAs during meals; when the MA on duty did not help with meal service, it was "even worse." -There were multiple residents that needed prompts and would eat more if staff stayed with them at meals, but when staff stayed with them it put "extra work" on the other person so the extra	D 189		

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D 189	Continued From page 5 prompts did not usually occur. -There nurses were not normally in the dining room at meals to assist residents with eating. -There were usually two NAs and one MA on duty on each shift in the SCU. -There were not enough staff to feed residents at meals considering the number. -Dietary duties took "staff off the floor." Confidential interviews with two PCAs working in the Assisted Living Section of the facility revealed: -The PCAs were responsible for cleaning dirty dishes off the dining room table after residents ate their meals. -The PCAs were responsible for removing the cloth napkins from the dining room tables after residents ate their meals. Interview with a housekeeping staff working on the SCU on 04/06/17 at 9:05am revealed: -The floors in the SCU dining area were cleaned twice daily by housekeeping, "but we get off at 3:00(pm) so we can't do it after supper." -He was not sure who cleaned the floors after dinner because he was not there. -The SCU unit staff cleaned the tables. Interview with a second housekeeping staff working in the SCU on 04/11/2017 at 9:00am revealed: -She was responsible for sweeping floors in the SCU dining room. -She swept the SCU dining room floors around 9:00am and at 1:00pm. -She did not clean the dining room tables. -Personal care aides wiped the dining room tables down. Confidential interview with a family member revealed:	D 189		

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D 189	Continued From page 6 -Sometimes staff cooked meals when the chef did not come to work or the "nutritionist was not at the facility. -PCAs were not always readily available in the dining room to help residents who needed assistance with ambulation. -PCAs were observed helping kitchen staff serve resident plates and beverages. Interview with the Director of the Special Care Unit on 04/12/17 at 9:40am revealed: -NAs in the SCU were responsible for setting the tables for meals which she estimated took about 30 minutes. -The NAs "bused" the tables during and after meals and swept the dining area if there was no housekeeper on duty. -A housekeeper had been hired to work 11:00am-7:00pm within the last month but prior to that they were "down a housekeeper." -NAs were not required to mop the SCU dining room. Interview with the facility's Regional Director of Health Services, Resident Services Director, and Executive Director (ED) on 04/06/17 between 6:25pm and 7:08pm revealed: -SCU staff were responsible for completing the meal service in the SCU and cleaning afterwards in accordance with the facility's "BTR dining program" (Bridge to Rediscovery). -The BTR dining program was built for "caregivers" to serve the residents because the caregivers knew the residents and could more easily interact with them. -Drinks were supposed to be on the table before food was served. -It was "unacceptable" for any resident to have to wait for a beverage while eating their meal. -The observations of the meal service in the SCU	D 189		

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D 189	Continued From page 7 dining room on 04/05/17 and 04/06/17 was only a "snap shot in time." -"We have some opportunities." -The meal service usually went more smoothly. -The SCU "BTR dining program" would be reviewed. Interview with the ED on 04/11/17 at 08:40am revealed: -The BTR dining program had been reviewed and a new position (BTR Dietary Liaison) had been created and implemented. -Staff had been trained regarding the new position. -The ED would provide a copy of the job description/duties of the BTR Dietary Liaison. Review of the "Bridge to Rediscovery Dining Liaison" revealed: -There was a detailed schedule for the Dietary Liaison. -There was documentation which included the Dining Liaison would set up the SCU dining room for meals, would deliver meals to the SCU dining room, serve meals using "butler style" service, clean tables, refill beverages as needed, clean up the dining room after meals, and return dishes to the kitchen for all meals/snacks. Observation of the SCU dining room on 04/11/17 from 11:25am-12:31pm revealed: -The dining table had already been set with dishes and utensils prior to the start of the observation. -At 11:25am, one dietary staff member was pouring beverages. -The facility's Regional Director of Food and Dining was present at 11:39am. -At 12:02pm, as the residents finished eating and left the dining area, the dietary staff and two NAs	D 189		

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D 189	Continued From page 8 were clearing the tables, the Regional Director of Food and Dining was still present. -At 12:12pm, there were six residents, one MA, and two NAs still in the dining area; all other residents had already left the dining room but all staff on duty stayed in the dining area. -At 12:31pm, the two NAs left the dining area and the dietary staff member was cleaning the tables. Observation of the SCU on 04/12/17 at 11:28am revealed a MA was placing dishes on the dining tables. Interview with the ED on 04/12/17 at 08:15am revealed: -She did not know why floor staff were still clearing the tables in the SCU. -She thought staff were nervous because they were being watched.	D 189		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide personal care to 1 of 6 residents sampled (#8) according to	D 269	**D269 – 10ANCAC 13F.0901(a) Personal Care and Supervision** • Measures put in place to correct alleged deficient practice for resident #8 – Contacted PACE to re-assess toileting needs and updated the care plan to reflect needs, educated and will re-educate staff on resident's toileting needs, developed an ADL sheet , re-evaluated resident fall risk and continued her on fall management program	5/12/17

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D 269	Continued From page 9 assessed needs and physician orders related to eating and assistance with toileting every two hours, resulting in the resident having multiple falls while toileting herself and sustaining a hand fracture due to a fall while toileting herself. The findings are: Observation of Resident #8 on 04/05/17 at 4:55pm revealed: -She was seated in her wheelchair at a dining table in the special care unit. -She was neatly groomed and had a short, soft, purple colored arm cast on her right hand and wrist. -Resident #8's thumb and middle finger were not in the cast; the thumb was swollen. Confidential staff interviews revealed: -Resident #8 had a history of falls to include several falls in her bathroom. -She broke her right hand due to a fall in her bathroom. Review of Resident #8's current FL-2 dated 05/26/16 revealed in the diagnoses section, there was documentation which read "see attached dx (diagnoses)." (There was no attachment to the FL-2). Review of Resident #8's physician orders dated 03/31/17 revealed diagnoses included vascular dementia, "choking episode," anemia, depression, hypertension, chronic atrial fibrillation (a-fib), chronic obstructive pulmonary disease (COPD), chronic kidney disease, incontinence, "recurrent falls," and vertigo. Interview with the Director of the Special Care Unit (DSCU) on 04/06/17 at 11:30am revealed:	D 269	• Measures put in place to prevent further occurrence - RSD/DSCU developed and implemented the communication board located on the first and second floor Re-assessed all AL residents care plans to ensure accuracy of needs (See attachment D) Will review all SCU (BTR) residents weekly for 3 months, then review quarterly Re-educated staff on fall management program on 3/23/17; 4/10/17 Conduct weekly fall risk meeting and update communication boards with changes as needed Conduct training with staff on ADL sheets process by 5/11/2017 (see attachment E) • ED/designee will conduct bi-weekly audits to ensure compliance for 3 months, then once each quarter. • Completion date – 5/12/17 and ongoing	

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D 269	Continued From page 10 -Resident #8 went to a day program twice weekly. -Resident #8's primary care physician was affiliated with and located at the day program. Interview with the DSCU on 04/12/17 at 9:40am revealed: -Resident #8 had a history of increased falls from December 2016 through March 2017. -Resident #8's falls occurred at "sporadic time frames" and were related to toileting. Review of Resident #8's current FL-2 dated 05/26/16 revealed: -Resident #8 was semi-ambulatory, wandered, and was intermittently disoriented. -"Continent" and "incontinent" were both marked for "bladder" and "bowel." -In the section labeled "Bowel and bladder program" there was an order to assist Resident #8 to the toilet every 2 hours. Review of the Resident Register dated 05/17/16 revealed: -Resident #8 was admitted to the facility on 05/17/16. -Resident #8 required assistance with bathing, dressing, grooming, getting in/out of bed, skin care, orientation to time and place, ambulation, and toileting. Review of a "Nursing Level of Care Assessment" for Resident #8 dated 05/18/16 revealed: -There was documentation the assessment was for "pre-admit." -In the block for "bowel/bladder," there was documentation that Resident #8 required "assistance with incontinence management/toileting during waking and sleeping hours 2 hour checks." -In the block for "fall risk," there was	D 269		

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D 269	Continued From page 11 documentation that Resident #8 was "a high risk for falls, requiring 1 or 2 hour documented checks." Review of the "Resident Service Notes" for Resident #8 revealed: -Between 12/26/16-03/28/17 there was documentation that Resident #8 "fell" or was found on the floor nine times to include falling or being found on the bathroom floor five of the nine times. -On 12/26/16, 12/28/16, and 03/03/17, Resident #8 was observed on the floor of her bedroom without injuries. -On 01/24/17, Resident #8 was found on the floor beside her bed; she complained of knee pain. -On 02/03/17, Resident #8 "fell on this shift while taking herself to bathroom," no visible injuries. -On 02/23/17, Resident #8 was found "sitting on floor at foot of toilet." -On 02/24/17 at 8:00pm, Staff heard Resident #8 "calling for help" at 4:00pm; she was found "sitting in upright position on bathroom floor." -On 03/17/17 at 4:00pm, Resident #8 "fell unwitnessed in her bathroom." -On 03/28/17, Resident #8 was "found on floor in bathroom." She said she hit her elbow; "elbow red." Review of the "Fall Review" for Resident #8 dated 12/29/16 revealed: -Resident #8 fell on 12/26/16 and 12/28/16 and did not sustain injuries. -It was discovered that Resident #8 moved her bed away from access to her grab bar. -The bed was moved back to the original position. -Resident #8's physician and Power of Attorney (POA) were notified of the intervention. -The box beside "Additional service required" was checked "no."	D 269		

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D 269	Continued From page 12 -The box beside "Service Plan Updated with Interventions" was checked "no." Review of the "Incident Report Form" for Resident #8 dated 02/03/17 revealed: -Resident #8 fell while ambulating in her bathroom at 1:00pm. -Resident #8 "fell this shift in bathroom while toileting self ...Will f/up (follow up) for interventions related to increased falls. No injuries observed." Review of a "Physician Communication for Resident #8 dated 02/03/17 revealed: -Suggestions for Resident #8 in relation to "increased falls" to include a possible wheel chair alarm and/or "therapy" were requested. -There was a new order that Resident #8 would be evaluated by physical therapy at her day program that was signed by the physician and dated 02/06/17. Review of the "Incident Report Form" for Resident #8 dated 02/23/17 revealed: -Resident #8 had an unwitnessed fall at 4:15pm in her bathroom. -Staff heard Resident #8 "yelling for help." As staff entered bathroom, she fell back from the wheelchair to the floor. -Resident #8 attended therapy at her day program for increased falls -Resident #8 "transfers well ... has periods of weakness ..." follow up would be made with her physician and "care team for a (sic) intervention." Review of the "Incident Report Form" for Resident #8 dated 03/02/17 revealed: -Resident #8 was found on the floor of her bedroom at 8:30pm. -A "technician" from Resident #8's day	D 269		

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D 269	Continued From page 13 program/physician office came to the facility to evaluate Resident #8's bed and provided a fall mat for use when Resident #8 was in bed. Review of the "Incident Report Form" for Resident #8 dated 03/17/17 revealed: -Resident #8 was found on the floor in the bathroom at 4:00pm. -"Unobserved fall" while Resident #8 was in the bathroom. Resident #8 reported she "fell backwards ...denied pain." -Resident #8 was diagnosed with a hand fracture on Monday (03/20/17) and a soft splint was applied. -Resident #8 had an appointment scheduled with an orthopedic medical provider on 03/21/17. Review of the "Resident Service Notes" for Resident #8 dated 03/21/17 revealed: -"F/up (follow up) from a fall on 3/17/17." Resident #8 denied pain and was alert and verbal. The RSD and DSCU were informed by the (named) Nurse Practitioner that morning by telephone that Resident #8 had a fractured hand. Resident #8 had been evaluated at the day program/medical provider's office on "Monday" (03/20/17) and a soft brace was applied at that time. Resident #8 had been transported to an orthopedic specialist on 03/21/17. -The note was signed by the DSCU. Review of a "Progress Note" for Resident #8 dated 03/22/17 revealed: -Resident #8 was evaluated by a Nurse Practitioner at her day program/primary physician's office. -The chief complaint was documented as follow up to a hand fracture. -Resident #8 had a short arm cast which would be removed in 4 weeks.	D 269		

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D 269	Continued From page 14 -Resident #8 had been evaluated by an orthopedic physician on 03/21/17. -Resident #8 had no complaints and was otherwise at her "baseline." Review of the "Incident Report Form" for Resident #8 dated 03/28/17 revealed: -Resident #8 was observed on her bathroom floor at 1:30pm. -"Transfer related fall." Review of a "Physician Communication" for Resident #8 dated 03/28/17 revealed: -"Fall while in bathroom. Observed on her back, some guarding of back of head." -"For interventions:" every two hour toileting, "I will need a (sic) order to put on care plan to lock resident's door to deter her from going to the bathroom unattended or please order a (sic) alarm to w/c (wheelchair). Please respond to update care plan." Review of the physician orders for Resident #8 dated 03/31/17 revealed: -There was an order for every two hour toileting. -There was an order for a wheelchair alarm. -There was an order to lock Resident #8's bathroom door to deter her from using the restroom unattended. Review of Resident #8's most current Assessment and Care Plan dated 03/31/17 revealed: -Resident #8 was "totally dependent" on staff for assistance with toileting, bathing, dressing, and grooming. -Resident #8 required "extensive assistance" with transfers. -Resident #8 was "independent" with ambulation.	D 269		

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D 269	Continued From page 15 Review of Resident #8's previous Assessment and Care Plan dated 12/16/16 revealed: -Resident #8 was "independent" in eating, transfers, ambulation, and toileting. -Resident #8 required "limited assistance" with dressing and "extensive assistance" with bathing and grooming. Review of the "Special Care Unit Resident Profiles" for Resident #8 revealed: -Dated 07/12/16: Resident #8 required "partial assistance" with ambulating and toileting and was able to transfer independently. -Dated 09/26/16: Resident #8 was "independent" in ambulation and toileting; "MD (physician) stated resident may ambulate at will with walker and use wheelchair if needed." -Dated 12/16/16: Resident #8 was "independent" in ambulation and toileting -Dated 03/16/17: Resident #8 required "total assistance" with ambulation and toileting; "Increased falls from previous quarter. Requires monitoring by staff." Interview with the DSCU on 04/12/17 at 9:40am revealed: -There was a "cheat sheet" for each resident which was a "condensed version" of their care plan kept in a book at the nurses' desk to communicate to staff what assistance each resident needed and the amount of assistance needed. -Each residents' "cheat sheet" was generated from their assessments and care plans. -The DSCU could not recall what Resident #8's previous "cheat sheets" dated prior to 04/06/17 had documented in relation to toileting; she felt like it would have said Resident #8 was independent with toileting because the "cheat sheet" was "just a condensed version of the care	D 269		

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D 269	Continued From page 16 plan" (the previous care plan stated she was independent with toileting). -She did not have copies of Resident #8's previous "cheat sheets", she had thrown them away "about 2 days ago." Confidential interviews with special care unit staff members revealed: -There was a book kept at the nurses' desk that communicated to staff what each residents' needs were. -The book contained information for each individual resident to include what type of assistance each resident needed and what level of assistance each resident required. -The book would need to be kept up to date in order for staff to know what each resident needed or of any changes. -Prior to breaking her hand (03/17/17), staff did not toilet Resident #8 every two hours, she went to the bathroom without staff assistance and called staff (by ringing her call bell) for assistance as needed. -Staff did not assist Resident #8 with toileting because it made her "agitated" (prior to the time that she broke her hand). -Staff "tried to watch her" but she was "quick" and would fall because she would toilet herself without help. -Since breaking her hand, Resident #8 was "total assist" with toileting; staff had started toileting Resident #8 every two hours and documented the toileting on a form in her room. -"Maybe two weeks ago" Resident #8's bathroom door had been locked to keep her from toileting herself and transferring without staff assistance. -Staff did not recall if Resident #8's previous care summaries (dated prior to 04/06/17) had documentation that she required assistance with toileting every two hours.	D 269		

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D 269	Continued From page 17 Review of the "Resident Summary" for Resident #8 revealed: -Printed on the bottom of the summary was 04/06/17 at 10:50am. -There was preprinted documentation that Resident #8 was a fall risk and was one person assist with ambulation. -There was preprinted documentation that Resident #8 was "total assist" with toileting and was on an every 2 hour toileting schedule. -There was handwritten documentation that Resident #8 was on every 2 hour checks, had a wheelchair alarm, and had order to "lock door" to deter self-transfers. Interview with the DSCU on 04/12/17 at 9:40am revealed: -There had been instances when Resident #8 was toileting herself and fell. -Best practice for incontinent residents was to provide two to three hour toileting checks but she was not sure if the facility had a specific toileting policy. -Since being admitted to the facility, Resident #8 had "improved" at some point (unsure of exactly when) and required less assistance with transfers, toileting, and ambulation, but she was never independent with toileting. -Resident #8 had "definitely" had a "decline" in her ability to transfer (unsure of the date). -She did not know why Resident #8's care plan dated 12/16/16 said she was independent with toileting. -It was an "error" on the care plan dated 12/16/16 because Resident #8 was never independent with toileting and required "some assistance." -She did not know how it would be communicated to staff or how staff would know that Resident #8 was supposed to be assisted with toileting every	D 269		

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D 269	Continued From page 18 two hours since the assessment and care plan had documentation that she was independent with toileting. -She was responsible for completing the assessments and care plans for all residents in the special care unit. -The expectation for the FL-2 order dated 05/26/16 to toilet Resident #8 every 2 hours was for staff to take or ask Resident #8 if she needed to use the toilet every two hours. -"It would be my fault for not having it on the MAR (Medication Administration Record) or care plan." -She did not think Resident #8 was put on every two hour toileting checks until "around 03/28/17." Observation on 04/12/17 at 3:49pm revealed: -Resident #8 was propelling herself in a wheelchair in the hallway of the special care unit near room #232. -Resident #8 told a Nurse Aide (NA) "When I got back, I tried to go to the rest room. I could not get in there. I called and nobody came. I almost fell. God knows what they'll do if I fall again." Attempted interview with Resident #8 on 04/05/17 at 5:02pm revealed Resident #8 responded "none of your business" when addressed. A second attempted interview with Resident #8 on 04/12/17 at 2:06pm revealed Resident #8 did not respond when spoken to. Telephone interview with Resident #8's family member/Power of Attorney (POA) on 04/06/17 at 3:15pm revealed: -The POA did not have any concerns with the care Resident #8 was receiving at the facility. -The facility was "very responsive," kept him informed, and always notified him when needed. -Resident #8 required staff assistance with all of	D 269		

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D 269	Continued From page 19 her activities of daily living (ADLs) except eating. -Resident #8 had a history of falls; her last fall was two to three weeks ago and resulted in a hand fracture. Interview with the DSCU on 04/12/17 at 9:40am revealed: -The facility had implemented various interventions to address Resident #8's multiple falls such as a fall mat, checking and changing her bed, medication changes, physical therapy, and the "butterfly fall program." -The butterfly program was implemented for Resident #8 on 03/22/17. Review of the "Updated Butterfly Program Guidelines" revealed: -"Effective immediately" (the document was not dated). -If a resident had two falls within 30 days, they would be placed on the butterfly program. -A butterfly would be placed on the resident's door. -The document contained guidelines for increased supervision of residents as related to their number of falls to include every 1-2 hour checks, every 30 minute to 1 hour checks, and every 15 minute to 30 minute checks. -Staff would document additional checks on the "PCS log book." -Medication Aides would also document interventions used in the nurse notes that were "successful and unsuccessful" Review of the "Fall Management Program" dated 10/27/11 revealed: -A "Fall Review" would be completed on each resident within eight hours of move in/re-move-in, after the 2nd fall in a calendar month, when the service plan was updated and when indicated by	D 269		

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D 269	Continued From page 20 a healthcare professional if there were new or changed risk factors that may lead to injury for a resident. -A service plan with resident specific interventions would be implemented with the resident and/or responsible party the RSD or designee. -Fall interventions would be "routinely reviewed" and updated to assure effectiveness. -An incident report would be completed for all falls. -A "Post Fall Investigation" would be completed by the RSD/Wellness Director or designee to review and analyze factors to the fall. -All falls would be investigated, documented, and reported. -The RSD/Wellness Director or designee would use the "Incident Analysis and Tracking Tool" to document each fall and analyze results for trends and patterns in resident falls. -The physician would be notified of residents with multiple falls to modify interventions as indicated. Interview with the facility's Resident Service Director (RSD) on 04/12/17 at 12:06pm revealed: -Resident #8 had "more than one" fall in her bathroom. -Resident #8 "thinks she can toilet herself but she can't." -Each residents' needs and level of assistance were communicated to staff verbally and also through utilization of the Resident Summaries (which was the "cheat sheets"). -The Resident Summaries were populated from each residents' original and subsequent assessments and care plans. -The Resident Summaries were printed by the DSCU or her (the RSD) and retained in a book that was readily available for staff. -If a resident's care plan was not done or was not accurate, the Resident Summary would not be	D 269		

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D 269	Continued From page 21 accurate in communicating to staff what assistance the resident needed. -The DSCU was responsible for completing the assessments and care plans for residents who resided in the special care unit. -Resident #8 had some improvements in January and February 2017. -The RSD acknowledged Resident #8 had multiple falls between December 2016 and March 2017 but felt her assessments and care plans were accurate. -The RSD acknowledged the physician order dated 05/26/16 to toilet Resident #8 every two hours. -The RSD expected FL-2 orders to be implemented as written. -If an order was no longer needed, the RSD expected a request to be sent to the provider to discontinue the order. -Staff were supposed to ask Resident #8 about toileting every two hours "as a reminder." -The RSD did not know or recall if Resident #8 was on an every two hour toileting schedule prior to March 2017. -The previous Resident Summaries for Resident #8 had been "shredded" and were not available for review. -She did not recall what documentation was on the previous summaries related to toileting Resident #8. -The Butterfly Program had been implemented in the facility on 03/22/17. -The Fall Management Program was "new to us" and was implemented "within the last week or two." -Prior to that time, they were not aware a fall policy existed; the facility used "common sense" to address falls and individualized interventions for each resident.	D 269		

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D 269	Continued From page 22 Telephone interview with Resident #8's physician and Registered Nurse (RN) on 04/06/17 at 1:05pm revealed: -Resident #8 had a history of falls. -Interventions implemented to address Resident #8's falls included a fall mat, evaluation of her bed, providing a new bed, and pushing the bed against the wall. -"Recently" (03/30/17) a wheelchair alarm had been put in place and the facility had requested an order to lock Resident #8's bathroom door due to her history of falls in the bathroom. -The physician expected Resident #8 to be supervised and monitored according to the facility policy. -The physician expected orders to be implemented as written. -The physician expected Resident #8 to be toileted by staff every two hours, per the physician orders. -Resident #8 had a history of agitation and aggressive behaviors; if she was exhibiting behaviors, the physician did not expect staff to make her go to the toilet, but would expect staff to ask/offer toileting every two hours. Review of Resident #8's current FL-2 dated 05/26/16 revealed there was an order for a mechanical soft, low lactose diet. Review of the physician orders for Resident #8 dated 12/27/16 revealed an order for a regular, low lactose diet. Review of "Physician Communication" dated 02/19/17 for Resident #8 revealed Resident #8 "has been having trouble swallowing liquids recently. Can she have a swallow eval and a possible order for thickened liquids?"	D 269		

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D 269	Continued From page 23 Review of the physician order's for Resident #8 dated 02/24/17 revealed an order to supervise Resident #8 during eating to remind of clearing of oral cavity, taking smaller bites, and monitoring for signs and symptoms of choking. Review of the physician orders for Resident #8 dated 03/31/17 revealed the order for a regular diet was renewed. Review of Resident #8's most current Assessment and Care Plan dated 03/31/17 revealed Resident #8 required "supervision" with eating. Review of the Licensed Health Professional Support (LHPS) Review for Resident #8 dated 03/03/17 revealed: -"Personal tasks currently present" included feeding techniques for residents with swallowing problems. -'She needs supervision to remind to clear oral cavity, take small bites, and monitor for s/s (signs and symptoms) of choking." -Recommendations included "supervise meals with above directions." -The LHPS Review was signed by an RN. Review of the "Resident Service Notes" for Resident #8 dated 03/20/17 revealed: -Resident #8 "is still choking" on her regular diet. -The day program/medical provider had been notified. Review of "Physician Communication" dated 03/20/17 for Resident #8 revealed: -"Informing you that resident is still choking on her reg. (regular) diet. Will you please eval (evaluate) her tomorrow" at the day program. -The physician responded "please see attached	D 269		

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D 269	Continued From page 24 speech therapy note" and was dated 03/21/17. Review of a "Quick Note" from Resident #8's medical provider's office dated 03/15/17 revealed: -Resident #8 had been receiving skilled speech therapy services for dysphagia. -Resident #8 did not wish to continue with speech therapy and did not want her diet changed. -Resident #8 would be discharged from speech therapy services that day (03/15/17); "maximum potential has been reached secondary to the patient does not want to follow the recommended diet of mechanical soft with ground meats." -Resident #8's wishes had been discussed with her family and the family was in agreement with the plan of care. Review of a second "Quick Note" from Resident #8's medical provider's office dated 03/22/17 revealed: -The facility had "recently" requested Resident #8 be evaluated by speech pathology after observing her choking when eating. -A modified diet had been recommended; a modified diet had been implemented in the past but Resident #8 "did not like or want it, so diet was changed back to regular." -Resident #8 remained on a regular diet despite dysphagia and risk for choking and aspiration; the resident and POA were willing to accept the risks "in order for quality of life and increased acceptance of diet." Review of the "Notes/Comments" on a "Facsimile Transmittal Sheet" for Resident #8 dated 03/28/17 revealed: -Per reports from "care staff," Resident #8 "continues to have episodes of difficulty swallowing." -A Nurse Practitioner's response dated 03/29/17	D 269		

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D 269	Continued From page 25 included the family and Resident #8 wanted to continue with a regular diet due to her preferences and wishes. Confidential staff interviews revealed: -Resident #8 was able to feed herself and staff assisted her as needed at meals; she was able to ask for help. -Two of four staff had observed Resident #8 cough while eating. -Staff had not been trained or told to implement any special interventions or monitoring for Resident #8 during meals. -Four of four staff were not aware of any special supervision or monitoring of Resident #8 during meals to include swallowing precautions or other interventions for Resident #8 being implemented prior to 04/11/17. -"You did not see it (supervision or swallowing precautions) because it was not in place." Observation of Resident #8 on 04/05/16 during the supper meal from 4:50pm-5:27pm revealed: -Resident #8 was served a sloppy joe, corn, french fries, water, and tea. -Resident #8 fed herself and drank her beverages without difficulty. -Resident #8 did not display any signs and symptoms of choking such as coughing, wheezing, or gagging. -Staff did not cut Resident #8's food into small pieces/bites. -Staff were not observed to monitor Resident #8's bite sizes or oral cavity. -Staff were not observed reminding Resident #8 to take small bites or chew her food. Observation of Resident #8 on 04/11/16 during the lunch meal from 11:45am-12:07pm revealed: -At 11:50am, staff served Resident #8 salmon	D 269		

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D 269	Continued From page 26 filet, mashed sweet potatoes, corn bread, tea, milk, and water. -At 11:51am, she took a large bite of sweet potato (approximately one-fourth of the amount she was served). -At 11:59am, staff cut her salmon filet (after she had already started to eat it). -Resident #8 did not exhibit any signs or symptoms of choking and was able to feed herself and drink her beverages. -At 12:06pm, Resident #8 left the table by propelling her wheelchair into the hallway. -During the lunch meal on 04/11/17, staff were not observed monitoring Resident #8's bite sizes or oral cavity, reminding Resident #8 to take small bites, or chew her food at any time during the lunch meal on 04/11/16. Attempted interview with Resident #8 on 04/05/17 at 5:02pm revealed Resident #8 responded "none of your business." A second attempted interview with Resident #8 on 04/12/17 at 2:06pm revealed Resident #8 did not respond when spoken to. Telephone interview with Resident #8's family member/Power of Attorney (POA) on 04/06/17 at 3:15pm revealed: -Resident #8 did not require staff assistance with eating. -The POA did not have any complaints or concerns related to Resident #8's care. -Resident #8's diet was changed due to preference. -The POA saw Resident #8 "this past Tuesday" (04/04/17) and she was able to feed herself and did not have any swallowing difficulty at that time. Interview with the DSCU on 04/12/17 at 9:40am	D 269		

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D 269	Continued From page 27 revealed: -The DSCU had not observed Resident #8 exhibiting any signs or symptoms of choking but had received reports from staff that she coughed while eating. -Resident #8 was on the "at risk list" kept at the nurses' station to communicate with staff to observe her for signs and symptoms of choking. -Resident #8's "cheat sheet" (Resident Summary) contained documentation for staff to observe her during meals. -The DSCU's expectation related to the physician ordered dated 02/24/17 to supervise Resident #8 during meals was that she was not to eat without staff present in the dining room with her. Review of the "Resident Summary" for Resident #8 revealed: -Printed on the bottom of the summary was 04/06/17 at 10:50am. -There was preprinted documentation that Resident #8 was on a "general" diet. -"Must be observed during meals..." -Resident #8 and her family "decline special diet as suggested." Telephone interview with Resident #8's physician and RN on 04/06/17 at 1:05pm revealed: -Resident #8 did not require one on one feeding assistance. -The physician wanted Resident #8 to be as independent as possible in feeding herself with staff assistance as needed. -Resident #8 had a history of swallowing difficulty. -Resident #8 and her POA had refused the diet recommended by speech therapy (mechanical soft diet). -The expectation for the order written 02/24/17 related to supervising Resident #8 while eating was as follows: staff were to remind Resident #8	D 269		

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D 269	Continued From page 28 to take small bites, chew her food, and drink liquids while eating; staff were to assure Resident #8's food was cut into small pieces; staff were to "monitor" Resident #8's bite sizes and ask Resident #8 to open her mouth to assure her "oral cavity is empty." Interview with the DSCU on 04/12/17 at 9:40am revealed the DSCU was attempting to clarify the physician order dated 02/24/17 which contained instructions for supervising Resident #8 during meals; an attempt to clarify that order had not been done "until this week." Review of a "Physician Communication" for Resident #8 dated 04/11/17 revealed: -"Please d/c (discontinue) special instructions 'supervision with eating to remind of clearing oral cavity, taking smaller bites and monitor for s/s (signs and symptoms) of choking' Thank you." -The "Physician's Instructions" section contained documentation which read "Agree with above. D/c (discontinue) supervision with eating to remind of clearing of oral cavity, taking smaller bites, and monitor" for signs and symptoms of choking. -The response was signed by a Nurse Practitioner (NP) and dated 04/12/17. Telephone interview with a RN at Resident #8's physician's office on 04/12/17 at 4:12pm revealed: -The RN was "unsure" what prompted the "Physician Communication" dated 04/11/17 requesting to discontinue the orders/instructions for supervision of Resident #8 during meals. -The RN observed the "Physician Communication" on the fax machine that day (04/12/17); the facility called to inquire if the office had received the "Physician Communication." -The "Physician Communication" was given to the	D 269		

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D 269	Continued From page 29 NP on duty; the NP reviewed the communication and responded that day (04/12/17). -The "Physician Communication" was faxed back to the facility 04/12/17. The facility failed to provide personal care to 1 of 6 sampled residents (Resident #8), who had a documented assessed need and history of requiring assistance with toileting, a history of being at increased risk for falls, a history of frequent falls, and physician's order to assist with toileting every two hours. The facility's failure to assist Resident #8 with toileting every two hours resulted in her falling multiple times while toileting herself, sustaining a hand fracture due to a fall while toileting herself, and placed her at substantial risk for serious physical harm. This noncompliance constitutes a TYPE A2 Violation. Review of the Plan of Protection submitted by the facility dated 04/12/17 revealed: -The physician would assess Resident #8's individualized toileting needs and the needs would be communicated to staff. -An ADL sheet would be created/implemented within 24 hours. -Training would be conducted/completed for staff on ADL sheets and care plans within the next 7 days. -Create "nursing assignments" in the special care unit within 24 hours. The RSD and DSCU would assure a communication board was updated daily. -A new 24 hour report would be implemented daily to communicate resident needs and condition changes. -The RSD and DSCU would review each residents care plan and ADL summary sheet to assure the assessed needs and care were accurate.	D 269		

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D 269	Continued From page 30 -This would be completed for special care unit residents within 24 hour and other residents within the next 3 weeks. -The assessments and care plans would be reviewed weekly for 3 months and then quarterly by the RSD and/or DSCU. -The facility would continue to follow their butterfly and fall management programs/guidelines. -The facility would continue the weekly fall risk meetings and tracking log and continue to review fall risk assessments with staff. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 12, 2017.	D 269		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Type A2 Violation Based on observations, record reviews, and interviews, the facility failed to assure 1 of 6 residents sampled (#1) was sent immediately to the hospital for emergency medical evaluation after the resident was found on the floor with multiple injuries to include bruising and abrasions on his face/forehead, disfigurement and swelling	D 271	**D271 – 10ANCAC 13F.0901{c} Personal Care and Supervision** • Measure put in place to correct alleged deficient practice – Resident #1 was sent ER for evaluation on 3/19/17, returned to community on 3/19/17 with no new orders, care plan reviewed and updated on 3/28/17, placed on fall management program and reviewed at weekly fall risk meeting. Resident no longer resides in community as of 5/9/17.	5/12/17

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D 271	Continued From page 31 to his nose, and skin tears on his elbow and knee. The findings are: Observation of Resident #1 on 03/20/17 at 4:00pm revealed: -He had a quarter sized abrasion on the center of his forehead that was red in color. -He had dark purple and black colored bruises underneath both eyes extending down his face into his upper cheeks. -His entire nose was swollen and there was an abrasion to the bridge of his nose extending upward between his eyes. -He had a skin tear on his right elbow and an abrasion on his right knee. Interview with Resident #1 on 03/20/17 at 4:00pm revealed Resident #1 was not oriented and did not know how his injuries were obtained. Observation of Resident #1 on 04/06/17 at 10:31am revealed he still had bruising under both of his eyes. Review of Resident #1's care notes dated 03/19/17 at 6:20am revealed: -"Summoned to room by staff, stating resident was found lying in floor." -Upon entering room, resident was lying on his back, tilted onto his left side. -A Nurse Aide (NA) stated she entered his room at 5:30am and observed him on the floor by the bed with a blanket tangled around his feet. -Resident #1 had blood in his nasal cavity and some dripping blood from a tiny cut round the bridge of his nose. -Resident #1's nose was swollen and appeared "deformed."	D 271	• Measures put in place to prevent further occurrence – Re-educated RSD and SDCU on emergency protocol policy RSD/DSCU to review incidents in a timely manner and conduct post fall investigation (see attachment F) Develop and implement follow-up log to ensure appropriate communication (see attachment G) Will discuss/review all incidents from prior 24 hours during daily leadership team stand-up meeting; Regional nurse will be notified within 24 hours of occurrence by RSD (see attachment H) Re-education of staff on emergency protocol policy will be conducted by 4/10/17 RSD/DSCU will continue to use "Hotbox" process to ensure appropriate follow-up post incident Continue with weekly at risk meetings to include residents who have had an incident that may be a potential for discharged (see attachment I) • ED/designee will conduct final review within 72 hours of	

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D 271	Continued From page 32 -He had some swelling and red discoloration on his forehead about the bridge of his nose. -Resident #1 was alert, verbal with coaxing, followed simple commands as per normal, and confused per normal. -An ice pack was applied to his forehead and nose as he allowed (2-3 minutes at a time). -He had a skin tear on his right elbow, that was cleaned and first aid was completed. -He had a small abraised (sic) open area above his right knee which was cleaned and treated with first aid. -Resident #1 was assisted by staff to sit on buttocks and then stand up on command. -Resident #1 ambulated with staff support to his bed and positioned for comfort and safety. -A Nurse Aide (NA) and Medication Aide (MA) were made aware of his fall and the outcome. -Resident #1's record said to contact the Power of Attorney (POA) before any transfers (to the hospital). -The POA was notified by the night MA and stated she would have another family member come over to look at him. -"No hospital transport at this time." -The note was signed by a Supervisor/Licensed Practical Nurse (LPN). Review of an Incident Report for Resident #1 dated 03/19/17 revealed: -Resident #1 had an unwitnessed fall in his bedroom on 03/19/17 at 5:30am. -Resident #1 was found lying on floor with bloody, swollen, disfigured nose. -Resident #1 had skin tear to his right elbow, abrasion on his right knee, and swollen forehead with a dark red color. -The incident was documented as "Level 4: Occurrence that results in serious injury or is potentially life threatening (i.e. laceration with	D 271	incident to ensure compliance with "Hotbox" process for 4 weeks, then monthly for 2 months, then quarterly • Completion date 5/12/17 and ongoing	

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D 271	Continued From page 33 sutures, fracture, subdural hematoma); treatment rendered outside facility." -An ice pack was applied as the resident allowed. - "Will contact POA for further instructions." - "Chart says: No transport to hospital prior to POA contact." -"The POA refuses to allow facility to send resident to the ER." -The POA stated they would arrive to take resident to an urgent care facility. -After this incident (5:30am fall), Resident #1 had a second fall. -After a second fall the director (Resident Service Director) was contacted and gave an order to send Resident #1 to the hospital per facility protocol for head injury since the family had not arrived to take him to an urgent care facility. -Resident #1 was sent to the ER by Emergency Medical Services (EMS) at 11:30am for further evaluation. -There is no indication the physician was contacted. -The responsible party was contacted at 6:20am. Review of Resident #1's current FL-2 dated 07/25/16 revealed: -Diagnoses included: senile dementia with behavioral disturbance, essential hypertension, diabetes type 2 (controlled), coronary artery disease, hypercholesterolemia, cardiac pacemaker, and coronary artery bypass grafting (times 4). -Resident #1 was constantly disoriented, ambulatory, and verbally abusive. Interview with MA on 3/21/17 at 4:42pm revealed: -The MA worked on 03/19/17 when Resident #1 had an unwitnessed fall at 5:30am. -Resident #1 was found on top of a blanket on the floor in his room by a NA.	D 271		

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D 271	Continued From page 34 -When the MA looked into Resident #1's room, resident had some bleeding coming from his nose and forehead and his nose appeared swollen. -The MA called downstairs for the 3rd shift Supervisor to come upstairs to assess Resident #1. -The MA called Resident #1's Power of Attorney (POA) who indicated they were out of town. -The MA informed the POA the resident was found face down on a blanket and had some swelling to his face, but he was in good spirits. -When the POA asked the MA if Resident #1's condition was good enough to remain at the facility, the MA informed the POA that Resident #1was smiling and laughing like his normal self and he had been assessed by a Supervisor (3rd shift) who was also a Licensed Practical Nurse. -The MA was instructed by the Supervisor (who was coming on for 1st shift) to send Resident #1 out to the hospital after the Supervisor saw Resident #1. - After talking with the POA, the MA informed the third shift Supervisor that the POA did not want the resident sent out. -According to the MA, the situation was out of her hands at that point. -The MA did not notify Resident #1's physician, as they left it up to the 3rd shift Supervisor to notify the physician. -The facility procedure was to send resident out to the hospital if they hit their head, but with Resident #1, the staff had to call family first as it is noted on the front of the residents' chart. Interview with a Supervisor (who is Licensed Practical Nurse) on 3/21/17 at 5:13pm revealed: -The facility procedure for a head injury was to send the resident out for further evaluation. -The Supervisor was on duty as the third shift	D 271		

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D 271	Continued From page 35 Supervisor on 03/19/17 when Resident #1 was found at 5:30am. -The Supervisor received a call from the MA that Resident #1 was found on the floor by a NA. -When the Supervisor went upstairs to assess Resident #1, he was laying on his back tilted to the side. -Resident #1 was alert and had some bleeding from his nose. -During assessment of Resident #1, the Supervisor noted that Resident #1 had some injuries to include skin tears to his elbow and knee and his nose was "swollen and deformed." -The 3rd shift Supervisor turned the case over to the 1st shift Supervisor about 6:50am. -The 1st shift Supervisor contacted the POA and informed the POA that Resident #1 needed to be sent to the hospital due to his injuries. -The POA did not want Resident #1 sent out to the hospital; a family member would come and take him to an urgent care facility. Interview with a MA/Supervisor on 03/22/17 at 11:10am revealed: -The MA was the first shift Supervisor on 03/19/17 when Resident #1 was found. -The facility procedure for a head injury or suspected head injury was "when in doubt, send them out." -At 6:00am, she received report from the 3rd shift Supervisor that Resident #1 had fallen and had a bad nose bleed; his nose "looked like it was broken." -The 1st shift Supervisor went upstairs around 6:10am-6:15am to complete an assessment of the situation to determine if Resident #1 needed to be sent out for further evaluation. -Resident #1 had an abrasion across his forehead and skin was turning black under both eyes.	D 271		

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D 271	Continued From page 36 -The 1st shift Supervisor called the POA and informed the POA they were not comfortable with not sending Resident #1 out due to his condition, as it was possible he had a broken nose. -The POA told the Supervisor a family member would come take the resident to an urgent care facility. -The 1st shift Supervisor called the Resident Services Director (RSD) and informed the RSD they were not comfortable with not sending Resident #1 out to the hospital for evaluation of his injuries after being told by the POA not to send him out. -The RSD told the Supervisor the facility had to honor the family's wishes. -There was no follow up with family to see where and when a family member was coming to take Resident #1 to the urgent care facility. Interview with NA/MA on 04/11/17 at 8:38pm revealed: -The NA/MA was on duty on 03/19/17 (the date Resident #1 was found). -The NA/MA was in the process of making last rounds around 5:30am and heard a loud noise when leaving another resident's room. -The NA/MA looked into Resident #1's room and saw him on the floor on top of a blanket. -Resident #1 was laying on his stomach with his face down. -Resident #1's nose was bleeding "bad." -The NA/MA instructed Resident #1 to lay down because he was trying to get up. -The NA/MA went to the bathroom to get a paper towel to stop his nose bleed. -The NA/MA informed the MA on duty that Resident #1 had fallen and it looked bad. -The facility procedure was to send a resident out to the hospital if they had a head injury to ensure they receive proper care, even if the resident had	D 271		

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D 271	Continued From page 37 a DNR, but Resident #1's situation is a little different. -Resident #1's family did not want him to be sent out to the hospital and got a MOST (Medical Orders for Scope of Treat) form completed so he would not have to be sent out to the hospital. -If the NA/MA had been the MA, they would have called 911 due to the significant injuries (nose bleeding, scrapes to forehead, and swollen nose) even though Resident #1 had the MOST form. -The NA/MA would let Emergency Medical Service (EMS) decide if the resident needed to go to hospital with the MOST form in place. Review of Resident #1's Medical Orders for Scope of Treat (MOST) form revealed: -The effective date of MOST form was 02/01/17. -The MOST form indicated: Do not attempt resuscitation. -Under the section regarding medical interventions (patient has pulse and/or is breathing); the box for comfort measures was checked; keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital unless comfort needs cannot be met in current location. Other instructions noted: call POA 1st. -The form was signed by a hospice nurse on 02/01/17. Review of Resident #1's care notes dated 03/19/17 at 10:15am revealed: -Resident #1 was found sitting on the floor in his room with no apparent injuries. -"Family called, told he had fallen again, will continue to monitor."	D 271		

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D 271	Continued From page 38 Telephone interview with Resident #1's family member on 04/11/17 at 11:08 revealed: -The family member was contacted by Resident #1's POA to go to the facility and take Resident #1 to an urgent care facility because the POA was out of town. -When the family member arrived at facility around 11:30am on 03/19/17, Resident #1 had already been sent to the hospital. -The family member did not receive any calls from facility staff to check on the status of taking Resident #1 to an urgent care facility or to let them know he had already been sent to the hospital. Review of Resident #1's care notes dated 03/19/17 at 11:15am revealed: -"Resident being sent out due to head injury from previous fall." - Resident #1 had a swollen nose with contusion to his forehead per RSD (Resident Service Director) and DON (Director of Nursing). - This note was signed by a MA. Interview with the Business Office Manager (BOM) on 04/12/17 at 11:10am revealed: -The BOM worked as the manager on duty on 03/19/17 from 9:00am to 1:00pm. -Due to Resident #1's injuries, he should have been sent out after 1st fall. -Residents were supposed to be sent out to the hospital for any head injury. Review of Resident #1's care notes dated 03/19/17 revealed: -"This nurse and RSD gave verbal to send to emergency room per facility protocol for head injury." - The family refused to have the resident sent out of the facility.	D 271		

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D 271	Continued From page 39 - 911 was called and Resident #1 was transported out of the facility via emergency medical service. - The family came to the facility later and spoke to this nurse. -"I explained that all facilities must send a resident out for any head injury per policy." - Facility staff had tried to set up hospice but the family had declined. -The note was signed by the Director of the Special Care Unit (DSCU). Review of Communication Event Report dated 03/19/17 revealed: -The facility called 911 regarding Resident #1 at 11:19am. -Nature of the call was documented as a fall. -The notes indicated the injury was to the head. Review of local emergency room (ER) report for Resident #1dated 03/19/17 revealed: -Resident #1's arrival time at the ER was 11:52am. -The chief complaint was documented as: Patient presents with multiple falls- found on the floor earlier this am; family refused transport, patient fell again, unknown LOC, bruising under bilateral eyes and bridge of nose. -History of Present Illness was documented as: Patient presents to emergency department after a fall. Patient has a history of dementia and is on memory care unit; struck face; the family let resident stay back and did not transport as resident seemed okay. -Bilateral periorbital soft tissue and ecchymosis; swelling to the bridge of nose. -The resident had forehead and facial contusion and was given closed head injury precautions. Interview with DSCU on 03/20/17 at 4:20pm revealed:	D 271		

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D 271	Continued From page 40 -Resident #1 was found on the floor in his room at the end of 3rd shift on 03/19/17. -Resident #1 had some bruising, nose bleed, and skin tears on his right knee and elbow. -The facility contacted the POA who instructed staff not to send Resident #1 out to the hospital because a family member would come to the facility to take him to an urgent care facility. -Resident #1 had a second fall that same day (03/19/17), prior to the DSCU arriving to the facility. -Resident #1 had some complaints about knee pain after the second fall. -The RSD instructed staff to send Resident #1 out after the second fall. -After the second fall, the facility sent Resident #1 out without notifying the family. -The facility policy was to send a resident out for evaluation for head injury unless the resident was on hospice. -Resident #1's family did not want him sent to the hospital as they felt the hospital wasn't going to do anything for him. Telephone interview with Resident #1's family member/POA on 03/21/17 at 4:10pm revealed: -The POA received a phone call from the facility around 6:00am on 03/19/17, indicating Resident #1 had a fall and injury to his nose. -The POA felt the situation could be handled at an urgent care facility; a family member could take Resident #1 to an urgent care facility. -The POA acknowledge telling staff not to send Resident #1 to the hospital because they were sending him out too much and he got agitated. -The 1st shift Supervisor indicated that Resident #1 should have been sent out as it was believed he had a broken nose and face swelling. -The POA acknowledged being told by the DSCU the policy for falls was to send a resident out for	D 271		

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D 271	Continued From page 41 head injury. Interview with DSCU on 4/12/17 at 10:40am revealed staff were to call EMS even if the resident had a MOST form. Confidential interviews with 7 of 7 additional direct care staff members from 3/20/17 to 4/12/17revealed: -The facility policy was to send a resident out for medical evaluation if the resident had a head injury. -It was standard facility procedure to send residents out for a head injury. Review of the facility's Emergency Response Guidelines (protocol) revealed: -The policy revision date was 11/14/05. -The purpose: Provide guidelines for staff response to resident emergencies that require intervention or treatment in an acute care setting. Examples of such emergencies include, but were not limited to the following: "cardiac arrest; respiratory arrest; suspected fractures; severe bleeding; burns; severe allergic reactions; and life-threatening changes in the resident's medical status." Interview with the Resident Service Director (RSD) on 03/20/17 at 2:10pm revealed: -Resident #1 was found on the floor in the room by staff at 5:30am with his sheets wrapped around his feet. -Resident #1 had injuries to his nose, bruising on his face and forehead, and two black eyes. -Resident #1 hit his forehead "like he face planted." -A facility staff contacted Resident #1's POA regarding the fall and was instructed by the POA not to send him to the Emergency Room (ER).	D 271		

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D 271	Continued From page 42 -The POA informed the facility staff member that a family member would come to the facility to take him to an urgent care facility. - Before the family member got to facility to take Resident #1 to an urgent care facility, Resident #1 fell again five hours later. -The RSD instructed staff to send Resident #1 to the hospital after receiving a call indicating he had a second fall. -The facility policy was to send a resident to hospital for head injury. -Resident #1 should have been sent to the hospital for evaluation after the first fall because he hit his head -The facility had a note on the front of Resident #1's chart with written instructions not to not sent him to the hospital. Telephone interview with Resident #1's physician on 04/11/17 at 2:19pm revealed: -The physician had consulted Hospice services for Resident #1 due to diagnosis of advanced dementia. -Resident #1 was a DNR (do not resuscitate) and his family did not want extraordinary medical procedures to be performed to prolong his life. -The orders on Resident #1's MOST form signed by the Hospice provider (dated 02/01/17) were valid orders, but when Resident #1 was found with his nose disfigured and bleeding on 03/19/17, this was "trauma" which would need to be addressed in order to maintain comfort measures for Resident #1. -The "standard of care" for "trauma" was to send Resident #1 to the hospital for evaluation. Interview with the Executive Director on 04/12/17 at 8:15am revealed: -The facility contacted Resident #1's family on 03/19/17 after the first incident and they did not	D 271		

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D 271	Continued From page 43 want him sent for emergency treatment. -The family told staff that a family member would come to the facility to take Resident #1 to the hospital; the family never came. -The facility did not follow up with the family on 03/19/17 after the first incident. -The facility should have followed up with the family after the first incident on 03/19/17. -Resident #1 fell a second time on 03/19/17 before he was sent to the hospital. -Resident #1 should have been sent to the hospital after his first fall on 03/19/17. The facility failed to assure 1 of 6 residents sampled (Resident#1) received immediate emergent medical evaluation in accordance with their policy after Resident #1 was found on the floor with a suspected nose fracture to include bleeding and disfigurement to his nose and suspected head injury to include bruising to his forehead. The facility's failure to send Resident #1 for emergent medical evaluation placed the resident at substantial risk for serious physical harm. This non-compliance constitutes a TYPE A2 Violation. Review of the Plan of Protection submitted by the facility dated 04/12/17 revealed: -The facility would follow the emergency response protocol [Emergency Response Guidelines dated 11/14/05] that was implemented on 03/23/17. -Residents would be sent out for referral and follow up per the emergency response protocol and physician orders. -The Emergency response policy/procedure had been reviewed with staff and in-service training had been completed. -The RSD and DSCU would receive "re-training" on the emergency response procedure within 24 hours.	D 271		

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D 271	Continued From page 44 -For "non-emergency incidents", follow up will be completed "immediately" with the medical provider, responsible party/POA and facility management. -The RSD and DSCU would meet daily to review all incidents and determine appropriate follow up needed. -The RSD and/or DSCU would notify the ED during daily stand up meetings of all resident incidents and follow up. -All significant injuries would be reported to Regional Nurse within 24 hours of occurrence. -A fax follow up form had been created and staff would be trained on the use of the form. -Weekly "at risk" meetings would be continued. -Training would be continued on the emergency response policy/procedure and random interviews would be conducted with staff regarding the policy. -The RSD and DSCU would conduct chart audits monthly and review orders daily. -The RSD and DSCU would continue to monitor the "Hot Box" daily. -The RSD and DSCU would review the "daily task sheets" and submit to the ED. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 12, 2017.	D 271		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310	**D310 10ANCAC 13F.0904{e}(4) Nutrition and Food Service** • Measures put in place to correct alleged deficient practice for resident #7 – followed up with MD and received amended diet order on 4/17/17 for general diet	5/17/17

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D 310	Continued From page 45 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 5 sampled residents (Resident #7) was served a healthy heart diet as ordered by the physician. The findings are: Review of Resident #7's current FL-2 dated 01/03/2017 revealed: -Current diagnoses included hypertension, coronary artery disease, osteoporosis, constipation, and arthritis. -There was a physician's order for a heart healthy diet. Review of the Spring/Summer 2016 Week 5 Day 31 dinner menu for a healthy heart diet posted in the kitchen for 04/05/2017 revealed: -The menu included 2 oz hamburger and a 2 slice hamburger bun or 6 oz of ravioli with sauce. -The menu included ½ cup of pineapple cubes. -There were no additional dessert choices listed on the menu spreadsheet. -The menu options for a heart healthy diet did not include sloppy joe meat on a bun. Observation of the dinner meal in the assisted living section of the facility on 04/05/2017 from 4:30pm to 5:20pm revealed: -Resident #7 was served sloppy joe on a hamburger bun at 4:45pm. -Resident #7 was served a tiramisu cake square at 5:12pm. -Resident #7 was not offered the cubed pineapple according to the menu prepared by the dietitian. Interview with the Cook on 04/05/2017 at 5:35pm	D 310	however recommends heart healthy diet, resident is free to choose own meal if desired • Measures put in place to prevent further occurrence – Education was conducted on 4/8-9/17 regarding therapeutic diets/alternative choices for the residents to dietary staff FSD will ensure that resident diet board in kitchen is updated with changes as they occur RSD/designee and FSD will meet at a minimum monthly to review resident's diets for accuracy (see attachment J) • ED/designee will audit diets and diet board quarterly for accuracy • Completion date 5/17/17 and on going	

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D 310	Continued From page 46 revealed: -The Cook had been employed at the facility for two months. -The tiramisu dessert was the only dessert option for the 04/05/2017 dinner meal. -If a resident wanted something other than what was offered, the resident would tell the staff. -The menu list prepared by the Food Service Director (FSD) and placed on the dining room tables did not represent the available menu according to the spreadsheet prepared by the dietitian. -The resident would not have known to ask for pineapple cubes if the diet list on the table did not reflect the pineapple cubes were available and recommended for the heart healthy diet instead of the tiramisu. -It was not advantageous to the budget to open a can of pineapple for one resident. -The Cook prepared meals according to the menu list prepared by the Food Service Director (FSD). -Tiramisu was on the menu and if the resident requested tiramisu, the Cook would give the resident the tiramisu. Interview with the Food Service Director (FSD) on 04/06/2017 at 11:20am revealed: -The residents were served "restaurant style" in the assisted living section of the facility. -The residents looked at the menu on the table and selected their food options. -She prepared the table menus from the spreadsheets prepared by the dietician. -There was usually one dessert option but the facility also offered no sugar added desserts for diabetics and pudding and applesauce for puree diets. Further interview with the FSD on 04/06/2017 at	D 310		

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D 310	Continued From page 47 12:35pm revealed: -The menu spreadsheet listed everything that was supposed to be prepared for each special diet -The FSD thought the menu choice list was "exactly" the same as the therapeutic spreadsheet. -Pineapple cubes were in the dry food pantry to prepare for the resident on a heart healthy diet. -When the dietary aides or resident assistants gave out desserts, pineapple cubes were offered to the resident. -The FSD was not aware Resident #7 was not offered pineapple cubes for dessert at the dinner meal on 04/05/2017. -She was "shocked" and "surprised" that Resident #7 got the sloppy joe. -She "honestly" thought Resident #7 would have refused the hamburger and bun if the resident had been told her menu called for her to have that. -She had a "hard time" with the resident wanting what everybody else had to eat. -She had spoken to the resident about diet choices but had not documented any of the conversations. -There had been no contact with Resident #7's physician about the resident's diet choices. -She knew the facility was supposed to encourage the resident to eat what was on the resident's diet. Interview with the Executive Director (ED) on 04/06/2017 at 1:10pm revealed: -She was not aware the heart healthy diet was not being served as ordered in the facility. -Her first day in the facility in the position of Executive Director was 04/05/2017. Interview with Resident #7 on 04/06/2017 at	D 310		

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D 310	Continued From page 48 3:50pm revealed: -She was not on a special diet. -She looked at the menu on the dining room table and made her meal selections. -She did not eat what was not good for the heart - "mainly salt". -She had talked to the FSD about how food was prepared and foods she did not like. -She denied having any heart problems but stated she had two stents placed at least 10 years ago. -She had fainted while sitting in the dining room about 4 weeks ago, went to the hospital, test were done, but could not find out why she fainted. -She was not aware she was prescribed a heart healthy diet. -Her ankles swell everyday but she was not going to wear TEDS or take Lasix. Telephone interview with the Regional Food and Dining Dietitian (RFDD) on 04/10/2017 at 3:40pm revealed: -She expected staff to follow the menus. -Resident #7 should have been served pineapple instead of tiramisu. -If Resident #7 refused the pineapple, staff should talk to the resident about her diet and document the contact with the resident. -If the resident continued to refuse to follow the physician ordered diet, the physician should be contacted, and the contact documented. -She had identified training issues and opportunities. -She had provided training to the staff. Interview with the FSD on 04/11/2017 at 12:05pm revealed the Corporate Dietitian had provided training to the dietary staff on 04/10/2017 regarding following the menu spreadsheets.	D 310		

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D912	Continued From page 49	D912	**D912 G.S. 131D-21(2) Declaration of Residents' Rights** • Measures put in place to correct alleged deficient practice for: Resident #8 - Contacted PACE to re-assess toileting needs and updated the care plan to reflect needs, educated and will re-educate staff on resident's toileting needs, developed an ADL sheet, re-evaluated resident fall risk and continued her on fall management program Resident #1 was sent ER for evaluation on 3/19/17, returned to community on 3/19/17 with no new orders, care plan reviewed and updated on 3/28/17, placed on fall management program and reviewed at weekly fall risk meeting. Resident no longer resides in community as of 5/9/17 • Measures put in place to prevent further occurrence: • RSD/DSCU developed and implemented the communication boards located on the first and second floor Re-assessed all AL residents care plans to ensure accuracy of needs, Will review all SCU (BTR) residents weekly for 3 months, then review quarterly Educated staff on fall management program on 3/23/17 and 4/10/17 Conduct weekly fall risk meeting and update communication boards with changes as needed Conduct training with staff on ADL sheets process by 5/11/17 Re-educated RSD and SDCU on emergency protocol policy RSD/DSCU to review incidents in a	5/12/17
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to provide personal care to 1 of 6 residents sampled (#8) according to assessed needs and physician orders related to eating and toileting every two hours, resulting in the resident having multiple falls while toileting herself and sustaining a hand fracture due to a fall while toileting herself. [Refer to Tag D269, 10A NCAC 13F.0901(a) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 6 residents sampled (#1) was sent immediately to the hospital for emergency medical evaluation after the resident was found on the floor with multiple injuries to include bruising and abrasions on his face/forehead, disfigurement and swelling to his nose, and skin tears on his elbow and	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	C 04/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D912	Continued From page 50 knee. [Refer to Tag D273, 10A NCAC 13F.0901(c) Personal Care and Supervision (Type A2 Violation)].	D912	timely manner and conduct post fall investigation Develop and implement follow-up log to ensure appropriate communication Will discuss/review all incidents from prior 24 hours during daily leadership team stand-up meeting Regional nurse will be notified within 24 hours of occurrence by RSD/designee Re-education of staff on emergency protocol policy will be conducted by 4/10/17 RSD/DSCU will continue to use "Hotbox" process to ensure appropriate follow-up post incident Continue with weekly at risk meetings to include residents who have had an incident that may be a potential for discharged • ED/designee will conduct bi-weekly audits to ensure compliance ED/designee will conduct final review within 72 hours of incident to ensure compliance with "Hotbox" process for 4 weeks, then monthly for 2 months, then quarterly • Completion date – 5/12/17 and ongoing	