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 07/27/2020

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 conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on July 13, 2020 and July 20, 2020 and a desk review survey on July 1, 2020 to July 27, 20202 with a telephone exit date on July 27, 2020.	D 000		
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: Based on observations, interviews and record reviews the facility failed to provide personal care assistance to 1 of 3 residents sampled (Resident #2) who demonstrated an inability to groom and dress themselves. The findings are: Review of Resident #2's current FL-2 dated 07/01/20 revealed: -Diagnoses included dementia, multiple falls and history of subdural hematoma. -Resident #2 Level of Care was Special Care Unit	D 269		

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(SCU).
-Resident #2 was constantly disoriented, wandered and was injurious of others.
-Resident #2's speech had functional limitations and he communicated verbally.
-Resident #2 was ambulatory and incontinent of bowel and bladder.

Review of the Resident Information sheet dated 07/06/20 revealed Resident #2 was admitted to the facility 11/27/19.

Telephone interview with Administrator on 07/27/20 at 10:08am revealed the Administrator had submitted for review all documentation available for Resident #2.

Review of Resident #2's care plan dated 12/10/19 revealed:
-Resident #2 had no problems with ambulation and upper extremities.
-Resident #2 was continent of both bowel and bladder.
-Resident #2 was always disoriented.
-Resident #2 was forgetful requiring reminders.
-Resident #2 required supervision with bathing.
-Resident #2 required limited assistance with grooming and personal hygiene.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 03/11/20 revealed:
-Diagnosis of major neurocognitive disorder.
-Resident #2 was unable to communicate.
-Resident #2 was identified as ambulating and transferring independently.
-Resident #2's plan of care was to continue.

Review of Resident #2's 6-month Senior Living Resident Evaluation dated 05/06/20 at 10:16am

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revealed:
-Resident #2 had memory loss.
-Resident #2 had cognitive impairment.
-Resident #2 was able to ambulate independently.
-Resident #2 was independent with transfers.
-Resident #2 required 1 or more staff to assist with his bathing.
-Resident #2 had episodes where he displayed resistance to bathing activities.
-Resident #2 was dependent on staff for all his grooming activity.
-Resident #2's assessed need for assistance with dressing was not indicated.
-Resident #2's toileting required assistance with brief changing.

Observations of Resident #2 on the SCU 07/13/20 from 11:27am-11:36am revealed:
-Observations from the entryway down the main resident hallway at 11:27am revealed there were two staff in the nurses' station area.
-Resident #2's rooms was the first room on the left side of the hall located closest to the nurses' station.
-Resident #2 was in his room slumped face down over the right arm of a chair.
-He was wearing a shirt, no pants, adult incontinent brief, and non-skid socks.
-At 11:36am, after being prompted, two personal care aides (PCA) had assisted Resident #2 to a sitting position in his chair.

Review of Review of Resident #2's Nursing Communication Progress Note dated 03/31/20 at 1:12pm revealed the facility had spoken with the Primary Care Provider (PCP), Responsible Party (RP) and liaison from Hospice and all were aware an order for a Hospice consult and transfer to a Skilled Nursing Facility (SNF) had been written.

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D 269	Continued From page 3 Review of Resident #2's Nursing Ancillary Communication Progress Note dated 05/08/20 at 1:37pm revealed Resident #2 appeared to be declining and required more assistance from staff than what he had required previously. Review of Resident #2's Nursing Communication Progress Note dated 05/11/20 at 3:26pm that Resident #2 was showing some decline as requiring increased hands on care with bathing, grooming and toileting. Review of Resident #2's Nursing Ancillary Communication Progress Note dated 05/28/20 at 11:02am revealed: -Resident #2 continued to show a steady decline as evidenced by increased lethargy. -Resident #2 continued to show a steady decline and required increased assistance from staff with Activities of Daily Living (ADL). -Resident #2 continued to show a steady decline as evidenced by increased incontinence of both bowel and bladder and decreasing mobility. Review of Resident #2's PCA Documentation Survey Report dated June 2020 revealed: -Resident #2 received no assistance dressing 07/13/20 on the 6:00am to 2:00pm shift. -Resident #2 received no assistance grooming 07/13/20 on the 6:00am to 2:00pm shift. -Resident #2 received no bath 07/06/20 -07/12/20. Review of Resident #2's Nursing Ancillary Communication Progress Note entry dated 06/09/20 at 11:06am revealed Resident #2 continued to show a slow decline in health and required more assistance from staff with all ADL.	D 269		

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Review of Resident #2's Nursing Health Status Note Progress Note dated 07/01/20 at 3:29pm revealed Resident #2's PCP was informed Resident #2's Level of Care was outside of the facilities ability to provide while maintaining the resident's safety.

Telephone interview with a PCA on 07/02/20 at 1:30pm revealed:
-He had worked on the SCU with Resident #2.
-Staff used a communication sheet to transmit resident information between shifts.
-Changes to resident care would have been updated in the staff tablets.
-Showers were given 2 or 3 times a week and skin was checked during showers for changes.

Telephone interview with a second PCA on 07/02/20 at 2:35pm revealed:
-She had worked on the SCU with Resident #2.
-If a resident refused care it would be documented in the tablet.
-Shaves were given on 6:00am-2:00pm shift as part of showers or morning care.
-Shaving was not documented.

Telephone interview with a third PCA on 07/23/20 at 2:17pm revealed:
-She had worked on the SCU with Resident #2.
-Resident #2 had declined and was incontinent.
-Resident assignments were obtained daily by reading the assignment in the tablets at the start of the shift.
-Shaves were done as needed not always on bath or shower day.
-She documented the care residents received in a tablet.
-Shaves were documented by typing in shave in the tablet in the section for showers and baths.
-Resident #2's care needs had increased

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D 269	Continued From page 5 requiring an increased assistance with showers, shaving, dressing and incontinence care. Telephone interview with a fourth PCA on 07/23/20 at 3:14pm revealed: -Resident #2 was able to perform most of his own care on admission and now required extensive assist including 2 person transfers. -The MA provided her directions regarding Resident #2's care needs and changes. -Documentation of Resident #2's care provided was completed in the PCA tablet. -She did not provide baths on her shift but believed there was a scheduled shower list identifying when residents were scheduled for showers and baths. -Shaving would be documented as a component of grooming when documented on the tablets. -When Resident #2 had been combative 2 caregivers were required for dressing, grooming, bathing and shaving. -Resident #2 was a 2 person assist for transfers. Telephone interview with a fifth PCA on 07/24/20 at 1:53pm revealed: -She had worked on the SCU with Resident #2. -Sometimes PCAs were told about changes in the residents' care by the facility or outside providers. -She was not aware of any place where she could find guidance when Resident #2's care needs changed -Resident #2 needed SNF care, had ambulation limitations and required two people for care assistance at times due to his strength. -Resident #2 received shaves on bath days. -Resident #2's shave would not be documented separately but would be documented as a shower. -Residents were not shaved unless it was shower day and they needed to be shaved.	D 269		

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-Resident #2 removed his clothing throughout the day.
-Resident #2 required assistance with dressing.

Telephone interview with a sixth PCA on 07/27/20 at 11:17am revealed:
-Resident #2 used to shave himself.
-Resident #2 required total care.
-Resident #2 frequently was not shaved.
-She had not tried to shave Resident #2 for a month.

Telephone interview with the Special Care Unit Director (SCUD) on 07/24/20 at 12:25pm revealed:
-Resident #2 was totally dependent on staff for care.
-Resident #2 was shaved on shower days two days per week.
-He had observed Resident #2 not allowing staff to shave him when he had heavy beard growth in the past.

Telephone interview with the Health and Wellness Coordinator on 07/02/20 at 2:03pm revealed:
-She had worked at the facility 12 years , also worked as a MA and PCA and worked all shifts as needed.
-She had worked in the SCU.
-Resident #2 required assistance to the restroom and due to aggression required additional staff to assist with his care.
-Assignments were in the tablets and when a task was due it populated on the screen.

Telephone interview with the Director of Resident Care (DRC) on 07/02/20 at 12:30pm revealed:
-Resident #2 was identified as requiring extensive care and attempts were being made to transfer him to a SNF.

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-PCAs used a tablet to document all resident care.
-PCAs followed a shower list or looked in their tablet to learn the care assigned to Resident #2 for their shift.
-It was challenging to ensure enough staff to provide care to the residents.
-She had observed staff encouraging residents to be shaved.
-If a resident had refused care PCAs were to take another approach, try a different time or have someone else attempt to provide the care.
-If a resident refused care the PCA reported the refusal to the MA.
-She was not aware of any facility policies regarding toileting or personal care for residents.
-Incontinent residents were to be checked every two hours and changed if necessary.
-The Health and Wellness Coordinator made PCA assignments.

Telephone interview with the Hospice Clinical Director on 07/10/10 at 3:02pm revealed:
-Resident #2 received Hospice services from 03/31/20 to 05/05/20.
-Resident #2 required two staff to perform care due to behaviors.
-Resident #2 required hands on care.
-Resident #2 could shampoo and shave himself, transfer with assistance and was unsteady with ambulation while on Hospice services.
-Hospice was discontinued as Resident #2 was to be transferred to another facility and the facility would not admit Resident #2 while he was receiving Hospice services.

Telephone interview with Resident #2's Responsible Party (RP) on 07/14/20 at 8:31am revealed:
-On admission Resident #2 could drive, shave,

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toilet and care for himself.
-Resident #2 had been observed with a beard twice in two months.
-Resident #2 had always wanted to be clean shaven.
-The facility had been provided with a bladeless electric shaver for use with Resident #2.
-She had observed Resident #2 using the electric razor when receiving prompts.
-Resident #2's clothing frequently had smelled of urine.

Telephone interview with the Social Worker from Resident #2's Primary Care Physician's practice on 07/09/20 at 3:20pm revealed Resident #2 needed help with bathing, dressing and incontinent care.

Telephone interview with Resident #2's PCP on 07/09/20 at 3:28pm revealed:
-Resident #2 attended an office visit on 06/30/20 and did not look well cared for and appeared disheveled.
-There was not information provided on whether this had been reported to the facility.

Telephone interview with the Administrator on 07/06/20 at 9:45am revealed:
-Resident #2's condition was declining.
-Resident #2 was impossible to shave without someone getting hurt.
-Resident #2 had displayed aggressive behavior and ripped off his clothes.
-Resident #2 required SNF Level of Care.

Second telephone interview with the Administrator on 07/27/20 at 10:12am revealed:
-She did not know why there were no changes to Resident #2's care plan related to his decline and Resident #2's need for personal care assistance

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D 269	Continued From page 9 had increased since admission. -Reassessments of Resident #2 would be performed by the DRC when they were needed from a clinical perspective. -Changes in Resident #2's status and care needs would not prompt a reassessment of Resident #2's care plan or care provided. Based on observations, record review and interviews it was determined Resident #2 was not interviewable.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision to meet the needs of 2 of 3 sampled residents (Resident #2 and #3) residing in a special care unit who experienced 12 falls from 03/21/20 to 07/03/20 resulting in pain, contusion, abrasion, and skin tear (Resident #2) and a resident experiencing 2 falls, 2 visits to the emergency room resulting in head lacerations that required sutures (Resident #3). The findings are: Review of the facility fall management and	D 270		

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D 270	Continued From page 10 investigation policy dated 09/01/18 revealed: -The facility was to utilize all reasonable efforts to provide a system to review residents' potential risk for falls. -The facility was to provide a proactive program of supervision, assistive devices and interventions to manage and minimize falls and identify residents continued needs. -A fall was defined as an unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. -A fall without injury was still a fall. -Unless there was evidence suggesting otherwise, when a resident was found on the floor, a fall was considered to have occurred. -Fall interventions were documented in the resident's service plan. -A service plan regarding falls was to have been updated with level of care and significant change in status and post-falls addressing potential risk factors and suggest interventions. -Post fall procedures were to include notification of the residents attending physician and if indicated, modifications to the resident's treatment and interventions accordingly. -The service plan was to have been reviewed and revised with interventions and changes communicated to the staff, resident and family. -Fall interventions were to have been reviewed for continued effectiveness. -Fall interventions were to be communicated to staff, family and the resident. 1. Review of Resident #2's current FL-2 dated 07/01/20 revealed: -Diagnoses included dementia, multiple falls and history of subdural hematoma. -Resident #2 Level of Care was Special Care Unit (SCU). -Resident #2 was constantly disoriented,	D 270		

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wandered and was injurious to others.
-Resident #2 was ambulatory.

Review of the Resident Information sheet dated 07/06/20 revealed Resident #2 was admitted to the facility 11/27/19.

Interview with the Administrator on 07/27/20 at 10:08am revealed she had submitted for review all documentation available for Resident #2.

Review of Resident #2's care plan dated 12/10/19 revealed:
-Resident #2 had no problems with ambulation and upper extremities.
-Resident #2 was continent of both bowel and bladder.
-Resident #2 was always disoriented.
-Resident #2 was forgetful and required reminders.
-Resident #2 required supervision with bathing.
-Resident #2 required limited assistance with grooming and personal hygiene.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 03/11/20 revealed:
-A diagnosis of major neurocognitive disorder.
-An entry Resident #2 was unable to communicate.
-Resident #2 was independent with transfers and ambulation.
-Resident #2's plan of care was to continue.

Review of Resident #2's 6-month Senior Living Resident Evaluation dated 05/06/20 at 10:16am revealed:
-Resident #2 had memory loss.
-Resident #2 had cognitive impairment.
-Resident #2 was able to ambulate

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independently.
-Resident #2 was identified as fall risk.
-Resident #2 required staff monitoring for falls on a daily basis.
-Resident #2 required fall risk safety intervention and required frequent room checks.
-Resident #2 was independent with transfers.
-Resident #2 required 1 or more staff to assist with his bathing.
-Resident #2's toileting required assistance with brief changing.

Review of the Resident #2's physician's orders dated 07/01/20 revealed:
-Ativan 0.5 mg one-half tablet (0.25 mg) three times a day for 2 weeks beginning 06/30/20.
-Seroquel 25mg twice a day.

Review of the Personal Care Aide (PCA) Documentation Survey Report revealed a section providing instructions for PCAs documenting care provided to Resident #2's titled Fall Risks/Safety Interventions: Frequent room checks with notation to enter Y if safety checks/interventions were completed and N if they were not completed during the PCAs shift.

a. Review of Resident #2's Primary Care Provider (PCP) medication order dated 02/11/20 revealed Seroquel 25mg twice a day, urinalysis and culture and sensitivity if indicated (A urinalysis and culture and sensitivity are used to determine if a resident may have a urinary tract infection).

Review of Resident #2's Nursing Communication Progress Note dated 02/12/20 at 12:08pm revealed:
-Resident #2 had a mark on his cheek which was pointed out by his family member.
-Resident #2 was interviewed by staff and he

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stated he had fallen.
-Resident #2 pointed to his cheek and hip when asked if he hurt.
-Resident #2 was to receive a urinalysis.

Review of the PCP visit summary dated 02/25/20 at 10:34am revealed:
-Resident #2 was seen for follow-up after a fall earlier in the week.
-The date of the fall was not documented.
-The resident had no injuries noted.

b. Review of the PCP visit summary dated 03/17/20 at 9:56am revealed Resident #2 was ordered Ativan 0.5mg three times a day related to aggressive behaviors.

Review of the PCP visit summary follow-up entry dated 03/19/20 at 3:34pm revealed resident #2 was reported to be sedated with the Ativan 0.5mg three times a day.

Review of Resident #2's Medication Administration Records (MAR) for March 2020 revealed:
-Ativan 0.5mg three times a day was discontinued on 03/19/20 prior to the 5:00pm dose.
-Ativan 0.5mg one-half tablet (0.25mg) three times a day was administered once on 03/20/20 at 8:00pm.

Review of Resident #2's Emergency Room (ER) Inpatient Abstract Report dated 03/21/20 revealed:
-Resident #2 was admitted to the ER at 1:08am after a fall out of a chair on 03/21/20 was Fall #1.
-Resident #2 fell sitting in a chair onto his right hip.
-Resident #2 had a small skin tear on his right arm.

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-Resident #2 had no fractures.
-Resident #2 had an abrasion to his right elbow and tenderness to the right hip.
-Resident #2 was discharged at 4:34am on 03/21/20.

Review of an Incident Report provided by county Department of Social Services revealed:
-Resident #2 fell from a chair onto the floor.
-Resident #2 complained of right hip pain.
-Resident #2 was seen by Emergency Medical Services (EMS) and transported to the hospital.
-No new orders were issued by the ER and Resident #2 was to follow-up with his PCP.
-There was no information provided that Resident 2's family was notified of the fall.

Telephone interview with one of Resident #2's PCP on 07/24/20 at 10:55am revealed:
-Resident #2 was found to be extremely sensitive to medication changes.
-Resident #2's Ativan 0.5mg three times a day was ordered to be discontinued on 03/19/20 with the 5:00pm dose as he was being sedated.
-Resident #2 was ordered Ativan 0.5mg one-half tablet (0.25mg) three times a day to be administered starting at 8:00pm.

Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #1.

c. Review of Resident #2's Nursing Communication Progress Note dated 03/21/20 was Fall #2 at 12:26pm revealed:
-Resident #2 was found on the floor by staff.
-Resident #2 was transported to the hospital.
-Resident #2's Responsible Party (RP) was notified by voice mail.

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D 270	Continued From page 15 Review of Resident #2's second ER Inpatient Abstract Report dated 03/21/20 revealed: -Resident #2 was admitted to the ER on 03/21/20 at 12:46pm. -Resident #2 had an unwitnessed fall and was found on the floor of his room. -Resident #2 expressed pain to his left neck and left shoulder to the facility staff. -Resident #2 was unable to verbalize pain to the physician. -Instructions were to be given for outpatient CT imaging in 72 hours. Review of Resident #2's Nursing Communication Progress Note dated 03/22/20 at 11:59pm revealed the facility was to schedule a follow-up appointment with neurology for Resident #2. Second telephone interview with Resident #2's prior PCP on 07/24/20 at 10:55am revealed the PCP had discontinued the neurology appointment as Resident #2 demonstrated no signs or symptoms warranting a neurology appointment. Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #2. d. Review of Resident #2's third hospital ER Inpatient Abstract Report dated 03/21/20 revealed: -Resident #2 had a witnessed fall from his bed to the floor upon return to the facility from the hospital ER on 03/21/20 was Fall #3. -Resident #2 was returned to the hospital ER by EMS on the same date. -Resident #2 was admitted to the hospital ER on 03/21/20 at 10:49pm.	D 270		

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-Resident #2 had no new injuries.
-An entry noted if falls continued provider would consider Physical Therapy and/or Occupational Therapy (PT/OT)

Telephone interview with one of Resident #2's PCP on 07/24/20 at 10:55am revealed Resident #2 was evaluated for PT/OT by the facility and was not accepted based on his inability to follow directions.

Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #3.

e. Review of Resident #2's Nursing Communication Progress Note dated 03/26/20 at 12:42pm revealed:
-Resident #2 was found on the floor by staff.
-Resident #2 was transported via EMS to the hospital.
-Resident #2's responsibile party (RP) was notified of transport.

Review of Resident #2's fourth hospital ER Inpatient Abstract Report dated 03/26/20 was Fall #4 revealed:
-Resident #2 had an unwitnessed fall and was found on the floor lying on his right side.
-Resident #2 was admitted to the ER on 03/26/20 at 11:47am.
-No injuries noted on the report.
-Resident #2 was to follow-up with his PCP.

Review of Resident #2's Nursing Communication Progress Note dated 03/26/20 at 4:17pm revealed:
-Resident #2 returned from the hospital with no new orders.

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-The RP requested a fall alert alarm and was informed they were not used in the SCU.
-The RP was concerned about Resident# 2's recent falls.
-Resident #2 was on 15-minute checks by staff on 03/26/20.

f. Review of Resident #2's second hospital ER Inpatient Abstract Report dated 03/26/20 was Fall #5 revealed:
-This was the second time on 03/26/20 Resident #2 was sent to the ER for an unwitnessed fall.
-Resident #2 was found on the ground.
-Resident #2 was admitted to the ER on 03/26/20 at 10:52pm.
-Resident #2 had baseline dementia and no evidence of any other trauma or injury.
-Resident #2 was to follow-up with his PCP.
-Resident #2 was discharged from the ER on 03/27/20 at 2:32am.

Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #3.

g. Review of Resident #2's Nursing Event Note Progress Note dated 03/30/20 at 3:15pm revealed:
-Resident #2 was found on the floor by staff.
-Resident #2 complained of right hip pain.
-Resident #2 was on 15-minute checks by staff and found between checks.
-Resident #2 was transported via EMS to the hospital.
-Resident #2's RP was notified of transport.

Review of Resident #2 fifth hospital ER Inpatient Abstract Report dated 03/30/20 revealed:
-Resident #2 was admitted to the ER on 03/30/20

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at 3:21pm.
-Resident #2 had a witnessed fall getting out of bed where he stumbled and fell.
-Resident #2 complained of right hip pain which was tender to palpation.
-Resident #2 was diagnosed with a contusion of his right hip.
-A recommendation was made Resident #2 be evaluated by his PCP for re-evaluation regarding increasing skilled nursing care verses PT/OT.

Review of Resident #2's Nursing Communication Progress Note dated 03/30/20 at 4:39pm revealed the facility had discussed Resident #2's fall with Hospice and his RP.

Review of Resident #2's Nursing Communication Progress Note dated 03/31/20 at 1:12pm revealed:
-Resident #2 had an unwitnessed fall on 03/30/20 and returned from the ER with no new orders.
-An order had been written by Resident #2's PCP for a Hospice consult and transfer to a Skilled Nursing Facility (SNF) for Resident #2.
-Resident #2 was on 15-minute checks by staff.
-The facility had spoken with the PCP, RP and liaison from Hospice and all were aware an order for a Hospice consult and transfer to a SNF had been written.

Review of Resident #2's PCP visit summary dated 03/31/20 at 10:04am revealed:
-Resident #2 had a diagnosis of abnormal gait.
-Resident #2 had at least 6 falls over the prior 2-3 weeks.
-Resident #2 could no longer be cared for at the facility adequately.
-There was a Hospice services referral for Resident #2.

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h. Review of Resident #2's Incident Report dated 04/16/20 was Fall #6 at 3:15pm revealed:
-Resident #2 had an unwitnessed fall and was found in the bathroom.
-Resident #2 sustained an abrasion to his left elbow.
-Resident #2's PCP was notified on 04/16/20 at 6:00pm.
-Resident #2's RP was notified 04/16/20 at 6:00pm.

Telephone interview with Hospice Clinical Director on 07/24/20 at 1:27pm revealed:
-Resident #2 was admitted to Hospice care on 03/13/20 by PCPs order and discontinued from services on 05/05/20.
-A fall mat, wheel walker and wheelchair were delivered to Resident #2 on 04/02/20 and removed from Resident #2 by Hospice on 05/15/20.
-Fall measures were in place on 04/12/20 and Resident #2 was on 15-minute checks per the facility.
-Hospice provided fall prevention education to the facility staff on 04/12/20 including use of the fall mats and placing Resident #2's bed in the lowest position.
-On 04/12/20, facility staff were instructed Resident #2 required fall prevention measures to be in place.

Review of Resident #2's Nursing Ancillary Communication Progress Notes dated 04/21/20 at 3:20pm revealed contact had been made with 32 skilled nursing facilities attempting to find placement for Resident #2.

Review of Resident #2's Nursing Ancillary Communication Progress Notes dated 04/22/20 at 4:18pm revealed contact had been made to 32

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skilled nursing facilities attempting to find placement for Resident #2.

i. Review of Resident #2's Incident Report dated 05/06/20 was Fall #7 at 8:30pm revealed:
-Resident #2 had an unwitnessed fall and was found on the floor in his room.
-Resident #2 sustained no injuries.
-Resident #2's PCP was notified on 05/06/20 at 6:00 AM.
-Resident #2's RP was notified 05/07/20 at 6:00am.
-Final outcome and disposition were to continue to monitor Resident #2 and provide assistance.

Review of PCA Documentation Survey Report for Fall Risk/Safety Intervention frequent room checks revealed there were no documented room checks for Resident #2 on 05/06/20 from 6:00am until 2:00pm.

j. Review of Resident #2's Nursing Orders General Note from eRecord Progress Note dated 05/07/20 was Fall #8 at 4:03am revealed Resident #2 was found on the floor in the hallway in his room with no injuries observed.

Review of the PCP fax notification cover sheet dated 05/07/20 revealed:
-Resident #2 was found on the floor in a lying position in the hallway in his room.
-Resident #2 had no injuries.
-Resident #2 was found lying on his back.

Review of Resident #2's Nursing Ancillary Communication Progress Note dated 05/08/20 at 1:37pm revealed
-The 15-minute checks by staff were continued for Resident #2.
-Resident #2 appeared to be declining and

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required more assistance from staff than he had previously.
-Resident #2 fell on 05/07/20 and was on 15-minute checks by staff were continued for Resident #2.

Review of Resident #2's Nursing Communication Progress Note dated 05/11/20 at 3:26pm revealed:
-Resident #2 remained on 15-minute checks.
-Resident #2 was requiring more hands-on care with bathing, grooming and toileting.
-Resident #2 continued to come out of his room briefly and ambulated short distances in the SCU.

Review of Resident #2's Nursing Ancillary Communication Progress Notes dated 05/11/20 at 3:29pm revealed contact had been made to 9 skilled nursing facilities attempting to find placement for Resident #2.

Review of the PCP visit summary dated 05/12/20 at 11:23am revealed:
-The PCP was concerned about the amount of sedating medications Resident #2 was being administered.
-Staff were to monitor Resident #2 for increased sedation.

Review of the Nursing Ancillary Communication Progress Notes dated 05/14/20 at 2:51pm revealed the facility requested from the PCP paperwork showing that Resident #2 required SNF Level of Care.

Review of the PCP visit summary dated 05/19/20 at 9:44am revealed:
-Resident #2 appeared a little sedated.
-No recent falls were reported.
-He planned to discharge Resident #2 to a SNF

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once it was available.
-Resident #2 had been seen and the PCP had performed a History and Physical in anticipation of Resident #2's move into a 2 person assist facility.

k. Review of Resident #2's Incident Report dated 05/23/20 was Fall #9 at 9:00am revealed:
-Resident #2 had an unwitnessed fall in the hallway.
-Resident #2 sustained no injuries.
-Resident #2's PCP was notified on 05/23/20 at 3:00pm.
-Resident #2's RP was notified 05/23/20 at 3:40pm.
-Final outcome and disposition was to continue to do 15-minute checks on Resident #2.

Review of Resident #2's Nursing Alert Note Progress Note dated 05/23/20 at 3:52pm revealed Resident #2 had an unwitnessed fall, an incident report was completed, and the PCP was notified via fax.

Review of PCA Documentation Survey Report for Fall Risk/Safety Intervention frequent room checks revealed no documented room checks for Resident #2 on 05/23/20 from 6:00am until 2:00pm.

l. Review of Resident #2's Incident Report dated 05/23/20 was Fall #10 at 9:30am revealed:
-Resident #2 had a fallen again and was found in his room.
-Resident #2 sustained no injuries.
-Resident #2's PCP was notified on 05/23/20 at 2:00pm.
-Resident #2's RP was notified 05/23/20 at 4:45pm.
-The final outcome and disposition were to

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continue to monitor Resident #2.

Review of PCA Documentation Survey Report for Fall Risk/Safety Intervention frequent room checks revealed no documented room checks for Resident #2 on 05/23/20 from 6:00am until 2:00pm and Resident #2 had 2 falls during that time.

Review of Resident #2's PCP visit summary dated 06/09/20 at 09:18am revealed:
-Resident #2 appeared a little sedated.
-No falls had been reported recently for Resident #2.

m. Review of Resident #2's Incident Report dated 06/21/20 was Fall #10 at 12:45am revealed:
-Resident #2 had a fall in his room and fell out of his chair.
-Resident #2 sustained right hip pain and a skin tear.
-Resident #2's PCP was notified on 06/21/20 at 2:00am.
-Resident #2's RP was notified 06/21/20 at 1:25am.

Review of Resident #2's PCP fax notification cover sheet dated 06/21/20 revealed:
-Resident #2 fell out of his chair onto his right hip.
-Resident #2 complained of right hip pain.
-Resident #2 was transported to the ER via EMS.

Review of Resident #2's sixth hospital ER Inpatient Abstract Report revealed;
-Resident #2 was admitted to the ER at 1:08am on 06/21/20.
-Resident #2 had a fall out of his chair onto his right hip.
-Resident #2 had tenderness to his right hip.
-Resident #2 had a contusion of his right hip and

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abrasion of the right elbow.

Review of Resident #2's Discharge After Visit Summary on 06/21/20 at 3:33am revealed Resident #2 was to follow-up with his PCP in 1 week.

Review of Resident #2's Incident Report dated 06/21/20 revealed:
-Resident #2 fell out of his chair onto the floor.
-Resident #2 complained of right hip pain.
-Resident #2 was transported to the hospital via EMS.
-Resident #2 had an X-Ray done at the hospital and no fractures were seen.
-Resident #2 had no new orders.
-Resident #2 was to follow-up with his PCP.

Review of Resident #2's Nursing Health Status Note Progress Note dated 07/01/20 at 3:29pm revealed Resident #2's PCP was informed Resident #2's Level of Care was outside of the facilities ability to provide to maintain the resident's safety.

Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #10.

n. Review of Resident #2's Incident Report dated 07/03/20 was Fall #11 at 12:00am revealed:
-Resident #2 had a fall in his room.
-Resident #2 sustain no injuries.
-Resident #2's PCP was notified on 07/03/20 at 6:30am.
-Resident #2's RP was notified 07/03/20 at 12:30am.
-The final outcome and disposition was to continue to monitor and assist Resident #2.

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D 270	Continued From page 25 Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #11. o. Review of Resident #2's Incident Report dated 07/03/20 was Fall #12 at 2:30am revealed: -Resident #2 had a fall in his room. -Resident #2 sustain no injuries. -Resident #2's PCP was notified on 07/03/20 at 6:00am. -Resident #2's RP was notified 07/03/20 at 3:00am. -Final outcome was to continue to assist Resident #2 with Activities of Daily Living (ADL). Observations on the SCU 07/13/20 from 11:27am-11:36am revealed: -Observations from the entryway down the main resident hallway at 11:27am revealed there were two staff in the nurses' station area. -Resident #2's room was the first room on the left side of the hall located closest to the nurses' station. -Resident #2 was in his room slumped face down over the right arm of a chair. -He was wearing a shirt, adult incontinent garment, and non-skid socks. -At 11:36am, after being prompted, two personal care aides (PCAs) had assisted Resident #2 to a sitting position in his chair. Review of PCA Documentation Survey Report Fall Risk/Safety Intervention for frequent room checks for Resident #2 revealed no documented room checks on 07/13/20 from 12:00am until 2:00pm. Telephone Interview with a PCA on 07/13/20 at	D 270		

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D 270	Continued From page 26 11:34am revealed: -She checked on Resident #2 about every 30 minutes because he slid out of his chair "a lot of times." -Resident #2 required assistance from two staff for transfers. -Resident #2 had also been found on the floor by staff "this morning" (07/13/20). Telephone interview with a second PCA on 07/02/20 at 1:30pm revealed: -He had been employed at the facility for 1 year and worked from 2:00pm to 10:00pm. -He had worked on the SCU with Resident #2. -He checked Resident #2 every 15-minute checks. -Staff encouraged Resident #2 to come out of his room. -Staff used a communication sheet to transmit resident information between shifts. -He was informed Resident #2 was on 15-minute checks during walking rounds at shift change by the off going staff and read 15-minute checks on his PCA tablet assignment. -He signed a monitoring sheet to document every 15-minute checks. -Changes to resident care would be updated in the staff tablets. Telephone interview with a third PCA on 07/02/20 at 2:35pm revealed: -She had been employed at the facility for four years and worked 6:00am to 2:00pm shift or 2:00 to 10:00 pm shift. -She had worked on the SCU with Resident #2. -The policy was all residents would be checked every 2 hours unless they were on 15- or 30-minute checks. -She made her own decision and checked her residents every 20 to 30 minutes to make sure	D 270		

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they were safe, there were no safety hazards, dressed and not incontinent.
-When she worked with Resident #2 she checked on him every 20 to 30 minutes.
-If a resident had fallen and was not sent to the ER periodic checks would be continued until the next day.
-An alert would have been put in the computer Progress Notes to notify staff.
-The alert would be put in the computer at the end of the shift by the MA.

Telephone interview with a fourth PCA on 07/23/20 at 2:17pm revealed:
-She had worked at the facility for 7 years on the 6:00am to 2:00pm shift.
-She had worked on the SCU with Resident #2.
-She documented the care residents received on a tablet.
-Resident #2 had been on every 15-minute checks in the past due to falls.
-She knew to perform every 15-minute or 30-minute checks when Resident #2 had a monitoring sheet in the nurses' station.
-Resident #2 had been on 30-minute checks since she start working and she documented each check with her initials on the monitoring sheet in the nurses' station.

Telephone interview with a fifth PCA on 07/23/20 at 3:14pm revealed:
-She had been working at the facility nearly 3 years on the 10:00pm to 6:00am shift and had worked with Resident #2 on the SCU.
-Changes in Resident #2's plan of care would be provided verbally by a Medication Aide (MA).
-Resident #2 was able to perform most of his own care on admission and required extensive assist including 2 person transfers.
-She did not mention what the facilities processes

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were when there was a change in Resident #'2 level of care.
-The MA gave her directions regarding Resident #2's care needs.
-Resident #2 had never been on 15-minute checks and was on every 2-hour checks.
-Resident #2 could not use his call bell.
-The only fall prevention measures that had been instituted for Resident #2 were checking him to make sure he was not having falls during his every 2-hour checks.
-Documentation of Resident #2's checks were completed in the PCA tablet.
-Resident #2 was in a regular bed so it could not be lowered.
-She did not know if Resident #2 was supposed to have a lower bed.

Telephone interview with sixth PCA on 07/24/20 at 1:53pm revealed:
-She had worked on the SCU with Resident #2.
-Sometimes PCAs were told about changes in the residents' care by the facility or outside providers.
-She was not aware of any place where she could find guidance related to changes in Resident #2's care needs.
-Resident #2 needed SNF care, had ambulation limitations and required two people for care assistance at times.
-She did not provide information how long Resident #2 needed two person assistance.
-Resident #2 was at risk of falling and required total care.
-She did not provide information on how long Resident #2 required total care.
-Residents who were identified as at risk for falling just needed a little more help on transfers such as spotting and needed supervision in the shower.
-Resident #2 was not on increased supervision

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checks.
-If Resident #2 was on every 1 hour checks it would be documented on the tablet.
-When Resident #2 experienced a fall and returned from the ER sometimes his vital signs were checked, or he was checked on more often.

Telephone interview with a seventh PCA on 07/27/20 at 11:17am revealed:
-She had provided care to Resident #2 for almost a year.
-Resident #2 was on 15-minute checks and then 30-minute checks after he had fallen.
-Resident #2 had been on 15-minute checks and the 30-minute checks during March 2020 and April 2020.
-Resident #2 currently was on every hour to 2-hour checks.
-Resident #2 was observed to ensure he was in his chair and not on the floor.
-She was informed about changes in Resident #2's care at report during change of shift by the PCA who had provided Resident #2 care or the Special Care Unit Director (SCUD).
-Changes in Resident #2's care should be on the tablet or the MAs would write changes in their computers.
-The MA computers were not for her to read.
-The fall prevention measures for Resident #2 had been to keep him in a chair.
-Resident #2 had a gradual decline in the 2 prior weeks and he had not been ambulating as he had prior.
-MAs documented alerts in their computers.
-Resident #2 never had a fall mat and never had a chair alarm.
-When she made entries to the PCA Documentation Survey Report Fall Risk/Safety Intervention section of the tablet she was documenting that sometime during her shift she

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had checked Resident #2.

Telephone interview with the SCUD on 07/24/20 at 12:25pm revealed:
-Resident #2 was at risk for falls and required every 15-minute checks.
-Resident #2 had not attempted to ambulate the last few weeks.
-Residents were checked every 30 minutes after a fall and for other incidents every 2 hours.
-Resident checks were continued for 24 hours post-fall.
-Resident #2's cowboy boots were removed, and non-slip shoes made available.
-Resident #2 had not fallen out of bed and did not have a fall mat.
-No fall prevention measures had been put in place for Resident #2 after his falls.
-No fall prevention measures were put in place for Resident #2 when he fell out of his bed to the floor.
-He was unaware of any updates to Resident #2's plan of care.
-Resident #2's Level of Care was totally dependent on staff for care.
-He was unaware of alerts in the Progress Notes.
-Alerts would trigger information for the PCA's but the PCA would first have to know the resident had fallen.
-Resident #2 was checked every 2 hours.
-At some time post admission, Resident #2's RP had taken Resident #2 for a CT scan but he did not remember when.

Telephone interview with the Health and Wellness Coordinator on 07/02/20 at 2:03pm revealed:
-She had worked at the facility 12 years and also worked as a MA and PCA.
-She worked all shifts as needed.
-She had worked in the SCU.

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D 270	Continued From page 31 -Residents were checked at least every 2 hours by PCAs. -Documenting resident checks was not required. -Residents with heavy fall histories or 3 falls in a month were placed on fall high risk. -High risk residents were checked every 15 to 30 minutes and the checks were documented on a monitoring sheet in the resident's room or nursing station. -Staff were made aware of the need for 15- or 30-minute checks when they saw the monitoring sheet posted in the resident's room or at the nursing station. -If a resident required 15-minute or 30-minute checks for longer than one month a PT referral would be made. -Once the PT evaluation was completed and the cause of the falls identified checks on the resident would no longer have been performed. -Checks on residents could not be documented in the PCA tablets. -A monitoring sheet was posted in Resident #2's room to track checks. -The MA completed an incident report and notified the resident's PCP and RP of falls. -She was unaware of how staff were informed of changes in resident monitoring, how a determination was made to change the frequency of resident checks or when checks would be instituted. Second telephone interview with the Health and Wellness Coordinator on 07/24/20 at 11:30am revealed: -Resident #2 was not on any increased supervision. -Falls for Resident #2 should have been documented in the computer Progress Notes as an alert notifying the MA to increase supervision, document on the resident for 3 days and updated	D 270		

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the staff communication sheet used for walking rounds.
-Alerts placed in the computer did not display on the PCA tablets.
-After a resident had fallen, the resident would have been checked every 30 minutes to an hour through the night.
-The next day the staff would have watched the resident.
-The facility had no policies directing resident monitoring or checking residents post falls.
-Staff developed their own procedures for resident monitoring or checking residents post falls.
-Resident monitoring needs were told to the PCAs and MAs.
-The facility did not monitor to ensure checks were completed by the PCAs or MAs.
-PCAs did not document resident checks.
-The fall prevention measures that were instituted for Resident #2 were to move furniture out of his pathway and to check him when he walked down the hall to make sure he had not fallen.
-At one time Resident #2 was on 15 to 30-minute checks but she could not remember when or for how long.
-She had never observed Resident #2 being excessively sedated or sleepy.

Telephone interview with the Hospice Clinical Director on 07/10/10 at 3:02pm revealed:
-Resident #2 received Hospice services from 03/31/20 to 05/05/20.
-Resident #2 required two staff to perform care.
-Resident #2 was unsteady with ambulation and required stand by assist for transfers.
-Resident #2's high number of falls was included as a reason for Hospice service requests.
-Hospice received a referral for services on 07/01/20 and Resident #2 was deemed not

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appropriate for care as his behaviors were stabilizing and he was talking.

Telephone interview with the Director of Resident Care (DRC) on 07/02/20 at 12:30pm revealed:
-Resident #2 was identified as requiring extensive care and attempts were made to transfer him to a SNF.
-PCAs used a tablet to document all resident care.
-PCAs opened their tablet at the beginning of their shift to locate their assignment.
-It was challenging to ensure enough staff to provide care to the residents.
-Residents were checked every two hours.
-Fall measures to include fall mats and chair alarms had never been used for Resident #2.

Telephone interview with Resident #2's RP on 07/14/20 at 8:31am revealed:
-Resident #2 had 13 falls in 6 months from 03/21/20 to 07/03/20.
-On admission Resident #2 could drive, shave, toilet and care for himself.
-Resident #2 had no fall mats after he was discontinued from Hospice.
-Resident #2 wore cowboy boots that would drag his feet and he would trip and fall.

Telephone interview with one of Resident #2's PCP on 07/24/20 at 10:55am revealed:
-He had been made aware of all Resident #2's incidents and falls by the facility in a timely manner.
-Resident #2 was highly sensitive to medications and Resident #2's medications have required adjustments when Resident #2 became sedated.
-A fall mat had not been ordered as Resident #2 was not falling out of bed.
-A wheel chair for Resident #2 was inappropriate

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as Resident #2 cognitively would not remember to lock the wheels.

Telephone interview with Resident #2's current PCP on 07/09/20 at 4:00pm revealed:
-Resident #2 had been accepted for care and had his first appointment with her on 06/30/20.
- Ativan was being tapered in an attempt to decrease falls.
-Her expectation was the facility would have standard fall prevention measures in place which would include fall mats and an increase in monitoring.
-Resident #2 was ambulatory and a wheelchair should only be used to push Resident #2 to the dining room or for longer distances.

Interview with the Administrator and Business Office Manager (BOM) on 07/13/20 at 12:34pm revealed:
-Resident #2 had a history of falls; they did not know the date of Resident #2's most recent fall.
-The resident required SNF services and the facility was trying to find placement for the resident at a higher Level of Care.
-Resident #2 was not on an increased supervision schedule and was checked on by staff every two hours which was the facility's standard protocol.
-Resident #2 had not fallen recently and had not required increased supervision.
-The Administrator and BOM did not share what fall preventions they had put in place for Resident #2.

Telephone interview with the Administrator on 07/06/20 at 9:45am revealed:
-Resident #2 required SNF Level of Care since fall #5.
-A discharge notice had been sent to Resident

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#2's RP in March 2020 based on Resident #2's aggressive behaviors and decreased condition.
-Resident #2 had periods of aggressive behavior March 2020 through April 2020 and had been on checks throughout this time period for safety related to aggressive behaviors.
-Resident #2 had not been on checks since April 2020 following adjustments to his medication and cessation of his aggressive behaviors.
-Resident #2 changed PCP last week and the new PCP ordered Hospice.
-Hospice evaluated the resident 07/01/20 and did not accept him for service as he no longer needed Hospice services.

Second telephone interview with the Administrator on 07/27/20 at 10:12am revealed:
She had been the Administrator for 3 years.
-The facility had followed the Fall Prevention policy to prevent falls.
-When a resident fell the MA, RCC or Health and Wellness Coordinator would evaluate for visual signs of injury.
-After a resident fell their PCP would be notified .
-An alert would be put in the computer to notify the PCAs.
-The frequency of resident fall supervision checks, and length of time checks were to be conducted, would be decided by the PCP, the post fall illness and what management decided was reasonable based upon needs of other residents in the facility.
-A clipboard was posted outside or in the resident's room if residents were on specific time checks and staff initialed the monitoring sheet on the clipboard when they had checked on the resident.
-The monitoring sheets for Resident #2 were not available for review.
-The nursing team had been responsible for

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D 270	Continued From page 36 conducting investigations when a resident had 2 or more falls in 30 days. -Any changes in care plans and updates identified during the investigation were placed in the PCA tablets. -She had no explanation as to why there were no changes to Resident #2's care plan related to his decline and PCA statements Resident #2 required increased care after his admission to the facility. -Reassessments would be done as needed clinically and changes in status and care would not prompt a reassessment of the resident's care needs and plan. -Resident #2 had a Level of Care review in May 2020 and the facility would follow policies regarding reassessing Resident #2. -The tablet would have alerted a PCA to conduct 15 minute and 30-minute checks on Resident #2. -The Administrator had no explanation as to why staff did not know or had not seen any alerts in their tablets . _She would have to look at the "facilities system." -Resident #2 had been on increased supervision checks over a couple of months but she did not have the exact dates. -She did not know if Resident #2 was on increased supervision checks. -She did not know of any fall prevention or monitoring measures were in place for Resident #2. -Training on fall prevention had been offered annually. -Prior to 07/01/20 staff were trained on fall prevention using the fall prevention policy. Based on observation, interview and record review, it was determined Resident #2 was not interviewable.	D 270		

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D 270	Continued From page 37 2. Review of Resident #3's current FL-2 dated 10/31/19 revealed: -Diagnoses included dementia, Alzheimer's, and vitamin B12 deficiency. -The resident was non-ambulatory and incontinent of bladder and bowels. -The resident's level care was documented as other, special care unit. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility in 2014. -The resident required assistance with dressing, bathing, nail care, toileting, grooming, skin care, and scheduling appointments. -The resident used a wheelchair. Review of Resident #3's current Assessment and Care plan dated 04/16/20 revealed: -The resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -The resident had daily incontinence of bowel and bladder. -The resident had significant memory loss and must be directed. a. Review of Resident #3's Incident/Accident reported dated 05/15/20 revealed: -The resident had a witnessed fall on 05/15/20 was Fall #1 at 8:15am. -The resident had received a head laceration to the left side of her forehead. -The resident was sent to the Emergency Room (ER). Review of the hospital ER Records for Resident #3 dated 07/09/20 revealed: -On 05/15/20 at 8:54pm Resident #3 presented to	D 270		

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the ER with a complaint of a fall and head laceration.
- Patient had mechanical ground level fall; she struck her head and the patient has a large deep laceration on her forehead.
-The ER physician had applied sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision) to a deep jagged forehead laceration.
-The resident was discharged back to the facility on 05/15/20.

Review of the electronic progress note for Resident #3 dated 05/16/20 at 12:33am revealed the resident was returned to the facility from her trip to the ER and she was resting in bed.

Review of the electronic progress note for Resident #3 dated 05/17/20 at 5:01pm revealed the resident was doing well and still on quarantine; vital signs were taken, and the resident had no complaints.

Review of the electronic progress note for Resident #3 dated 05/18/20 at 7:31pm revealed the resident was in bed resting and had a discoloration on her left eye and lower top lip; the bandage was intact on left forehead and the resident appeared to be ok, vital signs were taken.

Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #1.

b. Review of Resident #3's Incident/Accident report dated 07/09/20 revealed:
-The resident had an unwitnessed fall on 07/09/20 was Fall #2.

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D 270	Continued From page 39 -The resident had received a laceration to the left side of the forehead and forearm. Review of the hospital ER Records for Resident #3 dated 07/09/20 revealed: -On 07/09/20 at 1:50pm, Resident #3 presented to the ER with a complaint of an unwitnessed fall. -Patient had unwitnessed fall from wheelchair, laceration noted to left forehead and skin tear to the left posterior hand. -The resident had two lacerations to her left forehead. -One above the left eyebrow that was 2cm and the other laceration was 3cm on the left forehead approaching the left scalp line. -The ER physician had applied 3 sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision) to the laceration above the left eyebrow. -The ER physician had applied 4 sutures to the laceration on the left forehead approaching the left scalp line. -The resident was discharged back to the facility on 07/09/20 at 7:29pm. Review of the PCA Documentation Survey Report revealed there was no documentation of frequent room checks or safety checks/interventions after Fall #2. Interview with the Primary Care Physician (PCP) Social Worker on 07/16/20 at 4:02pm revealed: -The PCP was notified of Resident #3's fall on 05/15/20. -The PCP was notified that Resident 3 had fallen on 07/09/20 out of her wheelchair and had 2 lacerations to her head. -She did not know the PCP's expectation of being notified of falls.	D 270		

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D 270	Continued From page 40 Telephone interview with the Director of Resident Care (DRC) on 07/02/20 at 12:30pm revealed: -PCAs used a tablet to document all resident care. -PCAs opened their tablet at the beginning of their shift to locate their assignment. -It was challenging to ensure enough staff to provide care to the residents. -Residents were checked every two hours. Telephone interview with the Health and Wellness Coordinator on 07/24/20 at 11:30am revealed: -Alerts placed in the computer did not display on the PCA tablets. -After a resident fell, the resident would be checked every 30 minutes to an hour through the night. -The facility had no policies directing resident monitoring or checking residents post falls. -Staff developed their own procedures for resident monitoring or checking residents post falls. -The facility did not monitor to ensure checks have been completed by the PCAs or MAs. -PCAs did not document resident checks. -She did not have information on Resident #3's falls on 05/15/20 and 07/09/20. Interview with the Administrator on 07/27/20 at 10:12am revealed: -The facility had followed the Fall Prevention policy to prevent falls. -When a resident fell, the medication aide (MA), DRC or Health and Wellness Coordinator would evaluate. -When a resident fell, their PCP would have been notified. -An alert was put in the computer to notify the PCAs. -The frequency of resident fall supervision	D 270		

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D 270	Continued From page 41 checks, and length of time checks were to be conducted was been decided by the PCP, the post fall illness and staffing needs. -PCA and MAs were monitored by the SCUD to ensure fall monitoring occurred. -Changes in care plans and updates were placed in the PCA tablets. -Reassessments would be done as needed clinically and changes in status and care would not prompt a reassessment of the resident's care needs and plan. -She had no explanation as to staff statements they did not know or had not seen any alerts in their tablets and responded she would have to look at the facilities system. -Training on fall prevention had been offered annually. -She did not have information on Resident #3's falls on 05/15/20 and 07/09/20. Based on interviews and record reviews, it was determined Resident #3 was not interviewable. _____ The facility failed to provide supervision for 2 of 3 sampled residents (#2, #3) who had several falls. The facility's failure to supervise residents resulted in Resident #2, who resided in a special care unit experienced multiple falls with injuries resulting in pain, contusion, abrasion, and skin tear; Resident #3 who multiple falls that resulted in head lacerations that required sutures. The facility's failure to supervise Residents #2 and #3 placed the residents at substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/20 for this violation.	D 270		

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D 270	Continued From page 42 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 26, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure notification of the primary care provider for 1 of 3 sampled residents (#3) related to a positive COVID-19 (a deadly viral pandemic) test; and failed to arrange a follow up appointment via telehealth for the resident following a fall with injury that resulted in an emergency room visit due to a head laceration that required sutures (#3). The findings are: Review of Resident #3's current FL-2 dated 10/31/19 revealed: -Diagnoses included dementia, Alzheimer's, and vitamin B12 deficiency. -The resident was documented as non-ambulatory. -The resident's level care was documented as other, Special Care Unit (SCU). Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility in 2014,	D 273		

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the day and month was not documented.
-The resident required assistance with dressing, bathing, nail care, toileting, grooming, skin care, and scheduling appointments.
-The resident used a wheelchair.

Review of Resident #3's Care plan dated 04/16/20 revealed:
-The resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident had significant memory loss and must be directed.

a. Review of Resident #3's Incident and Accident report dated 07/09/20 revealed:
-The resident had an unwitnessed wall on 07/09/20.
-The resident had a laceration to the left side of the forehead and forearm.

Review of the hospital Emergency Room (ER) Records for Resident #3 dated 07/09/20 revealed:
-On 07/09/20 at 1:50pm Resident #3 presented to the Emergency Department with a complaint of an unwitnessed fall.
- "Patient had unwitnessed fall from wheelchair, laceration noted to left forehead and skin tear to the left posterior hand.
-The resident had two lacerations to her left forehead."
-One above the left eyebrow was 2cm and the other laceration was 3cm on the left forehead approaching the left scalp line.
-The ER physician had applied 3 sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision) to the laceration above the left eyebrow.
- The ER physician had applied 4 sutures to the

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laceration on the left forehead approaching the left scalp line.
-The resident was discharged back to the facility on 07/09/20 at 7:29pm.
-The ER physician discussed the discharge disposition with the resident.

Telephone interview with Resident #3's Primary Care Physicians (PCP) social worker on 07/16/20 at 4:14pm revealed:
-The resident had a telehealth follow-up appointment from her ER visit on 07/09/20 scheduled with her PCP on 07/15/20 at 3:00pm.
-The PCP had received the discharge instructions from the resident's ER visit on 07/09/20.
-The discharge instructions had documented the resident needed to follow-up with the PCP within a week.
-The resident missed her follow-up appointment on 07/15/20 at 3:00pm.
-The facility did not call the PCP's office for the resident's telehealth appointment.

Telephone interview with Resident #3's PCP on 07/15/20 at 4:21pm revealed:
-The facility called and cancelled the resident's appointment because they did not have anyone to facilitate the telehealth appointment.
-The resident's appointment should have been kept because the resident had stitches and needed to be checked for removal in 7 days after they were applied.
-She was concerned with the resident missing her appointment because she had not seen the resident since her fall on 07/09/20.
-She was concerned that the resident's stitches could become infected without follow up.

Interview with the Administrator on 07/27/20 at 10:19am revealed:

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-The front desk staff and the activity team were responsible for assuring telehealth appointments were completed.
-The front desk staff would be notified by families or physicians of telehealth appointments.
-The front desk staff would notify the activities team, that included the Activity Director and two activity assistants.
-The activities team would facility the telehealth appointment by calling the PCP on a tablet and taking the tablet to the resident's room.
-If the activities team was unavailable the Business Office Manager was the back up to facilitate the resident's telehealth appointments.
-Resident #3's appointment was cancelled on 07/15/20 due to staffing issues.
-She did not have staff available to facilitate the telehealth appointment for the resident.
-They had rescheduled Resident #3's follow-up appointment to 07/22/20.

b. Review of handwritten documentation provided by the Administrator on 07/14/20 at 11:10am identified as the list of residents with positive COVID-19 diagnoses revealed Resident #3 was COVID-19 positive.

Review of a local laboratory COVID-19 test report for Resident #3 dated 07/09/20 revealed the results were "Detected Critical".

Review of the hospital Emergency Room Records for Resident #3 dated 07/09/20 revealed a family member called the Emergency Room, reported residents with coronavirus that were in the nursing facility in close proximity to her and is requesting COVID-19 screening.

Telephone interview with Resident #3's PCP on 07/15/20 at 4:21pm revealed:

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D 273	Continued From page 46 -She received a call from the resident's family member on 07/13/20 the resident had been tested for COVID-19 at the ER and she was positive for COVID-19. -She was not notified by the facility that the resident was positive for COVID-19. -She had expected to be notified immediately by the facility that the resident was positive for COVID-19. -She was concerned the resident could have come into her office to have her sutures removed. -She needed to assess the resident to determine if she had any COVID-19 related symptoms. Interview with the Administrator on 07/27/20 at 10:19am revealed: -PCP's were notified when a resident was positive for COVID-19 in 24 hours. -The previous Director of Resident Care (DRC) was supposed to fax the positive lab results to each resident's PCP. -She did not know when the DRC notified Resident 3's PCP of the positive COVID-19 results. -She was told by the DRC that Resident #3's PCP was notified. -She did not know when and she had not received a fax confirmation to confirm the PCP was notified. -She had faxed Resident #3's positive COVID-19 results to her PCP on 07/22/20. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. _____ The facility failed to coordinate and ensure 1 of 3 residents sampled (#3) received health care services necessary to maintain their physical health and well-being by failing to notify the PCP	D 273		

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D 273	Continued From page 47 of Resident #3's positive COVID-19 test results which resulted in the resident's COVID-19 diagnosis to not be managed by her PCP and a failure to arrange a follow up appointment via telehealth for the resident following a fall with injury that resulted in a Emergency Room visit and a head laceration that required sutures. The facility's failure was detrimental to the health, safety and well-being of Resident #3, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/20 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2020.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect to the residents during the global coronavirus (COVID-19) pandemic for reduction	D 338		

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D 338	Continued From page 48 of infection and transmission of COVID-19 as related to the failure to maintain a system to identify the facility's protective equipment (PPE) requirements and strategies to ensure recommended PPE was available for staff use, staff using and reusing the same gowns and face shields when providing direct care to residents with COVID-19 diagnosis and without COVID-19 diagnosis, and use of PPE by staff and residents and practicing social distancing on the special care unit (SCU). The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed: -Implement social distancing of at least six feet apart among residents. -If COVID-19 is identified in the facility, restrict all residents to their rooms. -Residents with known or suspected COVID-19 should be cared for using recommended PPE including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N-95 mask is not available. -Facilities should be in communication with local health, state, and federal public health partners and emergency preparedness partners to identify PPE needs and additional PPE supplies. -Facilities along with their health care coalitions, local and state health departments, and local and state partners should work together to develop strategies that identify and extend PPE supplies, so that recommended PPE will be available when needed most. Review of the CDC strategies for optimizing the supply of eye protection and selected processes	D 338		

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for reprocessing eye protection revealed:
-When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider: While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
-Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
-Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
-Fully dry (air dry or use clean absorbent towels).
-Remove gloves and perform hand hygiene.

Review of the CDC strategies for optimizing the supply of isolation gowns revealed:
-Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same health care personnel when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort).
-This can be considered only if there are no additional co-infectious diagnoses transmitted by contact.

Review of the CDC Considerations for Memory Care Units in Long-term Care Facilities revealed:
-Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated).
-Cloth face coverings should not be used for anyone who has trouble breathing, or is

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unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
-Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel.

Interview with a Nursing Assistant (NA) on 07/02/20 at 2:35pm revealed:
-The special care unit (SCU) Director had not been feeling well and was out due to COVID-19.
-Staff and residents on the SCU were being tested for COVID-19 today (07/02/20).

Interview with the Administrator on 07/13/20 at 11:09am revealed all residents currently in the facility with a COVID-19 diagnosis resided in the SCU.

Review of handwritten documentation provided by the Administrator on 07/13/20 at 11:10am identified as the list of residents with positive COVID-19 diagnoses revealed:
-Eight residents residing in the SCU in room numbers #226, #234, #235, #238, #240, #242, and one resident in the assisted living section in room #218 had tested positive for COVID-19.
-Three of the nine residents who had tested positive for COVID-19 and resided in resident rooms #226, #242, and #218 were currently out of the facility.

Observation of a supply closet that contained the facilities PPE on 07/13/20 at 11:50am revealed:
-The Administrator had to unlock the door to enter the closet.
-There was a stack of about 30 or more respirator face mask visible on a filing cabinet.
-There was a large square box labeled "N95

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masks" that was closed, the contents were not visible.
-There was a box that contained about 50 or more face mask.
-There was a large square box of about 30 or more face shields.
-There were 3 large square boxes labeled "Face Shield", the contents were not visible.
-There was a large bag that contained blue plastic gowns.

Interview with the Administrator on 07/13/20 at 11:55am revealed:
-The supply closet that contained the PPE remained locked and only the Administrator and the supervisor had a key to the supply closet.
-The PPE in the closet was the only PPE in the entire building that had been available for staff use.

Interview with a staff member on the second floor of the assisted living section on 07/13/20 at 11:19am revealed:
-There were residents in the SCU who had been diagnosed with COVID-19.
-When staff were on the SCU, they were supposed to wear the following PPE: gown, gloves, face shield, bootie shoe covers, and an N-95 respirator mask.
-All residents (to include residents in the SCU and assisted living section) were supposed to stay in their rooms and were not supposed to be the hallways without a mask.
-Staff re-directed and reminded residents to wear a mask and to go back to their rooms.

Interview with a personal care aide (PCA) working on the SCU on 07/13/20 at 11:41am revealed:
-All the residents on the SCU did not have or wear masks.

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-Residents on the SCU who tested positive for COVID-19 had masks but did not wear their masks all of the time.
-All residents on the SCU were supposed to be staying in their rooms.

Interview with a second PCA working on the SCU on 07/13/20 at 11:41am revealed:
-Staff working on the SCU unit changed their gowns and shields only when they were leaving the SCU.
-Staff did not change their gown and shields when going from rooms of residents who had a positive COVID-19 diagnosis to resident rooms who were not diagnosed with COVID-19.
-The staff's face shields were saved and reused.

A second interview with the second PCA on the SCU on 07/13/20 at 11:50am revealed:
-The residents on the SCU did not have masks and did not wear masks or other PPE.
-Staff tried to keep the residents in the SCU in their rooms.

Observations on the SCU 07/13/20 from 11:27am-12:14pm revealed:
-The SCU was located on the second floor of the facility.
-Observations from the entryway down the main resident room hallway at 11:27am revealed there were two staff in the nurses' station which was located at the opposite end of the hallway.
-The nurses station was enclosed with glass windows and the door was closed.
-At 11:29am, a resident who was not wearing a mask entered the hallways from resident room #228 using a rollator to ambulate in the hallway; there was no staff present to redirect the resident to wear a mask or return to her room.
-At 11:30am, a second resident without a mask

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was observed sleeping on a sofa in the hallway located between resident rooms #234 and #236; there was no staff present to redirect the resident to wear a mask or return to her room. The resident was still asleep on the sofa at 12:14pm and was not reminded and/or prompted by staff at any time between 11:30am-12:14pm to wear a mask or return to her room.
-At 11:31am, a third resident without a mask was ambulating in the hallways near the sofa where the resident was asleep (for a total of 3 residents in the hallway); there was no staff present to redirect the resident to wear a mask or return to her room.
-At 11:41am, a staff identified as a medication aide (MA) walked down the main resident hallway and exited the SCU prior to removing her PPE which consisted of a N-95 respirator mask and gown that was not closed at the back and exposed her clothing. The MA was not wearing a face shield.
-At 11:43am, a PCA pushed a resident in a wheelchair into resident room #238 (the resident in room #238 was identified as having tested positive for COVID-19).
-The PCA left room #238 and walked back down the hall; she did not change her gown, or face shield after exiting room #238.
-At 11:44am, two female residents from rooms #229 and #230 who were not wearing masks were sitting side by side in chairs in the main hallway without practicing social distancing of at least 6 feet apart; there were no staff present to redirect the residents to wear a mask or return to their room.
-At 12:00pm, the residents were still sitting side by side when one of the two female residents coughed without using cough etiquette; there was no staff present to prompt or redirect either resident. The two residents were observed to still

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D 338	Continued From page 54 be seated in this manner at 12:14pm. -At 11:45am, Resident #1 was sitting in her wheelchair outside of her room in the main hallway. She was not wearing a mask; there was no staff present to redirect the resident to wear a mask or return to her room. (Resident #1 was identified as having tested positive for COVID-19). -From 11:49am-11:51am, there were four residents in the main hallway without masks; two of the four were not practicing social distancing; there were no staff present to redirect the residents to wear a mask or return to their room. -At 11:51am, a PCA was walking in the main hallway and prompted Resident #1 to return to her room; the resident went back into her room. -The PCA did not prompt the other 3 residents to wear a mask, social distance, or return to their rooms. -At 12:05 a PCA exited a COVID-19 positive resident's room without changing her gown, gloves, or face shield and entered resident room #228 (the resident in room #228 did not have a COVID-19 diagnosis). -The PCA removed a plastic covering from the resident in room #228's meal plate while telling the resident that it was time to eat; the resident was not offered or prompted to use hand hygiene prior to eating. -The PCA exited resident room #228 room without changing her gown, gloves, or face shield then proceeded down the hall to continue do deliver beverages to residents in other rooms. -At 12:08pm, the PCA served beverages to the two residents who had been sitting side by side in the hallway and they began eating their meal. -The residents were not offered or prompted to use hand hygiene prior to eating and were not prompted to return to their rooms.	D 338		

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D 338	Continued From page 55 Interview with the dietary aide on 07/13/20 at 12:10pm revealed: -She did not deliver meals to the rooms of the residents who were "quarantined" with COVID-19. -The PCAs delivered meals to the residents diagnosed with COVID-19. -When leaving the SCU, PPE was removed outside of the exit door in a designated room and disposed of in the trash can outside the door. Observation on 07/13/20 at 12:14pm revealed: -The room identified by the dietary aide for PPE removal was located directly across from the entrance door to the SCU. -The door was closed and there was a trash can in the hallway between the SCU entrance and entrance into the room. -Upon entrance into the room, beauty shop equipment was observed along with multiple bags labeled with staff names; PPE face shields were visible in some of the labeled bags. Interview with the Administrator and Business Office Manager (BOM) on 07/13/20 at 12:34pm revealed: -They acknowledged staff were not changing PPE on the SCU when going from rooms with residents who had a COVID-19 diagnosis to rooms with residents who had not been diagnosed with COVID-19. -Staff changed PPE only when it was dirty, soiled, or showed signs of wear (no additional information provided related to signs of wear). -The facility had a limited supply of PPE; they were short on gowns and the gowns were "hard to get." -The Administrator had reached out to the facility's corporate office today (07/13/20) to request additional PPE. -Additional PPE should be arriving at the facility	D 338		

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this week (date unknown).
-The LHD was aware of the facility's PPE supply.
-The Administrator had shared with the LHD the interventions implemented by the facility related to preventive measures for COVID-19 and the LHD told her to continue what they were doing.
-When the Administrator had spoken to the LHD she did not ask if the reuse of PPE on the SCU between COVID-19 positive and COVID-19 negative residents was acceptable.
-She did not know if the LHD had provided guidance on the reuse of PPE on the SCU.
-Residents who resided in the assisted living area of the facility had been given masks, told to wear the masks when they were outside of their rooms, and asked not to visit in other residents' rooms.
-Residents and staff had been told to use social distancing of 6 feet or more for less than 10 minute time frames unless staff were providing hands on personal care to residents.
-There were signs up in the facility to remind residents to wear masks, practice social distancing, and to stay in their rooms.
-Some residents refused to wear a mask, but staff reminded and encouraged them to wear the masks, use social distancing, and to stay in their rooms.
-She expected staff to be reminding and re-directing residents about use of a mask, social distancing, and staying in their room.
-Residents in the SCU were not using masks because the residents had not been able to keep the masks on.
-Staff on the SCU were expected to re-direct residents if they were not social distancing and/or were out of their rooms.

Interview with the Communicable Disease Nurse from the Local Health Department (LHD) on 07/13/20 at 3:12pm revealed:

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D 338	Continued From page 57 -She was notified by the facility on 07/05/20 that 4 residents were confirmed COVID -19 positive. -She was not aware of the facility's reuse of PPE. -Reuse of PPE was not best practice and the LHD did not endorse that. -She was notified today, 07/13/20, by the Administrator of their shortage of PPE. -She would expect to be notified immediately of any shortage of PPE. -She had a contact with an outside provider that would assist the facility with PPE if there was a shortage. -There should always be 14-day supply of PPE available in the facility. -She had directed the facility's Administrator to the CDC guidelines for social distancing and redirecting residents. Interview with a nursing assistant (NA) who worked on the SCU on 07/23/20 at 1:53pm revealed: -Staff on the SCU used PPE which included mask, gowns, face shields, and gloves. -She wore the same mask, gown, and face shield daily. -She would only replace her mask, gown, and face shield if it was dirty or if it broke. -She would put her mask, gown, and face shield in a paper bag with her name on it at the end of her shift and would use the same mask, gown, and face shield the next day she worked. -Her mask, gown, and face shield was not cleaned or disinfected. Interview with a PCA on 07/23/20 at 2:17pm revealed: -She used a separate gown for providing direct care to COVID-19 positive residents and COVID-19 negative residents. -She used the same mask for the assigned floor	D 338		

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she worked.
-PPE was only changed if soiled or broken.
-PPE was kept, stored in a bag with the staff's name, and reused the next day.
-Gowns were reused the next day.

Interview with a medication aide on 07/23/20 at 2:44pm revealed:
-The staff did not have access to the locked supply closet that contained the facility of PPE.
-If her PPE was soiled or torn over the weekend, she would have to continue to use the same PPE.
-There was not new or clean PPE available for the staff to use on the weekend.

Interview with another PCA on 07/23/20 at 3:21pm revealed:
-She stored her PPE in a bag with her name on it and reused it the next day.
-She had gowns for positive residents and negative residents.
-She did not feel it was safe to reuse PPE.
-She had used the same mask, gown, and face shield for a total of four days consecutively.

Interview with the Health and Wellness Coordinator on 07/24/20 at 11:45am revealed:
-The facilities supply of PPE was located in a supply closet on the first floor of the building.
-Only management had a key to the supply closet.
-When management was not in the building on the weekend or at night, clean PPE was left at the nurses station.
-She had not received any reports that staff did not have access to clean PPE when it was needed.
-Prior to the start of the survey, all staff on the SCU were only changing their masks, face shields, and gowns every 3 days or immediately if

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D 338	Continued From page 59 it became soiled or torn. -Staff on the SCU would store their mask, face shield, and gown in a paper bag with their name on it at the end of their shift to reuse the next time they worked. -The staffs' gowns, masks, and face shields were not cleaned or disinfected prior to storage or reuse. -Staff began changing their masks, face shields, and gowns out every day a few days ago (no date provided). Interview with the SCU Director on 07/24/20 at 12:31pm revealed: -There were now twenty-four residents on the SCU who were COVID-19. -These results were from tests conducted last week. Interview with the Administrator on 07/27/20 at 10:14am revealed: -Prior to the start of the survey and the facility receiving more masks, face shields, and gowns (no date provided), staff on the SCU were reusing their masks, face shields, and gowns for several days. -Staff on the SCU would store their mask, face shield, and gown in a paper bag with their name on it for reuse on their next shift. -The masks, face shields, and gowns were not cleaned or disinfected prior to placing them into the bag or after removing from the bag for reuse. -Staff were told to change out their mask, face shield, and gown only when they were soiled or torn. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and North Carolina Department of Health and	D 338		

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D 338	Continued From page 60 Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic. The facility failed to implement and maintain a process to ensure personal protective equipment (PPE) was available in sufficient quantity for staff use resulting in reuse of gowns and face shields by staff for multiple shifts/days without cleaning or disinfecting and staff wearing the same gowns and face shields when caring for residents with COVID-19 diagnosis and residents without COVID-19 diagnosis; and failed to prompt residents to wear masks and practice social distancing in the special care unit (SCU) in which 24 residents were diagnosed with COVID-19. The facility's failure placed all residents at increased risk for infection and transmission of the deadly COVID-19 virus and placed the residents at substantial risk for serious serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/14/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 26, 2020.	D 338		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical	D 451		

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D 451	Continued From page 61 evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the county Department of Social Services of 5 of 6 resident incidents requiring referral for emergency medical evaluation or treatment for 1 of 1 resident's sampled (#2). The findings are: Review of the facilities policy titled Incident Reporting and Investigation effective date 09/01/20 revealed: -An incident was defined as an unusual or unexpected event that was not consistent with the routine operation of the community or routine care of, or services provided to, a resident; an event involving a resident with unintended, undesirable or unexpected results or outcomes; or a Reportable Incident. -A Reportable Incident was defined as an incident or adverse event that was serious in nature and required by applicable statute or regulation to be reported to outside state and/or federal agencies, such as the local Department of Social Services (DSS). -Unless defined differently by applicable state law/regulation reportable Incidents included any resident injury requiring treatment in an acute care setting. -Unless defined differently by applicable state law/regulation reportable Incidents included any	D 451		

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resident injury of unknown origin (bruise, laceration, etc.).
-Reportable Incidents were reported to the applicable state Department of Health (or similar agency) in accordance with, within the timeframes prescribed by, and using any forms required by, applicable state laws and regulations.

Review of Resident #2's current FL-2 dated 07/01/2020 revealed:
-Diagnoses included dementia, multiple falls and history of subdural hematoma.
-Resident #2 was constantly disoriented, wandered and was injurious of others.
-Resident #2 was ambulatory and incontinent of bowel and bladder.

Review of the Resident #2's Progress Notes revealed:
-A Nursing Communication entry was made on 03/21/20 at 12:26pm that Resident #2 was found on the floor (place not identified) by staff and was transported to the hospital.
-A Nursing Communication entry was made on 03/26/20 at 12:42pm that Resident #2 was found on the floor (place not identified) by staff and was transported to the hospital.
-A Nursing Event Note entry was made on 03/30/20 at 5:15pm that Resident #2 was found on the floor (place not identified) with complaints of right hip pain by the housekeeper and transport to the hospital was initiated.

Review of Resident #2's hospital Emergency Department (ER) Inpatient Abstract Report revealed Resident #2 was admitted to the ER on 03/21/20 at 12:46pm with notation Resident #2 was found on the ground in the morning and expressed pain to left neck and shoulder.

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D 451	Continued From page 63 Review of Resident #2's ER Inpatient Abstract Report revealed Resident #2 was admitted to the ER on 03/21/20 at 10:49pm with notation Resident #2 had fallen from his bed to the floor. Review of Resident #2's ER Inpatient Abstract Report revealed Resident #2 was admitted to the ER on 03/26/20 at 11:47am with notation Resident #2 had an unwitnessed fall and was found on his right side. Review of Resident #2's ER Inpatient Abstract Report revealed Resident #2 was admitted to the Emergency Medical Service (EMS) on 03/26/20 at 10:52pm with notation Resident #2 was sent to the ER for an unwitnessed fall and was found on the ground. Review of Resident #2's ER Inpatient Abstract Report revealed Resident #2 was admitted to the ER on 03/30/20 at 3:21pm with notation Resident #2 had a witnessed fall getting out of bed and complained of right hip pain. Review of the facility Incident Reports from 03/21/20 at 12:46pm to 03/30/20 revealed no reports submitted from the facility to DSS for Resident #2's falls requiring referral for emergency medical evaluation or treatment. Telephone interview with the DSS Adult Home Specialist (AHS) on 07/14/20 at 1:20pm revealed she had not received any notification from the facility of Resident #2's referral for emergency medical evaluation or treatment for incidents that occurred from 03/21/20 at 12:46pm to 03/30/20. Telephone interview with the Health and Wellness Coordinator on 07/24/20 at 12:05pm revealed:	D 451		

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D 451	Continued From page 64 -She was responsible for submitting facility Incident Reports to the county DSS. -Resident incidents were to be reported to the county DSS as specified in the facility policy Incident Reporting and Investigation. -The policy required the facility to submit an Incident Report to the county DSS for fall incidents that had transport to the hospital ER. -She was not able to explain why the county AHS reported DSS had received no report from the facility for Resident #2's fall incident's on 03/21/20 at 12:46pm, 03/21/20 at 10:49pm, 03/26/20 at 11:47am, 03/26/20 at 10:52pm and 03/30/20 at 3:21pm requiring referral for emergency medical evaluation or treatment. Telephone interview with the Administrator on 07/27/20 at 10:45am revealed facility Incident Reports were to be submitted as per the facility incident reporting policy. Based on interviews and record reviews the facility failed to notify the county Department of	D 451		

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D 451	Continued From page 65 Social Services (DSS) of 5 of 6 resident incidents requiring referral for emergency medical evaluation or treatment for 1 of 3 resident's sampled (#2). The findings are: Review of Resident #2's current FL-2 dated 07/01/20 revealed: -Diagnoses included dementia, multiple falls and history of subdural hematoma. -Resident #2 was constantly disoriented, wandered and was injurious of others. -Resident #2 was ambulatory and incontinent of bowel and bladder. Review of Resident #2's current care plan dated 12/10/19 revealed: -Resident #2 had no problems with ambulation and upper extremities. -Resident #2 was continent of both bowel and bladder. -Resident #2 was always disoriented and forgetful requiring reminders. Review of the Resident #2's Progress Notes revealed: -A Nursing Communication entry was made on 03/21/20 at 12:26pm that Resident #2 was found on the floor (place not identified) by staff and was being transported to hospital. -A Nursing Communication entry was made on 03/26/20 at 12:42pm that Resident #2 was found on the floor (place not identified) by staff and was transported to hospital. -A Nursing Event Note entry was made on 03/30/20 at 5:15pm that Resident #2 was found on the floor (place not identified) with complaints of right hip pain by the housekeeper and transport to the hospital was initiated.	D 451		

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	HAL065045	A. BUILDING: _____ B. WING _____	C 07/27/2020

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D 451	Continued From page 66 Review of Resident #2's hospital Emergency Department Inpatient Abstract Report revealed Resident #2 was admitted to the Emergency Department on 03/21/20 at 12:46pm with notation Resident #2 was found on the ground in the morning and expressed pain to left neck and shoulder. Review of Resident #2's Emergency Department Inpatient Abstract Report revealed Resident #2 was admitted to the Emergency Department on 03/21/20 at 10:49pm with notation Resident #2 had fallen from his bed to the floor. Review of Resident #2's Emergency Department Inpatient Abstract Report revealed Resident #2 was admitted to the Emergency Department on 03/26/20 at 11:47am with notation Resident #2 had an unwitnessed fall and was found on his right side. Review of Resident #2's Emergency Department Inpatient Abstract Report revealed Resident #2 was admitted to the Emergency Services on 03/26/20 at 10:52pm with notation Resident #2 was sent to the Emergency Department for an unwitnessed fall and was found on the ground. Review of Resident #2's Emergency Department Inpatient Abstract Report revealed Resident #2 was admitted to the Emergency Department on 03/30/20 at 3:21pm with notation Resident #2 had a witnessed fall getting out of bed and complained of right hip pain. Review of the facilities policy titled Incident Reporting and Investigatio revealed: -An incident was defined as an unusual or unexpected event that is not consistent with the	D 451		

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D 451	Continued From page 67	D 451		

routine operation of the community or routine care of, or services provided to, a resident; an event involving a resident with unintended, undesirable or unexpected results or outcomes; or a Reportable Incident.
-A Reportable Incident is defined as an incident or adverse event that is serious in nature and required by applicable statute or regulation to be reported to outside state and/or federal agencies, such as the local Department of Human Services (DSS).
-Unless defined differently by applicable state law/regulation reportable Incidents include any resident injury requiring treatment in an acute care setting.
-Unless defined differently by applicable state law/regulation reportable Incidents include any resident injury of unknown origin (bruise, laceration, etc.).
-Reportable Incidents are reported to the applicable state Department of Health (or similar agency) in accordance with, within the timeframes prescribed by, and using any forms required by, applicable state laws and regulations.

Review of the county DSS Incident Reports revealed no report from the facility for Resident #2's fall incident's on 03/21/20 at 12:46pm, 03/21/20 at 10:49pm, 03/26/20 at 11:47am, 03/26/20 at 10:52pm and 03/30/20 at 3:21pm requiring referral for emergency medical evaluation or treatment.

Telephone interview with the DSS Adult Home Specialist (AHS) on 07/14/20 at 1:20pm revealed she had not received any notification from the facility of Resident #2's referral for emergency medical evaluation or treatment for incidents that occurred on 03/21/20, 03/26/20 and 03/30/20.

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D 451	Continued From page 68 Telephone interview with the Health and Wellness Coordinate on 07/24/20 at 12:05pm revealed: -Submitting county DSS Incident Report County Reports to the county. -Resident incidents are to be reported to the county DSS as specified in the facility policy Incident Reporting and Investigation. -The policy was that all falls with a transport to the hospital required the facility to submit a DSS Incident Report County Report. -She was not able to explain why the county AHS reported they had received no report from the facility for Resident #2's fall incident's on 03/21/20 at 12:46pm, 03/21/20 at 10:49pm, 03/26/20 at 11:47am, 03/26/20 at 10:52pm and 03/30/20 at 3:21pm requiring referral for emergency medical evaluation or treatment. Telphone interview with the Administrator on 07/27/20 at 10:45am revealed county DSS Incident Reports are to be submitted as per the facility incident reporting policy.	D 451		
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 regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate,	D912		

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D912	Continued From page 69 appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care. The findings are: Based on record reviews and interviews, the facility failed to ensure notification of the primary care provider for 1 of 3 sampled residents (#3) related to a positive COVID-19 (a deadly viral pandemic) test; and failed to arrange a follow up appointment via telehealth for the resident following a fall with injury that resulted in an emergency room visit due to a head laceration that required sutures (#3). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to ensure residents were free from neglect as related to resident rights and personal care and supervision. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of Health and Human Services (NC	D914		

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D914	Continued From page 70 DHHS) were implemented and maintained to protect to the residents during the global coronavirus (COVID-19) pandemic for reduction of infection and transmission of COVID-19 as related to the failure to maintain a system to identify the facility's protective equipment (PPE) requirements and strategies to ensure recommended PPE was available for staff use, staff using and reusing the same gowns and face shields when providing direct care to residents with COVID-19 diagnosis and without COVID-19 diagnosis, and use of PPE by staff and residents and practicing social distancing on the special care unit (SCU). [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Right (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to provide supervision to meet the needs of 2 of 3 sampled residents (Resident #2 and #3) residing in a special care unit who experienced 12 falls from 03/21/20 to 07/03/20 resulting in pain, contusion, abrasion, and skin tear (Resident #2) and a resident experiencing 2 falls, 2 visits to the emergency room resulting in head lacerations that required sutures (Resident #3). [Refer to Tag D270, 10A NCAC 13F .0901(b) Supervision (Type A2 Violation)].	D914		