

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER WEXFORD HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WEXFORD LANE DENVER, NC 28037
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D 000	Initial Comments	D 000		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record review, the facility failed to provide supervision in accordance with the resident's assessed needs, care plan and current symptoms for 1 of 3 sampled residents (Resident #1) related to falls.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 11/18/15 revealed: -Diagnoses included dementia (unspecified) with behavioral disturbances, muscle weakness, abnormality of gait/mobility, aortic valve disorder, endocarditis and fractured left femur on 10/30/15. -Medications included Arixtra 2.5mg (anti-coagulant) SQ (subcutaneously-under the skin) every day for 28 days (start 11/3/15), aspirin 81mg every day (anti-coagulant), Aricept 5mg at bedtime (treatment of moderate to severe dementia in Alzheimer's disease) and Namenda 28mg every day (treatment of moderate to severe</p>	D 270		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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D 270	<p>Continued From page 1</p> <p>dementia in Alzheimer's disease).</p> <ul style="list-style-type: none"> -No information the resident exhibited inappropriate behaviors or was disorientated. -The resident was semi-ambulatory. -No information regarding the use of assistive devices. -The resident was continent of bowel and continent of bladder during the day and incontinent of bladder at night. -The resident required personal care assistance with bathing and dressing. <p>Review of the Resident Register for Resident #1 revealed she had been admitted to the facility on 4/10/14 and had been ambulatory with a walker.</p> <p>Review of Resident #1's current Care Plan dated 2/3/16 revealed:</p> <ul style="list-style-type: none"> -"Significant change in status due to fall." -"Went to the hospital, to rehab and returned to facility." -The resident required extensive assistance with bathing, dressing and toileting and limited assistance with eating and mobility. -No documentation of falls interventions. <p>Observation of Resident #1 on 4/27/16 at 1:30pm revealed:</p> <ul style="list-style-type: none"> -She was sitting in her wheelchair in the lobby with six other residents. -A personal alarm was clipped to the back of her shirt. -A pad alarm had been placed under her in the wheelchair. -She did not interact with the residents around her. -She did not attempt to leave her wheelchair. <p>Review of Resident #1's records from 11/18/15 through 4/23/16 revealed:</p>	D 270		

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D 270	<p>Continued From page 2</p> <ul style="list-style-type: none"> -A total of 22 documented falls. -Five falls with time of the falls unavailable for review. -Three falls occurred on the 7:00am-3:00pm shift. -Ten falls occurred on the 3:00pm-11:00pm shift. -Four falls occurred on the 11:00pm-7:00am shift. -Nine falls occurred in the resident's room. -One fall occurred in the Lobby. -Two falls occurred in the hallway. -Two falls occurred in the dining room with staff present. -Eight falls occurred in the resident's bathroom or as a result of the resident trying to get to the bathroom. -On 11/18/15: Resident #1 had returned to the facility from rehabilitation at a skilled nursing facility for a fractured left femur. -On 11/20/15: She had been found on the floor in her bathroom, no injury noted. She had unhooked her alarm. No post fall interventions noted by the staff. -On 11/22/15: A recommendation from Physical Therapy for a bed alarm, pad for the resident that can be used in the bed and wheelchair for safety due to fall after return to the Assisted Living Facility. -On 11/25/15: The resident had complained of left hip pain, "was crying all night" and sent to the ER at the family's request. X-ray negative. -On 11/28/15: Staff heard her calling "Help" and found her sitting on the bathroom floor. She had been found holding her alarm. No injury noted. No post fall interventions noted by the staff. -On 12/6/15: She had been found on the floor of her room complaining of right hip and leg pain and was sent to the ER. Xray showed osteoporosis but was negative for fracture. No interventions noted by the staff. -On 1/3/16 at 10:00pm: Resident's roommate alerted staff who found resident on the bathroom 	D 270		

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D 270	<p>Continued From page 3</p> <p>floor.</p> <p>-On antibiotics for 10 days for a urinary tract infection.</p> <p>-On 1/15/16 at 1:00pm: She stood up from wheelchair in the Lobby and had fallen over sideways. No injury noted.</p> <p>-On 1/29/16: She had gotten out of bed and fallen. No injury noted. She had turned off her alarm and was not wearing hipsters (they were in the laundry). Staff changed the battery in the alarm.</p> <p>-On 2/9/16: A physician's order to discontinue the Aricept and Namenda.</p> <p>-On 2/19/16 at 8:00am: She had been found on the floor of doorway to the shower room (hallway). No injury noted.</p> <p>-On 2/26/16 at 4:30pm: She had been found on the floor in front of her closet. No injury noted.</p> <p>-On 2/27/16 at 10:20am: She had been found on the floor of her bathroom. No injury noted.</p> <p>-On 2/29/16 at 6:00pm: She had fallen in the dining room with staff present. No injury noted.</p> <p>-On 3/8/16, there was a staff note stating the resident continues to fall, forgets to call for help or use wheelchair locks.</p> <p>-On 3/11/16 at 12:00am: She had been found on floor of her room, attempted to go to the bathroom. No injury noted.</p> <p>-On 3/16/16 at 4:00am: She had been found on the floor of her room. No injury noted.</p> <p>-On 3/16/16, a physician's order for an xray of the pelvis and left hip due to pain (reported by PT) and fall. Results: No injury noted.</p> <p>-On 3/23/16: A signed physician's order for a personal alarm.</p> <p>-On 3/25/16 at 8:00pm: She had been found on the floor in the hallway outside her room (needed the bathroom). No injury noted.</p> <p>-On 4/5/16 at 12:00am: She had been found on floor of her bathroom with a scalp laceration, to</p>	D 270		

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D 270	<p>Continued From page 4</p> <p>ER for sutures. CT scan of head: negative.</p> <p>-On 4/5/16: The ER physician suggested a follow-up with the resident's physician to discuss the resident's need for a higher level of care. The facility staff notified the attending physician who wrote an order stating the resident needed skilled care.</p> <p>-On 4/6/16 at 3:15pm: She had been found sitting on the floor of her room against the wall. No injury noted.</p> <p>-On 4/6/16 at 4:30pm: She had been found on floor in her room in front of her wheelchair. No injury noted.</p> <p>-On 4/7/16 at 8:00pm: She had been found on the floor of her room. No injury noted.</p> <p>-On 4/8/16 at 6:15pm: She had been found on floor in her bathroom. No injury noted.</p> <p>-On 4/9/16 at 10:15pm: She was heard yelling for help from her room and had been found sitting on a floor mattress (falls pad by the bed) leaning against her bed. No injury noted.</p> <p>-On 4/15/16 at 5:15pm: She had gotten out of her chair in the dining room and fell with staff present. No injuries noted.</p> <p>-On 4/16/16 at 5:45am: She had been found on floor in her room. No injuries noted.</p> <p>-On 4/23/16 (no time noted): Another resident pushed a wheelchair to this resident who got up and fell. No injury noted.</p> <p>Review of Resident #1's fall reports from 11/20/16 through 4/23/16 with follow-up notes made by the Resident Care Director (RCD) revealed:</p> <p>-No falls reports for 11/20/15, 11/28/15 and 12/6/15 available for review.</p> <p>-On 1/3/16 at 10:00pm: No injury noted. No post fall interventions noted by staff. RCD review on 1/4/16: "The Resident's bed had been placed against wall, quarter side rail was in place, bed pad alarm on bed, hipsters (briefs with padded</p>	D 270		

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D 270	<p>Continued From page 5</p> <p>hips used to decrease and/or prevent hip injury), chair pad alarm in wheelchair and family member had brought in a dry erase board to write down reminders such as do not get out of bed and use call light to see if it would aid to decrease likelihood of falls."</p> <p>-On 1/15/16 at 1:00pm: No post fall interventions noted by staff. RCD review on 1/19/16: "Resident has alarms, hipster, bed against the wall and quarter siderail. Unable to retain safety."</p> <p>-On 1/29/16: No falls report available for review.</p> <p>-On 2/19/16 at 8:00am: No post fall interventions noted by staff. RCD review on 2/22/16: "Hipsters on. She turned off alarm (had sounded earlier per staff). Hospice evaluated Resident but was found not to be a candidate for Hospice. All preventive measures are in place to lessen likelihood of injury due to fall."</p> <p>-On 2/26/16 at 4:30pm: No post fall interventions noted by staff. RCD review on 2/29/16:" Hipsters. Alarm. Staff education, bed against the wall and quarter siderail."</p> <p>On 2/27/16 at 10:20am: Chair alarm was not in place and she was not wearing hipsters. No post fall interventions noted by staff. RCD review on 2/29/16: "Staff educated alarms, hipsters, one hour checks, bed against the wall on one side and quarter siderail. Hospice did not pick up-ried."</p> <p>-On 2/29/16 at 6:00pm: No post fall interventions noted by staff. No falls report available for review.</p> <p>-On 3/11/16 at 12:00am: Resident's alarm was going off, hipsters were not on. Staff put on hipsters, the call light was given to the resident and she was reminded to use it. RCD review on 3/15/16: "Alarms, bed against wall, quarter siderail, Hipsters (resident had hidden the hipsters), call light within reach and 30 minute checks from 7:00pm until 7:00am."</p>	D 270		

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D 270	<p>Continued From page 6</p> <p>-On 3/16/16 at 4:00am: Alarm sounding, not wearing hipsters. Staff toileted resident and put on hipsters, placed call light within reach and instructed resident to use it. RCD review on 3/24/16: "Hipsters (unable to locate), alarm sounding, all fall precautions possible in place."</p> <p>-On 3/25/16 at 8:00pm: No post fall interventions noted by staff. No falls report available for review.</p> <p>-On 4/5/16 at 12:00am: No post fall interventions noted by staff. RCD review on 4/11/16: "Stitches to back of head, continued alarms, bed against the wall, Hospice evaluated but not a candidate."</p> <p>-On 4/6/16 at 3:15pm: Alarm had been sounding. Staff moved the resident to the lobby. "RCD review on 4/11/16: Alarms, quarter siderail, bed against wall, preventives in place."</p> <p>-On 4/6/16 at 4:30pm: Resident had removed her alarm, hipsters were on the resident. Staff toileted resident and placed her in the lobby. RCD review on 4/11/16: "Alarms, bed against wall, quarter siderail, preventives in place."</p> <p>-On 4/7/16 at 8:00pm: No post fall interventions noted by staff. RCD review on 4/11/16: "Will have NP (nurse practitioner) re-evaluate [resident's] need for routine Ativan at bedtime."</p> <p>-On 4/8/16 at 6:15pm: The resident's pants were down, hipsters were not on, the wheelchair was not locked and the door to her room was closed. Staff took resident to the lobby "to be around others." RCD review on 4/11/16: "Alarms, quarter siderails, preventives in place. Very confused as usual."</p> <p>-On 4/9/16 at 10:15pm: She was heard yelling for help from her room and had been found sitting on a floor mattress (falls pad by the bed) leaning against her bed. No injury noted. No post fall interventions noted by staff. RCD review on 4/11/16: "Resident usually calls for assist. Will monitor to make sure needs are met."</p>	D 270		

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D 270	<p>Continued From page 7</p> <p>-On 4/15/16 at 5:15pm: No post fall interventions noted by staff. RCD review on 4/15/16: "Level of care increased to Skilled Nursing Facility." -On 4/16/16 at 5:45am: Resident's alarm was sounding. No post fall interventions noted by staff. RCD review on 4/19/16: "MD increased level of care to SNF. Awaiting physician to sign FL2. Family aware." -On 4/23/16: No post fall interventions noted by staff. No falls report available for review.</p> <p>Review of 30 Minute Checklists dated 4/11/16 through 4/26/16 for Resident #1 revealed: -Each 30 minute block contained the location of the resident and the initials of the staff monitoring the resident. -On April 11-12: No documentation for 3:30am until 7:00am. -On April 12-13: No documentation for 7:00pm until 8:30pm. -On April 13: No documentation for 5:00pm until 6:30pm and for 10:30pm through 6:30am. -On April 14: No documentation for 10:00am, 12:30pm, 1:30pm and for 3:00pm until 11:00pm. -On April 15: No sheet had been completed for this day. -On April 16: No documentation for 1:30pm through 6:30am. -On April 17: No documentation for 3:30pm through 6:30am. -On April 18: No documentation for 7:00am through 3:00pm and for 10:00pm through 6:30am. -On April 19: No documentation for 11:00pm through 6:30am. -On April 20: No sheet had been completed for this day. -On April 21: No documentation for 9:00pm through 6:30am. -On April 22: No documentation for 6:00pm</p>	D 270		

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D 270	<p>Continued From page 8</p> <p>through 6:30am. -On April 23: No documentation for 1:00pm through 10:30pm. -On April 25: No documentation for 7:00am through 2:30pm.</p> <p>Review of Physical Therapy (PT) notes in Resident #1's record revealed: -On 11/22/15: A recommendation for a bed alarm, pad for the resident that can be used in the bed and wheelchair for safety due to fall after return to the Assisted Living Facility. -On 1/11/16: The resident was noted "to have increased confusion, had been unable to follow instructions and did not remember how to get back into bed after therapy." -On 3/16/16: The resident was complaining of pain in her groin, vaginal area and hips, 8-10 intensity on the pain scale (10 being most severe). No complaints of pain upon urination. -Note: On 3/16/16, a physician's order for an xray of the pelvis and left hip due to pain (reported by PT) and fall. Results: No injury noted. -On 4/26/16: PT was discontinued, not all goals met. The resident was at maximum rehabilitation potential at that time.</p> <p>Review of a physician's note for Resident #1 dated 3/11/16 revealed: -He had seen the resident for a routine visit. -He did not address the resident's falls.</p> <p>Review of a Progress Note dated 4/3/16 written by the Family Nurse Practitioner revealed: -The Resident had dementia. -She continued to decline physically. -She continued to fall frequently. -It had been recommended that she be transferred to a facility with a higher level of care but the family requested another referral to</p>	D 270		

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D 270	<p>Continued From page 9</p> <p>Hospice.</p> <p>Interview with a Medication Aide on 4/27/16 at 10:25am revealed:</p> <ul style="list-style-type: none"> -The resident had fallen "quite a few times" since admission to the facility. -She had two alarms, one on her wheelchair and one clipped to the back of her clothes which she turned off and removed and the family and the facility leadership was aware and "we put them on anyway." -The Personal Care Aides (PCAs) checked on Resident #1 every 30 minutes and documented where she was and who observed her. -The checklists were reviewed by the Resident Care Director (RCD) and the Lead Supervisor/Medication Aide (MA) for completion. -The alarm batteries could be a problem but they were checked by the Lead Supervisor/MA. -She did not like to wear the hipsters and frequently took them off and hid them and the family, the RCD and the Lead Supervisor were aware of this and we had been told to "put them on anyway." -She heard the resident had been upgraded to skilled care but she was not sure it would really happen since the family wanted the resident to stay at this facility. -She was not aware of an assignment sheet or other means by which the floor staff would know the residents who were falls risks and the interventions that were in place for that resident other than them being told by another co-worker. <p>Confidential interviews with 5 staff regarding Resident #1 revealed:</p> <ul style="list-style-type: none"> -They were not aware of a facility fall policy and/or procedure. -They were aware the resident was a falls risk. -She was on 30 minute checks and the staff filled 	D 270		

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D 270	<p>Continued From page 10</p> <p>out a sheet that noted her location and who saw her there and the time.</p> <ul style="list-style-type: none"> -The staff tried constantly to remind her to ask for help and to lock her wheelchair. -They had been using two alarms on her wheelchair (chair alarm and personal alarm) and an alarm for her bed at night but she took them off, turned them off and hid them in her room. -She frequently removed her hipsters because she didn't like them and frequently hid them in her room. -She had been put on a before and after meals toileting program. -They did not have assignment sheets which identified the residents who were falls risks, on falls precautions or had falls interventions in place. -They kept doing the "same things" (interventions) even though they didn't work for this resident because "the family and management told us to." -Five of five were afraid Resident #1 would fall and be seriously injured. -Five of five felt Resident #1 needed a higher level of care. <p>Interview on 4/27/16 at 2:40pm with the Lead Supervisor/Medication Aide revealed:</p> <ul style="list-style-type: none"> -She was not aware of a facility fall policy or procedure. -She was not aware if other floor staff had received training on a facility policy/procedure regarding falls. -She was aware of what to do if a resident fell from past experiences. -Resident #1 had interventions in place that were purchased by the family such as the alarms, hipsters and a message board. -Despite the many interventions put in place, Resident #1 kept falling. 	D 270		

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D 270	<p>Continued From page 11</p> <p>- "The resident's family had discussed with me basically what I should do for the resident such as locking the door to keep her out of her room or placing her wheelchair by the bed in such a way to keep her from getting in."</p> <p>- Resident #1's family member knew the resident had been removing the alarms, shutting off the alarm and removing her hipsters, "but wanted them on the resident anyway".</p> <p>- "PT had been working with the resident to lock her wheelchair and for gait training but the therapist told me the resident couldn't remember from one day to the next."</p> <p>- The facility had asked the doctor to consider prescribing Oxybutynin which is used to decrease symptoms of urgency, nocturia (excessive urination at night) and incontinence. He declined the request.</p> <p>Interviews with the Resident Care Director (RCD) on 4/27/16 at 3:00pm and on 4/28/16 at 11:00am revealed:</p> <p>- She was not aware of a facility fall policy or procedure.</p> <p>- Resident #1's physician had been notified each time the resident had fallen.</p> <p>- If a resident fell and had cognitive loss, she would notify the physician and get an order for an alarm.</p> <p>- If the resident had cognitive loss and was not ambulatory, she would request a mattress pad for the floor in case the resident rolled out of the bed.</p> <p>- If appropriate, she would request orders for PT and Occupational Therapy (OT).</p> <p>- The resident's bed would be moved against the wall.</p> <p>- If continent, she would request a bed pad alarm.</p> <p>- She would request hipsters if the resident had fallen off the commode.</p> <p>- She would talk with the family and the physician</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER WEXFORD HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WEXFORD LANE DENVER, NC 28037
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D 270	<p>Continued From page 12</p> <p>regarding the falls.</p> <ul style="list-style-type: none"> -She logged each fall as to time, place and circumstances to see if there is a pattern. -She would increase staff rounds on the resident from every 2 hours to every hour and if falls continued, to every 30 minutes. -She would have the staff keep the resident in the lobby to be with other residents. -She would have the resident included in activities for monitoring. -She would get an order for Hospice, if possible, as an intervention. They could do medication management and had staff that can help with the resident's care. -She sent all incident/accident reports to Risk Management and would receive feedback regarding interventions. -Resident #1's falls interventions included placing her bed along the wall, a quarter siderail on the bed, three alarms (bed, chair and a personal alarm), PT had worked with her, medication changes, hipsters, call bell within reach, scheduled toileting before and after meals and 30 minute checks. -She stated the resident did not like the hipsters and would remove and hide them in her room or use them as a pillow. -She was aware the resident had been removing the alarms and hiding them in her room. -She was aware the resident had been turning off the alarms and on at least one occasion an alarm battery had not been working and was replaced by the staff. -There was no system in place to monitor the functioning of alarm batteries and bed and chair pad alarms. -Explaining things to the resident worked "sometimes". -The staff tried to keep her busy with activities or to keep her close by where they could see her. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2016
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D 270	<p>Continued From page 13</p> <ul style="list-style-type: none"> -Some of the Medication Aides, especially on the 3:00pm-11:00pm shift, kept her with them while they passed medications. -She could not recall when the 30 minute checks changed from 7:00pm-7:00am to every shift by the staff after the resident had fallen. -She stated they had put a lot of falls interventions in place but the falls continued and "I don't know what else to do." <p>Interview with Resident #1's family member on 4/28/16 at 1:00pm revealed:</p> <ul style="list-style-type: none"> -The family member visited three times each week. -The resident had been declining due to her dementia. -She and the facility staff had tried several things to help keep the resident from falling but "nothing has worked". -The resident can't remember instructions like using her call bell or to lock her wheelchair. -The resident thinks she can still walk and takes off her chair alarm and turns off the personal alarm and will hide them in her room. -She does not like the hipsters and will take them off and hide them. -The facility was as concerned as the family member over the many falls that had occurred. -The facility always called her when there was a fall. -The family member was hoping that if the Resident had Hospice she could remain at the facility. -The family had requested Hospice on two occasions but the resident did not meet their requirements for admission. -The resident would be going to a skilled facility out of state on 5/13/16 and she had not yet informed the facility. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2016
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D 270	<p>Continued From page 14</p> <p>Interview with the Administrator on 4/28/16 at 11:30 revealed:</p> <ul style="list-style-type: none"> -She had been the facility Administrator since 1/1/16 but was not new to the company. -She was not aware of a company or facility falls policy or procedure. policy -She was not very familiar with Resident #1 but knew she had been falling. -She was not aware of the large number of falls the resident had experienced. -An incident/unusual occurrence report is completed each time a fall occurs. -The report is reviewed by the RCD who then completes the "Follow up" section of the report and sends it to the Director of Quality Management where it is entered into a data base. -The Director of Quality Management makes recommendations to the RCD to be recommended to the physician. -The RCD can call the Director of Quality Management at any time if she has concerns or questions. -Monthly risk management meetings are held at the facility and falls are reviewed during that meeting. -"Falls can't always be prevented so we try to minimize them and prevent injury." -The RCD had some "pretty good" falls interventions such as alarms and increased rounds. -She didn't feel the ER physician knew Resident #1 well enough to suggest an increased level of care. -"We try to keep residents where they are and after the last ER visit we knew the family wanted her to stay here, so we called Hospice but she was not eligible." -"Everyone has had concerns about the resident's falls but no one has expressed concerns about whether she was properly placed." 	D 270		
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Division of Health Service Regulation

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D 270	<p>Continued From page 15</p> <ul style="list-style-type: none"> -The facility has not met or talked with the family to discuss a change in the resident's level of care that she was aware of. -She had not spoken with the family but heard they were considering moving the resident to a skilled facility out of state. -She would arrange a meeting with the family, after speaking with the Family Nurse Practitioner, and figure out what direction to go. -She had located a copy of a Falls Prevention Program that was not currently in used by the facility. -The Falls Prevention Program would be reviewed, evaluated and if appropriate, put into use by the facility. <p>Attempted telephone interviews on 4/28/16 at 11:00am and 2:20pm with the physician and the Family Nurse Practitioner were not returned prior to exit.</p> <p>_____</p> <p>A Plan of Protection was provided by the facility on April 28, 2016 and included the following:</p> <ul style="list-style-type: none"> -The facility will provide one on one supervision for Resident #1 as long as the resident remains in the building. -Facility staff will immediately review falls occurring within the past month to identify residents requiring falls interventions and determine appropriate interventions for each identified resident. -All new admissions will be assessed for fall risk upon admission and interventions will be implemented as appropriate. <p>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 28, 2016.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2016
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D912	Continued From page 16	D912		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide care and services which are adequate, appropriate and in compliance with relevent federal and state laws and rules and regulations in the area of supervision.</p> <p>The findings are:</p> <p>1. Based on observations, interviews and record reviews, the facility failed to provide supervision of 1 of 3 sampled residents (Resident #1) in accordance with the resident's assessed needs, care plan and current symptoms related to falls. [Refer to Tag 270, 10A NCAC 13F .0901(b) (Type A2 Violation)].</p>	D912		

Plan of Correction for State Survey completed April 28, 2016.

Facility: Wexford House
License: HAL-055-008
County: Lincoln

10A NCAC 13F .0901(b) – Personal Care and Supervision

Tag# D270

(shall be provided in accordance with each resident's assessed needs, care plan and current symptoms)

As implementation of the Plan of Protection, Resident #1 received one-on-one supervision until date of discharge, May 13, 2016. A review of all falls occurring in the month of April 2016 was completed as well to identify those residents with multiple falls who required fall interventions. Interventions have been implemented as appropriate.

Facility care staff has be in-serviced on the Fall Risk Management process.

Date of Completion: May 28, 2016

In addition to the above measures, a new process of identifying residents at risk for fall will be initiated. Each resident deemed to be at risk for fall will have an identifying marker placed on their name plate outside of their assigned room that will alert staff to more frequent monitoring for that resident.

A comprehensive list of residents at risk for fall will be maintained. The list will correspond with resident room assignments for all shifts and will be posted and available for care staff to check daily. The list will identify each resident, the fall interventions in place and any other pertinent instructions as related to their fall history and required cares. The need for new or additional interventions will be updated on the list as the resident's needs change.

Care staff will be responsible for being familiar with the needs and the changing needs of each resident they care for and will check the listing throughout the week to observe any new residents added to/or changes made to the list. Changes to the list will be flagged to draw attention to the updates.

Changes will also be communicated at the end of shift by the supervisors as a fall occurs. The on-coming supervisor will inform her co-workers of a resident fall and staff will monitor that resident and initiate any additional interventions. Residents will also be assessed for any complaints or changes in the resident's condition that may be related to the fall that was not immediately evident and would require further evaluation.

Resident Care employees have been instructed in this new procedure and are aware of the expectations in carrying out their responsibility to ensure the residents safety.

The Resident Care Director will update and maintain the Fall Intervention List as the residents' needs change and ensure the new interventions are posted.

The Administrator will check the List weekly to verify it is in place.

The Regional Director and Quality Management Team will review the above noted list during monthly visits to the facility to ensure the lists are current and posted.

Date of Completion: May 28, 2016

G.S 131D - 21(2) – Declaration of Residents' Rights

Tag# D912

(to receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations)

With the implementation of the above noted changes to the care and practices in regard to fall interventions, it is the intention of this facility to improve the safety of our residents, decrease the risk of falls and employ all available ancillary resources to obtain this goal.

Date of Completion: May 28, 2016



Melissa Silverman-Connolly, Regional Director/Acting Administrator

6/3/16
Date

6/10/16
S. Hill