STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092252	A. BUILDING: _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO LIVE	1410 KILDAIRE FARM ROAD CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual survey and a complaint investigation from 06/16/21-06/17/21. The Wake County Department of Social Services initiated the complaints on 05/13/21.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 direct care staff (Staff C) was tested upon hire for tuberculosis (TB) disease in compliance with the TB control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's personnel record revealed:	C 140		

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C 140	Continued From page 1 -She was hired on 06/15/21. -There was no documentation a TB skin test was administered, or a TB screening was performed. Interview with Staff C on 06/16/21 at 10:10am revealed: -She had been providing direct care to residents since 03/25/21. -She was hired as permanent staff on 06/15/21. -She had not scheduled, nor had she taken a TB test prior to being employed. -She was leaving to go out of town on 07/22/21 and was planning to complete the TB screening once she returned. -She was asked to work today to cover shifts. Interview with the Administrator on 6/16/21 at 10:30am revealed: -Staff C had previously worked at another facility and she would obtain a copy of her TB screening for her records. -Staff C had been working at the facility since 03/25/21. -She was responsible to ensure personnel records were correct and complete and staff completed required TB screenings and had TB skin test on file. for new staff upon hire. -She did not answer the question regarding why she thought Staff C brought her a copy of the TB, although she was responsible for ensuring staff records were complete.	C 140		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall:	C 145		

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C 145	Continued From page 2 (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 direct care staff (Staff A and B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1.Review of Staff A's personnel record revealed: -Her date of hire was 05/17/21. -Her title at the facility was a personal care aide (PCA). -There was no documentation a HCPR check was completed prior to Staff A beginning her employment at the facility. Observation of the back porch of the facility on 06/16/21 from 11:50am to 12:06pm revealed: -Residents #1 and 2 were sitting at a table eating lunch. -Staff A was sitting at the table. -Staff A was at the table serving lunch. Observation of Staff A on 06/16/21 at 2:00pm revealed Staff A was sitting next to Resident #2's bed while he slept. Interview with Staff A on 06/16/21 at 3:00pm revealed: -She had been employed at the facility since 05/2021 but could not remember her exact date of hire. -She was not aware if the Administrator completed a Health Care Personnel Registry	C 145		

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C 145	Continued From page 3 check on her prior to hire. Interview with the Administrator on 6/16/21 at 10:30am revealed she was aware HCPR checks were required for all staff but she failed to complete because a lot of times she waited to complete forms to see if the staff was going to work before she officially hired them. Refer to the interview with the Administrator on 6/16/2021 at 10:30am. 2. Review of Staff B's personnel record revealed: -Her date of hire was 05/17/21. -Her title at the facility was a personal care aide (PCA). -There was no documentation a HCPR check was completed for Staff B upon hire. Interview with the Administrator on 6/16/21 at 10:30am revealed she was aware HCPR checks were required for all staff but she failed to complete because a lot of times she waited to complete forms to see if the staff was going to work before she officially hired them. Attempted telephone interview with Staff B on 06/16/21 at 3:45pm was unsuccessful. HCPR check was not completed for Staff A and B by the end of the survey on 06/17/21. _____ Interview with the Administrator on 6/16/21 at 10:30am revealed: -It was her responsibility to ensure all documents were completed for staff prior to hire. -She did not always get all the new hire documents on potential new staff, just in case things did not work out.	C 145		

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C 244	Continued From page 4	C 244		
C 244	10A NCAC 13G .0901(c) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION The facility failed to ensure an immediate response and intervention by staff and in accordance with the facility's policies and procedures during an incident in which 1 of 3 sampled resident (#3) with falls was found on the floor on 01/24/21. The findings are: Review of the facility's contract services provided revealed: -Arrangement for the services of a physician and other specialized health care providers on a regular and emergency basis. -In emergency situations the facility would contact emergency medical personnel for transportation to the documented hospital of choice. -Immediate response in case of an emergency, accident, or incident involving a resident. Review of the facility's incident/accident policy revealed: -The Administrator would notify the county department of social services of any accident or incident resulting in resident death or any serious	C 244		

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C 244	Continued From page 5 accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. -Immediately upon receiving a report of an accident or incident which caused harmed to the resident the Administrator would coordinate delivery of appropriate medical and/or psychological care attention. -Ensuring safety and well-being for the vulnerable individual was the utmost priority. -Safety, security, and support of the resident, their roommate, if applicable and other residents with the potential to be affected would be provided. -In addition to following required state reporting the facility would complete its own incident report, would update as the issue unfolded until all aftercare was given and until resident was stabilized working with all medical providers and responsible parties. Review of Resident #3's current FL-2 dated 06/23/20 revealed: -Diagnoses included advanced dementia, hypertension, constipation, depression, and anxiety. -The resident was intermittently disoriented. -The resident required total care with personal care tasks such as bathing, feeding, and dressing. -The resident was incontinent of bladder. -The resident was semi-ambulatory. -There was not an assistive device indicated to assist with ambulation. Review of Resident #3's care plan dated 08/12/19 revealed: -She was sometimes disoriented. -She had significant memory loss. -She had wandering behaviors.	C 244		

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C 244	Continued From page 6 -She had limited ability with ambulation. -She required supervision with bathing, toileting, ambulation, dressing, personal hygiene. -She was independent with transferring. Review of Resident #3's Accident/Incident report dated 01/26/21 revealed: -The date and time of the accident/incident was 01/24/21 after dinner. -A personal care aide (PCA) found Resident #3 on the floor. -There were no visible injuries on her body. -She was calm, and her appetite was good. -Her blood pressure, temperature, and oxygen were normal. -She went to sleep and was given her scheduled pain medication. -Resident #3's family was notified on the morning of 01/25/21. -Resident #3's primary care provider (PCP) was notified on 01/26/21. -There was no time documented with the PCP notification. -The PCP orders included an x-ray. -There was no date documented with the PCP order. -Resident #3 refused to move because she appeared to be in "pain." -Her condition was observed; her vital signs and appetite were good. -The report was signed and dated by the Administrator on 01/26/21. Review of Resident #3's progress note dated 01/24/21 for first and second shifts revealed: -She was very agitated throughout the day. -A skin tear was observed to her left lower leg. -An antibiotic ointment and a band-aid were applied after dinner. -Resident #3 was found on the floor after meal	C 244		

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time by a PCA.
-She was alert and her blood pressure reading was 157/83.
-There were no "obvious" injuries on her skin surface.
-Family was informed about accident.
-There was no documentation Resident #3's primary care provider was notified of the Resident #3's fall dated 01/24/21.

Review of Resident #3's progress note dated 01/25/21 for second shift revealed:
-Resident #3 had trouble standing; she seemed tired after taking a couple of steps.
-She was very quiet and somewhat alert.
-Her vital signs were a temperature of 97.7 degrees Fahrenheit (F) and a blood pressure reading of 122/77.
-Her eyes were closed, and she was observed sleeping throughout the shift.
-She continued to eat fine but "grimaced" when moving her left leg.
-A discussion was completed with Resident #3's family member, they were "observing" her condition until tomorrow, 01/26/21.
-There was no documentation Resident #3's primary care provider (PCP) was notified of the Resident #3's fall on 01/24/21.

Review of Resident #3's progress note dated 01/26/21 revealed:
-Resident #3 was not calm.
-Her appetite was normal.
-She was complaining and refused to move.
-There was no documentation Resident #3's PCP was notified of the Resident #3's fall on 01/24/21.

Review of Resident #3's progress note dated 01/27/21 revealed:
-Resident continued to "complain."

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C 244	Continued From page 8 -Resident #3's family would consult with her PCP today, 01/27/21. Review of Resident #3's progress note dated 01/27/21 for second shift revealed: -Resident #3 had a normal appetite. -She continued to have pain with movement which should have been less as possible. -X-ray technician took pictures of her back, left hip, and right side. -She was resting as comfortably "as possible." -Her temperature was 97 degrees Fahrenheit and a blood pressure reading of 115/65. Review of email message to Resident #3's PCP from Resident #3's family member dated 01/27/21 at 10:38am revealed: -On 01/24/21, the family member found out Resident #3 was found on the floor. -She had been in a wheelchair. -The family did not know if she stood up and fell or had slid forward from the chair. -The Administrator told the family member she found no sign of bruises or overt injury, but Resident #3 did not want to walk this morning (01/27/21) and she did not want to get out of bed. -The family member requested Resident #3's PCP to visit her soon. -Her family member asked if Resident #3's PCP would recommend X-rays of her spine, pelvic area and lower extremities or could she just be sore from the trauma. Review of email message to Resident #3's family member from Resident #3's PCP dated 01/27/21 at 10:58am revealed: -Resident #3's PCP could not make it to the facility this week. -Resident #3's PCP was scheduled to be at the facility routinely on Tuesday, 02/02/21.	C 244		

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-The PCP recommended visits <72 hours after a fall.
-Resident #3's PCP requested the Team Lead/Clinical Organizer from his office call the Administrator to find out if Resident #3 had any bruising, wounds, or obvious injuries.
-X-rays of anteroposterior or posteroanterior lumbar spine, pelvis and bilateral hips were ordered immediately.

Review of Resident #3 PCP's progress note dated 01/27/21 at 11:59am revealed:
-A message was sent from the Team Lead/Clinical Organizer to Resident #3's PCP.
-The Team Lead/Clinical Organizer just spoke with the Administrator a few moments ago.
-The Administrator stated Resident #3 was not happy and she was refusing to get out of her bed to the wheelchair.
-The Administrator stated she needed advice on what to do.
-The Administrator stated there were no bruises or any changes to her skin or "anything."
-Resident #3 was "just" refusing to move.

Review of Resident #3 PCP's progress note dated 01/27/21 at 1:31pm revealed:
-A message was sent from Resident #3's PCP to the Team Lead/Clinical Organizer.
-He would get x-rays to rule out fractures.
-He provided the instruction to leave Resident #3 in bed until we could rule out fracture.
-If the Administrator was demanding a visit, we would need approval from Resident #3's power of attorney.

Review of email message to the Administrator and Resident #3's family member from Resident #3's PCP dated 01/28/21 at 5:54am revealed:
-Resident #3's had a broken proximal left femur

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per her x-ray report.
-Resident #3 needed to go to the Emergency Department (ED) for care.
-If Resident #3's family member felt otherwise to contact the Administrator as soon as possible.
-He thought the ED was indicated for Resident #3.

Review of Resident #3's Emergency Medical Services (EMS) call report dated 01/28/21 revealed:
-EMS was dispatched to the facility for a fall at 11:09am.
-EMS arrived at 11:18am to find Resident #3 who was conscious but not alert lying supine in her bed at the facility.
-Staff was present.
-Staff stated Resident #3 fell on 01/24/21 and did not appear injured.
-Staff stated Resident #3 started to complain more when she was moved and the PCP ordered an x-ray technician come to the facility to obtain an X-ray.
-The x-ray showed a left femur fracture and EMS was called to transport today.
-During assessment, Resident #3 was found to have a temperature of 100.5 degrees Fahrenheit (F).
-Staff stated Resident #3 did not have a fever earlier today but was given Tylenol as a course of her regular medication administration.
-Resident #3 had a smell of urine and staff stated the Resident #3 had been more incontinent as of late.
-Resident #3 was unable to answer normal assessment questions due to her dementia.
-Resident #3's skin was hot.
-The resident was transported to the local emergency department (ED).

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C 244	Continued From page 11 Telephone interview with a local EMS Paramedic on 06/17/21 at 11:21am revealed: -He responded to and provided care for Resident #3 on 01/28/21. -Upon arrival to the facility, Resident #3 was laying in a supine position in her bed. -Staff informed him Resident #3 had fallen 4 days ago at the facility on 01/24/21. -Resident #3 had started to complain of "more pain" and an x-ray confirmed the fracture of her left femur, so EMS was called. -Resident #3 appeared to be in "poor general health." -She appeared to be in "poor general health" because she was bedbound; and she could not take care of herself. -Her skin was very warm to touch. -It was an "odd call" because when a resident fractured their femur it was "painful"; residents would have "immediate" pain from a femur fracture because the femur was one of the biggest bones in the human body. -Most facilities called EMS the same day the resident's fall occurred for medical attention; this was normal procedure. Review of Resident #3's ED hospital admission documentation dated 01/28/21 revealed: -The chief complaint was leg pain, traumatic. -Resident #3 was sent out from facility for left femur fracture. -She had a history of dementia and presented for evaluation of hip injury. -Per EMS, Resident #3 fell 4 days ago at the facility and her x-ray report came back on 01/28/21 indicating she broke her left hip. -She was found to have a temperature by EMS and had a fever reducing medication before EMS arrival. -She would respond to pain only.	C 244		

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-The physical assessment of her extremities included her left lower extremity was shortened and there was tenderness to palpation over her left posterior hip.
-Her urine analysis showed an infection and intravenous (IV) Ceftriaxone was started (IV Ceftriaxone is an antibiotic used to bacterial infections).
-Hip surgery would be discussed with the Orthopedic department and she was admitted to a medical floor of the hospital.
-On 01/28/21, her computed tomography result was a proximal left femur fracture, intertrochanteric and/or basicervical, varus angulation, overriding of fracture fragments.

Review of Resident #3's orthopedic consult dated 01/28/21 revealed:
-Due to Resident #3's severe dementia and limited mobility baseline and highly likelihood of failure requiring multiple surgeries with attempt at operative fixation, the recommendation was a non-operative treatment.
-She could weigh bear as tolerated, although resident was essentially non-ambulatory.
-Plan was discussed with Resident #3's family member.
-The recommendation was hospice consult and pain management.

Review of Resident #3's hospital discharge summary documentation dated 01/30/21 revealed:
-Her discharge diagnosis was an intertrochanteric fracture of her left femur.
-She did not appear to be in pain when lying still.
-Her physical therapy consult was pending.
-She would likely be total assist for the rest of her life.
-Her assessment/plan included an

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intertrochanteric fracture of her left femur.
-She was not a candidate for surgery as per the orthopedic consult.
-She had a decreased level of consciousness likely secondary to her urinary tract infection and dehydration; there were orders to continue IV antibiotics and to start IV fluids.
-She had a urinary tract infection present on admission; her urine culture and blood cultures were pending; and there was an order to continue IV antibiotics.
-Resident #3 would be transferred to in-patient hospice.
-She may need IV morphine and Ativan and her hospital PCP would defer medication review and management to the hospice team.

Interview with the County Department of Social Services (DSS) Adult Home Specialist (AHS) on 06/16/21 at 1:30pm revealed:
-She conducted a telephone interview with a former PCA on 06/10/21 at 8:36pm.
-The former PCA was hired in 2020 and her last day of employment was in March 2021.
-She worked various shifts at the facility.
-Resident #3 was semi-ambulatory with a wheelchair and walker.
-Resident #3 was total care with all her activities of daily living.
-She was a fall risk because she had frequent falls.
-She was not working when Resident #3 had a fall but was working the morning she was sent to the hospital on 01/28/21.
-On 01/28/21 at approximately 8:30am, when she came on shift, she observed Resident #3 sitting in her wheelchair staring with a look of distress on her face.
-She reported Resident #3's look of distress on her face to the Administrator on 01/28/21.

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	fcl092252	A. BUILDING: _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO LIVE	1410 KILDAIRE FARM ROAD CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 244	Continued From page 14 -She refused to eat. -She was not sure how long Resident #3 had been sitting in her wheelchair. -She had a strong urine odor. -She was unable to provide personal care because Resident #3 was in pain. -The Administrator directed her to assist Resident #3 to stand but she began moaning and screaming. -She could see the discomfort, pain and distress on Resident #3's face. -Her face was pale, red, and warm. -She reported to the Administrator what she observed when she tried to assist Resident #3 to stand. -The Administrator did not respond to the PCA and walked away. -She recommended to the Administrator to send Resident #3 to the hospital because she appeared to be pain. -The Administrator waited approximately thirty minutes on 01/28/21 before calling Resident #3's family member to obtain consent to send her out to the hospital. Telephone interview with a second PCA on 06/17/21 at 12:45pm revealed: -She was employed at the facility until 03/14/21. -She was not working the morning of 01/24/21 when Resident #3 had a fall. -She worked with Resident #3 on the evening of 1/26/21 along with another staff. -Resident #3 could not speak and appeared to be in pain and distress. -Her face was a slight pink pale color. -She made loud noises and screamed when staff tried to assist her to stand. -She had a strong smell of urine. -On 01/26/21, she reported to the Administrator that Resident #3 might have hurt her leg because	C 244		

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C 244	Continued From page 15 she could not stand. -The Administrator did not act on her report of Resident #3's inability to stand at baseline. -On 01/26/21, she could only provide personal care to Resident #3 while in bed because of the significant pain and distress and discomfort she was in. -Staff did not call EMS, because it was the responsibility of the Administrator. Second interview with the County DSS AHS on 06/16/21 at 2:30pm revealed: -She conducted a telephone interview with Resident #3's family member on 06/07/21 at 1:08pm. -The Administrator reported to Resident #3's family member on 01/24/21 at approximately 12:00pm, Resident #3 was left alone in her room, slipped from under a gait belt, while sitting in her wheelchair. -The Administrator reported to him Resident #3 had no signs of injury. -He was not sure what time the Administrator contacted him about Resident #3's accident on 01/24/21. -He had no knowledge of why "this belt" was being used, until the Administrator reported it to him. -The Administrator reported the gait belt was used to prevent Resident #3 from falling. -He was unaware of any previous falls and she was not a fall risk. -She was able to ambulate with stand by assistance. -She utilized a walker and wheelchair occasionally for ambulation. -He tried to contact the facility for a zoom call but was unsuccessful. -He came to visit on 01/26/21 because the zoom calls did not go through.	C 244		

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C 244	Continued From page 16	C 244		

-He did not recall the Administrator asking him to come to the facility.
-He had not been able to see Resident #3 in a while and wanted to see if she was ok after the fall.
-The facility did not refuse to allow him to visit Resident #3.
-He did not visit the facility because he lived with a family member who had severe asthma and he was fearful of COVID-19.
-If he contracted COVID-19, he did not want to spread it to Resident #3 or the family members he lived with.
-He could not remember the time he tried to reach the facility, but he knew it was on the evening of 01/24/21 and again on 01/25/21.
-He came to the facility on 01/26/21 and was able to see Resident #3 through the doorway.
-Resident #3 was in the living room sitting in a wheelchair with a sad look on her face.
-Resident #3 would not look at him; she would not make eye contact with him.
-He started to cry during his visit with Resident #3.
-He felt there was something "significantly" wrong with Resident #3 which he discussed with the Administrator.
-He informed the Administrator he would be contacting Resident #3's PCP.
-He contacted Resident #3's PCP by email on 01/27/21 at 10:38am and an x-ray was ordered.
-He and the Administrator were notified by Resident #3's PCP by email on 01/28/21 of the x-ray results of a left femur fracture close to the hip.
-He did not know why the Administrator did not send Resident #3 to the hospital after receiving the x-ray results.
-She was sent to the ED on 01/28/21.
-He was not sure why the Administrator did not

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C 244	Continued From page 17 send Resident #3 out to the hospital after the fall on 01/24/21. -He did not know why the Administrator had to contact him first in case of an accident, especially if Resident #3 needed immediate medical care. -He did recall saying he did not want Resident #3 being sent to the hospital. Third interview with the County DSS AHS on 06/16/21 at 3:30pm revealed: -She conducted an interview with the Administrator on 06/11/21 at 12:52pm. -The Administrator was not at the facility when Resident #3 had a fall on 01/24/21. -She arrived at the facility at approximately 7:00pm, when staff reported the incident. -She observed Resident #3 lying in bed and she did not appear to have pain or injuries. -Staff reported that Resident #3 slipped out of the wheelchair and was found on the floor at approximately 5:30pm. -She could not remember when she notified the family about the incident. -She did not notify the PCP after Resident #3 had the fall. -The facility policy was to notify the PCP and the resident's family member or responsible party after an incident or accident. -Resident #3's family did not want her to be sent to the hospital due to the potential risk of contracting COVID-19. -She did not observe Resident #3 being in distress from 01/24/21 to 01/28/21. -She could not remember if staff reported to her whether Resident #3 was in pain or distress prior to Resident #3 being sent out to the hospital. -Resident #3 began experiencing pain later during the week so she notified Resident #3's family member and administered as needed Tylenol.	C 244		

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C 244	Continued From page 18 -Resident #3's family member notified the PCP. -She did not contact the PCP because Resident #3's family member had a better relationship with the PCP, and she felt it was best the family member speak with the PCP. -The PCP ordered x-rays and the results were sent to her by email. -She could not remember the date she received the x-ray results. -She did not send Resident #3 out to the hospital immediately after she received the x-ray results from the PCP. -She did not know why she did not send Resident #3 out to the hospital after receiving the x-ray results. -She did not send Resident #3 out to the hospital because her family member did not want her to go due to the risk of being exposed to COVID-19. Telephone interview with the Clinical Manager at the local hospice inpatient center on 06/17/21 at 12:58pm revealed: -An inpatient hospice setting would be recommended for patients for symptom management that could not be controlled in a home setting. -For example, uncontrolled pain, uncontrolled nausea and vomiting, shortness of breath, and anxiety. -Resident #3 was a patient at the local hospice inpatient center from 01/30/21 to 02/08/21. -Resident #3 expired on 02/08/21. Telephone interview with Resident #3's PCP on 06/17/21 at 8:25am revealed: -He worked at his assigned facilities every week on Tuesdays and Thursdays. -He expected to be notified by the Administrator or designee of a resident's fall "shortly" after the fall.	C 244		

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C 244	Continued From page 19 -A follow-up PCP visit post resident fall would "ideally" occur within a 72-hour timeframe of the resident's fall. -He would prioritize the scheduling of the resident's follow-up visit post fall based on information received from EMS. -He was not able to access Resident #3's medical records to confirm any PCP notifications or updates concerning Resident #3. -He should have been notified immediately of Resident's #3 fall on 01/24/21 by the Administrator to provide medical interventions. -He should have been notified immediately by the Administrator of Resident's #3 verbal and physical signs of pain and her decrease in her functional status, not wanting to move or not wanting to stand. -Resident #3 should have sent to ED for a hospital evaluation after the fall. A second telephone interview with Resident #3's PCP on 06/17/21 at 9:08am revealed: -He was able to access Resident #3's medical record. -There were no PCP notifications related to Resident #3's fall on 01/24/21 between 01/24/21 to 01/27/21 by phone or email. -The first notification he received related to Resident #3's fall was on 01/27/21 from Resident #3's family member. Interview with the Administrator on 06/17/21 at 10:00am revealed: -When a resident had a fall, the Administrator and staff would observe the resident's condition. -The staff would observe for obvious injuries, the resident's level of consciousness was the resident less alert; and staff would take their vital signs. -The resident's family member would be notified	C 244		

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C 244	Continued From page 20	C 244		

of the resident's fall at the facility within a 24-hour timeframe.
-She "tried" to notify the resident's PCP at the same time she notified the resident's family member or responsible party.
-When she notified a resident's family member about a resident's fall, she would ask them to come to the facility to see the resident.
-Some resident's family members did not want the resident to go to the hospital due to COVID-19 especially during the height of the pandemic.
-If the resident required care above "our responsibilities" she would call 911 and the resident would go to the hospital for evaluation.
-Resident #3's family member did not always want her to go to the hospital due to the risk of her contracting COVID-19.
-On 01/24/21, she was not in facility, she was running errands outside of the facility.
-She arrived back to the facility after 6:00pm on 01/24/21.
-When she arrived back to the facility, Resident #3 was in her room within her bed.
-On 01/24/21, the PCA working with Resident #3 informed the Administrator upon her return to the facility; Resident #3 fell and her vital signs were obtained.
-There were no abnormal vital signs reported to her.
-The evening of 01/24/21, the Administrator went into Resident #3's room.
-Resident #3 did not look in distress and she was sleeping.
-The morning of 01/25/21, she notified Resident #3's family member of Resident #3's fall on 01/24/21.
-She asked Resident #3's family member if he would come to the facility "right away."
-She relayed to Resident #3's family member she

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C 244	Continued From page 21	C 244		

did not observe any injuries, but she did tell him Resident #3 would not stand up.
-She could not recall if Resident #3's family member came to the facility on 01/25/21.
-She was not aware Resident #3's PCP was not notified of Resident #3's fall on 01/24/21 till 01/27/21 by her family member.
-She "thought" Resident #3's family member had notified Resident #3's PCP prior to 01/27/21.
-Resident #3's family member had a good relationship with her PCP, and he would communicate with her PCP on regular basis.
-She did not know why there was no communication with Resident #3's PCP from 01/24/21 to 01/27/21.
-She should have notified her PCP of Resident #3 fall on 01/24/21 and not have expected her family member to notify the PCP.
-It was "inappropriate."
-Even though Resident #3's PCP was not able to come to the facility due to having lots of appointments she should have notified Resident #3's PCP prior to 01/27/21.
-The PCP was a licensed medical professional; he was the only one that could assess Resident #3 to determine the need for emergency care.
-We "tried" to move her, and she refused us transferring her.
-Resident #3 had "increased" pain so "we" gave Tylenol and had x-rays completed.
-She was "nervous" when Resident #3 fell on 01/24/21, there were no additional details given.
-She should have called her PCP due to Resident #3 refusing transfers and having an increase in her pain level.
-She should have called 911 sooner than 01/28/21 for Resident #3 to receive emergency care.
-She should have called 911 when Resident #3 had increased complaints of pain or decrease

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C 244	Continued From page 22 movement of any extremity. -She expected staff to follow the same procedure to notify 911 when a resident had increased complaints of pain or decrease movement of any extremity because there was unlicensed medical staff in the facility. -The staff and herself needed to be more "urgent." Attempted telephone interviews with another PCA who was working on 01/24/21 on 06/07/21 at 11:37am and on 06/09/21 at 11:38am were unsuccessful. _____ The facility staff failed to respond immediately after an accident for one resident who fell from her wheelchair, had complaints of pain, and a significant change in her ability to move, transfer, bare weight, and ambulate at baseline, Resident #3. This failure to resulted in the resident declining and experiencing untreated pain from a complex fracture of the left femur as well as a delay in treatment for a urinary tract infection . The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/17/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 30, 2021.	C 244		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse,	C 914		

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C 914	Continued From page 23 neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were provided with the necessary care and services to maintain their physical and mental health as related to personal care and supervision. The findings are: The facility failed to ensure an immediate response and intervention by staff and in accordance with the facility's policies and procedures during an incident in which 1 of 3 sampled resident (#3) with falls was found on the floor on 01/24/21. [Refer to Tag C244, 10A 13G .0901(c) Personal Care and Supervision (Type A1 Violation)].	C 914		