Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0097	A. BUILDING: ______ B. WING ______	C 06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

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L 000	INITIAL COMMENTS An unannounced licensure complaint investigation was conducted in the facility on 06/23/20, and the survey was continued remotely through 06/29/20. 1 of 1 complaint allegations was substantiated with a state deficiency. See tag L-0039 (.2208 e-2), Event ID #EJZ911.	L 000		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on record review, staff interview, nurse practitioner and medical director interviews, the facility failed to identify that a resident being found on the floor was a fall, and failed to consider and develop interventions that addressed the resident's behavior surrounding the fall. The facility failed to discuss and review the interventions with the responsible party. There was no intervention for floor time on the care plan, and the facilities Fall Risk and Prevention Policy dated 2/28/18 failed to include parameters for monitoring and supervising a resident that remained on the floor for "floor time" after a fall, for a severely cognitively impaired resident (Resident # 1) who was left on the bedside floor mat from 10:00 AM to 5:30 PM for 1 of 1 resident	L 039	The following plan of correction is required by rules found in 10A NCAC 13D, the Rules for the Licensing of Nursing Homes and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents to continue to receive care here. This plan of correction is not an admission of lack of compliance with licensure requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation.	7/18/20

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/15/20

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L 039	Continued From page 1 (Resident #1) reviewed for accidents. Findings included: The Fall Risk Assessment and Prevention Policy revised 2/28/18 is utilized to prevent and minimize falls by identifying residents at risk and taking appropriate precautions. Procedures included in part; completion of a fall risk assessment within 24 hours of admission. The Fall Risk Assessment would be repeated quarterly thereafter and as indicated by significant change. If the resident is at high risk for falls a prevention program should be initiated immediately and documented on the care plan. The Fall Prevention Program included in part; to educate residents and families, perform environmental safety checks, keep call bell and personal items within reach, offer frequent assistance, avoid leaving unprotected, unattended, or non-visualized, and document efforts. When a fall occurs immediately notify the supervisor or other member of nursing management and complete a Fall Event with associated notes to include notification and interventions. Resident #1 was admitted to the facility 2/24/20 with diagnoses to include in part; Lewy Body Dementia with behavioral disturbances, Psychotic Disorder, History of Falls, Parkinson's, Anxiety, and Major Depression. The Minimum Data Set admission assessment dated 3/1/20 documented Resident #1 had severely impaired cognition. He required assistance with one person for bed mobility, transfers, and activities of daily living. Resident #1 had an ileostomy and urinary incontinence. He had no falls since admission.	L 039	1.) Interventions for affected resident: The identified resident in this survey is no longer a resident. 2) Interventions for residents identified as having potential to be affected: Current residents exhibiting behaviors that are high risk for and/or have documented falls within the last 30 days have been reviewed and updated to reflect appropriate behavioral interventions and family notifications of the interventions. 3.) Systemic Change Staff education completed 07.15-07.17.2020 by the Director of Nursing Services and designees on: a. Nursing staff retrained for identification of a fall b. Nursing staff retrained for appropriate behavioral interventions surrounding a fall. c. Nursing staff retrained on proper notifications of the responsible party to discuss and review interventions. The DON or designee will audit resident falls weekly for 4 weeks and monthly for 2 months for appropriate identification of a fall, appropriate behavioral interventions and proper notifications of the responsible party. 4.) Monitoring of the change to sustain system compliance ongoing:	

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L 039	Continued From page 2 The care plan initiated 3/6/20 revealed Resident #1 had a history of falls related to Parkinson's disease, with a long-term goal to remain free from injury. Interventions included; analyzing resident's falls to determine a pattern or trend, assure floor is free of foreign objects, give verbal reminders not to ambulate or transfer without assistance, keep call light and frequently used items within reach, observe frequently, place in a supervised area when out of bed, and orient resident to changes in environment. The facility 24 hour/5day report dated 6/5/20 documented; nurse reported that resident was left on the floor for 10 hours. The facility investigation summary documented; Resident #1 had a BIMS (brief interview for mental status) of 0 reflective of his severe impairment. He had chronic restlessness. It was not unusual for residents with these diagnoses to have care planned "floor time" as resident demonstrated a sense of safety closer to the floor. The resident was profoundly restless the night before, supported with as needed medication which impacted his circadian rhythm. The following day the resident deliberately made himself comfortable on the floor with a pillow and blanket where he slept soundly for a few hours. Staff attested to frequent eyes on resident, once deep sleep was discerned, staff were able to provide care and resident was comfortably placed in bed. The allegation was unsubstantiated, and the family was notified. During the facility's investigation a witness statement dated 6/9/20 was written by Nurse Aide #1 who was assigned to care for Resident #1on the day of the incident. The statement documented; she believed it was March 15th (Sunday) around 10:00 AM, she checked on	L 039	Falls Committee will review resident falls weekly and report to the Quality Assurance Committee quarterly. The Quality Assurance Committee will discuss and review the results of the audits of resident falls quarterly. Revisions/adjustments will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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Resident #1 to see if he was ready for breakfast. She immediately saw him, with room lights off, on the floor, stuck underneath the meal tray (bedside table), his legs were stuck. She obtained his vital signs and put a pillow underneath his head to keep him calm and comfortable. She notified the clinical coordinator (Nurse #1 the residents assigned nurse) who came in to assess him. After the assessment she (Nurse #1) pulled him out which was very hard because he was stuck in between the metal of the meal tray (bedside table). After she managed to get him out, he began to bleed. She (Nurse #1) said to get him comfortable and we will do floor time. Nurse Aide #1 reported she asked the nurse what floor time was because she had never heard of it. By that time a second nurse aide (Nurse Aide #2) came in to help. Nurse #1 informed them, it was for residents who were a fall risk, and this is what they do to keep residents safe. Nurse Aide #1 reported on her statement that she did not agree with floor time because she felt that after hurting himself and what he went through he would be comfortable in bed. Nurse Aide #1 understood her point in not wanting more injuries, she gave him a blanket, and she and Nurse Aide #2 put pillows around him to keep him comfortable.

A phone interview was conducted with Nurse Aide #1 on 6/24/20 at 2:45 PM. She stated she worked 12-hour shifts, and typically worked on Riverbend (location of Resident #1's room). She stated she went into the residents room (Resident #1), the lights were off, he was restless, fidgety, and bleeding on his lower leg, she stated he was raveled underneath the bedside table, his vital signs were checked, she told the nurse (Nurse#1) who came in and pulled him out from under the table. She notified the nurse of his skin tear, but the nurse didn't bandage it and it eventually

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stopped bleeding. Nurse #1 said to give him floor time, so she gave him pillows and a blanket. Nurse Aide #1 stated she didn't know what floor time was, so the nurse explained it. She reported he (Resident #1) didn't seem uncomfortable, he fell asleep, and she continued to check on him and he was fine. She stated later that day Nurse #2 asked if he was still on the floor and said it should be care planned. Nurse Aide #1 stated she was told he would not stay in bed, and didn't feel he was in distress, but he was still fidgety. Nurse #2 helped them get him back in bed around 5:30 PM approximately dinner time. She stated while he was on the floor, he was sleeping, restless, grabby, fighting, wanting to try and pull on things. After they put him back in his bed, he drank a milkshake. She stated between 10:00 AM through 5:30 PM she checked on him 4-5 times. She reported she didn't document "floor time" or monitoring while he was on the floor and stated the nurses would document that.

In a follow up interview on 6/24/20 at 5:20 PM with Nurse Aide #1 she stated that Resident #1 refused to eat all day on the day of the incident, but was offered water while he was on the floor, and did not eat his breakfast that morning, he refused lunch so she offered crackers and ginger ale which he also refused, but once he was back in his bed he drank a milkshake and refused a sandwich.

The facility's investigation statement dated 6/9/20 written by Nurse Aide #2 documented; she (Nurse Aide #2) didn't remember the exact date, and believed it was mid-March. She reported Nurse Aide #1 found Resident #1 on the floor caught up underneath the bedside table. She checked his vital signs while Nurse Aide #1 notified the nurse (Nurse #1) and told her that he had fallen. She

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reported Nurse #1 came into the room, got him, and pried him off the bedside table, which caused a skin tear on his lower leg. Nurse #1 didn't bandage his leg and instructed her to give him a pillow and blanket and let him stay on the floor for floor time. Nurse #1 told her it was for people who repeatedly fell out of bed to keep them from getting hurt. The Nurse Aide reported they checked on him periodically, but Nurse #1 wouldn't let them get him back in bed. Later, Nurse #2 relieved Nurse #1, she was informed of the fall and the Nurse Aides asked Nurse #2 if they could get him up because he had been on the floor for a while. Nurse #2 assisted the Nurse Aides with getting him back in bed, he was changed, and they got him comfortable.

During a phone interview with Nurse Aide #2 on 6/24/20 at 2:55 PM, she stated Nurse Aide #1 found Resident #1 on the floor, she checked his vitals, and they notified the nurse (Nurse #1). The Nurse assessed him, got him unraveled, and he had a skin tear on his leg. She stated the nurse (Nurse #1) wanted to give him floor time, but she didn't know what floor time was. She gave Resident #1 a pillow and blanket and checked on him frequently. She stated they (Nurse Aide #1 and #2) kept asking the nurse if they could get him up and stated Nurse #1 was adamant about floor time , so they didn't try to get him back to bed because they were doing what the nurse said to do. Nurse #2 came in later and said he shouldn't have been left on the floor that long. She stated Resident # 1 was put back to bed around 5:30 PM by both Nurse Aides and Nurse #2. Nurse Aide #2 stated he was still agitated, but he was okay once he was back in bed. She stated Resident #1 was always restless and agitated, and he declined after that day. She stated she checked on him probably every 1-2

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hours while he was on the floor, he was restless, he would sleep, then he would wake up.

In a follow up interview on 6/25/20 at 4:46 PM with Nurse Aide #2 she stated Resident #1 had a colostomy and she emptied his bag while he was on the floor and checked for urine incontinence. She reported he was continent at times and was not changed during time on the floor due to low urine output that day.

A phone interview was conducted on 6/29/20 at 8:15 AM with Nurse #1. She stated she worked at the facility approximately six months, but no longer worked there. She stated she was a clinical coordinator at that time (in March 2020) and not a floor nurse, and on the day of the incident she was responsible for two houses, Riverbend (where Resident #1's room was located) and Haven House (the adjoining unit with resident rooms). She stated she had not cared for Resident #1 as a nurse but knew of him as a clinical coordinator (CC). As a CC she knew he would put himself on the floor, and thought he was a wanderer too but wasn't sure, and stated again, she didn't really know him that well. She stated that floor time was done with the best intention, and once he was on the floor and sleeping, he slept well. She reported she had another resident in Haven House (different house) who had floor time and that resident had a sitter, mats on the floor, a pillow and blanket, the resident would nap and then they would get him back to bed, but wasn't sure if that resident had floor time care planned. She didn't remember if Resident #1 fell but stated the nurse aides came to her one or two times, and stated she only remembered a conversation about the floor, not about a fall. He had a mat, bed was in low position, and she checked on him frequently. She

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L 039	Continued From page 7 left the facility around 12:00 PM that day and gave her assignment to Nurse #2, also a clinical coordinator. She stated personally she would not have left him on the floor that long and would have tried putting him back to bed at some time. She stated Nurse #2 was a prudent nurse and wouldn't have neglected the resident. She reported the facility had a staffing crisis at that time. She stated she thought the incident occurred between Friday-Sunday, but not sure of dates. She stated the day of the incident was the last day she worked there. She could not remember her nurse to resident ratio, but stated it was a lot caring for both Riverbend House and Haven House. She reported Resident #1 had a sitter in the evenings (not a family sitter but a nurse aide that the facility assigned to resident) and on that day Resident #1 kept putting himself on the floor. She discussed with both nurse aides that if Resident #1 kept putting himself on the floor, to make him safe, and they gave him blankets and pillows, he was on a floor mat, and they moved everything out of the way and checked him every 20-30 minutes. She stated she kept watching him, he slept and was comfortable. Nurse #1 stated she finished her med pass, reported off to Nurse #2 around 12:00 PM and told her he was not care planned, and Nurse #2 needed to do a care plan. She didn't remember discussing a floor time intervention with Resident #1's family. She stated she worked 12-hour shifts and had worked Monday through Friday, off Saturday and back on Sunday if she remembered correctly. Nurse #1 stated even with staffing concerns the level of care was there, and no feeling of neglect for any of her residents ever occurred. She felt he was safer on the floor and it was not about convenience, if so, she would have had the nurse aides put him back to bed, and he didn't want to be in the bed. Nurse #1 stated there	L 039		

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was no time to document resident care during her shift, and she usually documented resident care at the end of her shift in the nursing progress notes. She stated floor time was usually documented in the nursing progress notes. She stated she did not recall offering Resident #1 any medications to help with behaviors. She stated she was in the residents room a lot, and had a med aide also, so she could run back and forth. She reported she didn't consider that Resident #1 had a fall, and he would get himself in a kneeling position. She stated, she couldn't say for certain what his cognition was because she didn't know him that well, but thought he had Lewy body dementia, and wandering. She stated floor time should be care planned, and she couldn't remember if time frames were required but it was according to individual resident. Nurse #1 stated; staffing became progressively worse during her time at the facility. She stated she was responsible as clinical coordinator and as a floor nurse for two houses. She reported as a clinical coordinator her responsibilities included; MDS, staffing, safety, nurse aides, communication, and education. There was no witness statement from Nurse #1.

The facility's investigation statement obtained from Nurse #2 (not dated) documented; on said day, Nurse #2 took report from Nurse #1 at 1:00 PM. It was reported to her that Resident #1 had been care planned to have floor time due to being restless and a danger to self. After report we went into residents room together, he was resting quietly on the mat bedside his bed with a pillow under his head and a blanket. She checked on Resident #1 multiple times during her time in the house. Later that afternoon maybe around 4:00 PM she had the nurse aides (Nurse Aide #1 and #2) help her get him up and into bed. He was still

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sleeping at her shift change at 7:00 PM.

An interview was conducted on 6/23/20 at 2:50 PM in the facility with Nurse #2. She stated she split the shift on that day with Nurse #1 and didn't know the resident well. She stated she was aware of floor time, and had a previous resident on floor time who wanted to be on the floor , they would move his stuff out of his room, and put mats down, they talked to his family and the Physician, and helped that resident onto the floor and they would check on him frequently. Nurse #2 stated that Nurse #1 had care planned him (Resident #1) for floor time and he was already on the floor when she came in to work. She (Nurse #2) stated he was there (on the floor) 3-4 hours and staff constantly checked on him during that time. She stated he fell asleep, and later they managed to get him into the bed she thought around 4:00 PM. She reported that floor time was not commonly used, and they generally tried to avoid using floor time, she stated that it was used because it was not a restraint and the resident would be provided with a floor mat.

In a follow up phone interview on 6/25/20 at 4:51 PM, Nurse #2 stated she came into work the day of the incident at 1:15 PM. She reported that Resident #1's room was near the nurse's station, and she would peek in at him each time she walked by his room. She stated he had a floor mat, blanket and pillow, and no "fixed" time to be on the floor. He was agitated, she cleansed the skin tear on his lower leg and applied a bandage.

A record review on 6/23/20 of the nursing progress notes from Resident #1's admission date on 2/24/20 through 3/19/20 revealed no documentation of Resident #1 being on the floor for floor time or being monitored for floor time.

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The nursing progress notes revealed Resident #1 had a fall without injury on 3/7/20 and 3/8/20. The nursing progress notes from 2/24/20 through 3/19/20 revealed Resident #1 had frequent behaviors of wandering in hallway and resident rooms, restlessness, and agitation.

Further record review on 6/23/20 revealed no documentation of a fall assessment, skin assessment, or frequent monitoring for Resident #1 on or after the day of the incident.

A phone interview was conducted with the facility Medical Director on 6/25/20 at 10:15 AM. She stated floor time was not common, through the years she had some residents that may have had floor time. She stated it could be considered if redirection or other interventions didn't work. If used, the nurse should assess the resident to determine, are they safe, clean, and nothing in the floor that could harm resident, it would be included in residents care plan, and no physician order was needed. She stated it was hard to predict the amount of time that would be needed for the resident. She stated she trusted nursing judgement at the facility and sees it as an intervention. She stated, if it was not working the Nurse Practitioner or Physician should be notified, and staff should check on resident. The Physician stated that if the nurses said he was okay, and had no pain, and the nurse really assessed the resident then she would be okay with it. She stated from 10:00 AM until 5:30 PM (7.5 hours) was not the best number (referring to the amount of time Resident #1 remained on the floor).

A phone interview was conducted on 6/25/20 at 5:00 PM with the facility Nurse Practitioner. She reported that she was aware of floor time, and

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DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

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L 039	Continued From page 11 indicated she was not aware of floor time for Resident #1. She stated floor time would be used to decrease agitation but couldn't say what the time frame to keep a resident on the floor would be and stated it would need to be included in the residents plan of care. An interview was conducted 6/23/20 with the Director of Nursing (DON). She stated floor time was a nursing intervention used to meet the needs of residents with significant behaviors, it was a nonpharmacologic intervention, and would be care planned. She stated after reviewing Resident #1's progress notes and speaking with staff, that on that day he had safety issues. She reported floor time for Resident #1 was an acute response to the situation, it was a household model. She stated floor time had no defining time limit, it was individualized to the resident's needs. She stated monitoring should be done in progress notes. She stated Resident #1 had hourly checks or less, and resident's room was close to the nurses station, and no order was needed for nursing interventions. She stated it was difficult to say what a reasonable amount of floor time would be. In a phone interview with the Administrator on 6/29/20 at 12:56 PM she stated the facility had no defined program or policy for floor time. She stated the Medical Director in conjunction with nursing services worked together to support residents with dementia when they lowered themselves to the floor.	L 039		