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	HAL014014	A. BUILDING: _____ B. WING _____	C 11/14/2014

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D 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an annual survey and complaint investigation on November 04, 2014 through November 14, 2014.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record review the facility failed to provide supervision and interventions for 4 of 6 residents with falls in the SCU (Special Care Unit) which resulted in fractures and death for Resident #7, fracture for Resident #6, severe facial bruising for Resident #5 and hip contusion for Resident #2. The findings are: Review of the facility Fall Policy and Procedure, dated 09/17/2009 included: - Residents will be evaluated for fall risk within 72 hours of admission. - If a resident is found to be a fall risk, a star will be placed on the resident's chart and door. - The care plan will reflect assistance required to meet individual needs. - Residents will be counseled to be sure to call for	D 270		

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help when needed.
- Restraint will not be used unless physician has ordered it to keep resident safe.
- Throw rugs not allowed.
- Residents encouraged to use hand rails, to wear shoes with good support and that have non-slip soles.
- If a fall occurs, resident will be assessed and incident report done, family notified, MD notified if injury.
- If injury, send to ED to evaluate and treat and notify DSS.
- If no injury, monitor closely for 24 hours.

A. Review of Resident #7's record revealed an FL2 dated 01/27/14 with diagnoses that included mental retardation and Parkinson disease.

Review of the most current FL2 dated 03/16/14 revealed diagnoses that included UTI (Urinary Tract Infection) and hypotension.

Review of the current Care Plan dated 07/07/14 revealed:
- Resident #7 wandered, did not speak, and used gestures to make needs known.
- Resident #7 was independent with ambulation and transfers.
- The goals on the care plan included providing the highest level of care within a safe environment.

Review of Resident #7's SCU quarterly profiles, dated 05/05/14 and 08/04/14, revealed the resident:
- Propelled self in wheel chair and needed assistance with transfers.
- Was ambulatory with wheel chair.
- Was a fall risk and wandered.
- Did not walk well or very far.

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D 270	Continued From page 2 - Had severe cognitive impairment. Review of Incident Report dated 03/01/14 at 9:45pm revealed: - Resident #7 rolled out of bed, hit right side of head on floor and had red spot above right eye. - Resident #7 was sent out by ambulance for evaluation at ED (Emergency Department) and returned with no new orders, diagnosis of head injury. - No interventions noted. Review of a Progress note dated 03/05/14 revealed: - Resident #7 was seen by the Physician Assistant for follow-up after the fall on 03/01/14. - No further falls reported. - Small contusion over right orbit. - Remains high-risk for falls. Continue to monitor. - Medications were reviewed. "No change in current medication regimen required at this time." - No other interventions noted. Review of Incident Report dated 04/06/14 at 2:30pm revealed: - Resident #7 fell while trying to self transfer from bed to wheel chair. - The resident was assessed for injuries (none noted) and taken to dining room to be observed. - No interventions noted. - Review of Incident Report dated 04/09/14 at 4:00pm revealed: - Resident #7 rolled out of bed onto floor. - The resident was assessed for injuries (none noted), assisted to wheel chair and taken to the dining room. - No interventions were noted. Review of Incident Report dated 08/23/14 at	D 270		

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3:40am revealed:
- Resident had vomiting and diarrhea off and on during third shift.
- Staff heard a noise in the resident's room and found resident had "fallen face first to floor".
- The resident had sustained a "large gash to right temple, skin tears to right shoulder and knuckle of right hand" and was sent to ED for evaluation.

Review of local hospital records dated 08/23/14 beginning at 4:32am revealed:
- Admitting diagnosis that included Multiple Cervical Vertebra Fractures and Respiratory Failure.
- Vital signs were: pulse 107; respirations 24; rectal temperature 99; blood pressure 83/47; and oxygen saturation 83% on 3 liters of oxygen per minute.
- Triage assessment at 04:33am: "Based on my assessment, there is no clinical suspicion of infection currently present, negative Severe Sepsis Screen.
- The resident had PEA (Pulseless Electronic Activity) at 4:57am, received compressions and was intubated at 5:00am.
- Differential diagnosis included Closed Head Injury with Intracranial Hemorrhage.
- The resident had a "2.6 to 7.5" centimeter full thickness laceration to right side of forehead that was repaired with sutures.
- Resident #7 was transported at 9:00am to a trauma center due to need of "higher level of care" and "neurosurgical care".

Review of records from the Trauma Center where Resident #7 was transferred revealed:
- Chief complaint: Septic Shock.
- CT spine showed "severely displaced fracture through base of dens, expected mass on cord;

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minimally displaced fracture of R lamina C1, spinous process of C6, anterior corner of T1 vertebra body."
- "Found to have C2 fractures as described above".
- "The patient is critically ill with the following critical problems: Septic Shock; Cardiac Arrest; Acute Respiratory Failure; Aspiration Pneumonia; Severe Hypoxemia and C2 Fracture."

Review of the Trauma Center Discharge Summary revealed:
- Admit date: 08/23/14, critical.
- Discharge date: 09/10/14 at 11:29am, deceased.
- Admitting diagnoses: Cardiac Arrest; Acute Hypoxemic Respiratory Failure; and Unstable C2 Fracture.
- Discharge diagnoses: Acute Hypoxemic Respiratory Failure due to Pseudomonal Pneumonia and Traumatic C2 Fracture.

Review of the trauma center Hospital Course summary included:
- The resident had recurrent hypotension during the hospitalization that was multifactorial; initially due to sepsis from aspiration pneumonia and "possibly also neurogenic due to spinal injury."
- The resident's C2 fracture stabilized by being placed in traction and followed closely by neurosurgical consult team, the resident was unable to be medically stabilized enough to be considered for surgical intervention for this problem.
- Through multiple meetings between Palliative care team the family a decision was made for compassionate extubation.

Telephone interview with Staff A (Supervisor/Medication Aide) on 11/06/14 at

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D 270	Continued From page 5 12:30pm revealed: - Staff A had worked third shift on 08/23/14. - Resident #7 was not restrained, independent with ambulation and was up and down all the time. - Resident #7 had been sick off and on with vomiting and diarrhea during her shift, which was not unusual. - Staff A had given the resident soda in hopes of settling the resident's stomach. - Staff A stated Resident #7 seemed better for a while but around 3:00am she heard a noise in the resident's room and found the resident had fallen. - Staff A sent resident to ED. Refer to interview with Nurse Supervisor on 11/05/14 at 4:30pm. Interview with the Nurse Supervisor on 11/06/14 at 11:00am revealed: - Resident #7 was assessed for falls on admission but had only scored a "1". - The resident was re-assessed after each fall and per their scoring sheet, the resident's highest score was a "6", not enough to be considered high risk. Refer to interview with Administrator on 11/06/14 at 10:45am. B. Review of Resident #6's FL2 dated 01/06/14 revealed: - Diagnosis of Alzheimer's. - The resident was constantly disoriented, ambulatory and a wanderer. Review of Resident #6's Special Care Unit Profile dated 08/08/14 revealed the resident: - Wandered. - Required assistance with bathing and dressing.	D 270		

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D 270	Continued From page 6 - Was constantly disoriented. Review of Resident #6's admission Fall Assessment dated 01/10/14 revealed: - A score of 4 (Refer to interview with Nurse Supervisor on 11/05/14 at 4:30pm). - No reassessment for falls. Review of Incident Report dated 05/09/14 at 9:00am revealed Resident #6: - Lost balance and fell into a bathroom cabinet. - Had a mark on her left eye. - Was reassessed at 11:00am and had a bruising on her left eye and arms. - No interventions noted. Review of a Progress Note dated 05/14/14 revealed: - Resident had been seen by Physician's Assistant for a lump on left bicep - Fall was not addressed. - No interventions noted. Review of an Incident Report dated 08/26/14 at 4:00am revealed: - Resident was found standing in a bathroom bleeding profusely from the head. - The resident was not able to report what happened. - Resident was transported to the emergency room and returned to the facility with staples. - No interventions noted. Review of a Progress Note dated 08/27/14 revealed Resident #6 was: - Seen by physician for follow-up after fall. - Remains high risk for further falls and fractures. - No interventions noted. Review of a Nursing Note dated 10/17/14	D 270		

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revealed:
- Resident #6 slipped and fell in the dining room after getting up from her chair
- Resident hit the back of her head.
- EMS was called and assessed the resident, however, did not transport the resident the ED.
- The resident was "monitored rest of shift".
- No other interventions noted.

Review of an Incident Report date 11/01/14 at 10:30am revealed Resident #6:
- Started to stand up beside bed, lost balance and went down to the floor.
- Had no complaints of pain.
- Had a portable X-ray completed at 9:30pm "due to swelling in the knee"
with results received the morning of 11/02/14 that revealed a femur fracture.
- Was transported to the emergency room on 11/02/14.

Review of local hospital Admission record dated 11/02/14 at 11:38am revealed:
- Resident presented with pain of right leg; symptoms "alleviated by nothing"; symptoms "aggravated by movement", unable to bear weight;
"at their worst the symptoms were severe".
- Vital signs: BP 146/94; pulse 150; respirations 24; rectal temperature 97.1.
- Decreased ROM, swelling, tenderness in lateral aspect of right thigh.
- Differential diagnoses "dislocation, closed fracture, contusion".
- Initial diagnosis: Right Femoral Neck fracture; Pneumonia; atrial Fibrillation.

Review of local hospital Discharge Summary dated 11/11/14 revealed:
- Patient expired.

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D 270	Continued From page 8 - Final diagnoses of Pulmonary Emboli , Pneumonia, Right Femoral Neck Fracture; repaired. - Hospital course included: anticoagulation therapy for PE; surgical repair of femoral fracture; mechanical ventilation; antibiotic treatment for pneumonia; enteral feeding; 11/10/14 the resident had questionable "intracranial hemorrhage or ischemic event"; little to no improvement on 11/11/14, all supportive care, treatment and medical evaluation stopped per family request. During an interview on 11/05/14 at 11:45am the SCU coordinator stated: - She was not aware of any interventions put into place to prevent Resident #6 from falling. - She "did not work those days" but that was "not a good excuse". During an interview with Staff B (Supervisor/Medication Aide) on 11/05/14 at 3:05pm, Staff B stated: - Resident #6 fell on 11/01/14 while trying to stand up beside the bed and "just went to the floor". - The resident had no complaint of pain. - An X-ray was done around 9:30pm that evening because of "swelling" in the Resident's knee. - At the time of X-ray Resident could still bend knee and had no complaints of pain. Interview with Nursing Supervisor on 11/06/14 at 11:30am revealed: - Resident #6 was not assessed as high risk for falls - After the fall on 05/09/14 Resident#6 was placed on 15 minute checks for a week. - After the fall on 08/26/14, Resident#6 was placed on 15 minute checks for 3 days. - After the fall on 10/17/14, Resident#6 was	D 270		

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placed on 15 minute checks for a week.
- A new fall assessment was not completed and no other interventions were put in place.

Refer to interview with Nurse Supervisor on 11/05/14 at 4:30pm.

Refer to interview with Administrator on 11/06/14 at 10:45am.

C. Observation of Resident #5 on November 04, 2014 at 10:45am revealed:
- Resident #5 was sitting in a chair, slumped over and leaned to the right side with torso resting on the chair arm.
- A dark bluish/purple area covering the resident's right eye, forehead and right cheek.
- The resident stated "I hit the floor."
- During interview at this time, the Special Care Unit coordinator stated, "[the resident] sits that way."

Review of Resident #5's current FL2 dated 03/05/14 revealed:
- Diagnosis included Vascular Dementia.
- The resident was intermittently disoriented.
- The resident was semi-ambulatory with a wheelchair at times.

Review of Admission Fall assessment dated 03/06/12 revealed Resident #5:
- Was assessed as a 10 (Refer to interview with Nurse Supervisor on 11/05/14 at 4:30pm).
- Was reassessed on 01/14/13 as an 11.
- Was reassessed on 5/17/13 as a 9 with no further reassessments after 05/17/13.

Review of Care Plan dated 06/16/14 revealed Resident #5:
- Had several falls.

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D 270	Continued From page 10 - Had PT ordered 06/11/14. - Required a one person assist with most activities of daily living. - Used wheelchair when out of room. - Ambulated short distances with a walker. - Needed limited assistance with ambulation. - Was "sometimes" disoriented. Interview with Resident #5 on 11/4/14 at 3:05pm revealed: - The resident was alert and oriented to person and place. - The resident had frequent falls and did not know why. - The resident would like for someone to "figure out" what made her fall. - The resident was frequently dizzy. - The resident could not recall what had been done to prevent falls. Review of an Incident Report dated 3/24/14 at 11:05 (not specific to am or pm) revealed Resident #5: - Slid out of bed. - Did not have any bruises or injuries. - No interventions noted. Review of Incident Report dated 05/25/14 at 2:30pm revealed Resident #5: - Got dizzy and fell. - Tried to get up but had pain in hip. - Was transported to the ED for further examination but no other interventions noted. Record review revealed ED Discharge Instructions dated 05/25/14 with diagnoses of Hip-Thigh Sprain and Right Forearm Contusion. Review of Physician Progress Note dated 05/29/14 revealed:	D 270		

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- Resident #5 was seen for evaluation after the fall (on 05/25/14) and ED visit.
- The resident's medication was reviewed.
- The resident was non-compliant with use of walker and the MD discussed the need to use assistive devices.
- No other interventions were noted.

Review of an Incident Report dated 06/04/14 at 9:50pm revealed Resident #5:
- Tried to get out of bed, fell and hit her head on the right side.
- Had a bruise above the right eye; skin tears on right arm; had hit head on night stand.
- Had reported to staff she was dizzy.
- Was transported to the ED; returned with no new orders.
- No interventions noted.

Review of Incident Report dated 06/08/14 at 2:00pm revealed Resident #5:
- Was in her room, got dizzy, fell and hit her head on the night stand.
- Was transported to the ER due to head injury.
- Was returned to the facility with staples.
- Was placed on 15 minute checks until follow-up with primary physician.

Review of Emergency Room Discharge Instructions dated 06/08/14 revealed:
- Diagnoses of Scalp Laceration, Hip Contusion and Hand Contusion.
- Staples to be removed in one week.

Review of Physician Progress Note dated 06/11/14 revealed:
- Resident continued to be high risk for falls.
- Was encouraged to use assistive devices.
- Recommended Physical Therapy Evaluation.
- Medications were adjusted.

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D 270	Continued From page 12 Review of Physical Therapy Records revealed: - Resident received physical therapy from 07/01/14 to 8/29/14 - Resident was instructed on the use of assistive devices, safety in activity of daily living, fall precautions, and mobility safety. Record review revealed no other interventions were put in place after the therapy. Review of Incident Report dated 10/17/14 at 9:00pm revealed Resident #5: - Was getting something out of dresser drawer and fell hitting left hand. - Had a skin tear on top of left hand. - No interventions noted. Review of Incident Report dated 10/26/14 at 10:30pm revealed Resident #5: - Was found lying in the floor, face down. - Had a skin tear on left arm. - Had a large knot of the right side of forehead. - Was transported to the ED and returned with no new orders. - No interventions noted. Review of Emergency Room Discharge Instructions dated 10/26/14 revealed diagnoses that included: - Closed Head Injury. - Back Sprain. - Upper Limb Abrasion. Review of Physician Progress Note dated 10/27/14 revealed: - Resident #5 was seen for follow-up of recurrent falls and had no obvious etiology for falls. - "Ther are no other measures that have not already been taken to reduce falls".	D 270		

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D 270	Continued From page 13 Interview with Guardianship Case Manager on 11/5/14 at 2:25pm revealed: - The Case Manager visited at least quarterly and talked to the facility at least monthly. - The Case Manager was very concerned about Resident #5's falls. - On 6/9/14, the Case Manager spoke with the Nurse Supervisor and discussed providing fall mats for Resident #5 and moving the resident's night stand. - On 6/14/14, the Case Manager was told the facility would use fall mats. - On 10/27/14, Case Manager visited facility and no fall mats were in place. - A Personal Care Aid informed the Case Manager Resident #5 had never had fall mats. Interview with Staff E (Personal Care Aid) on 11/5/14 at 9:50am revealed Staff E: - Did not know if any interventions were put in place to prevent Resident #5 from falling. - Had personally tried to make sure Resident #5 had things she needed within the resident's reach. Interview with Special Care Unit (SCU) Coordinator on 11/05/14 at 10:45am revealed: - A mattress had been placed under Resident's bed that morning, with a note for staff to pull mattress out at night. - Resident #5 usually falls in the evenings, so the SCU Coordinator was not sure what interventions were previously in place. During an Interview on 11/05/14 at 10:50am the Nurse Supervisor stated: - Resident #5 had been seen by the Physician's Assistant "today." - The Physician's Assistant had ordered a PT	D 270		

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	HAL014014	A. BUILDING: _____ B. WING _____	C 11/14/2014

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and Neurology Consult.
- A mattress had been placed under Resident#5's bed to be used at night to prevent injury in the event of a fall.
- Resident #5's nightstand had been relocated.

During a follow-up interview on 11/06/14 at 9:45am the SCU Coordinator stated she did not know anything about placing stars on resident's beds to indicate a fall risk.

Refer to interview with Nurse Supervisor on 11/05/14 at 4:30pm.

Refer to interview with Administrator on 11/06/14 at 10:45am.

D. Review Resident #2's FL2 dated 08/04/14 revealed diagnoses that included:
- Alzheimer's with delusions and psychosis.
- Fall with hip fracture.

Review of Resident #2's admission Fall Assessment dated 08/07/13 revealed:
- A score of 9. (Refer to interview with Nurse Supervisor on 11/05/14 at 4:30pm).
- No reassessments for falls since admission.

Review of Resident #2's initial Care Plan completed 09/06/13 revealed the resident:
- Wandered.
- Was ambulatory, but used a wheel chair or walker at times.
- Needed only supervision with ambulation.

Review of Incident Report dated 03/26/14 at 6:35 (not specific to am or pm) revealed Resident #2:
- Got out of bed and fell on floor hitting left hip and left knee.
- Was sent out to ED due to pain and "possible

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injury".
- Was admitted to hospital.

Review of Hospital Discharge summary dated 04/01/14 revealed Resident #2 was admitted 03/27/14 with left hip fracture that required hemiarthroplasty.

Review of Physical Therapy discharge summary revealed:
- Resident #2 received therapy 04/02/14 through 05/21/14.
- The resident progressed well throughout course of therapy, however balance and gait was limited by cognitive decline.

Review of Incident Report dated 04/06/14 at 2:15pm revealed:
- Resident #2 tried to get up and walk, slid down on foot rest of geri-chair, no injuries.
- No other interventions noted.

Review of Significant Change Assessment dated 04/09/14 revealed:
- Recent Hip Fracture.
- Geri-chair for locomotion and may use wheelchair as needed.
- Resident needed total care with all activities of daily living.
- Receiving Physical Therapy to strengthen resident's ability to be able to walk again.

Review of Incident Report dated 08/22/14 at 3:20pm revealed:
- Resident #2 got out of bed, fell to the floor.
- Initial assessment revealed no injury, during transfer to Geri-chair, resident complained of left hip pain and swelling was noted.
- The resident was sent to ED for evaluation.

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Review of the Hospital ED visit dated 08/22/14 at 5:16pm revealed diagnoses of Contusion of left hip and single hematoma (a bruise with swelling and some bleeding under the skin).

Review of Nurses' Notes dated 08/22/14 revealed:
- Resident fell getting out of bed.
- Sent to ED.
- Has contusion to left hip/single hematoma.
-Will watch resident for any changes/complaints.
- No other interventions were noted.

Interview with the Nurse Supervisor on 11/05/14 at 4:30pm revealed:
- Upon admission, all residents were assessed for falls.
- If a resident scored 10 or greater, the resident was considered at risk for falls and a "star" was placed on their charts and on the head of their beds to alert staff.
- After the first fall, the resident was seen by the physician or the physician assistant for medication review.
- If a resident fell again, they were seen by the physician and 15 minutes checks were initiated for a few days.
- There really was no other system to manage falls.

During an interview on 11/06/14 at 10:45am, the Administrator stated the facility did not have an adequate system to manage and prevent falls.

An follow-up interview was conducted with the Nurse Supervisor on 11/14/14 at 8:50am. The Nurse Supervisor stated:
- On admission, Resident #2 was ambulatory with walker.
- The resident had scored "9" on the initial Fall

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D 270	Continued From page 17 Risk Assessment, which did not put the resident at high risk (per their assessment tool). - After the resident's first fall March 26, that resulted in a fractured hip, the resident was now non-ambulatory, received physical therapy and placed in a Geri-chair, therefore the resident was not reassessed for being a fall risk. - At the time of the April 6th fall, the resident was currently receiving physical therapy so no other interventions were put in place. - After the August 22nd fall, the resident was placed on 15 minutes checks for 24 hours but no additional interventions were initiated. --- A Plan of Protection was submitted by the facility on November 05, 2014 that included: - Physical therapy, neurology, and cardiology consult was ordered for Resident #5. - The nightstand was moved and a fall mat will be placed on the floor beside Resident #5's bed. - Resident #5 will be evaluated for a higher level of care. - All staff will receive immediate education on closer monitoring of residents then a Registered nurse would do further training. - Residents who are high risk for rolling out of bed will have a roll blanket placed behind them and a fall mat placed on the floor. - Residents shoes will be checked to ensure they are tied and/or are wearing non-slip socks. - 15 minutes checks will be initiated for residents with or at risk for falls. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 14, 2014.	D 270		

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D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to treat residents with dignity and respect for 5 of 7 residents who were alert and oriented. The findings are: Confidential interviews with 5 of 7 Resident revealed: - Staff "get an attitude" when asked to provide assistance. - Staff working at night were rude at times. - Sometimes staff were hateful to Resident's in the facility. - Staff sigh and groan when Resident requested help. - Resident had seen staff "picking on" other resident's. - Staff at night sometimes refused to help resident's to bed. - Staff talked "hateful" and "get smart" with residents. - Resident had been recently told to "get out" of the dining area when trying to locate a staff member to assist another resident. - Staff had been regularly hateful to a resident who "cuts a shine" by threatening to take her	D911		

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D911	Continued From page 19 pocketbook. - Staff were hateful and upset if Resident's request condiments during meals. - Staff seemed "like they just don't have time to help anybody". Telephone interview with Personal Care Aide on 11/5/14 at 4:25pm revealed: - Staff understood resident rights to mean if residents were "in their right mind you cannot force them to do something". - You are to treat them with "respect & dignity". - Staff reported concerns about resident rights to the Medication Aide or Nurse Supervisor. Interview with Nurse Supervisor on 11/6/14 at 10:45am revealed: - Staff were aware to report any concerns about Resident Rights to the Nurse Supervisor. - Resident Rights are reviewed with residents during Resident Council meeting and any concerns are addressed. - The facility does not tolerate staff being rude or disrespectful to residents.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which are adequate,	D912		

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D912	Continued From page 20 appropriate and in compliance with relevant federal and state laws and rules and regulations related to fall prevention. The findings are: Will add prelininary statementn after QICXXXXXXXXXXXXX [Refer to tag D270, 10A NCAC 13F .0901(b). (Type A1 Violation)]	D912		