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TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

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D 000	Initial Comments The Adult Care Licensure Section conducted a Complaint Investigation and a COVID-19 focused Infection Control survey with an onsite visit on September 09, 2020 and a desk review and telephone exit on September 14, 2020.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: THIS IS A TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the acute healthcare needs were met for 1 of 5 sampled residents (Resident #1) related to injuries sustained after a fall and evidence of blood in her brief. The findings are: Review of Resident #4's current FL2 dated 01/10/20 revealed: -Diagnoses included Alzheimer's dementia, hypertension, asthma, depression, anxiety, and urinary tract infection. -Resident #1 was documented as constantly disoriented, ambulatory, and incontinent of bowel and bladder. Review of the facility's policy on "How to Report a Resident Incident" dated 01/21/18 revealed: -"It was the facility's policy to ensure resident incidents were reported internally, and if required,	D 273		

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externally, in a consistent manner for risk management and quality assurance and improvement purposes."
-Examples of resident incidents included when "a resident exhibited signs of an injury such as scratches, scrapes, bruising, fractures, etc." and when "a resident suffered a suspected fall."
-Resident incidents were to be reported by the supervisor.

Review of the facility's policy on "Physician Notification Regarding Resident's Condition" dated 01/21/18 revealed:
-"It was the facility's policy that when the Executive Director (ED), Resident Services Director (RSD), or other responsible person felt the primary physician or specialist of a resident should be consulted on health concerns, the following steps should be taken."
-The steps to be taken included if a resident had not been able to assume responsibility for themselves, the contact noted in their record should be contacted, the situation discussed, and the discussion documented.
-Possible reasons for contacting the physician included "any condition or incident which required documentation on an incident report; any time notification of a physician was required under state regulations; and if a resident's condition became serious or deteriorated significantly."

A. Review of Resident #1's accident report dated 09/01/20 revealed:
-The date of the accident was documented as 08/31/20 (no time was documented).
-There was documentation Resident #1 was being assisted out of bed by a personal care assistant (PCA).
-The PCA was holding Resident #1 by the arm, the PCA turned to cut off the bed alarm, the

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resident pulled loose from the PCA, and before the PCA could get to the resident, the resident stumbled and fell on her left side.
-The medication aide (MA) checked Resident #1 and the resident had no visible injuries, she was assisted up, and was able to walk with no pain or discomfort.
-Resident #1's Power of Attorney (POA) was notified on 09/01/20 (no time was documented).
-Resident #1's Primary Care Provider (PCP) was notified on 09/01/20 at 12:30pm.

Review of Resident #1's progress note dated 08/31/20 revealed:
-The progress note was completed by the facility's Registered Nurse (RN).
-There was documentation, the MA notified the facility's RN that Resident #1 had a bruise under her breast.
-The RN assessed Resident #1, and she did not have any complaints of pain or shortness of breath (SOB) noted at that time.
-The supervisor was to notify the PCP to request an order for an X-ray.
-The staff were to monitor Resident #1 and notify the supervisor of any changes.

Review of Resident #1's progress note dated 09/01/20 at 1:15am revealed:
-Resident #1 was found to have a bruise under her right breast, a swollen breast, and a rapid pulse.
-Emergency Medical Services (EMS) was called and Resident #1 was transported to the local hospital.
-The facility's supervisor left messages, beginning at 1:40am and throughout the night for Resident #1's POA, but she did not return the call.
-Resident #1's PCP was notified on 09/01/20 at 12:30pm.

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D 273	Continued From page 3 Review of a fax dated 09/01/20 at 1:42pm revealed: -The fax was sent to Resident #1's PCP by the facility. -The fax contained documentation that a PCA was assisting Resident #1 out of bed, the PCA was holding the resident by the arm, the PCA turned to cut off the bed alarm, the resident pulled loose from the PCA, and before the PCA could get to the resident, the resident stumbled and fell on her left side. -The fax contained documentation that Resident #1 had no visible injuries, was assisted up to walk, and had no pain or discomfort. -There was documentation the fax had been returned to the facility on 01/09/20 at 6:41pm with a handwritten note from the PCP "no new orders." Review of Resident #1's record revealed: -There was no documentation the PCP was notified of Resident #1's swollen breast, bruising, or rapid pulse. -There was no documentation the PCP was notified Resident #1 was sent to the hospital via EMS. Review of Resident #1's EMS report dated 09/01/20 revealed: -EMS was dispatched to the facility at 1:32am, and they reached the resident at 1:42am. -Facility staff reported Resident #1 "was having trouble walking and we helped her to the floor gently." -Facility staff reported that Resident #1's "left breast looked like it had a heart beat." -"Facility staff denied having any knowledge of patient being injured or falling and hitting anything." -EMS staff assessed Resident #1 and found her	D 273		

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"left breast to be swollen and badly bruised. The bruising was noted to be black and blue covering left breast. Patient's breast was pulsating. The breast was noted to pulsate when patient took a breath. Patient's ribs assessed and crepitus noted on palpation." (Crepitus is a grating sound or sensation produced by friction between bones and cartilage or the fractured parts of bone).
-Resident #1 was found to have tachypnea respirations (abnormally rapid breathing).
-Resident #1's initial oxygen saturation was 85% on room air (a normal level is 95-100%).
-EMS staff administered 4 liters/minute (L/M) oxygen via nasal cannula to Resident #1 and her oxygen saturation improved to 95%.

Review of Resident #1's Emergency Department (ED) documentation note dated 09/01/20 at 2:11am revealed:
-Resident #1 presented to the ED for evaluation of "right chest wall injury."
-According to EMS, Resident #1 "had a fall about 12 hours ago. She was lowered to the floor without any definite direct trauma."
-Facility staff noticed that Resident #1's "right breast had a pulse and EMS was called."
-EMS reported "oxygen saturation in the mid-80s on room air. She was placed on nasal cannula and it brought her oxygen saturation up in the mid-90s."
-Resident #1 had a "flail chest on exam." (Flail chest is a life-threatening medical condition that occurs when a segment of the rib cage breaks due to trauma and becomes detached from the rest of the chest).
-Resident #1 had "crepitus and bruising and swelling of her right breast."
-When Resident #1 would "breathe in, her right breast got larger."
-There was a "concern for rib fractures as well as

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underlying pneumothorax." (Pneumothorax is a collapsed lung).
-"The injury occurred 12 hours ago and therefore we will hold off on calling trauma code."

Review of Resident #1's hospital History and Physical dated 09/01/20-09/04/20 revealed:
-Resident #1 presented to the ED with "right-sided subcutaneous emphysema and palpable deformity of the right chest wall." (Subcutaneous emphysema refers to a condition where air is trapped in the tissue beneath the skin).
-A chest X-ray showed Resident #1 had a "50% right pneumothorax."
-Initially, a percutaneous chest tube was placed, but this would not expand Resident #1's lung adequately.
-Resident #1 was "taken over to radiology for CT (computerized tomography) scanning for evaluation of her blunt torso trauma."
-The CT scan showed Resident #1 had "multiple right-sided rib fractures with what appeared to be anterior posterior fracture right ribs 3 and 4."
-The CT scan showed Resident #1 had "a large pneumothorax still after the placement of a percutaneous chest tube."
-The small chest tube was removed, and a larger one was inserted.
-Resident #1 was admitted to the Intensive Care Unit (ICU).
-Plating (reconstruction using plates and screws) of the chest wall was being considered.
-Resident #1 "seemed to have some pulmonary contusion involving the right lung." (pulmonary contusion is a bruise of the lung caused by chest trauma).

Review of Resident #1's hospital discharge summary revealed:

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-Resident #1 was discharged from the hospital on 09/04/20.
-Resident #1 had been "admitted to the ICU and remained stable."
-Resident #1 "had a continued air leak from the right chest and Heimlich valve had been placed." (A Heimlich valve is a small one way valve for chest tube drainage for fluid to leave the lung).
-Resident #1 was "discharged home with right chest tube and chest drain valve."
-"Palliative care consulted and with incidental finding c/w (consistent with) metastatic liver disease and possible focal mural mass in sigmoid colon," the family had elected to take Resident #1 "home for end of life care with assistance of Hospice."

Review of Resident #1's Addendum to her hospital Final Report dated 09/02/20 at 12:54pm revealed:
-The addendum was electronically signed by the physician.
-There was documentation given Resident #1's "significant chest wall disruption and injury, I have concerns for nonaccidental trauma. The story initially by EMS on the scene, per their documentation, showed that the caretakers did not know she had sustained any trauma however this story was different in the ER (emergency room) that she had sustained trauma 12 hours earlier but that it was a gentle fall to the floor. Neither story is consistent with the patient's traumatic injuries."
-There was documentation "it would have taken a significant force to disrupt her chest wall in this fashion, either a fall onto an object or blunt trauma."
-There was documentation Resident #1 had what "appears to be a liver full of metastatic lesions and possible colon primary. She has severe

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dementia. This combination of factors puts her at significant risk of an extremely poor prognosis and possibly even death from respiratory insufficiency. Clinically she is stable right now on 2L, (oxygen) however I do have serious concerns that she is going to continue to decline. She is at risk of developing a pneumonia as well. She is unlikely to be able to participate in any pulmonary toileting." (Pulmonary toileting refers to exercises and procedures that help clear the airways of mucus and other secretions).

Telephone interview with a third shift PCA on 09/11/20 at 2:40pm revealed:
-Resident #1 had dementia and only spoke in one-word sentences.
-Resident #1 was ambulatory, but often required assistance with guiding her because she walked with her eyes closed.
-Resident #1 required 1-person assistance to transfer.
-She worked the night of 08/31/20 when Resident #1 fell.
-She entered Resident #1's room around 6:20am to get her up for the day.
-She sat Resident #1 on the side of her bed to "allow her to wake up."
-She stood Resident #1 up facing her, and then moved her to her right side.
-She realized a cord from Resident #1's bed alarm was wrapped around her foot (the PCA's foot) so the PCA bent down with her left hand to remove the cord while still holding Resident #1's pants waistband with her right hand.
-Resident #1 was holding the PCA's arm.
-Resident #1 slipped out of the PCA's grip and fell to the floor on her left side.
-Resident #1's body did not come in contact with the PCA's body as she fell.
-"It happened so fast," she could not say if

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Resident #1 hit her right side on anything.
-The PCA yelled for the MA, and the MA came to Resident #1's room.
-The MA stayed with Resident #1 while the PCA left the room to get the supervisor.
-The supervisor instructed the PCA to have the MA assess Resident #1 for injuries and call her back.
-The PCA and the MA patted Resident #1's entire body, and she did not complain of pain.
-She asked if Resident #1 was in pain, and she replied "no."
-The MA lifted Resident #1's clothes and did not find any evidence of bruising.
-The MA and PCA placed Resident #1 in a recliner in her room and sat with her for "a few minutes."
-The MA and PCA then assisted Resident #1 to walk to the activity room.
-Resident #1 was seated in a chair and provided a cup of water.
-Resident #1 was able to lift the cup of water to her mouth with no complaints, and she was reaching toward the floor with her arms without complaint.
-The PCA did not dress Resident #1 after her fall because she had already changed her clothes during a prior round at 3:00am.
-She left her shift at approximately 7:05am and did not work the following night.
-She did not report the fall to any oncoming morning shift staff because that was the supervisor's responsibility.
-She later found out Resident #1 was sent to the hospital via EMS with significant injuries approximately 19 hours later.
-She did not think Resident #1's injuries could have resulted from the fall she witnessed.

Telephone interview with a third shift MA on

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D 273	Continued From page 9 09/11/20 at 2:20pm revealed: -She worked the night of 08/31/20 when Resident #1 fell. -She was not in Resident #1's room when the fall occurred. -At approximately 6:20am, the PCA yelled for her. -She entered Resident #1's room and found her lying on her left side with her hands behind her head at the foot of her bed. -She instructed the PCA to call the supervisor on duty in the building. -She stayed with Resident #1 while the PCA called the supervisor. -The PCA reported the supervisor wanted her to assess the resident and let her know if she was injured. -She patted Resident #1 down both of her sides, and she had no complaints. -She lifted Resident #1's shirt and her pants legs and found no bruising. -She and the PCA assisted Resident #1 from the floor and placed her in a chair in her room. -She and the PCA sat with Resident #1 in her room for approximately 5 minutes and then assisted her to a table in the activity room. -The PCA sat with Resident #1 in the activity room. -The PCA dressed Resident #1 after her fall, and she still had no complaints of pain. -She did not have a conversation with the PCA regarding the fall prior to leaving the facility. -She assumed Resident #1 had an assisted fall, because the position she found her in, was similar to the position Resident #1 was in when she had previously assisted her to the floor and because she did not hear Resident #1 fall. -She reported the incident to the morning shift MA as an assisted fall. -Usually either the MA or the supervisor would complete an incident report, contact the resident's	D 273		

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POA, and the PCP.
-She did not complete an incident report because she thought the supervisor was completing it.
-She did not contact the PCP because that was to be done when the incident report was completed by the staff person completing the incident report.
-She left her shift around 7:30am and did not work the following night.
-The PCA later told her (when they worked together again) that Resident #1 had slipped from her hands and fell to the floor, unassisted.

Telephone interview with a third shift supervisor on 09/11/20 at 12:08pm revealed:
-She was working as the supervisor on 08/31/20 when Resident #1 fell.
-Around 6:20am, the PCA called her to report Resident #1 had fallen.
-She instructed the PCA to have the MA assess Resident #1 for injuries and call her back.
-She did not see Resident #1 because she was not allowed to go on the COVID-19 positive hall.
-The PCA and MA reported that Resident #1 had no complaints of pain or any injuries.
-It was her responsibility to complete an incident report, call the POA, and call the PCP, but she was busy with another resident and forgot to do it.
-She did not write the incident up in the 24-hour log book for the next shift to see, and she did not report the incident to the oncoming morning shift which were also her responsibilities.
-The morning was "so hectic that her mind went blank."
-She thought the MA reported the incident to the oncoming morning shift.

Telephone interview with a first shift PCA on 09/10/20 at 2:27pm revealed:
-She worked the morning shift on 09/01/20 after Resident #1's fall.

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-Resident #1 was dressed when she arrived at her shift at 7:00am.
-Resident #1 started complaining of pain shortly after her shift began (sometime between 7:00am-8:00am) when she moved her from the activity room.
-Resident #1 would say "ouch" and grab her side whenever she attempted to move her.
-She took Resident #1 to the dining room for breakfast around 8:00am, and she complained of pain.
-She did not report Resident #1's complaints of pain to anyone and could not say why she did not.
-She and another PCA were assisting Resident #1 back to her room after lunch, and Resident #1 complained of pain again.
-The other PCA reported Resident #1 had a fall earlier that morning on 3rd shift.
-She and the other PCA lifted Resident #1's shirt and found a bruise under her right breast wrapping around to her back.
-Resident #1's bruise was red in color, the length of her hand, and the width was "a little larger than a quarter in size."
-She and the other PCA reported Resident #1's bruise to the Memory Care Coordinator (MCC) and the supervisor on duty.
-The MCC and the supervisor on duty, both, looked at Resident #1's bruise.
-Resident #1 continued to complain of pain throughout her shift.
-She left her shift at 3:00pm.

Telephone interview with a first shift PCA on 09/10/20 at 11:43am revealed:
-She worked first shift on 09/01/20 after Resident #1's fall.
-Her shift began at 7:00am.
-Resident #1 was already dressed by third shift when she arrived.

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-She was told by the first shift MA, Resident #1 had a fall earlier that morning on third shift.
-Resident #1 was "not too much herself that morning."
-It usually only took one person to stand her up, but that day it took two people.
-She and the other PCA were walking Resident #1 back from breakfast around 8:30am-8:50am.
-Resident #1 "jerked in pain" and said "ouch" when she and the other PCA put their hands under her arms to transfer her and assist her with ambulation.
-She and the other PCA lifted Resident #1's shirt to find a bruise going from the middle of her breast, underneath her arm, and around her back.
-Resident #1's bruise was purplish black and about the width of her wrist.
-She and the other PCA immediately reported Resident #1's pain and bruise to the supervisor on duty.
-The supervisor looked at Resident #1's bruise immediately and notified the facility's RN.
-She did not know if the RN assessed Resident #1 because she went on her break.
-Resident #1 continued to complain of pain throughout the day when they would attempt to toilet her.
-She left her shift at 3:00pm.

Interview with a first shift MA on 09/09/20 at 11:42am revealed:
-She worked first shift on 09/01/20 after Resident #1's fall.
-Resident #1 could ambulate on her own, but staff would often guide her because she would "walk into walls with her eyes closed."
-Resident #1 was a one person assist with transfers and personal care.
-When she arrived at her shift, she was told by

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third shift staff, Resident #1 was "lowered to the floor" on their shift.
-Around 12:30pm, a PCA reported Resident #1 kept saying "oww, oww, oww," when she would try to assist her with walking, by holding her under her arms.
-She lifted Resident #1's shirt and saw a "big bruise" on her side.
-She immediately reported the bruise to the supervisor on duty.
-The supervisor on duty looked at Resident #1's bruise and talked to the RN about it.
-She did not remember the RN assessing Resident #1.

Interview with a first shift supervisor on 09/09/20 at 3:10pm revealed:
-She worked first shift on 09/01/20 after Resident #1's fall.
-When she arrived at her shift, third shift staff reported Resident #1 was "lowered to the ground" on their shift.
-Third shift staff reported Resident #1 was not injured.
-Around 11:00am, Resident #1's MA reported she was complaining of pain and had a bruise.
-She looked at Resident #1's bruise and reported the bruise to the RN.
-She thought the RN was going to assess Resident #1, but she could not recall seeing her do so.
-It was either the MA or the supervisor's responsibility to complete an incident report, call the POA, and the resident's PCP.
-She did not complete an incident report on Resident #1's bruising because that would have been third shift staff's responsibility since the bruising was a result of the fall that occurred on their shift.
-She did not notify Resident #1's PCP of her pain

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and bruising.
-She only did what the RN told her to do, and the RN did not tell her to contact Resident #1's PCP.

Telephone interview with the MCC on 09/14/20 at 11:00am revealed:
-She normally worked 8:30am-5:00pm on Resident #1's hall.
-She was responsible for providing oversight to the staff on her hall.
-When she arrived at her shift on 09/01/20, first shift staff reported Resident #1 was "lowered to the floor" earlier that morning on third shift.
-Resident #1 was eating breakfast when she arrived at her shift.
-Resident #1 did not seem any different to her than normal.
-Shortly after lunch, the PCAs were assisting Resident #1 to the bathroom and noticed bruising on her breast and side.
-She looked at Resident #1's bruise and found it to be purple/blueish in color and about the size of an apple.
-She reported the bruise to the supervisor on duty and asked her to report it to the RN.
-The supervisor looked at Resident #1's bruise.
-She did not see the RN perform an assessment of Resident #1.
-The supervisor on duty was normally responsible for contacting the resident's PCP when needed.
-She was "under the impression" the supervisor was contacting Resident #1's PCP to request an order for a mobile X-ray.
-She left her shift at 5:00pm.
-She never heard, and no one ever reported to her, that Resident #1 was in any pain.

Interview with the facility's RN on 09/09/20 at 3:13pm revealed:
-She was the Regional Clinical Operations

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Specialist.
-She acted as the Resident Services Director (RSD) in her absence.
-On 09/01/20 between 10:00am and 12:00pm, the 1st shift supervisor on duty reported staff had found bruising on Resident #1's right side.
-She instructed the 1st shift supervisor to contact Resident #1's PCP to request an order for a mobile X-ray because this should be the process anytime a resident had unexplained bruising.
-She assessed Resident #1 and found a "small" bruise about the width of three fingers under her breast.
-Resident #1 had no complaints of pain or SOB.
-She pressed on the area of Resident #1's bruising, and she did not complain of pain.
-The MCC watched Resident #1 "all day," and told her, she was fine.
-She checked on Resident #1 between 4:00pm and 6:00pm, before she left her shift, and Resident #1 had no complaints of pain or SOB.
-She did not observe Resident #1's bruise a second time.
-She found out the next morning (09/02/20), Resident #1 had been sent to the hospital via EMS for labored breathing and SOB.
-She was told by third shift staff, Resident #1's breathing "was so fast, and she was struggling so much," they had to call EMS.
-She found out about Resident #1's fall that occurred on 08/31/20 at the same time she found out about her being sent out via EMS.
-The supervisor on 3rd shift was responsible for completing an incident report for the fall, but she did not complete one until after Resident #1 was sent out via EMS (approximately 19 hours after the fall occurred).
-She was not made aware of Resident #1's fall when she was assessing her bruising.
-She learned on 09/02/20, the first shift

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supervisor had not contacted Resident #1's PCP for an X-ray order, as she instructed her to, because there was "miscommunication" on whether the supervisor was to do it, or whether she was doing it.

Telephone interview with a second shift PCA on 09/10/20 at 11:43am revealed:
-She worked 2nd shift on 08/31/20 after Resident #1's fall.
-She arrived to work at 3:00pm.
-The first shift MA reported Resident #1 had a fall that morning during 3rd shift.
-The MA showed her Resident #1's bruise.
-Resident #1's bruise looked "pretty bad."
-Resident #1's bruise was black in color, on her right side, and extended underneath her entire breast and all the way around to her side where her bra strap began.
-Resident #1 complained of pain when she changed her shirt for bed that night around 8:30pm.
-Resident #1 did not complain of SOB on her shift.

Telephone interview with another second shift PCA on 09/14/20 at 11:05am revealed:
-He worked second shift on 08/31/20 after Resident #1's fall.
-He arrived at his shift at 3:00pm.
-First shift staff reported Resident #1 had a fall that morning on third shift and was "lowered to the ground" by staff.
-First shift staff reported Resident #1 was sore and sensitive in the area of her side.
-He lifted Resident #1's shirt and saw her side was black, alongside her ribs.
-Resident #1's bruised area was about nine inches in length and about two to three inches wide and extended under her right breast around

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her side.
-The extent of Resident #1's bruising "was not good."
-He noticed Resident #1 was sitting in her chair with her legs outstretched, and her torso extended, which was unusual for her, because she usually sat upright.
-Resident #1 did not want to stand up, was not eating well, and would say "ouch" with any movement.
-It seemed like Resident #1 did not want to bend her torso.
-He informed the MCC of his concerns and asked her if she was aware.
-The MCC told him she was aware and had already seen the bruise.
-The MCC did not look at Resident #1's bruise, at that time, and did not provide any instructions to the PCA.
-He last saw Resident #1 around 7:30pm, because the other PCA put her to bed, and he left his shift at 11:00pm.

Telephone interview with a third shift PCA on 09/14/20 at 1:23pm revealed:
-She worked third shift on 08/31/20-09/01/20 after Resident #1's fall.
-She arrived at her shift around 11:00pm.
-Second shift staff did not tell her Resident #1 had a fall that morning on 3rd shift, or that she was bruised and complaining of pain.
-Third shift staff completed rounds on the residents at 1:00am, 3:00am, and 5:00am.
-She and the MA went to Resident #1's room around 1:15am.
-When they lifted Resident #1's shirt to pull up her brief, she saw a bruise under her right breast, about the size of a grapefruit, that wrapped around her side.
-It looked like Resident #1's breast "had a pulse."

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-The MA asked Resident #1 if she was in pain, and she replied "yeah."
-They immediately called the supervisor on duty.
-The supervisor assessed Resident #1 and called EMS.

Telephone interview with a third shift MA on 09/14/20 at 4:00pm revealed:
-She worked third shift on 08/31/20-09/01/20 after Resident #1's fall.
-She arrived at her shift around 11:00pm.
-A second shift PCA reported Resident #1 was bruised and complained of pain, on their shift, when she would raise her arms.
-The third shift supervisor, reported Resident #1, had a fall that morning on third shift.
-At 11:00pm, she peaked in on Resident #1 from the hallway, and saw she was in bed.
-She and the PCA began their 1:00am rounds, and went to Resident #1's room, around 1:15am.
-She lifted Resident #1's shirt to look at her bruise.
-Resident #1's bruise looked "terrible and scary."
-Resident #1's right breast was red, double in size, and moving up and down, "like it was breathing."
-Underneath Resident #1's breast was purple.
-She had "never seen anything like that before."
-Resident #1's breathing was labored, and when she went to move her right arm, Resident #1 said "oww."
-She immediately called the supervisor on duty.
-The supervisor on duty assessed Resident #1 and called EMS.

Telephone interview with a third shift supervisor on 09/11/20 at 12:08pm revealed:
-She worked third shift on 08/31/20-09/01/20 after Resident #1's fall.
-She was working on the "front 2 halls" and not on

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Resident #1's hall.
-Around 1:15am, the MA called her, asking her to come look at Resident #1.
-She found Resident #1 to have a bruise that covered her entire right breast and all around her side.
-"It looked like her [Resident #1's] heartbeat was on the wrong side."
-She had "never seen a rapid heartbeat like that before."
-She called EMS, and Resident #1 was transported to the local hospital.
-She completed an incident report for Resident #1's fall after she was sent to the hospital.
-Resident #1 had a fall on 08/31/20 at 6:20am; she was sent to the hospital via EMS on 09/01/20 at 1:15am; and she (the supervisor) faxed notification of Resident #1's fall to her PCP on 09/01/20.

Telephone interview with Resident #1's POA on 09/10/20 at 9:51am revealed:
-Resident #1 had a fall on 08/31/20.
-Resident #1 was sent to the local hospital via EMS on 09/01/20.
-She was not notified of Resident #1's fall until after she was sent to the hospital.
-She had missed calls on her phone, from facility staff, beginning around 7:00am on 09/01/20.
-Facility staff reported they found Resident #1, "breathing funny," and called EMS.
-Facility staff reported Resident #1, had an "assisted fall," approximately 16 hours prior to being sent to the hospital.
-When she saw Resident #1 in the hospital on 09/01/20, she had black bruising under her entire right breast that traveled around to the right side of her back and trunk.

Telephone interview with Resident #1's PCP on

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D 273	Continued From page 20 09/10/20 at 11:45am revealed: -He could not verify when his office was notified of Resident #1's fall, due to having transitioned to a new electronic medical record system. -He did not know Resident #1 had been sent to the hospital and then sent home with Hospice services. -It was "concerning," that the facility had not notified him of Resident #1's bruising, when it was first noticed. -If the facility had notified him of Resident #1's bruise and complaints of pain, he would have either ordered a mobile X-ray, or he would have ordered for her to be sent to the hospital immediately. -Early detection of the broken ribs, could have possibly, prevented the lung from being punctured. Telephone interviews with Resident #1's hospital Trauma Surgeon on 09/09/20 at 9:08am and 09/14/20 at 9:24am revealed: -Resident #1 was seen in the hospital with a flailed chest, multiple rib fractures, a massive amount of bruising, and a significant amount of trauma. -EMS staff reported, facility staff found Resident #1's breast to "look like it had a pulse," and she had a "gentle fall" at least 12 hours prior to being brought to the hospital. -As soon as the injury occurred, the staff should have been able to hear her ribs breaking and should have noticed her chest wall flailing in. -"There should have been immediate concern for significant injury." -It was possible, Resident #1's punctured lung could have progressively released air throughout the day, resulting in a progressive worsening of her breathing rather than an immediate SOB. -While in the hospital, Resident #1 had one chest	D 273		

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tube placed, but it would not re-inflate her lung, so she had to have a second chest tube placed.
-Any trauma, needed to be addressed, immediately.
-If Resident #1's trauma had been addressed immediately, it may have prevented the need for a second chest tube.
-Resident #1, was at risk for, developing pneumonia and dying from the pneumonia.
-With Resident #1's cognitive issues, she would not be able to do deep chest breathing and other rehabilitative breathing exercises, because she could not follow commands.
-Resident #1 was discharged from the hospital with a chest tube and Hospice services.

Interview with the Administrator on 09/09/20 at 3:44pm revealed:
-The facility's RN had assessed Resident #1 on 09/01/20, after her fall occurred, and found only a small amount of bruising.
-The facility RN did not feel Resident #1's injuries, were significant enough, to warrant sending her to the hospital.
-Her expectation, was for the supervisor on duty, to complete an incident report immediately when a fall occurred and to contact the resident's POA and PCP, immediately.

Refer to interview with the Administrator on 09/09/20 at 3:44pm.

B. Review of Resident #1's progress notes dated 07/14/20, revealed a MA documented "On last rounds during 3rd shift, RA [PCA] noticed there was dark red blood in resident's brief, from front to back. Resident is having no complaints of pain."

Review of Resident #1's hospital history and

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physical dated 09/01/20-09/04/20 revealed:
-Resident #1, was found to have multiple lesions in her liver, that were concerning of metastatic disease.
-Resident #1, had no history of known metastatic disease.
-Resident #1, only had a history of skin cancer in the past.

Review of Resident #1's, hospital discharge summary, dated 09/04/20 revealed Resident #1's CT scan, had findings consistent with metastatic liver disease, with a possible focal mural mass in the posterior distal sigmoid colon.

Telephone interview with a 3rd shift MA on 09/14/20 at 4:00pm revealed:
-She documented blood in Resident #1's brief on 07/14/20.
-She observed, a "clot" of blood, a little larger than a quarter in size, in Resident #1's brief.
-She thought the blood was coming from Resident #1's rectum.
-She reported the blood to the supervisor on duty, but could not remember, who the supervisor was.
-She did not notify Resident #1's PCP of blood in her brief.
-She could notify, residents' PCPs about any issues she was concerned with, but she generally only notified the PCP if she thought the resident might need to be seen by the PCP immediately, or sent to the hospital.
-In the case of Resident #1 having blood in her brief, she documented it in Resident #1's progress notes, and in the 24-hour log book.
-She "thought" the facility's RN reviewed all information in the 24-hour log book and contacted the PCP if needed.

Telephone interview with Resident #1's PCP on

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09/10/20 at 11:45am revealed:
-He could not verify his office was notified of Resident #1 having blood in her brief due to having transitioned to a new electronic medical record system.
-He could not recall being notified of Resident #1 having blood in her brief.
-He would have expected, to be notified of a resident, having blood in their brief.
-If he had been notified, he would have ordered tests to determine where the blood was coming from.
-Blood in a brief could be the result of a urinary tract infection (UTI), or it could be concerning for vaginal or colon cancer.

Telephone interview with the facility's RN on 09/14/20 at 1:53pm revealed:
-The MA was responsible for notifying Resident #1's PCP of blood in her brief.
-She could not locate any documentation of Resident #1's PCP being notified of the blood in her brief.
-She had contacted Resident #1's previous home health (HH) provider to ask if they had been notified of the blood in her brief, or if they had notified her PCP.
-Resident #1's HH provider was not notified of the blood in Resident #1's brief, and so they had not reported it to her PCP.

Refer to interview with the Administrator on 09/09/20 at 3:44pm.

Interview with the Administrator on 09/09/20 at 3:44pm revealed:
-She left, all "clinical" responsibilities, to the facility's RN.
-She expected MAs and supervisors, to report

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D 273	Continued From page 24 any medical concerns to the facility's RN, so she could assess the situation. _____ The facility failed to ensure Resident #1's acute healthcare needs were met, by not notifying her PCP regarding bruising and complaints of pain sustained after a fall, and there being a 19 hour delay in sending Resident #1 to the hospital resulting in Resident #1 being hospitalized with a flailed chest, multiple rib fractures, a massive amount of bruising, and and a pneumothorax which required placement of two different chest tubes. This failure resulted in significant 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 09/09/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 14, 2020.	D 273		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from neglect as related to healthcare	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023048	A. BUILDING: _____ B. WING _____	C 09/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

(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
D914	Continued From page 25 referral and follow-up. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure the acute healthcare needs were met for 1 of 5 sampled residents (Resident #1) related to injuries sustained after a fall and evidence of blood in her brief. [Refer to Tag 273 10A NCAC 13F .0902 Healthcare (Type A1 Violation)].	D914		