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
	HAL017054	A. BUILDING: _____ B. WING _____	C 03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from 03/07/23 to 03/10/23 with an exit via telephone conference on 03/13/23.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the environment was clean and free of hazards related to the cleanliness of residents' wall air-conditioner/heater units, bathrooms floors and commodes, and a shower floor that was broken. The findings are: Observation of the shared bathroom in the suite for rooms 607/609 on 03/09/23 at 8:25am revealed: -The baseboard in the bathroom had dust and grime build-up. -There were black spots throughout the bathroom floor, especially around the base of the commode. -There was a large brown stain between the base of the commode and the wall. -The shower had a large crack approximately 14	D 079	Caswell House shall be maintained in an uncluttered, clean, and orderly manner; free of all obstructions and hazards. Housekeeping will implement a deep cleaning schedule, and will notify the Executive Director (ED) of which rooms that are to be deep cleaned each morning during management meeting. ED or Designee will follow-up with the Maintenance Tech daily during management meeting on any open work orders or reported maintenance issues. They will discuss the status of the repair, any areas of concerns, as well as an estimated date of completion. ED/RCC/SCC or any Management will note maintenance or housekeeping concerns during facility rounds and will ensure report is promptly made to maintenance. Once work orders are in place, ED will follow-up with maintenance to ensure all areas are addressed, and to receive a date of completion. ED will verify during	4/27/23 4/27/23 4/27/23

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

Casandra Nixon 04/29/23

Reviewed and acknowledged on 05/01/23. P.D.

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D 079	Continued From page 1 inches in length on one side and 7 inches on the other side making a semi-circle. -The area was soft to the touch and was easily pushed down to open. Interview with one of the two residents who reside in this suite on 03/09/23 at 9:01am revealed: -He did not know who cleaned his bathroom or how often. -He did not know what the stains were but they had been there a long time. -The shower had been broken for several months. -The facility staff knew the shower floor was broken and was working on getting it repaired. -He took his showers in the shower but had to be careful where he stood to not break the floor further. Observation of resident rooms on 03/09/23 between 8:11am-9:01am revealed: -Room 101, the wall heater/air-conditioning unit had a buildup of dirt and grime. -Room 501, the wall heater/air-conditioning unit had a build-up of dirt and grime; there were specks of a black substance coating the louvers on both the top and front of the unit. -When wiped with a slightly damp tissue the black substance was wiped off. -Room 503, the screw that attached the commode to the floor was not cut off flush or capped at the base of the commode; the screw was sticking out of the base of the commode two inches. -The base of the commode had a buildup of dirt and grime. -Room 504, the wall heater/air-conditioning unit had a buildup of dirt and grime; there were specks of a black substance coating the louvers on both the top and front of the unit.	D 079	facility rounds. ED in-serviced Housekeeping staff and Maintenance Tech on the process of cleaning a room from start to finish, the importance of cleaning the PTAC units, under beds, closets, and bath-rooms.	3/15/23

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D 079	Continued From page 2	D 079		

-Room 508, there was no grout between the commode and the floor; the floor around the base of the commode was stained brown.
-Room 608, the wall heater/air-conditioning unit had a buildup of dirt and grime; there were specks of a black substance coating the louvers on both the top and front of the unit.

Interviews with the residents in rooms observed on 03/09/23 between 8:11am-9:01am revealed:
-They had not seen anyone clean their wall heater/air-conditioning units.
-They did not know what the black specks of build-up were on the wall heater/air-conditioning units.

Interview with a housekeeper on 03/09/23 at 4:23pm revealed:
-She knew the shower was broken in the 607/609 suite and she had reported it to the Maintenance Director.
-She did not recall when, but it had been a while.
-She was supposed to have a sheet that told her what cleaning needed to be done, but she did not go by that sheet, she did what she knew needed to be done.
-She used her duster on the wall units, but not every day.
-She had not cleaned the units with anything but a "duster."
-She did not know what the black specks were in the picture of the wall unit.
-She cleaned all the bathroom floors, so the dirty floor had to have been in a room that was not hers.
-She cleaned all the rooms in the 500 and 600 halls.
-"It must have been a day she was not here."

Interview with the Director of Housekeeping and

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D 079	Continued From page 3 Maintenance on 03/09/23 at 4:33pm revealed: -He knew the shower floor was broken in the suite. -He had sent the required paperwork to corporate on 02/06/23, it had been approved, and they were waiting for it to be repaired. -He tried to go into all the resident rooms at least once a week, but he had been tied up with corrections from another inspection. -He had been replacing the wall heating/air-conditioning units. -He expected the housekeeping staff to clean the wall heating/air-conditioning units. -He expected the housekeeping staff to clean the floors, baseboards, and base of the commodes. -The housekeeper should have put the cap back on the exposed screw. -The housekeeping staff had a checklist that was provided to them on Mondays and returned on Fridays to ensure cleaning was being done. Interview with the Administrator on 03/10/23 at 3:08pm revealed: -She was aware of the broken shower floor in the 607/609 suite. -She was not sure of the date of the broken shower floor, but it was before 02/02/23. -The shower floor had been communicated "up" for approval and was now waiting on the parts to replace the shower floor. -The residents in rooms 607 and 609 did not want to move. -She thought they were still using the shower that was broken. -The residents in rooms 607 and 609 had the option of using the shower in the spa room. -The housekeepers were responsible for the general cleaning of the resident rooms. -Cleaning the air-conditioner units was part of the housekeeping staff's tasks.	D 079		

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D 079	Continued From page 4 -When she reviewed the pictures of the black build-up on the air-conditioners she stated she did not know what it was, but if it was wiped off with a tissue, she would expect it to be cleaner. -She did not think the wall unit should "get to that condition." -She expected the Director of Housekeeping and Maintenance to check behind the housekeeping staff at least weekly.	D 079		
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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's current symptoms for 1 of 5 sampled residents (#3) which resulted in a fall with a head injury which required seven sutures (#3). The findings are: Review of Resident #3's current FL-2 dated 07/20/22 revealed: -Diagnoses included major depressive disorder, history of traumatic subdural hemorrhage, and Alzheimer's disease.	D 270	Caswell House shall ensure that staff provides supervision of Residents according to each Resident's assessed needs, care plan, and current symptoms. Area Clinical Director (ACD) in-serviced care staff on the importance of making rounds for Resident safety; also the importance of staff assigned to the Memory Care Unit remaining on the Memory Care Unit for the shift. 4/11/23 ACD in-serviced Care Staff that Residents with a history of falls or identified as Risk for Falls are to be monitored more frequently than the standard every 2 hours; as well as the importance of Resident engagement with activities to decrease the risk for falls and behaviors. 4/11/23 RCC/SCC will complete record reviews to ensure falls risk evaluation has been completed on all Residents. Any Resident 4/24/23	

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D 270	Continued From page 5 -The resident was constantly disoriented. -She was non ambulatory. -She was incontinent to bladder and bowel. -She needed assistance with bathing, feeding, and dressing. Review of Resident #3's current care plan dated 01/31/23 revealed: -She was non ambulatory and required two staff to assist with transferring. -Staff were required to perform all bathing, dressing, personal hygiene, and feeding. -She required two staff to provide incontinent care and bathing. Review of Resident #3's physician's after visit report dated 02/15/23 revealed: -Resident #3 had gait instability, muscle wasting and weakness. -She had limited mobility and ambulated in a wheelchair due to muscle wasting and weakness. -No recent falls were reported by staff. -Fall precautions were recommended. Review of Resident #3's progress notes from January 2023 to March 2023 revealed: -On 01/13/23 at 5:30pm, she had a fall but was not sent out to the hospital. -There was no other information about the fall on 01/13/23. -On 03/07/23 at 7:00am, she had a fall and was sent out to the hospital; the primary care provider (PCP) and the guardian were notified. -There was no other information about the fall on 03/07/23. Review of Resident #3's incident and accident reports revealed: -On 11/10/22 at 4:30am, Resident #3 had a witnessed fall in the dayroom with an injury to her	D 270	identified as a high risk for falls will have a safety emblem that is consistent throughout the community placed by their nameplate outside of their door. ED/RCC/SCC will ensure that Incident Reports are discussed in management meeting Mon-Fri, and are discussed in the weekly at-risk meeting to ensure interventions are appropriate and effective. 4/24/23 ED/RCC/SCC/ and Interdisciplinary Team will ensure Residents with falls are discussed monthly during the falls team meeting to ensure appropriate interventions, activities, and medical management is in place. 4/24/23 ED will make facility rounds no less than twice daily to ensure appropriate care and supervision of Residents per their care planned needs. 4/24/23 RCC/SCC will make unit rounds no less than twice daily to ensure appropriate care and supervision of Residents per their care planned needs. 4/24/23	

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forehead.
-She was sitting on the floor.
-She had bruising and swelling on her forehead.
-She was transported via emergency medical services (EMS) to the local emergency room (ER).
-She was not hospitalized.
-On 03/07/23 at 7:00am, Resident #3 had an unwitnessed fall in the dayroom with an injury to her forehead.
-She was transported via EMS to the local ER.
-She received seven sutures to her forehead but was not hospitalized.

Observation of Resident #3 on 03/07/23 at 11:10am revealed:
-The resident had a cut above her left eye; she had seven sutures and the area around the cut was purple and red.
-Her left eye was swollen shut and the area around it was purple and red.
-She had a large red, square shaped scrape on her left cheek that was one inch by one inch.

Observation of Resident #3 on 03/08/23 at 5:19am revealed:
-Two staff assisted Resident #3 to her feet from her bed.
-She could not support her own weight and could not pivot once standing; staff had to support her as they moved her from the bed to the wheelchair.
-Once Resident #3 was seated in the wheelchair, she leaned forward as if she was attempting to begin to stand.
-Resident #3 did not stand but continued to lean forward until staff redirected her to sit back in her wheelchair.
-Resident #3 continued to lean forward and had to be redirected by staff four more times.

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D 270	Continued From page 7 -She was moved to the dayroom where the medication aide (MA) sat with her. Interview with Resident #3's PCP on 03/08/23 at 12:47pm revealed: -Resident #3 was a "horrible" fall risk because she had no upper or lower body strength and could not stand without support. -Resident #3 had falls out of her wheelchair but they were not always documented; staff would tell her when she visited Resident #3. -Resident #3 would fall because she leaned too far forward in her wheelchair and then she would fall out. -Resident #3 needed to be supervised when she was in her wheelchair because she leaned forward and was at a risk to fall out of the wheelchair. Interview with a personal care aide (PCA) on 03/07/23 at 2:14pm revealed: -Resident #3 was considered a fall risk because she leaned forward while seated in her wheelchair. -She would lean forward in her wheelchair when she was tired. -When staff noticed Resident #3 was leaning forward, they would place her in her bed. -She had a fall mat next to her bed. -Resident #3 could move her wheelchair short distances with her feet. -Resident #3 could not be left alone and had to be watched when she was in her wheelchair to make sure she did not lean forward. -She was told at the shift change that Resident #3 had a fall that morning, 03/07/23; she was told the resident fell forward and fell in the dayroom. -She did not recall Resident #3 having a fall before today, 03/07/23.	D 270		

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Interview with a second PCA on 03/08/23 at 5:07am revealed:
-She was getting residents up and dressed beginning at 4:30am on 03/07/23.
-She had dressed Resident #3 and moved her to the dayroom; she did not recall the time.
-There was not a PCA in the dayroom; she checked on the residents in the dayroom as she brought other residents in the room.
-The first PCA to get all the residents up would sit in the dayroom with the residents.
-At about 6:40am, she was outside of the dayroom in the hallway assisting another resident towards the dayroom when she saw Resident #3 through the doorway; Resident #3 was leaning forward in her wheelchair.
-She knew Resident #3 was going to fall because she was leaning so far forward but she could not get to her fast enough to catch her before she fell.
-Resident #3 was laying on the floor when she entered the dayroom; another PCA went to get the MA while she stayed with Resident #3.
-Resident #3 was bleeding above her left eye and had a "mark" on her left eye and nose; she also had a spot on her right knee and her left hand had a scratch.
-The MA assessed Resident #3 and EMS came to transport her to the hospital.
-She was not sure if Resident #3 was considered a fall risk; she had never been told the resident was a fall risk.
-She felt Resident #3 was a fall risk because she leaned forward so much, and she was afraid the resident would fall out of her wheelchair.
-Before the fall she always did 30 minutes to one-hour checks on Resident #3.
-She did not think Resident #3 had any other falls.

Telephone interview with a third PCA on 03/09/23

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D 270	Continued From page 9 at 8:58am revealed: -She was getting residents dressed and assisting them to the dayroom on 03/07/23, towards the end of third shift. -She was in the hallway with a resident when she saw another PCA also with a resident in the hallway. -She could see Resident #3 from the hallway, and she saw Resident #3 lean forward, but it was too late, and she fell out of her wheelchair and hit her head. -Resident #3 was in the dayroom with other residents; there was not a PCA in the room when she fell. -There was a PCA who was supposed to be in the dayroom watching the residents on 03/07/23. -She saw the PCA coming in through the doorway that lead outside; the PCA was facing the dayroom and was halfway in the room. -The residents were not supposed to be alone in the dayroom without staff but some days there was a space of time in the mornings when they were getting residents up so staff were not available to stay in the dayroom. -While the PCAs were getting residents ready in the morning they would pop into the dayroom and check on the residents. -The MA was usually in and out of the dayroom administering medication or in the hallway just outside of the dayroom. -If a PCA was finished getting the residents ready, that PCA would sit in the dayroom. -On 03/07/23 there were enough PCAs working so a [named] PCA was assigned to stay in the dayroom with the residents. Telephone interview with a fourth PCA on 03/09/23 at 1:05pm revealed: -She was working on 03/07/23 when Resident #3 fell in the dayroom.	D 270		

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D 270	Continued From page 10 -Resident #3 had a habit of leaning forward in her wheelchair and had to be told to sit back. -Resident #3 would lean too far forward and would look like she was going to fall out of her wheelchair. -She would constantly tell Resident #3 to sit back or touch her shoulder and guide her to sit back. -The PCAs would get residents up out of their bed from 5:00am to a little after 6:00am. -When they got the residents up, they would put them in the dayroom. -Sometimes there were enough PCAs working that one could stay in the dayroom with the residents. -If there were not enough PCAs, they would check on the residents as they put residents in the dayroom. -Once all the residents were up, the PCAs made sure at least on of them was in the dayroom with the residents. -Resident #3 fell out of her wheelchair on 03/07/23 and fell into the back of a resident's wheelchair that was in front of her; the wheelchair was what cut Resident #3's eye. -She was not assigned to Resident #3 on 03/07/23. -She was watching the residents in the dayroom on 03/07/23. -At about 6:30am, she told the other two PCAs she was stepping out to the patio because she was hot. -While she was outside, one of the residents knocked on the glass of the door to get her attention when she came to the door the resident told her Resident #3 had fallen. -She came inside and saw Resident #3 was on the floor bleeding and one of the other PCAs was already with her. -Resident #3 was sent out to the hospital.	D 270		

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D 270	Continued From page 11 Interview with a MA on 03/08/23 at 7:11am revealed: -She considered Resident #3 a fall risk because she leaned forward in her wheelchair. -Resident #3 could not be left alone once she was in her wheelchair because she leaned forward. -If there was a resident in the dayroom, then there was always supposed to be a PCA in the dayroom with the residents. -When Resident #3 fell out of her wheelchair there was supposed to be a [named] PCA in the dayroom. -She was told by one of the PCAs the [named] PCA was outside on the patio smoking and had left the residents alone. -The reason Resident #3 fell on 03/07/23 was because she was left alone in the dayroom. -She was the only MA in the building, so she was on the Assisted Living (AL) side of the facility administering medications. -One of the PCAs came and told her Resident #3 had fallen. -Resident #3 was laying on the floor in the dayroom and was bleeding; she had a cut above her eye. -Resident #3 required two PCAs to transfer her because she could not stand on her own; she tried but would not get up so far and sit right back down. Interview with the Memory Care Manager (MCM) on 03/09/23 at 11:55am revealed: -Resident #3 fell on 03/07/23 in the dayroom; she had an injury to her head and was sent to the hospital because she was bleeding. -Resident #3 hunched over while sitting in her wheelchair and fell out. Telephone interview with the MCM on 03/10/23 at	D 270		

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D 270	Continued From page 12 11:15am revealed: -The PCAs began getting residents out of bed and dressed between 5:00am and 5:30am. -The residents were then moved to the dayroom. -The PCAs took turns monitoring the residents in the dayroom while the other PCA got residents out of bed. -The PCAs know staff had to always be in the dayroom with residents because they were trained to monitor the dayroom. -The residents were never in the dayroom alone without staff present; a PCA or MA had to be in the dayroom at all times with residents. -Staff needed to be in the dayroom when residents were in there to keep eyes on them and make sure nothing happened. -Residents needed to be monitored in case there was a fall or behaviors between residents. -As far as she was aware, there was always one staff in the dayroom with residents because when she came in for the day there was staff in the dayroom. -She had seen times on first shift when the residents were left alone, and she had to tell staff to go back into the dayroom. -If the staff in the dayroom had to leave for anything, they had to get another staff to relieve them; they could not leave the dayroom and residents alone. -Usually there were two staff in the dayroom when she monitored it. -She did not know if Resident #3 was alone in the dayroom when she was injured. -Someone told her Resident #3 fell but she had not had a chance to ask about the injury. Interview with the Administrator on 03/10/23 at 2:08pm revealed: -Staff began getting residents up in the special care unit (SCU) between 4:00am and 5:00am;	D 270		

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first shift also got residents up and dressed.
-Some of the residents would sit in the dayroom once they were up.
-The PCAs monitored the dayroom as they got the residents up by taking turns staying in the dayroom.
-The MA was also right outside the dayroom at the medication cart in the mornings and could help monitor the residents once they were in the dayroom.
-She always expected staff to be in the dayroom with the residents, even if there was only one resident in the dayroom.
-Staff were required to be in the dayroom with residents in case a resident had an incident or to prevent an incident.
-She was aware staff were not in the dayroom when Resident #3 fell on 03/07/23 because staff did not witness how she was injured.
-She was told staff did not see Resident #3 fall; Resident #3 was found on the floor bleeding.
-Resident #3 rocked in her wheelchair and was a risk for falls.
-There should have been staff in the dayroom with Resident #3 when she fell and was injured.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's guardian on 03/09/23 at 1:34pm was unsuccessful.

_____

The facility failed to provide supervision for a resident (#3) who was known to lean forward while seated in her wheelchair and required redirection and supervision from staff, which resulted in the resident having a fall from her wheelchair with an injury to her head requiring

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D 270	Continued From page 14 seven sutures when staff left her alone in the dayroom. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/10/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 24, 2023.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .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: Based on record reviews and interviews, the facility failed to ensure an immediate response and intervention for 2 of 5 sampled residents (#4, #5) for a resident who had an unwitnessed injury to her head and no vitals were checked and the resident was not monitored (#4) and a resident who had a fall and was not assessed by a medication aide (MA), vitals checked or monitored (#5).	D 271	Caswell House shall ensure that staff will 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. ACD in-serviced Care Staff that Med Techs will evaluate Resident for injury after a fall prior to anyone moving them; also that a Resident with a head injury- known or suspected- is to be sent to the hospital for evaluation; and Residents are to have ongoing monitoring for symptoms or complaints after an event. 4/11/23 ED/RCC/SCC will include responding to emergencies as an education topic in staff meetings at a minimum of quarterly to ensure that newly hired staff as well as seasoned staff are receiving the training on a 4/24/23	

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D 271	Continued From page 15 The findings are: Review of the Accidents and Falls Policy dated September 2021 revealed: -An accident is an unexpected, unplanned event that may or may not cause injury. -Assess the resident. -If an injury was apparent or possible, do not move the resident. -Call/notify the resident's physician and responsible party. -If injured, complete the report of accident and incident form. 1. Review of Resident #4's current FL2 dated 01/25/23 revealed: -Diagnoses included pulmonary embolism, cellulitis of the right lower extremity, dementia without behavior, hypothyroidism, heart murmur, and anxiety. -Resident #4 was intermittently disoriented. -Resident #4 required assistance with bathing and dressing. -Resident #4 was semi-ambulatory. Review of Resident #4's electronic progress notes dated 03/06/23 revealed: -At 5:51am, there was documentation that Resident #4 had a bruise on her forehead and the on-call provider was notified for your information (FYI). -At 3:19pm, there was documentation that Resident #4 was sent to the hospital and was transported by family. Review of Resident #4's incident reports revealed there was no incident report dated 03/06/23. Interview with a first shift medication aide (MA) on	D 271	regular basis. ED/ Care Managers will ensure that Incident Reports are discussed in management meeting Mon-Fri, and are discussed in the weekly at-risk meeting to ensure interventions are appropriate and effective. 4/24/23 Care Staff will ensure that interventions assigned after a fall are implemented appropriately for each Resident. 4/24/23 ED/Care Managers/Interdisciplinary Team will ensure Residents with falls are discussed monthly during the falls team meeting to ensure appropriate interventions, activities, and medical management is in place. 4/24/23 ED/RCC/SCC/SIC will round no less than daily to ensure that falls interventions are being implemented appropriately for Residents at risk for falls. 4/24/23	

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D 271	Continued From page 16 03/07/23 at 3:16pm revealed: -The third shift MA reported to her at shift change when she went into Resident #4's room, the resident had a knot and bruise on her head. -She was very busy that morning working both medication carts and training a new employee and did not go into Resident #4's room to check on her. -The first time she saw Resident #4, was when the resident was in the dining room at breakfast and she was talking, took her medications without any noted problems, and was eating her breakfast. -She had not monitored Resident #4 between 7:00am-and breakfast. Interview with the third shift medication aide (MA) on 03/08/23 at 5:01am revealed: -She went into Resident #4's room on 03/06/23 around 6:00am to administer her morning medications and the resident said look here and pointed at her head. -She moved Resident #4's hair and there was a purple bruise about the size of a nickel at the resident's hairline. -The bruise did look like a "fresh" bruise, and she told the first shift MA to keep an eye on Resident #4. -Before seeing the resident at 6:00am, she had last checked on Resident #4 between 3:30am-4:00am. Telephone interview with the same third shift MA on 03/08/23 at 9:40am revealed: -She did a skin assessment and Resident #4 did not have any other bruises. -She did not check Resident #4's vitals. -She did not initiate an incident report or 15-minute checks.	D 271		

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D 271	Continued From page 17 Interview with the third shift PCA on 03/08/23 at 5:19am revealed: -At 6:00am, Resident #4 was still in her recliner and when she cut the light on in the resident's room, Resident #4 stated "look at my head." -She could see a bruise on Resident #4's forehead about the size of a quarter and slightly raised. -She did not check on Resident #4 after she had assisted her in getting ready because the resident seemed okay. -She did not round with the next shift's PCA because the PCA did not want to do rounds. Interview with the Resident Care Coordinator (RCC) on 03/08/23 at 2:53pm revealed: -If an accident occurred after hours, the MA should reach out to the on-call provider and follow their instructions. -The MA should ask to speak to the provider. -For a bruise on the head she would like to have the resident sent out, but they had to call on call first to get the "ok." -If a resident was bleeding, they could go ahead and send out, but otherwise, they had to get permission from the on-call provider to send someone out. -She saw Resident #4 around 8:45am. -She looked for an incident report and did not see one, just a progress note. -She asked the first shift MA what happened, and the MA told her the third shift MA "found her like that" and had left a VM for the family. -The first shift MA should have immediately gone and assessed Resident #4 and reached back out to the family. -Ideally, the third shift MA and the first shift MA should have gone and assessed the resident together. -She tried to contact the third shift MA herself, but	D 271		

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it was time for her meeting and before she could do anything, a friend of Resident #4's family came to the facility.
-She did not check Resident #4's vitals because the resident was getting ready to eat her breakfast.
-She was trying to see what the on-call provider had told the third shift MA to do because there was no documentation of what the provider told her to do.

Interview with the Administrator on 03/08/23 at 2:26pm revealed:
-If a resident had a fall the MA was responsible for calling the on-call provider and following their direction.
-She would expect the MA to talk directly to the on-call provider if a resident had any bruising or swelling.
-She would have expected the Resident Care Coordinator (RCC) to have gotten involved in the situation, at the latest would be by the 9:30am stand-up.

Interview with the Administrator on 03/10/23 at 1:49pm revealed:
-She would have expected the MA to have completed an incident report and initiated 15-minute checks for 72 hours.
-For the resident's safety, the resident should have been monitored.

2. Review of Resident #5's current FL-2 dated 12/14/22 revealed:
-Diagnoses included dementia, atrial fibrillation, hypertension, anxiety, heart failure, and muscle weakness.
-She was intermittently disoriented.
-She was non-ambulatory.

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Review of Resident #5's Care Plan dated 08/18/22 revealed:
-She required limited assistance with eating, toileting, ambulation, dressing, and transfers.
-She required extensive assistance with bathing and grooming.

Review of Resident #5's electronic progress notes from 03/01/23-03/10/23 revealed there was no documentation related to a fall.

Review of Resident #5's incident reports revealed there was no incident report dated from 03/09/23-03/10/23.

Interview with a medication aide (MA) on 03/10/23 at 7:15am revealed:
-On 03/09/23, she was finishing her cart count with the first shift MA around 7:30am, when she heard a loud pop sound in the living room.
-When she looked, Resident #5 was laying on the floor in front of her wheelchair.
-The personal care aides (PCA) picked Resident #5 up and put her back in her wheelchair.
-When she returned to the facility on third shift on 03/09/23 she asked the second shift MA how Resident #5 was doing and the MA did not even know Resident #5 had a fall earlier in the day.
-She initiated 15-minute checks when she came in on third shift on 03/09/23.

Telephone interview with the second shift MA on 03/10/23 at 8:47am revealed:
-No one told her Resident #5 had a fall on 03/09/23.
-When the third shift MA came in at 10:50pm, the MA told her Resident #5 had a fall earlier that morning.

Interview with a PCA on 03/10/23 at 9:58am

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revealed:
-She was in the living room when she saw Resident #5 bending over and she fell from her wheelchair.
-Two named PCAs assisted in getting Resident #5 back into her wheelchair.

Interview with another PCA on 03/10/23 at 10:01am revealed:
-She had seen Resident #5 asleep in her wheelchair in the living room.
-She did not see Resident #5 fall but did see her laying on the floor.
-Resident #5 had a scratch on her forehead.
-Two named PCAs got Resident #5 off the floor and told the two MAs.
-No one told her to do 15-minute checks, she just knew to do it.
-She documented the 15-minute checks; she provided the documentation sheet.
-She did not know why the 15-minute checks had not started until 11:00pm when the fall occurred earlier that day.

Review of the increased supervision and accountability checklist on 03/10/23 at 10:11am revealed:
-At the top of the form Resident #5's name was listed with the date of 03/09/23, 7:30am, fall.
-Columns included time, location, and initials.
-Documentation started at 11:00pm with no date.
-There was documentation of time, location, and initials from 11:00pm every 15-minutes until 7:00am.
-There was documentation of time and location from 7:15am-7:45am but no initials.
-There was documentation of time at 9:00am and 9:15am, but no location or initials.

Interview with a third PCA on 03/10/23 at

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10:04am revealed:
-She saw Resident #5 leaning forward in her wheelchair and when she turned back around the resident was laying on the floor.
-She did not have to tell the MA because both MAs saw it.

Interview with Resident #5 on 03/10/23 at 10:08am revealed she did not know how she had injured her head.

Telephone interview with the MCM on 03/10/23 at 11:14am revealed:
-She knew Resident #5 fell on 03/09/23.
-There were two MAs in the memory care unit when Resident #5 fell.
-Both MAs refused to write up the incident related to Resident #5's fall.
-She told the Administrator that Resident #5 had a fall and hit her head and the Administrator told her to apply ice.
-She did not know the circumstances of the fall but knew at some point Resident #5 hit her head.
-The Administrator looked at Resident #5's head and again told her to apply ice.
-She did not call Resident #5's primary care provider (PCP), one of the MAs should have called.
-She did not ask the MAs if they called the PCP about Resident #5's fall.
-When a resident had a fall, the resident should be assessed, and the provider called for direction.
-They used to automatically send residents out if they hit their heads, but now they had to call for instructions.
-For Resident #5 the MAs should have called hospice and the PCP.

Telephone interview with Resident #5's PCP on 03/10/23 at 11:41am revealed:

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-She was not aware Resident #5 had a fall on 03/09/23.
-She was concerned the facility staff was not following protocol.
-Resident #5 was on a blood thinner and she could have had a brain bleed that was not identified.
-She would have expected the resident to be monitored for 72 hours after any incident to ensure the resident did not have a change in their condition.

Telephone interview with Resident #4's hospice nurse on 03/10/23 at 2:16pm revealed:
-The last telephone call they had received on Resident #5 was on 03/04/23.
-She would have expected to have been called on 03/09/23 when Resident #5 had a fall.
-Because Resident #5 hit her head, they would have sent a nurse out and would have called Resident #5's family to discuss sending the resident to the hospital to be evaluated since it was a head injury.
-If the family member refused to send Resident #5 out, she would have expected staff to monitor the resident.
-Usually, if there was a head injury they would send a resident out, but knowing Resident #5 was on a blood thinner, it was even more concerning because the resident could have a brain bleed.

Interview with the Resident Care Coordinator (RCC) on 03/10/23 revealed:
-She knew Resident #5 had a fall on 03/09/23 and the MAs did not do an incident report.
-She would have expected the MAs to do an IR and initiate 15-minute checks.

Interview with the Administrator on 03/10/23 at 1:49pm revealed:

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D 271	Continued From page 23 -She was not aware Resident #5 had a fall yesterday, 03/09/23. -Resident #5 should have been assessed by the MA. -She would have expected an incident report and initiated 15-minute checks to be done immediately following the incident. -For the safety of the resident, the resident needed to be monitored every 15 minutes for 72 hours. Telephone interview with Resident #4's family member on 03/13/23 at 4:44pm revealed: -When she visited her family member on 03/11/23 and noted a scratched area on her head. -Her family member told her she stood up from her wheelchair and fell. -When she asked the staff about it, she was told her family member had a fall; no one had called her to inform her of the fall.	D 271		
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: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 3 of 5 sampled residents (Residents #2, #4, and #5) related to the failure to notify the primary care provider (PCP) of an unwitnessed injury and immediately send the resident to the emergency department (ED) for further evaluation (#4); a	D 273	Caswell House shall ensure referral and follow-up to meet the routine and acute health care needs of residents. ACD in-serviced Care Staff on Incident Reporting, Documentation, and Notifications- including Resident Representative and PCP; they are in-serviced on continued monitoring and hot box charting; and shift to shift reporting. ACD in-serviced the ED/RCC/SCC/ and management team on the importance of prompt reporting of Resident incident/accidents, ensuring proper notifications have been completed,	4/11/23 3/9/23

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D 273	Continued From page 24 witnessed fall that involved the resident hitting her head on the floor and the PCP nor hospice provider were notified (#5); and a delayed evaluation of a change in condition (#2). 1. Review of Resident #2's FL-2 dated 03/30/22 revealed: -Diagnoses included Alzheimer's disease, and history of falls. -She was constantly confused. -She ambulated with a walker and wandered. Review of Resident #2's Care Plan dated 09/18/22 revealed she required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring and she resided in the Special Care Unit (SCU). Review of Resident #2's incident and accident report dated 02/26/23 revealed: -Resident #2 had an incident noted as medical pain. -Resident #2 was observed laying in her bed crying and holding her leg. -First aid was not administered. -Resident #2 was transported via local Emergency Medical Services (EMS) to a local emergency department (ED). -Status of the resident after the ER visit was noted as requiring surgery. Review of Resident #2's EMS report dated 02/26/23 revealed: -EMS responded to the facility on 02/26/23 at 4:10pm for a complaint of left leg pain. -Resident #2 was laying on her left side in her bed and was complaining of left leg pain. -The emergency medical technician (EMT) examined Resident #2 and noted swelling in her left knee.	D 273	and interventions put in place; PCP must be notified promptly and documented; RP/POA/ Guardian must be notified of Incidents/Accidents, and Change of Condition promptly after MD notification. ACD reviewed promptness of MD notification in case of Incidents, missed meds, change in Resident condition, or lack of improvement in condition within 24 hours. RCC/SCC will pull electronic facility documentation Mon-Fri for review to ensure appropriate notifications, interventions, and documentation is in place in the Resident's record. This will be reviewed with the ED in management meeting Mon-Fri to ensure any areas of concern are addressed promptly and appropriately. 4/12/23 ED/Care Managers/SIC/Med Tech will make rounds no less than daily to ensure Residents are receiving appropriate care, and are able to voice any needs that they may have. Any noted concerns will be addressed promptly with MD and RP notification as appropriate. 4/12/23	

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D 273	Continued From page 25 -Resident #2 required a two person assist to the stretcher and was visibly in distress and began crying when her leg was moved. -Resident #2 repeatedly stated that her leg hurt throughout transport. Review of Resident #2's hospital admission report dated 02/26/23 revealed: -Resident #2 was admitted to the hospital after visiting the ED on 02/26/23 for injuries from a suspected fall. -Resident #2's diagnoses included a left displaced femoral neck fracture (the bone becomes moved out of its original position) and a closed subcapital fracture of the left femur (a fracture in the neck of the thigh bone) with delayed healing. -On 02/27/23, Resident #2 had hemiarthroplasty (surgical procedure to treat a fractured hip) of the left hip Review of Resident #2's progress notes revealed: -On 02/27/23 at 10:10am, there was notation Resident #2 was transported by EMS to the hospital with complaint of leg pain on 02/26/23. -The primary care provider (PCP) and the Power of Attorney (POA) were notified. -On 02/27/23 at 9:40am, the POA notified the facility that Resident #2 would be in the hospital for a couple of days. -On 02/27/23 at 11:45am and 12:07am, a nurse from the hospital notified the facility Resident #2 would return [to the facility] in a couple of days and a physician's order was requested; no other information was given by the nurse. -On 02/28/23 at 1:45pm, the POA contacted the Memory Care Manager (MCM) and notified her Resident #2 had a broken hip, a compression fracture of the back and a neck fracture.	D 273		

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D 273	Continued From page 26 Telephone interview with the POA on 03/06/23 at 2:15pm revealed: -On 02/26/23 at approximately 2:00pm, she went to the facility to visit Resident #2. -As she passed by the nurses' station, she was told by a staff member that Resident #2 had been crying and asking for her all day long. -Resident #2 was in bed laying on her left side and was sobbing when she went into the room. -Resident #2 cried out in pain when she rolled her onto her back. -She tried to get Resident #2 out of the bed to assist her to the toilet and Resident #2 cried out in pain again. -She went back to the nurses' station and asked staff what happened to Resident #2 and if she had fallen. -The staff told her Resident #2 had not fallen on first shift and third shift had not reported a fall. -Staff told her they had no idea what had happened to Resident #2. -The POA asked staff to change Resident #2 because she was in an adult incontinent brief and it was soild. -Resident #2 screamed when staff tried to move or reposition her. -The POA asked staff to call for EMS because Resident #2 was in so much pain and could not be moved. -Resident #2 was transported by EMS to the local ED where she was diagnosed with a compression fracture in her neck and back and a broken hip. -Resident #2 had a history of falls and was a fall risk; she had a fall in April 2022 and had a broken hip that was replaced. -Resident #2 used a wheelchair and required assistance with dressing, showering, toileting and transferring. -Resident #2 could take a few steps on her own and could assist staff when standing and sitting	D 273		

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during transfers.
-Resident #2 had a history of attempting to stand up and walk.
-Resident #2 had a bed alarm because she had a history of falls and she was a fall risk.
-Resident #2 was confused but could carry small conversations with people and did not have aggressive behaviors.
-Since her admission to the hospital Resident #2 could not carry on a conversation any more.
-The POA was told by the physician at the ED Resident #2's injuries did not just happen that day and were due to some kind of trauma.
-She was also told by the physician Resident #2 would not be able to stand or get up on her own with the injuries she had.
-Resident #2 had hip replacement surgery on 02/27/23.

Interview with Resident #2's PCP on 03/08/23 at 9:44am revealed:
-Resident #2 had a history of falls.
-She was not aware of any recent falls for Resident #2; the last fall she was aware of was 12/23/22.
-She was aware Resident #2 had a complaint of left hip pain on 02/18/23 because the MCM sent her an email.
-She had ordered an X-ray on 02/21/23 and an acute visit with the resident on 02/22/23.
-She performed a passive range of motion on Resident #2's left hip and Resident #2 did not have a complaint of pain.
-She did not observe Resident walking or standing because the resident denied any pain.
-She was contacted on 02/23/23 by an unknown facility staff because the X-ray company did not do the X-ray for Resident #2 when they visited the facility.
-She was in the process of setting up another

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mobile X-ray but Resident #2 was sent out to the hospital before she could set it up.

Telephone interview with Resident #2's PCP on 03/10/23 at 12:00pm revealed:
-Resident #2 most likely had a fall to fracture her femur bone; it could not have happened from sitting in a chair.
-She had performed a thorough range of motion on Resident #2 on 02/22/23; Resident #2 had a low threshhold for pain and she would have reacted when her hip was moved.
-Resident #2 could have had a fall between 02/22/23 and 02/26/23 and broken her femur.
-She could have had a fall prior to 02/22/23 which caused an injury and a second fall after 02/22/23.
-At some point Resident #2 had a fall.
-She was not notified of any other concerns with Resident #2 until she was told the resident was sent out to the hospital on 02/26/23.
-If Resident #2 had anything else going on with her after she saw her on 02/22/23 the facility should have notified her.

Interview with a personal care aide (PCA) on 03/08/23 at 1:50pm revealed:
-She remembered being told at first shift change that Resident #2 had fallen during third shift; she thought it was a week or so ago but she did not remember the date of the fall or who reported it to her.
-She was told Resident #2 was found on the floor in her room and put back to bed.
-Resident #2 had complaints of left hip pain after the fall on third shift; Resident #2 was able to say which hip hurt.
-Resident #2 would stand on her own and could walk on her own as well as pull up on the bar at the toilet in the bathroom, but the week before 02/26/23, Resident #2 complained of hip pain and

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was unable to stand up on her own.
-Resident #2 required more assistance with sit to stand position and could not pull herself up at the grab bar at the toilet.
-She would hold onto the bar and shake while the PCA assisted her at the toilet; that was not Resident #2's normal behavior.
-The week before 02/26/23, she reported Resident #2's complaint of pain and not being able to stand well to the medication aide (MA).
-She thought the MA told the MCM about Resident #2 not being able to stand on her own and her new complaint of pain.

Interview with a second PCA on 03/08/23 at 5:52am revealed:
-Resident #2 had complained of pelvic pain and was whimpering and crying when she moved on the mornings of 02/25/23 and 02/26/23.
-Resident #2 could usually roll over in the bed, swing her legs over the side of the bed and sit up on her own.
-Resident #2 could stand and walk on her own and was not a fall risk.
-Resident #2 had a bed alarm because she would get out of the bed on her own.
-On 02/25/23 and 02/26/23 she could not roll over or sit up and was complaining of pelvic pain.
-Once she assisted Resident #2 to stand, she thought the resident was doing better and could walk to the bathroom.
-Resident #2 could not support herself while holding on to the railing at the toilet; she had to assist Resident #2 to sit down on the toilet.
-She had to place her arm around the resident's waist to assist her back into her room and into her wheelchair.
-She reported Resident #2 was in pain to the MA and she thought the MA administered a pain medication to Resident #2.

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-Resident #2 seemed better on 02/26/23; the staff painted her fingernails in the dayroom, and she was smiling.

Telephone interview with a third PCA on 03/09/23 at 8:20am revealed:
-She was told by a PCA during shift change Resident #2 had fallen on second shift and did not have any injuries.
-She could not remember the date she was told about Resident #2 falling but thought it was a few days before 02/25/23.
-Resident #2 was stiff and sore; she complained of hip pain and held her hip and pelvic area.
-Resident #2 whimpered and hesitated when she tried to get her out of the bed.
-Resident #2 would not extend her legs to stand so she had to hold onto the resident's wrist to assist her to stand.
-Resident #2 would not bare weight on her legs and her knees buckled; she eased her down to sit.
-Resident #2 pointed to her left hip when she asked her where she was hurting.
-Resident #2 always tried to stand up and walk but she did not try to stand and walk after the fall.

Interview with a fourth PCA on 03/09/23 at 10:03am revealed:
-A few days before Resident #2 was sent out to the hospital a second shift PCA told her at shift change that Resident #2 fell in the dayroom.
-She checked on Resident #2 and Resident #2 was in the bed crying; Resident #2 said her left leg hurt her.
-She noticed Resident #2's left knee was swollen; she reported it to the MA, and she thought the MA rubbed something on her knee.
-Before Resident #2 fell in the dayroom she would stand up and walk and staff would have to

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redirect her to sit.
-After she was told Resident #2 fell in the dayroom, she noticed Resident #2 did not try to stand or walk anymore she just sat in her wheelchair.
-Resident #2 would get out of her bed at night and wanted to walk or go to the bathroom but she did not get out of bed on her own after she was told about the fall on second shift.
-Resident #2's change in behavior was a few days before she went to the hospital.

Interview with a MA on 03/08/23 at 7:11am revealed:
-She thought Resident #2 was considered a fall risk because she tried to stand up and walk on her own.
-She could not recall the last time Resident #2 had a complaint of pain or when she had to administer pain medication to her.
-She did not recall staff reporting Resident #2 having any recent falls to her during any shifts.
-She did not think Resident #2 could get up from the floor on her own if she fell; she would need assistance to get up off the floor.
-She did not recall staff reporting Resident #2 could not stand or had difficulty transferring.

Telephone interview with a second MA on 03/09/23 at 4:40pm revealed:
-She did not recall anyone reporting Resident #2 falling in February 2023.
-She came to work on 02/11/23 and noticed a skin tear on Resident #2's left elbow and staff did not know where it came from; she cleaned and bandaged the skin tear.
-She reported the skin tear to the next shift MA.
-Staff had not told her Resident #2 did not stand or walk on her own anymore.

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D 273	Continued From page 32 Interview with a third MA on 03/10/23 at 7:33am revealed: -She thought Resident #2 had a fall about two weeks ago because she was on a seventy-two-hour watch and was being checked every fifteen minutes. -She was told by a PCA Resident #2 had complaint of leg pain after the fall, but she did not know which leg. -She offered Resident #2 an as needed (PRN) acetaminophen but Resident #2 refused it. -She was not told anything else or nothing unusual about Resident #2 by the staff. Interview with the MCM on 03/07/23 at 8:04am revealed on 02/26/23 Resident #2 complained of hip pain and was transferred by EMS to the local ER; Resident #2 had surgery on 02/27/23. Second interview with the MCM on 03/08/23 at 3:17pm revealed: -A MA notified her on 02/15/23 that Resident #2 was complaining of leg pain. -She noticed Resident #2 was rubbing her left leg on 02/18/23; it was not normal for Resident #2 to rub her leg because of pain. -She did not assess Resident #2 on 02/18/23; she notified Resident #2's PCP via email on 02/18/23 that Resident #2 was complaining of hip pain. -Sometimes the MAs administered PRN pain medications when a resident had a complaint of pain. -She was told by the MA she administered PRN acetaminophen to Resident #2. -The PCP ordered an X-ray on 02/21/23 and visited with Resident #2 on 02/22/23. Interview with the Administrator on 03/10/23 at 1:49pm revealed:	D 273		

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-Resident #2 was sent to the ED due to complaints of pain.
-When the PCAs noticed a resident had a change of condition, they should have notified the MAs or the MCM.
-If the PCA notified the MA, then the MA reported the change in condition to the MCM who would then report the change to the PCP.
-Changes in condition for residents in the Special Care Unit (SCU) were addressed quarterly when care plans were done.
-If Resident #2 could not stand or bare her own weight, the PCP should have been notified immediately.
-There should have been something documented in the progress notes about Resident #2's change in condition.

Attempted telephone interview with the physician from the ED on 03/09/23 at 8:41am was unsuccessful.

Attempted telephone interview with Resident #2's orthopedic physician on 03/09/23 at 11:02am was unsuccessful.

2. Review of Resident #4's current FL2 dated 01/25/23 revealed:
-Diagnoses included pulmonary embolism, cellulitis of the right lower extremity, dementia without behavior, hypothyroidism, heart murmur, and anxiety.
-Resident #4 was intermittently disoriented.
-Resident #4 required assistance with bathing and dressing.
-Resident #4 was semi-ambulatory.

Review of Resident #4's electronic progress notes dated 03/06/23 revealed:

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D 273	Continued From page 34 -At 5:51am, Resident #4 had a bruise on her forehead and the on-call provider was notified. -At 3:19pm, Resident #4 was sent to the hospital and was transported by her family. Review of Resident #4's incident reports revealed there was no incident report dated 03/06/23. Review of Resident #4's hospital medical record dated 03/06/23 revealed: -Resident #4 had an acute and traumatic subdural hematoma. -The head computerized tomography (CT) scan showed left convexity subdural hematoma with 0.4cm midline shift due to trauma (fall). -Given the patient's age, history of dementia, and recent Eliquis (a blood thinner) use, the risks of surgical intervention (as well as the high morbidity/mortality of her injury in her patient population) did not outweigh the benefits. -Resident #4 required admission to the Neuroscience Intensive Care Unit (ICU) for management. Telephone interview with a friend of Resident #4 on 03/07/23 at 7:45pm revealed: -A family member received a call from another resident at the facility informing them Resident #4 had a fall. -She received a call from the family member between 8:30am-9:00am and went straight to the facility. -She tried to call the facility but there was no answer. -When she arrived at the facility, Resident #4 was sitting in her recliner. -Resident #4 did not know what happened but was complaining her head was hurting. -A family member transported Resident #4 to the emergency department (ED) in her vehicle.	D 273		

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-The ED doctor reported Resident #4 had a brain bleed, and between the first and second CT scans there was noted pressure increase and told them to call the family in.
-Today, 03/07/23, Resident #4 was stable but "not out of the woods" per the ED doctor.

Interview with a resident on 03/09/23 at 8:11am revealed:
-He had seen Resident #4 getting up and down a lot on second shift.
-He told the personal care aide (PCA) to watch Resident #4 because she was getting up and down a lot.
-He was mopping the floors around 10:45pm when he heard Resident #4's bed/chair alarm go off.
-He ran down to check on Resident #4 and reminded the resident she was not supposed to be getting up on her own.
-He did not see the PCA.
-The last time he saw Resident #4 was around 11:20pm and she appeared to be fine.
-He went in to check on Resident #4 before breakfast on 03/06/23 and he noticed a bruise on her forehead.
-He did not know how Resident #4 got a bruise on her forehead, but he had not seen the bruise at 10:45pm.
-He told another resident to call Resident #4's family.

Interview with a first shift medication aide (MA) on 03/07/23 at 3:16pm revealed:
-The third shift MA reported to her at shift change when she went into Resident #4's room, the resident had a knot and bruise on her head.
-She was very busy that morning working and did not go into Resident #4's room to check on her.
-The first time she saw Resident #4, was when

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the resident was in the dining room at breakfast.
-Resident #4 was talking, took her medications without any noted problems, and was eating her breakfast.
-Resident #4's family member came to the facility and requested to see the Resident Care Coordinator (RCC).
-She was not sure what time Resident #4's family came to the facility, but the RCC was in a "stand-up meeting."

Interview with the third shift MA on 03/08/23 at 5:01am revealed:
-She went into Resident #4's room on 03/06/23 around 6:00am to administer her morning medications and the resident said, "look here" and pointed at her head.
-She moved Resident #4's hair and there was a purple bruise about the size of a nickel at the resident's hairline.
-The bruise looked like a "fresh" bruise, and she told the first shift MA to keep an eye on Resident #4.
-Prior to 6:00am, she last checked on Resident #4 between 3:30am-4:00am.

Interview with the third shift PCA on 03/08/23 at 5:19am revealed:
-She checked on her residents at 11:00pm, 1:00am, and 3:00am, and she started getting residents up for the day around 5:30am.
-She looked in on Resident #4 around 3:00am and the resident was in her recliner; she did not cut the light on.
-At 6:00am, Resident #4 was still in her recliner and when she cut the light on in the resident's room, Resident #4 stated "look at my head."
-She could see a bruise on Resident #4's forehead about the size of a quarter and slightly raised.

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-She did not have to move Resident #4's hair to see the bruise.

Telephone interview with the same third shift MA on 03/08/23 at 9:40am revealed:
-Resident #4 could not tell her what happened to cause the bruise.
-She assumed Resident #4 hit her head on the door or something.
-Resident #4 did not say anything about a fall.
-If Resident #4 had a fall, she would not have been able to get herself off the floor.
-Resident #4 was not acting like she was hurt or anything, she just showed her the bruise.
-Resident #4 did not complain to her, but when she was at the medication cart counting off with the first shift MA, a PCA reported Resident #4 asked for a Tylenol.
-She left a message when she called the Primary Care Provider (PCP) after-hours on-call message center, notifying the PCP Resident #4 had a bruise on her forehead.
-She left a message on Resident #4's family member's voicemail.
-She did a skin assessment and Resident #4 did not have any other bruises.

Interview with Resident #4's family member on 03/08/23 at 9:50am revealed:
-She transported Resident #4 to the ED in her vehicle.
-She was not sure what time she arrived at the facility but thought she got to the ED around 1:00pm.
-When she arrived at the facility, Resident #4 had a knot on her head.
-They were told by her PCP when Resident #4 began taking a blood thinner that if the resident hit her head, she needed to be checked out.
-When she walked into Resident #4's room, the

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resident was rubbing her head and had a "goose egg" on her forehead.
-The staff had done nothing, so she did not want to wait any longer to get Resident #4 evaluated.
-When they arrived at the ED, they were immediately taken back, and Resident #4 was assessed.
-The ED doctor came in after doing a CT scan on Resident #4 and told her to call the family in.
-The ED doctor said Resident #4 had bleeding on her brain, and emergently sent Resident #4 to a larger hospital.
-They were told Resident #4 was not a candidate for surgery due to her age and being on a blood thinner.
-Even after knowing Resident #4 had an injury to her head, the MA still gave her the blood thinner on 03/06/23.
-She was not upset Resident #4 had a fall, because "falls happen"; the lack of care after the fall was what bothered her.

Telephone interview with Resident #4's PCP on 03/07/23 at 1:52pm revealed:
-She was concerned Resident #4 had an unexplained bruise on her head and the family had to transport the resident to the hospital.
-The facility should have transported Resident #4 as soon as the bruise was discovered because if the bruise came from a fall and the resident hit her head, the resident could have a brain bleed.
-Resident #4 was on a blood thinner and when a person was on a blood thinner, falls were dangerous.
-Brain bleeds could cause increased limitations with mobility, increased dementia, paralysis, and unconsciousness,; the resident could "bleed out" and ultimately die if the brain bleed went untreated.

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Interview with Resident #4's PCP on 03/08/23 at 1:51pm revealed:
-She would have expected the facility staff to send Resident #4 to the ED because she was on a blood thinner and had an injury to her head.
-Resident #4's progress notes in her office showed a call came in at 5:56am reporting Resident #4 had a bruise on her forehead.
-The message was an alert to her and the provider on call was not notified.
-The picture provided to her by Resident #4's family was an "enormous goose egg."

Telephone interview with Resident #4's PCP on 03/10/23 at 11:41am revealed:
-Resident #4 should have been transported to the hospital immediately after an unknown injury to the head had occurred.
-The brain bleed could not have been stopped, but they could have reversed the anticoagulant (blood thinner) and kept her stable.
-Getting emergent care sooner may have kept Resident #4 out of the ICU.

Telephone interview with Resident #4's PCP's Office Supervisor on 03/07/23 at 3:47pm revealed:
-There was documentation in Resident #4's record that a call came into the on-call center on 03/06/23 at 5:56am by a MA.
-The MA did not ask to speak to a provider; she left a message as an FYI.
-When calls were made, the caller had two choices, either leave a message or ask to speak to a provider.
-If a resident had a fall and hit their head, the caller should have asked for the provider on call or sent the resident to the ED.
-She thought a resident with a bruise on the head and not knowing how the resident got the bruise,

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the MA should have asked to speak to the on-call provider.
-When a call came into the PCP's office after hours, they would reach a receptionist.
-The receptionist "just answered" the telephone and was not trained to make decisions or recommendations.

Interview with a receptionist with the on-call center on 03/07/23 at 7:32pm revealed:
-When facility staff called, they requested basic information and whether the call was urgent and needed to speak to the provider on call or if they wanted to leave a message to be delivered to the PCP on the next delivery date.
-If the call was an emergency, they immediately reached out to the provider on call.
-She was the one who took the call from a [named] MA on 03/06/23 at 5:56am related to Resident #4.
-The caller wanted to leave a message for Resident #4's PCP.
-The message was Resident #4 had a bruise on her forehead. It was not known if she had injured herself or what happened, and she would keep an eye on her.

Interview with the RCC on 03/08/23 at 2:53pm revealed:
-If an accident occurred after hours, the MA should reach out to the on-call provider and follow their instructions.
-The MA should ask to speak to the provider.
-For a bruise on the head she would like to have the resident sent to the ED, but they had to call the Provider on call first to get the "ok."
-If a resident was bleeding, they could go ahead and send to the ED, but otherwise, they had to get permission from the on-call provider to send someone to the ED.

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D 273	Continued From page 41 -A bruise to the head could indicate something going on that they could not see, and the resident's condition could worsen. -She saw Resident #4 in the dining room around 8:45am on 03/06/23. -Resident #4 had darker bruising the size of a quarter and nickel together. -There was lighter bruising around it, shaping out like the shape of a "pretzel potato chip." -The resident complained of a headache. -The resident did not know what happened to cause the bruise. -She looked for an incident report and did not see one, just a progress note. -She asked the first shift MA what happened, and the MA told her the third shift MA "found her like that" and had left a voicemail for the family. -The first shift MA should have immediately gone and assessed Resident #4 and reached back out to the family. -Ideally, the third shift MA and the first shift MA should have gone and assessed the resident together. -She tried to contact the third shift MA herself, but it was time for her meeting and before she could do anything, a friend of Resident #4's family came to the facility. -She did not check Resident #4's vitals because the resident was getting ready to eat her breakfast. -She was trying to see what the on-call provider had told the third shift MA to do because there was no documentation of what the provider told her to do. Interview with the Administrator on 03/08/23 at 2:26pm revealed: -If a resident had a fall, the MA was responsible for calling the on-call provider and following their direction.	D 273		

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D 273	Continued From page 42 -She would expect the MA to talk directly to the on-call provider if a resident had any bruising or swelling. -She would have expected the RCC to have gotten involved in the situation, at the latest would be by the 9:30am stand-up. 2. Review of Resident #5's current FL-2 dated 12/14/22 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, anxiety, heart failure, and muscle weakness. -Resident #5 was intermittently disoriented. Observation of Resident #5 on 03/10/23 at 7:00am revealed: -There were multiple bright red areas on the right side of her forehead. -There was one area one inch in length and a second area the size of a pencil eraser, both were abrasions. Interview with a medication aide (MA) on 03/10/23 at 7:15am revealed: -On 03/09/23, she was finishing her cart count with the first shift MA around 7:30am, when she heard a "loud pop" sound in the living room. -When she looked, Resident #5 was laying on the floor in front of her wheelchair. -The personal care aides (PCA) picked Resident #5 up and put her back in her wheelchair. -She told the first shift MA to follow up on Resident #5's fall because she was leaving the facility. -The first shift MA should have called Resident #5's primary care provider (PCP). -When she returned to the facility on third shift on 03/09/23, she asked the second shift MA how Resident #5 was doing and the MA did not know Resident #5 had a fall earlier in the day.	D 273		

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Telephone interview with the second shift MA on 03/10/23 at 8:47am revealed:
-No one told her Resident #5 had a fall on 03/09/23.
-When the third shift MA came in at 10:50pm, the MA told her Resident #5 had a fall earlier that morning.
-She did not know if Resident #5's PCP had been notified of the fall.

Interview with a PCA on 03/10/23 at 9:58am revealed:
-She was in the living room when she saw Resident #5 bending over and she fell from her wheelchair.
-Two PCAs assisted in getting Resident #5 back into her wheelchair.

Interview with another PCA on 03/10/23 at 10:01am revealed:
-She had seen Resident #5 asleep in her wheelchair in the living room.
-She did not see Resident #5 fall but saw her laying on the floor.
-Resident #5 had a scratch on her forehead.
-Two PCAs got Resident #5 off the floor and told the two MAs the resident fell out of her wheelchair.

Interview with a third PCA on 03/10/23 at 10:04am revealed:
-She saw Resident #5 leaning forward in her wheelchair and when she turned back around the resident was laying on the floor.
-She did not have to tell the MA because both MAs saw it.

Interview with Resident #5 on 03/10/23 at 10:08am revealed she did not know how she had

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injured her head.

Telephone interview with the Memory Care manager (MCM) on 03/10/23 at 11:14am revealed:
-She knew Resident #5 fell on 03/09/23.
-There were two MAs in the special care unit when Resident #5 fell.
-Both MAs refused to write up the incident related to Resident #5's fall.
-She told the Administrator that Resident #5 had a fall and hit her head and the Administrator told her to apply ice.
-She did not know the circumstances of the fall but knew at some point Resident #5 hit her head.
-The Administrator looked at Resident #5's head and again told her to apply ice.
-She did not call Resident #5's PCP, one of the MAs should have called.
-She did not ask the MAs if they called the PCP about Resident #5's fall.
-When a resident had a fall, the resident should be assessed, and the provider called for direction.
-They used to automatically send residents to the ED if they hit their heads, but now they had to call the resident's PCP for instructions.
-For Resident #5; the MAs should have called hospice and the PCP.

Telephone interview with Resident #5's PCP on 03/10/23 at 11:41am revealed:
-She was not aware Resident #5 had a fall on 03/09/23.
-She was concerned the facility staff was not following protocol.
-Resident #5 was on a blood thinner and she could have had a brain bleed that was not identified.
-Falls, when a person was on a blood thinner, were dangerous.

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D 273	Continued From page 45 -Brain bleeds could cause increased limitations with mobility, increased dementia, paralysis, and unconsciousness, the resident could "bleed out" and ultimately die if the brain bleed went untreated. Telephone interview with Resident #4's hospice nurse on 03/10/23 at 2:16pm revealed: -The last telephone call they had received regarding Resident #5 was on 03/04/23. -She would have expected to have been called on 03/09/23 when Resident #5 had a fall. -Because Resident #5 hit her head, they would have sent a nurse to the facility and would have called Resident #5's family to discuss sending the resident to the hospital to be evaluated since it was a head injury. -If the family member refused to send Resident #5 to the ED, she would have expected staff to monitor the resident. -Usually, if there was a head injury the staff would send a resident to the ED, but knowing Resident #5 was on a blood thinner, it was even more concerning because the resident could have a brain bleed. Interview with the Administrator on 03/10/23 at 1:49pm revealed: -She was not aware Resident #5 had a fall yesterday, 03/09/23. -Resident #5 should have been assessed by the MA. -No one had told her Resident #5 had an abrasion on her forehead. -She did not go and look at Resident #5's forehead after her fall. -She did recall someone telling her in the hallway, a resident had a fall (she was not sure which resident) and she told the staff (did not recall who) to do an incident report and to call the PCP.	D 273		

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D 273	Continued From page 46 The facility failed to contact the PCP and send three residents to the hospital for evaluation (#2, #4, #5) after an unwitnessed fall with a head injury and the family had to transport the resident to the hospital to be evaluated and was later diagnosed with a brain bleed and admitted to the intensive care unit (#4); a resident who had a fall and the PCP nor the hospice provider were notified and the resident was on a blood thinner and needed to be evaluated (#5); and a resident (#2) who had a change in condition and she complained of pain for three days, she stopped standing and walking and was diagnosed with a dislocated hip and fractured thigh bone requiring hip replacement surgery. This failure resulted in serious physical injury and pain and serious neglect to the residents and constitutes a Type A 1 Violation. The facility provided a plan of protection for this violation on 03/08/23 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 12, 2023.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338	Caswell House shall ensure that the rights of all Residents guaranteed under the Declaration of Resident Rights, are maintained and may be exercised without hindrance. ED completed HCPR reporting and MD notification for allegation of abuse on Resident #4.	3/8/23

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D 338	Continued From page 47 Based on interviews, record reviews, and observations, the facility failed to maintain residents' rights for 1 of 5 sampled residents related to verbal and physical abuse for a resident who had an injury to her finger (#5). The findings are: Review of Resident #5's current FL-2 dated 12/14/22 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, anxiety, heart failure, and muscle weakness. -Resident #5 was intermittently disoriented. Review of Resident #5's Primary Care Provider after visit summary dated 03/08/23 revealed: -Resident #5's right hand was injured by manipulation by staff, and edema was noted on the right hand and middle finger. -Resident #5 was noted to have right-hand bruising after interaction with staff during a toileting episode per the resident's family member. -Thankfully no fracture and bruising increased as Resident #5 was on anticoagulation therapy. -Resident #5 denied pain and had full range of motion. Observation of Resident #5's right hand on 03/09/23 at 11:37am revealed: -Her middle finger was swollen and there was red and purple bruising at the bottom of the finger and hand area. -The finger to the right of the middle finger was bruised from the knuckle to the base of the finger where it attached to the hand. Review of a picture of Resident #5's hand taken by Resident #5's family member on 03/04/23 at	D 338	Regional Director of Operations (RDO) in-serviced staff on Resident Rights, especially focusing on #2,4, and 5; also re-educated staff on the importance of prompt and accurate reporting of any Resident incidents/accidents. ED continued education with staff on the importance of prompt reporting of any Resident incident/accident to management and ensure proper notifications are completed, and interventions are put in place. PCP must be notified and documentation of this notification. Life Enrichment Coordinator will schedule monthly Resident Council Meetings, with the date clearly posted for the knowledge of all Residents. Any concerns voiced will be reviewed with the ED upon completion of the meeting to allow for prompt follow-up and intervention including the respective department head. ED will ensure new hire staff have a clear understanding of Resident Rights education received during orientation.	3/10/23 4/12/23 4/24/23 4/24/23

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D 338	Continued From page 48 10:18am revealed Resident #5's middle finger was swollen compared to her other fingers and there was significant discoloration, red and blue, from her knuckle to the tip of the finger. Interview with Resident #5 on 03/09/23 at 11:36am revealed: -"A few days ago, "while sitting in her wheelchair in her room, a female staff grabbed her from behind and it startled her, and she threw her right hand up in the air. -The female staff said, "you are not doing that to me, I will show you" and grabbed her hand and twisted it "real hard." -Another female staff was watching and looked surprised. -She did not tell anybody that day because the staff would not do anything about it anyway. -She had other things happen to her and no one did anything. -The next day her finger was hurting worse, and a different staff asked her what happened. -She told the staff what happened, and another staff came to her room and looked at her hand. -The Primary Care Provider (PCP) had looked at her hand too. -The incident happened around 12:00pm the day before staff asked her about it. -She did not know the name of the staff who twisted her hand but described her as "your height" about 190 pounds and had shoulder-length curly hair. -She could not describe the staff who witnessed the incident. Interview with a personal care aide (PCA) on 03/09/23 at 10:31am revealed: -Resident #5 complained a lot about a female staff being mean to her but she could never tell her who or when it happened.	D 338	ED/Care Managers/SICs will round no less than daily to ensure Residents' needs are met, and no concerns are voiced.	4/24/23

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-On Saturday morning, 03/04/23, Resident #5 complained of her right-hand hurting.
-Her finger appeared to be swollen and bruised.
-Resident #5 told her a female staff was mean to her but would not say who the staff member was or when the incident occurred.
-Resident #5 told her the female staff took her finger and squeezed it "real tight."
-Resident #5 would not tell her who the female staff was because the next time the female staff would do it worse.
-She told the medication aide (MA) about Resident #5's finger and what the resident stated happened.
-She heard Resident #5 tell the MA the same story she had told her about how her finger was injured.

Interview with another PCA on 03/09/23 at 1:16pm revealed:
-She went in to "wash up" Resident #5 for breakfast on Saturday, 03/04/23, and the resident told her another PCA had twisted her hand.
-She immediately went and told the MA.

Interview with the MA on 03/09/23 at 1:21pm revealed:
-The PCA told her about Resident #5's finger and what the resident claimed happened to her finger.
-She checked the progress notes and did not see anything documented about Resident #5's hand.
-No one had told her anything about Resident #5's hand at the change of shift.
-She did not know if Resident #5's hand was broken or not.
-Resident #5's finger was slightly swollen and had a lot of bruising.
-Resident #5 had not complained of any pain to her.
-She did not write a progress note on Resident

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#5's finger.
-She called Resident #5's hospice nurse and the PCP.

Interview with the Memory Care Manager (MCM) on 03/09/23 at 1:25pm revealed:
-When she woke up on Saturday, 03/04/23, she had a text message from the third shift MA about Resident #5's hand being bruised and the resident claimed one of the staff had squeezed her finger.
-She did not tell the Administrator about the allegation until 03/06/23 because she did not want to bother the Administrator on the weekend.
-On Monday, 03/06/23, she told the Administrator about Resident #5's hand and that Resident #5 had accused a female staff of hurting her hand.
-She told the Administrator face-to-face in the Administrator's office.
-The Administrator said she would "look into it."

Interview with the Administrator on 03/09/23 at 1:38pm revealed:
-The first time she heard anything about Resident #5's finger was when the PCP told her on Wednesday, 03/08/23, about the resident's hand.
-Resident #5's PCP told her to call the family member.
-She was not told by any staff that Resident #5 had accused staff of the injury to her finger.
-Staff did not come to her office and tell her about Resident #5's finger and allegation on 03/06/23.
-Resident #5's family member did not contact her about an injured finger before the PCP told her on 03/08/23.

Telephone interview with the MCM on 03/13/23 at 10:48am revealed:
-Resident #5 reported an incident where a staff pushed her against the wall, talked nasty to her,

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and slid her up in the bed.
-The Administrator was aware of the incident in the bed; it happened a couple of weeks before the incident with Resident #5's finger.
-She did not recall the exact date, but Resident #5's family member had also called her about the incident in the bed, and that was the day she went to the Administrator about it.
-There had been two incidents where Resident #5 reported an incident with staff.
-The first incident was when Resident #5 was pushed up against the wall and the second incident was when the resident had an injured finger.

Telephone interview with a MA on 03/13/23 at 2:16pm revealed:
-She recalled Resident #5 telling her and the resident's family member that staff had pushed her against the wall.
-Resident #5 had described a [named] staff as pushing her against the wall and the same staff as hurting her finger.
-The staff described was the same staff who had another allegation several months ago and nothing was done because that staff "\was "friends" with the MCM and the Administrator.
-She did not tell anybody what Resident #5 had said because another staff had reported an abusive situation involving staff and a resident and the staff was told by the Administrator if they told anyone they would be fired, and that staff member did get fired.

Telephone interview with Resident #5's family member on 03/10/23 at 9:31am revealed:
-When she visited Resident #5 on 03/04/23 she discovered the resident's finger/hand was bruised and swollen.
-Resident #5 told her a female staff yanked her

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hand because the staff was mad that she needed to go to the bathroom.
-Resident #5 stated when she told the staff, "You should not have done that", the staff mocked her and said, "you should not have done that" and then said, "well, I did."
-She described the female staff as a lady with glasses and "longer" hair.
-She asked the PCA what happened, but she did not know what happened and there were no notes in the resident's record about the incident.
-She talked to the Administrator on 03/06/23, face to face, in the Administrator's office about the incident.
-On 03/06/23, the Administrator mentioned to her she could put a nanny cam in the resident's room.
-She had reported another incident to the Administrator on a previous visit (about two weeks prior) when Resident #5 told her a female staff was mad because the resident had an incontinent episode in the bed and the female staff had pushed the resident up against the headboard and told her you nasty [expletive].
-The Administrator told her she could not believe anyone would hurt Resident #5 but she would look into it.
-Resident #5's family member had taken the picture of her hand and sent it to Resident #5's PCP because she was concerned about the resident's finger.
-Resident #5 identified the staff on Saturday, 03/11/23, who had pushed her up against the headboard and who talked to her "ugly."

Telephone interview with the Administrator on 03/13/23 at 10:11am revealed:
-Resident #5 told her family member someone was being ugly and mean to her and hurt her hand.
-On Wednesday, 03/08/23, a staff told her

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D 338	Continued From page 53 Resident #5's family member wanted the Administrator to call her. -She had talked to Resident #5's family member another day (she did not recall when) but the family member did not say anything about Resident #5's finger or staff that day. -She did not know anything about Resident #5's finger until the PCP told her on 03/08/23. -On Friday, 03/10/23, she asked Resident #5 if anyone was being mean to her, and the resident told her no. -She told Resident #5's family member she could put a camera in Resident #5's room, but she did not recall when or what the exact circumstances were at the time when she told her. -When Resident #5's PCP told her about the resident's finger she knew she needed to investigate, but before that, she did not have enough information to investigate. -She had not had an opportunity to interview staff about Resident #5's injured finger. Second telephone interview with the Administrator on 03/13/23 at 5:22pm revealed other than Resident #5's allegation a staff injured her finger, she could not recall any complaints from staff, residents, or family members brought to her attention about any resident abuse or neglect. _____ The facility failed to keep residents free of physical and mental abuse by not intervening and protecting Resident #5, after the resident had verbalized a staff talked nasty to her and pushed her up against the wall and headboard of her bed; and a second incident occurred approximately two weeks later when the resident reported staff had purposefully hurt her finger. This failure resulted in the facility failing to protect the resident and constitutes a Type B Violation. _____	D 338		

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D 338	Continued From page 54 The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/13/2023 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2023.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents, (#4 and #5) related to a medication used to treat an underactive thyroid (#4) and medication used to treat high blood pressure and a diuretic (#5), The findings are: 1. Review of Resident #4's current FL2 dated 12/13/22 revealed: -Diagnoses included pulmonary embolism, cellulitis of the right lower extremity, dementia without behavior, hypothyroidism, heart murmur, and anxiety. -There was an order for Levothyroxine (used to	D 358	Caswell House shall ensure that the preparation and administration of medications and treatments by staff are according to Provider's orders, which are maintained in the Resident's record; the facility's policies and procedures; and rules in section .1004(a). ED in-serviced Med Techs on the technique for applying transdermal medications. 3/14/23 ACD in-serviced Med Techs on the importance of using scanners during med pass for increase accuracy; clarified med pass times i.e. before meals, after meals, on an empty stomach; insulin administration times; the importance of notifying Care Managers/ED as soon as possible of any medication related concerns including orders that need to be clarified. 4/11/23 Care Managers will pull medication compliance reports daily to ensure medications are administered per MD orders. 4/24/23	

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D 358	Continued From page 55 treat a thyroid deficiency) 50mcg daily. Review of Resident #4's primary care provider (PCP) after-visit summary dated 12/21/22 revealed there was an order to begin Levothyroxine 50mg on an empty stomach, one hour before food or other medications. Review of Resident #4's primary care providers (PCP) after-visit summary dated 01/04/23 revealed: -There was an order to discontinue Levothyroxine 50mg. -There was an order to begin Levothyroxine 125mg, take ½ tablet to equal 62.5mg, on an empty stomach, one hour before food or other medications. Review of Resident #4's signed physician orders dated 01/25/23 revealed there was an order to administer Levothyroxine 125mg, take ½ tablet to equal 62.5mg daily; there were no directions to administer on an empty stomach with no food or other medications. Review of Resident #4's signed physician order dated 03/01/23 revealed an order to take Levothyroxine 112mcg, take one tablet every morning at 6:00am with six ounces of water one hour before other medications. Review of Resident #4's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 50mg with special instructions take one tablet on an empty stomach one hour before other medications or food with a scheduled administration time of 6:00am. -Levothyroxine 50mg was documented as	D 358	Report will be brought to management meeting daily for review with ED for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any intervention needed. Med Techs will complete MAR to Cart audits per facility schedule to ensure availability and accuracy of medications on med carts. The audits will be reviewed by Care Managers and ED for compliance, and to ensure accurate medications are on hand at all times. Care Managers will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance.	4/24/23 4/24/23 4/24/23

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administered at 6:00am from 01/01/23-01/08/23; there were no exceptions documented.
-There was a second entry for Levothyroxine 50mg (there were no special instructions) with a scheduled administration time of 6:00am.
-Levothyroxine 50mg was documented as administered at 6:00am from 01/09/23-01/216/23; there were no exceptions documented.

-There was an entry for Levothyroxine 25mg, take ½ tablet (12.5mcg) along with 50mcg=62.5mcg.
-Levothyroxine 25mg ½ tablet was documented as administered at 6:00am from 01/09/23-01/31/23; there were no exceptions documented.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Levothyroxine 50mg with a scheduled administration time of 6:00am.
-Levothyroxine 50mg was documented as administered at 6:00am from 02/01/23-02/28/23; there were no exceptions documented.
-There was a second entry for Levothyroxine 25mg, take ½ tablet (12.5mcg) along with 50mcg=62.5mcg.
-Levothyroxine 25mg ½ tablet was documented as administered at 6:00am from 02/01/23-02/28/23; there were no exceptions documented.

Review of Resident #4's March 2023 eMAR from 03/01/23-03/10/23 revealed:
-There was an entry for Levothyroxine 50mg with a scheduled administration time of 6:00am.
-Levothyroxine 50mg was documented as administered at 6:00am on 03/01/23 and 03/02/23; there were no exceptions documented.
-There was a second entry for Levothyroxine 25mg, take ½ tablet (12.5mcg) along with

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D 358	Continued From page 57 50mcg=62.5mcg. -Levothyroxine 25mg ½ tablet was not documented as administered at 6:00am on 03/01/23; there were no exceptions documented. Levothyroxine 25mg ½ tablet was documented as administered at 6:00am on 03/02/23. -There was a third entry for Levothyroxine 112mcg take one tablet by mouth every morning at 6:00am with 6 ounces of water one hour before other medications; the start date was 03/02/23. -There was documentation that Levothyroxine 112mcg was administered on 03/03/23-03/06/23; 4 tablets were documented as administered. Observation of Resident #4's medication on hand on 03/07/23 at 10:48am revealed: -There was a multi-dose punch card dispensed on 03/02/23. -The bubble pack was labeled as early morning. -The bubble pack contained 3 tablets, a ½ tablet of Levothyroxine 25mcg, 1 Levothyroxine 50mg, and 1 Omeprazole (used to treat indigestion) 20mg. -There was a prescription bottle labeled as Levothyroxine 112mcg take one tablet by mouth every morning at 6:00am with 6 ounces of water one hour before other medications were dispensed on 03/01/23 for a quantity of 2 tablets; Two tablets remained in the prescription bottle. Observation of Resident #4's medication on hand on 03/08/23 at 5:53am revealed: -There was a single bubble pack labeled as Levothyroxine 112mcg take one tablet by mouth every morning at 6:00am with 6 ounces of water one hour before other medications. -The package was dispensed on 03/01/23 with a quantity of 11 tablets. -One tablet had been administered from the package with 10 remaining tablets available.	D 358		

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D 358	Continued From page 58 Telephone interview with a representative from the facility's contracted pharmacy on 03/07/23 at 1:50pm revealed: -Resident #5's Levothyroxine 62.5mg was discontinued out of cycle filled 03/02/23 and Levothyroxine 112 was dispensed. -Two tablets of Levothyroxine 112 were dispensed from the backup pharmacy on 03/01/23 and 11 tablets were dispensed on 03/02/23. -The two tablets of Levothyroxine 112 were dispensed from the back up pharmacy which was local to allow time for their dispensing to arrive at the facility. Interview with a medication aide (MA) on 03/08/23 at 5:39am revealed: -Resident #4 had three medications that "popped" on the computer for a 6:00am administration. -She administered all three medications and had never disposed of any of the tablets. -She did not know Levothyroxine should not be administered with other medications. -She did not know Resident #4's Levothyroxine order had changed, and she was supposed to administer the Levothyroxine from the individual punch card. -She had not administered Resident #4's Levothyroxine 112 from the single punch card. -If a medication changed, they usually put a sticker on the multi-dose package to identify there had been a change. -If she documented she had administered Resident #4's Levothyroxine 112, it was in error because she had not administered that medication. Interview with another MA on 03/08/23 at 5:54am revealed:	D 358		

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-When she administered Resident #4's Levothyroxine "the other day" she disposed of two tablets in the multidose package and administered a Levothyroxine 112mcg from the individual package.
-She did not recall what day she disposed of the medication but that was the only time she had disposed of any of Resident #4's Levothyroxine.
-Both the Levothyroxine 112mcg and Omeprazole "popped" on the computer to be administered at 6:00am; she did not know the medication should not be administered together.

Interview with the Resident Care Coordinator (RCC) on 03/08/23 at 7:15am revealed:
-When the primary care provider (PCP) wrote new orders, she discontinued the medication out of the system and pulled the medication off the cart.
-If a medication was in a multidose package, she would put a discontinue sticker on the package.
-Orders were sent to the pharmacy, they input the information and then she or another care manager (CM) would approve the order on "our end."
-They were not supposed to add anything to the computer system as they were supposed to reach out to the pharmacy and let them make the change.
-Resident #4's Levothyroxine 112 was approved on 03/02/23 and the first administration should have been on 03/03/23.
-She would have expected the MAs to look at the computer screen and verify the correct order and administer the Levothyroxine 112mcg.
-There should have been 4 tablets of Levothyroxine 112mcg administered.
-She was concerned 4 tablets of Levothyroxine 112 were documented as administered and only one tablet had been dispensed from the punch

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D 358	Continued From page 60 card. Interview with the Administrator on 03/08/23 at 7:49am revealed: -When new orders were received one of the CMs would process the order. -Orders were sent to the pharmacy for input and the CM would ensure the order was entered correctly and then approve the order. -If an order was not entered correctly, the CM should contact the pharmacy and the PCP for clarification. -The order should not be approved until the order and entry had been clarified. -Resident #7's Levothyroxine should have been delivered separately. -The CMs should have called the pharmacy when the medication was delivered with other medications since there were special instructions. Telephone interview with Resident #4's PCP on 03/07/23 at 1:53pm revealed: -She had increased Resident #4's Levothyroxine on 03/01/23 because the resident's thyroid levels had been running high. -Resident #4's thyroid level could have been high because the Levothyroxine was not being administered correctly. -Resident #4's Levothyroxine should be administered one hour before all food and all other medications. -If Resident #4's Levothyroxine was administered with Omeprazole t would affect the absorption of the Levothyroxine. Based on observations and interviews it was determined that Resident #4 was not interviewable. 2. Review of Resident #5's current FL-2 dated	D 358		

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12/14/22 revealed diagnoses included dementia, atrial fibrillation, hypertension, anxiety, heart failure, and muscle weakness.

a. Review of Resident #5's signed physician's orders dated 12/14/22 revealed an order for Carvedilol (used to treat high blood pressure) 25mg twice daily.

Review of Resident #5's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Carvedilol 25mg with a scheduled administration time of 8:00am and 8:00pm.
-Carvedilol 25mg was documented as administered from 01/01/22-01/31/22; there were no exceptions documented.

Review of Resident #5's February 2023 eMAR revealed:
-There was an entry for Carvedilol 25mg with a scheduled administration time of 8:00am and 8:00pm.
-Carvedilol 25mg was documented as administered from 02/01/22-02/28/22; there were no exceptions documented.

Review of Resident #5's March 2023 eMAR from 03/01/23-03/10/23 revealed:
-There was an entry for Carvedilol 25mg with a scheduled administration time of 8:00am and 8:00pm.
-Carvedilol 25mg was documented as administered at 8:00am and 8:00pm from 03/01/22-03/10/22; there were no exceptions documented.

Observation of Resident #5's medication on hand on 03/09/23 at 11:32am and 4:57pm revealed:

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D 358	Continued From page 62 -There was a multi-dose punch card dispensed on 02/27/23. -Carvedilol 25mg was listed on both the am blister pack and the pm blister pack. -The am blister pack had 6 medications listed and identified by a description/picture; 6 tablets were observed and identified. -The pm blister pack had 4 medications listed and identified by a description/picture; 3 tablets were observed and identified. -The pm blister pack did not contain Carvedilol 25mg based on the description and picture provided by the pharmacy on the package. -There was a 2nd multi-dose punch card dispensed on 02/27/23 in the medication room; Carvedilol was listed on the pm blister back but was not included in the medication; there were 4 tablets listed and 3 pills in the pm package. -The package contained seven doses of medications. Telephone interview with a representative from Resident #5's pharmacy on 03/10/23 at 8:55am revealed: -Resident #5's Carvedilol was packaged with her other medications in a multidose blister pack. -She had not packaged Resident #5's Carvedilol individually. -Resident #5's medication was packaged for 4 weeks at a time and was dispensed on 01/16/23, 02/10/23, and 03/9/23 for delivery next week. -She did not recall any staff contacting her about Carvedilol not being in the multidose blister pack. -If she had been contacted, she would have repackaged the medication to include the Carvedilol or packaged the Carvedilol in a separate card. Telephone interview with a pharmacist from Resident #5's pharmacy on 03/10/23 at 9:15am	D 358		

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revealed:
-Resident #5's medication was filled for 4 weeks at a time but was only packaged and delivered every two weeks.
-The date of 02/27/23 observed on the current package reflected the two weeks' worth of medication that had been delivered to the facility.
-There was no documentation the facility staff had called the pharmacy about the Carvedilol not being in the multidose package.
-The pharmacy had not dispensed any Carvedilol other than in a multidose package.
-He would have expected the facility staff to notify the pharmacy when medication had not been delivered correctly.

Telephone interview with a representative from the facility's contracted pharmacy on 03/10/23 at 9:28am revealed:
-Carvedilol had not been dispensed for Resident #5.
-They only profiled Resident #5's medication.

Interview with Resident #5 on 03/09/23 at 11:36am revealed she did not know what medications she took but she took whatever was given to her.

Interview with a medication aide (MA) on 03/09/23 at 4:58pm revealed:
-She administered Resident #5's evening medications.
-She administered three tablets in the blister pack which included a medication used for edema (Furosemide), an antidepressant (Quetiapine), and a blood thinner (Xarelto).
-Resident #5's blister pack had not contained Carvedilol since the resident moved to memory care.
-She told the Assisted Living (AL) Manager that

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D 358	Continued From page 64 Resident #5's blister pack was missing the pm dose of Carvedilol. -She had not told the Memory Care Manager. -If she documented the medication had been administered, it was documented by mistake. Interview with the AL Manager on 03/10/23 at 10:13am revealed: -Resident only received medications from a named pharmacy. -No one had told her Resident #5's Carvedilol was not in the multidose blister pack. Interview with the Resident Care Coordinator (RCC) on 03/10/23 at 10:24am revealed: -No one had told her Resident #5's Carvedilol was not packaged in the multidose package. -It would have been easy to correct it if someone had told her. -The multidose package could be sent back for repackaging or the pharmacy would have dispensed Carvedilol separately. Telephone interview with Resident #5's primary care provider (PCP) on 03/10/23 at 11:41am revealed: -Resident #5's hypertension had been significant before she lost weight. -Resident #5's blood pressure was stable, and she was not concerned the resident had missed the Carvedilol. -She was very concerned the pharmacy had not been notified the Carvedilol had not been packaged. -If it had been with another resident who did have BP problems there could have been problems. -If a resident needed Carvedilol and it was not administered the resident could experience a stroke from high blood pressure.	D 358		

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b. Review of Resident #5's signed physician's orders dated 12/14/22 revealed an order for Furosemide (a diuretic) 20mg take one tablet twice a day.

Review of Resident #5's physician's order dated 02/22/23 revealed an order to stop Furosemide 20mg twice daily and begin Furosemide 20mg once daily.

Review of Resident #5's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Furosemide 20mg with a scheduled administration time of 8:00am and 4:00pm.
- Furosemide 20mg was documented as administered from 01/01/22-01/31/22; there were no exceptions documented.

Review of Resident #5's February 2023 eMAR revealed:
There was an entry for Furosemide 20mg with a scheduled administration time of 8:00am and 4:00pm.
- Furosemide 20mg was documented as administered from 02/01/22-02/28/22; there were no exceptions documented.

Review of Resident #5's March 2023 eMAR from 03/01/23-03/10/23 revealed:
There was an entry for Furosemide 20mg with a scheduled administration time of 8:00am and 4:00pm.
- Furosemide 20mg was documented as administered at 8:00am and 4:00pm from 03/01/22-03/10/22; there were no exceptions documented.

Observation of Resident #5's medication on hand

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D 358	Continued From page 66 on 03/09/23 at 11:32am and 4:57pm revealed: -There was a multi-dose punch card dispensed on 02/27/23. -Furosemide 20mg was listed on both the am blister pack and the pm blister pack. -The am blister pack had 6 medications listed and identified by a description/picture; 6 tablets were observed and identified. -The pm blister pack had 4 medications listed and identified by a description/picture; 3 tablets were observed and identified. -Furosemide was listed for both the am and pm doses. -Furosemide was identified in both the am blister pack and the pm blister pack. Interview with Resident #5 on 03/09/23 at 11:36am revealed she did not know what medications she took but she took whatever was given to her. Interview with a medication aide (MA) on 03/09/23 at 4:58pm revealed: -She administered Resident #5's evening medications. -She administered three tablets in the blister pack which included Furosemide, Quetiapine, and Xarelto. -If Resident #5 had a discontinued medication she would not know it had been discontinued unless it had been stopped on the eMAR and a discontinued sticker on the package. -The care managers made the changes in the eMAR. Telephone interview with a representative from Resident #5's pharmacy on 03/10/23 at 8:55am revealed: -Resident #5's Furosemide 20mg was packaged with her other medications in a multidose blister	D 358		

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pack to be administered twice daily.
-They did not have the order to discontinue one of the doses of Resident #5's Furosemide 20mg.
-The facility should have notified the pharmacy of the discontinued medication and returned the packages to be repacked or they could have identified one dose of the Furosemide as discontinued.

Interview with the Resident Care Coordinator (RCC) on 03/108/23 at 7:15am revealed:
-When she received an order for the medication to be discontinued, she took the medication off the cart or put a discontinued sticker on the package; this was the protocol for discontinued medication.
-All care managers [RCC, Memory Care Manager (MCM), and Assisted Living Manager (AL)] should use the same protocol.

Interview with the RCC on 03/10/23 at 10:24am revealed:
-When medications were discontinued one of the care managers would send the discontinued order to the facility's contracted pharmacy so the medication could be discontinued on the eMAR.
-One of the care managers would verify the order and once verified it would be removed from the eMAR.
-A sticker would be placed on the package to identify the medication had been discontinued.
-She was concerned that discontinued medications had not been discontinued.

Interview with the Administrator on 03/09/23 at 7:49am revealed:
-When an order was written, the CMs were responsible for processing the order.
-The CMs would send the order to the pharmacy, the pharmacy staff input the order, and the CM

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D 358	Continued From page 68 approved the order once it was verified as correct. Telephone interview with Resident #5's primary care provider (PCP) on 03/10/23 at 11:41am revealed: -She was concerned Resident #5's Furosemide had not been discontinued as ordered it could cause the resident to be over diuresis (excessive production of urine). -Over diuresis could lead to dehydration, an electrolyte imbalance, and cause the residents' protein to be too low. -Resident #5's protein was already low due to not eating and refusing protein supplements and she had a wound that needed protein to heal. -Being administered the extra dose of Furosemide after it had been discontinued did not cause the wound to not improve, but it did not help it either.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge of resident injuries for 2 of 5 residents (#2 and #5), including a resident who	D 438	Caswell House shall comply with G.S. 131E-256 and supporting rules related to HCPR Reporting. Regional Director of Operations (RDO) re-educated the ED on the importance of prompt completion of required reporting to HCPR for Abuse/ Neglect/ Exploitation/Injury of unknown origin within 24 hours of discovery, as well as completing Investigation and final report within 5 working days to the HCPR. 3/10/23 RDO in-serviced staff on Resident Rights, especially focusing 3/10/23	

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D 438	Continued From page 69 reported an incident in her room involving staff and had an injury to her finger (#5) and a resident who had injuries of unknown origin and required surgery (#2). The findings are: 1. Review of the facility's policy on resident abuse, neglect, and exploitation dated September 2021 revealed: -In the event of physical and/or verbal abuse, neglect, fraud, or exploitation of the resident or resident property or allegations of physical or verbal abuse, neglect, fraud, or exploitation of the resident or facility property by facility staff, the facility would complete the Health Care Personnel Registry (HCPR) 24-hour report now referred to as the Initial Report. -Upon notification of any of the above allegations the facility would begin an investigation and document findings on the HCPR 5-day report now referred to as the Investigation Report and submit it to the HCPR. -In the event of any accusation of abuse of a resident by staff, visitors, or other resident(s), management would direct staff to assure the immediate safety of the resident. -The physician would be notified for any additional orders which may include referral to outside resources for further medical evaluation, and the family, responsible party, and/or guardian would be notified and advised of their right to request notification of local authorities. -If there was any physical harm or injury present, the resident(s) would be sent out to the hospital for further evaluation unless the resident or responsible party declined further evaluation. -All required reporting would be completed as required not limited to local law enforcement and the Department of Social Services (DSS).	D 438	on #2, 4, and 5; also re-educated staff on the importance of prompt and accurate reporting of Resident Incident/Accidents. ED completed HCPR reporting and MD notification for allegation of abuse on Resident #4. 3/8/23 ED will ensure accurate and timely completion of reporting to HCPR regarding allegations of abuse. 4/24/23 ED will ensure that any staff member accused of abuse is suspended pending completion of the investigation to ensure Resident safety, and will complete a thorough investigation of the allegation. 4/24/23 Care Managers and ED will review electronic documentation reports Mon-Fri in management meeting to ensure that any documentation of injury of unknown origin has a report completed to HCPR within the required timeframe. 4/24/23 ED/Care Managers/SICs will round on Residents no less than daily to ensure Residents are 4/24/23	

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D 438	Continued From page 70 -The facility would complete the HCPR 24-hour report and begin an immediate investigation. -Immediate suspension of the accused individual (staff) if named or suspected parties pending investigation. -Complete the HCPR 24-hour report within 24 hours of discovery or knowledge of alleged abuse. -Facility Management would begin the investigation to substantiate or unsubstantiate the allegations for reporting on the HCPR 5-day working report. -Interview all staff present or any individuals present during the allegation. -Interview any providers or ancillary support services that may have details regarding the alleged abuse. -Complete and submit the 5-day working report either substantiated or unsubstantiated Review of Resident #5's current FL-2 dated 12/14/22 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, anxiety, heart failure, and muscle weakness. -Resident #5 was intermittently disoriented. Observation of Resident #5's right hand on 03/09/23 at 11:37am revealed: -Her middle finger was swollen and there was red and purple bruising at the bottom of the finger and hand area. -The finger to the right of the middle finger was bruised from the knuckle to the base on the finger where it attached to the hand. Review of a picture of Resident #5's hand taken on 03/04/23 at 10:18am revealed: -Resident #5's family member had taken the picture and sent it to Resident #5's Primary Care	D 438	being supervised appropriately, have needs met, and have no noted or voiced concern. Any allegation reported or injury of unknown origin noted will be reported to the ED immediately to allow for prompt intervention, follow-up, and reporting as required. ED continued education with staff on the importance of prompt reporting of any Resident Incident/ Accident to management and ensure proper notifications are completed, and interventions are put in place. PCP must be notified and documentation of this notification. 4/12/23 ED in-serviced staff on Resident Rights. 4/11/23	

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Provider (PCP) because she was concerned about it.
-Resident #5's middle finger was swollen compared to her other fingers and there was significant discoloration, red and blue, from her knuckle to the tip of the finger.

Interview with Resident #5 on 03/09/23 at 11:36am revealed:
-A "few days ago" while sitting in her wheelchair in her room, a female staff grabbed her from behind and it startled her, and she threw her right hand up in the air.
-The female staff said, "you are not doing that to me, I will show you" and grabbed her hand and twisted it "real hard."
-Another female staff was watching and looked surprised.
-She did not tell anybody that day because the staff would not do anything about it anyway.
-She had other things happen to her and no one did anything about it; she did not want to talk about it.
-The next day her finger was hurting worse, and a different staff asked her what happened.
-She told the staff what happened, and another staff came to her room and looked at her hand.
-The PCP looked at her hand too.
-The incident happened around 12:00pm the day before staff asked her about it.
-She did not know the name of the staff who twisted her hand but described her as "your height" about 190 pounds and had shoulder length curly hair.
-She could not describe the staff who witnessed the incident.

Interview with the medication aide (MA) on 03/09/23 at 1:21pm revealed:
-The personal care aide (PCA) told her about

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Resident #5's finger and what the resident claimed happened to her finger.
-She checked the progress notes and did not see anything documented about Resident #5's hand.
-No one had told her anything about Resident #5's hand at change of shift.
-Resident #5's finger was slightly swollen and had a lot of bruising.
-Resident #5 had not complained of any pain to her.
-She did not write a progress note on Resident #5's finger.
-She called Resident #5's hospice nurse and PCP.

Interview with the Memory Care Manager (MCM) on 03/09/23 at 1:25pm revealed:
-When she woke up on Saturday, 03/04/23, she had a text message that Resident #5's hand was bruised.
-She did not tell the Administrator about the allegation until 03/06/23 because she did not want to bother the Administrator on the weekend.
-On Monday, 03/06/23, she told the Administrator about Resident #5's hand and that Resident #5 had accused a female staff of hurting her hand.
-She told the Administrator face to face in the Administrator's office.
-The Administrator said she would "look into it."

Interview with the Administrator on 03/09/23 at 1:38pm revealed:
-Resident #5's PCP told her on Wednesday, 03/08/23, about the resident's hand.
-Resident #5's PCP told her to call the family member.
-She was not told by any staff Resident #5 had accused a staff of the injury to her finger.
-A staff did not tell her about Resident #5's finger and allegation on 03/06/23.

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	HAL017054	A. BUILDING: _____ B. WING _____	C 03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(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
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-Resident #5's family member did not contact her about an injured finger prior to the PCP telling her on 03/08/23.
-She initiated a Health Care Personnel Registry (HCPR) Investigation as soon as the PCP told her about the allegation on 03/08/23.

Review of a faxed transmission and HCPR initial allegation report on 03/10/23 revealed:
-The fax cover sheet was dated 03/09/23 at 4:08pm and the fax number was verified as the number for the HCPR.
-The form was signed by the Administrator on 03/09/23.
2. Review of Resident #2's FL-2 dated 03/30/22 revealed diagnoses included Alzheimer's disease, and history of falls.

Review of Resident #2's incident and accident report dated 02/26/23 revealed:
-Resident #2 had an incident noted as medical pain.
-Resident #2 was observed laying in her bed crying and holding her leg.
-First aid was not administered.
-Resident #2 was transported via local Emergency Medical Services (EMS) to a local emergency room (ER).
-Status of the resident after the ER visit was noted as requiring surgery.

Review of Resident #2's progress notes revealed:
-On 02/27/23, at 10:10am, there was notation Resident #2 was transported by EMS to the hospital with complaint of leg pain on 02/26/23.
-On 02/28/23 at 1:45pm, the Power of Attorney (POA) contacted the Memory Care Manager (MCM) and notified her Resident #2 had a broken hip, a compression fracture of the back and a neck fracture.

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Review of an email from Resident #2's POA to the Administrator dated 03/03/23 revealed:
-The POA notified the Administrator Resident #2 had severe injuries including a compound fracture of her back and neck and had surgery to repair her broken hip.
-The POA also informed the Administrator that Resident #2 would not be returning to the facility.
-She noted that when she inquired about Resident #2's injuries the facility staff could not tell her what happened to Resident #2 to cause the injuries.

Interview with the Memory Care Manager (MCM) on 03/09/23 at 5:23pm revealed:
-Resident #2's POA called her on 02/28/23 and told her Resident #2 had neck and back injuries and a broken hip; the POA told her Resident #2 required surgery to repair the hip fracture.
-She told the Administrator about Resident #2's injuries at the morning stand up meeting on 02/28/23 or 03/01/23.
-She had asked the staff about what had happened to Resident #2, but no one knew anything and none of the staff had reported a fall.
-She completed an incident report on 02/27/23 because Resident #2 was sent out to the hospital with a complaint of pain.
-She was not responsible for reporting to the HCPR.

Interview with the Administrator on 03/10/23 at 1:11pm revealed:
-She was responsible for initiating notification of the Health Care Personnel Registry (HCPR).
-She knew she had 24 hours to initiate an HCPR report after discovering the injuries with unknown causes.
-She had initiated a HCPR for Resident #2 on

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D 438	Continued From page 75 03/09/23, because she had injuries that were unexplainable. -She knew Resident #2 was sent out to the hospital on 02/26/23 but she had to wait for the hospital to discharge the resident to get a report with the injuries. -She had not heard from the family or the PCP what Resident #2's injuries were so she had no reason to initiate an HCPR report until she found out on 03/07/23. -She did not recall the MCM telling her in the morning stand up meeting about Resident #2's injuries. -She did not know about the email sent by Resident #2's POA on 03/03/23 informing her about the injuries or the intent to move Resident #2 to another facility. _____ The facility failed to ensure an injury of unknown origin to a resident (#2) and an injury to a resident caused by a staff reported by the resident (#5) was reported to the HCPR. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/10/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 24, 2023	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county	D 451	Caswell House shall notify the county department of social services of any	

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D 451	Continued From page 76 department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 1 of 4 residents (#2) who had a fractured hip after being transported to the local hospital by emergency medical services (EMS). The findings are: Review of Resident #2's FL-2 dated 03/30/22 revealed diagnoses included Alzheimer's disease, and history of falls. Review of Resident #2's Care Plan dated 09/18/22 revealed she required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring and she resided in the Special Care Unit (SCU). Review of Resident #2's incident and accident report dated 02/26/23 revealed: -Resident #2 had an incident noted as medical pain. -Resident #2 was observed laying in her bed crying and holding her leg. -First aide was not administered. -Resident #2 was transported via local Emergency Medical Services (EMS) to a local emergency department (ED). -Status of the resident after the ED visit was	D 451	accident or incident resulting in Resident death or any accident or incident resulting in injury to a Resident requiring treatment greater than first aid. RDO in-serviced staff on the importance of prompt and accurate reporting of Resident Incidents/Accidents. 3/10/23 ACD in-serviced staff on proper way to report Incidents as well as completing Incident Reports correctly with Resident events. 4/3/23 ED continued staff education on the importance of prompt and accurate reporting of any Resident Incident/ Accidents, proper notifications, interventions, and documentation of all. 4/12/23 Care Managers and ED will review incidents daily in management meeting to ensure appropriate follow-up and reporting has occurred within the required 48 hour timeframe. 4/24/23 Reportable Incident Reports will be stored in a binder with the confirmation of successful submission attached. This binder will be maintained in the ED's office for reference. 4/24/23	

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D 451	Continued From page 77	D 451		

noted as requiring surgery.

Review of Resident #2's progress notes revealed:
-On 02/27/23+ at 10:10am, there was notation Resident #2 was transported by EMS to the hospital with complaint of leg pain on 02/26/23.
-On 02/28/23 at 1:45pm, the Power of Attorney (POA) contacted the Memory Care Manager (MCM) and notified her Resident #2 had a broken hip, a compression fracture of the back and a neck fracture.

Review of an email from Resident #2's POA to the Administrator dated 03/03/23 revealed:
-The POA notified the Administrator Resident #2 had severe injuries including a compound fracture of her back and neck and had surgery to repair her broken hip.
-The POA also informed the Administrator that Resident #2 would not be returning to the facility.
-She noted that when she inquired about Resident #2's injuries the facility staff could not tell her what happened to Resident #2 to cause the injuries.

Telephone interview with the Resident #2's POA on 03/06/23 at 2:15pm revealed:
-On 02/26/23 at approximately 2:00pm she went to the facility to visit Resident #2.
-As she passed by the nurses' station, she was told by a staff member that Resident #2 had been crying and asking for her all day long.
-Resident #2 was in bed laying on her left side and was sobbing when she went into the room.
-Resident #2 cried out in pain when she rolled her onto her back.
-She went back to the nurses' station and asked to staff what had happened to Resident #2 and asked if she had fallen.
-Staff told her they had no idea what had

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happened to Resident #2.
-Resident #2 was transported by EMS to the local ED where she was diagnosed with a compression fracture in her neck and back and a broken hip.
-Resident #2 had hip replacement surgery on 02/27/23.

Second telephone interview with Resident #2's POA on 03/08/23 at 6:04pm revealed:
-She had notified the Memory Care Manager (MCM) about Resident #2's injuries when she called the facility on 02/28/23; the day after Resident #3 had hip surgery.
-She also sent an email to the Administrator on 03/03/23 informing her of Resident #2's injuries and surgery to her repair her broken hip.
-She informed the Administrator in the email dated 03/03/23, Resident #2 would not be returning to the facility.

Telephone interview with the Adult Home Specialist (AHS) for the local county Department of Social Services (DSS) on 03/06/23 at 8:19am revealed she did not have an incident or accident report for Resident #2 from the facility.

Second telephone interview with the AHS on 03/10/23 at 1:58pm revealed the county DSS had not received an incident or accident report for Resident #2 from the facility.

Interviews with the MCM on 03/09/23 at 12:31pm and 5:23pm revealed:
-Resident #2's POA had called her on 02/28/23 and told her Resident #2 had neck and back injuries and a broken hip; the POA told her Resident #2 required surgery to repair the hip fracture.
-She told the Administrator about Resident #2's injuries at the morning stand up meeting on

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D 451	Continued From page 79 02/28/23 or 03/01/23. -She completed an incident report on 02/27/23 because Resident #2 was sent out to the hospital with a complaint of pain. -She completed incident reports for all falls and injuries, even for unexplained injuries. Interview with the Administrator on 03/10/23 at 1:11pm revealed: -She knew Resident #2 was transported by EMS to the local ED on 02/26/23 for complaint of pain. -She had not heard from the family or the PCP about Resident #2's injuries so she had no reason to notify the county DSS about an injury or incident concerning Resident #2. -She had to wait for the hospital to discharge Resident #2 to get a report with the injuries. -She was notified by another facility on 03/07/23 that Resident #2 was admitted to the other facility and discharged from the hospital. -She did not recall the MCM telling her in the morning stand up meeting about Resident #2's injuries. -She did not know about the email sent by Resident #2's POA on 03/03/23 informing her about the injuries or the intent to move Resident #2 to another facility. -She knew she was required to report injuries or incidents that required emergency medical attention to the local DSS within a 24-hour period. -The MCM should have sent the incident and accident report to the local county DSS but she could have as well.	D 451		