STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045130	A. BUILDING: _____ B. WING _____	R-C 11/01/2023

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TERRABELLA OF HENDERSONVILLE	3851 HOWARD GAP ROAD HENDERSONVILLE, NC 28792

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D 000	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services conducted a follow up and complaint survey on 10/31/23 - 11/01/23.	D 000		
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: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately for 1 out of 1 sampled residents when staff became aware Resident #4's bathroom door was locked, and Resident #4 was nowhere to be found. The findings are: Review of the facility's Elopement/Missing Resident Policy dated 08/27/20 revealed: -The policy provided a logical, systematic process if a resident was unaccounted for at any given time. -A search was to be initiated by the staff who	D 271		

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identified the resident as missing.
-The search was to include all community rooms, closets, storage areas, etc, as well as the outside structures.
-If the resident was not found within 10 minutes, the Administrator was to notify the Regional Director of Operations, responsible party/family, physician, hospitals, police and State Regulatory agencies.

Review of Resident #4's current FL2 dated 7/17/23 revealed:
-Diagnoses included hypercoagulation state, and hypertension.
-She required Assisted Living level of care.
-An order for Xarelto (a medication used to thin blood) 20mg 1 tablet daily.

Review of Resident #4's Resident Register revealed an admission date of 08/03/23.

Review of Resident #4's Care Plan dated 07/18/23 revealed:
-She required supervision with ambulation.
-She required limited assistance with toileting.

Review of Resident #4's Emergency Medical Services (EMS) report dated 08/29/23 revealed:
-On 08/29/23 at 6:44pm, EMS was notified a resident had fallen.
-At 6:46pm, EMS arrived on scene at the facility.
-Resident #4 was alert, vital signs were obtained, blood pressure of 138/79 (normal was 120/80), heart rate of 104 (normal was 60 to 100 beats per minute), respirations were 17 (normal was 12 to 20 per minute), and a temperature of 98.7 (normal was 97.6 to 99.6).
-Resident #4 was found on the floor, with right side facial swelling and bruising and complaining of neck pain.

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-At 7:03pm, Resident #4 was placed in a cervical collar (a neck brace used to support/stabilize the neck and spine and limit head movement after an injury) and transported to the hospital.

Review of Resident #4's hospital admission documents dated 08/29/23 to 08/30/23 revealed:
-Resident #4 experienced an unwitnessed fall with a closed head injury.
-Resident #4 was on anticoagulation medications (used to thin the blood).
-Resident #4's injuries included a large facial hematoma and was diagnosed with a urinary tract infection.
-Due to the number and complexity of problems including high-acute or chronic illness or injury that posed a threat to life i.e., the closed head injury and the urinary tract infection (UTI), Resident #4 was admitted to the hospital for care.
-There was documentation Resident #4 was last seen by staff at the facility around 1:00pm, and later in the afternoon.
-Resident #4 had diarrhea, cleaned herself up and fell because she was weak.
-A Computed Tomography (CT Scan) of Resident #4's head showed a 12x12mm hematoma to her right infraorbital (below the right eye).
-Resident #4 received intravenous antibiotic therapy, fluids and pain medications during hospital stay as well as her prescribed home medications.
-Resident #4 received a Physical Therapy (PT) evaluation and PT was ordered once a day for 5-6 weeks.
-Resident #4 was discharged to a skilled nursing facility on 09/04/23.

Telephone interview with one of Resident #4's hospital admitting physician on 11/01/23 at 10:55am revealed:

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-On 08/29/23, Resident #4 was admitted to the hospital after a fall which resulted in facial brusing and a hematoma.
-Resident #4 was on blood thinners and was at an increased risk of bleeding.

Review of Resident #4's Incident/Accident Report dated 08/2923 revealed:
-On 08/29/23 at 6:30pm Resident #4 sustained an unwitnessed fall.
-On 08/29/23 at 6:00pm, Resident #4's family member called and notified the facility Resident #4 was lying on the floor and did not know what happened.
-Resident #4 was transported to the emergency room.
-Resident #4 was found between the bathroom and the bedroom, in her room.
-Resident #4 had a bowel movement and appeared to be cleaning herself.

Review of Resident #4's progress note dated 08/29/23 at 6:30pm revealed the medication aide (MA) documented Resident #4 sustained an unwitnessed fall and it was reported to the facility by Resident #4's family member.

Telephone interview with Resident #4's family member on 10/31/23 at 1:52pm revealed:
-Resident #4 normally received her breakfast in her room.
-On 08/29/23 at 5:45pm she called Resident #4 and Resident #4 did not answer the phone.
-She assumed Resident #4 did not answer the phone because she normally would have been returning from dinner around that time.
-On 08/29/23 a little after 6:00pm, she called Resident #4 again.
-ON the second call Resident #4 answered the phone and informed her she was looking for her

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clothes, she could not get up off the floor.
-On 08/29/23 at 6:05pm, she called the facility and let it ring 10-12 times with no answer.
-She attempted a second call immediately after and informed the Administrator Resident #4 fell and required assistance.
-On 08/29/23, she arrived at the facility about 6:30pm and the MA was applying ice to Resident #4's face.
-There were 2 blankets over Resident #4 and Resident #4's breakfast plate was still in her room.
-Resident #4 was lying on the floor with her feet toward the bathroom wall and her head towards the bathroom sink.
-There was smeared feces on the floor and looked like it was wiped up.
-Resident #4's right eye was black with redness and bruising, the tip of her chin and throat was black, and it looked like someone used a black marker on her face and neck.
-Resident #4's right arm was bleeding about 5 inches above her wrist.
-Resident #4 recognized her.
-Resident #4's phone was found under her body when they moved her.
-At that point staff had not called 911.
-The personal care aide (PCA) told her that she last saw Resident #4 between 11:20am and 11:35am when she was walking down the hall and told Resident #4 that it was time for lunch.
-Resident #4 normally went to the dining room for lunch and dinner, so it concerned her that the staff did not check to see why Resident #4 was not in the dining room.

Interview with a MA on 10/4/2023 at 11:06am revealed:
-On 08/29/23 she was the MA from 7:00am to 7:00pm.

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-The last time she saw Resident #4 was between 2:00pm and 2:30pm when Resident #4 was sitting in her chair in her room.
-On 08/29/23, around dinner time, which was 5:00pm, Resident #4's family member called the Administrator to notify him that Resident #4 was lying on the floor.
-She did not know how long Resident #4 was lying on the floor.
-Staff were to check on residents every 2 hours.
-She did not remember who the staff that was working with her on 08/29/23.

A second interview with the MA on 11/01/23 at 9:55am revealed:
-On 08/29/23, she was the MA on duty and started her medication pass at about 11:30am.
-At some point during the medication pass between 11:30am and 2:00pm she saw Resident #4 in her room in her recliner.
-She could not be sure of the exact time because it was so long ago.
-On 08/29/23, between 5:30pm and 6:00pm she was alerted by the Administrator that Resident #4 family called stating Resident #4 fell in her room around lunch time and needed help.
-She and the Administrator went to Resident #4's room and found Resident #4 on the floor just outside the bathroom door.
-There was wet feces on the floor in the bathroom, and Resident #4 was only wearing an adult brief.

Interview with a PCA on 11/01/23 at 9:30am and 10:05am revealed:
-On 08/29/23, she was Resident #4's PCA from 7:00am to 7:00pm.
-On 08/29/23 between 11:30am and 11:45am she walked down the hall and saw Resident #4 sitting in her recliner in her room and she told Resident

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D 271	Continued From page 6 #4 it was time for lunch. -Resident #4 usually ate breakfast in her room and went to the dining room for lunch and dinner. -On 08/29/23 at 12:15pm, after not seeing Resident #4 in the dining room, she went to Resident #4's room to check on her. -When she entered Resident #4's room, Resident #4 was not sitting in her recliner but her bathroom door was shut, so she went over to the bathroom door and called Resident #4's name twice, knocked on the bathroom door and there was no answer. -She attempted to open the bathroom door but it was locked. -She did not hear any water running in the sink or shower and there was not any noise coming from the bathroom. -She assumed Resident #4 went out to lunch with her family, which was not unusual. -She did not think at the time about the locked bathroom door but now felt Resident #4 could have been in there and had fallen. -She should have notified the MA about the locked bathroom door because a bathroom door could only be locked if someone was in there. -On 08/29/23 around 4:30pm, she came down the hall to let residents know dinner was ready and she went into Resident #4's room and Resident #4 was not in her recliner and the bathroom door was closed but she did not check at that time to see if it was locked. -She assumed Resident #4 was still out with her family member. -Resident #4 was not in the dining room for dinner. -On 08/29/23 around 6:00pm the MA told her Resident #4 fell in her room. -When she walked into Resident #4's room she saw Resident #4 lying on the floor in the door way to the bathroom.	D 271		

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D 271	Continued From page 7 -Resident #4 was covered with blankets and there was feces on the bathroom floor. -Resident #4 was bruised on the right side of her face. -Resident #4 was transported to the hospital for evaluation and admitted for her injuries. Interview with the Administrator on 10/4/2023 at 10:20 am revealed: -On 08/29/23 around 6:30pm, he was notified by Resident #4's family member that Resident #4 was on the floor in her room and could not get up. -When he arrived in Resident #4's room, he found Resident #4 on the floor without clothing and wearing only an adult brief. -He covered Resident #4 and called for staff assistance. -Resident #4's family member arrived while staff were assessing her. -A MA assisted with Resident #4. -Resident #4 reported no pain. -There was feces in the toilet and a soiled adult brief. -He was not sure when she was last checked on by staff, on 08/29/23. -Resident #4 reported not being on the floor for a long time. -He did not know how Resident #4 was able to call her family member to get help. -There were no records Resident #4 attended lunch and dinner in the dining room and there were no resident rounding sheets. -Staff should round/check on residents every few hours. Interview with the Administrator on 11/01/23 at 3:00pm revealed: -On 08/29/23, he was not aware Resident #4's bathroom door was locked and Resident #4 was not located when the PCA checked at 12:15pm	D 271		

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D 271	Continued From page 8 when she was telling residents to come to lunch. -If staff could not locate Resident #4 and her bathroom door was locked and there was no answer, he expected the staff to inform the MA and the door should have been unlocked. -The missing person/elopement policy should have been activated, and Resident #4 should have been searched for. -Unlocking the bathroom door would have allowed the staff to know if Resident #4 had fallen in the bathroom and was hurt and unable to call for help, and then Resident #4 could have received help sooner. _____ The facility failed to immediately respond when Resident #4 was not located around 12:15pm when her bathroom door was locked, and she did not answer after staff called her name twice and there was no sound coming from the bathroom. Approximately 6 hours later the staff were alerted by Resident #4's family member that Resident #4 fell in her room and required help. Resident #4, was on blood thinners and as a result of the fall sustained a facial hematoma (blood collection under the skin) requiring Resident #4 to be hospitalized for 6 days. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/01/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 01, 2023.	D 271		