Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Terra Bella Southport
Address: 1125 W Leonard St. Southport, NC 28461
County: Brunswick
License Number: HAL-010-010

II. Date(s) of Visit(s): 04/10/24 and 05/02/24
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 06/07/24

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0902 Rule/Statutory Reference: 10A NCAC 13F .0902 Healthcare (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Level of Non-Compliance: Type A1 Violation Findings: This Rule area is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral to meet the acute health care needs of 1 of 5 sampled residents, (#2), who had symptoms of shortness of breath, chest pain, and atrial fibrillation beginning on 03/08/24 and died at the facility two days later on 03/10/24. The findings are: Review of the facility's Response to Resident Incidents policy dated 10/01/22 revealed: -A resident incident would include anything that resulted in the resident requiring medical and other outside services. -If needed, the resident was to be transferred to an appropriate healthcare facility to stabilize and treat the resident's condition. -The Primary Care Physician (PCP) was to be notified.	☑ POC Accepted TR *DSS Initials* 10A NCAC13F .0902(b) The facility will assure referral and follow up is done to meet the routine and acute healthcare needs of our residents. Clinical Staff received Inservice training regarding reporting procedures and follow up for resident needs. Staff will immediately report to the supervisor on duty any issues or concerns. The supervisor on duty will immediately activate 911 for emergency care as needed and ensure notification of primary care physician and family. For non-emergent issues, the supervisor on duty will follow appropriate reporting procedures including but not limited to physician notification and notification of family members. Front line staff were instructed to notify a member of the management team immediately if they have any concerns with follow up to issues reported to the supervisor. 6/26/24 Executive Director will review shift to shift report in morning meeting and follow up to ensure appropriate notifications were completed and ensure ongoing compliance.	

Review of Resident #2's current FL-2 dated 08/29/23 revealed:
-Diagnoses included Alzheimer's disease, type 2 diabetes mellitus, hypertriglyceridemia, primary hypertension, and vitamin D deficiency.
-Resident #2 was disoriented and required Special Care Unit (SCU) placement.
-Resident #2 was ambulatory, verbal, and continent of bowel and bladder.

Review of Resident #2's medication standings orders dated 09/19/23 revealed there was an order for Geritussin (used to treat cough and improve breathing) 10mg to be given every 4 hours as needed.

Confidential staff interview revealed:
-On Friday, 03/08/24, a Special Care Unit (SCU) resident, (#2), was having shortness of breath (SOB) and appeared discolored.
-An aide informed the Director of Health and Wellness (DHW) and the DHW called Emergency Management Services (EMS).
-When EMS arrived, they informed the DHW that Resident #2 was having atrial fibrillation (an irregular, often rapid, heartbeat) (AF), but his heart rate might not be high enough for the hospital to admit him.
-The DHW made the decision not to send Resident #2 to the hospital and did not notify the resident's PCP of his symptoms.
-On 03/10/24, Resident #2 suddenly went limp in a staff member's arms and died.
-Resident #2 was a full code but could not be resuscitated by staff or EMS workers.
-Many staff were very upset about Resident #2's death and thought there was a chance it could have been prevented if he had received medical care for his symptoms.

Review of Resident #2's incident reports for March 2024 revealed:
-There was not an internal or reportable incident report dated 03/08/24.
-There was an internal incident report dated 03/11/24 that stated on 03/10/24 "Resident #2 was eating ice cream and passed out; staff began Cardiovascular Pulmonary Resuscitation (CPR) on him and called 911; EMS staff

continued CPR before pronouncing the resident dead."
-The "Final Notes" section of the report stated Resident #2 was being given as-needed medication for cough and congestion.

Review of Resident #2's hand-written progress notes for March 2024 revealed:
-On 03/08/24 there was no entry.
-On 03/09/24 (no time of entry noted) there was an entry Resident #2 complained of having to cough up mucus; vitals and oxygen were checked and were in normal range; an as-needed cough medication was given every four hours for congestion.
-On 03/10/24 (no time of entry noted) there was an entry Resident #2 was given an as-needed cough medication, was feeling better, and ate a good breakfast and lunch.
-Below the 03/10/24 entry dated as "03/08/24 late entry" (the actual date entered was not given) there was an entry by the DHW that EMS was called on 03/08/24 at 4:40pm for Resident #2 due to shortness of breath; EMS stated Resident #2 had mild atrial fibrillation (an irregular often rapid heartbeat) with a heart rate of 120 which would not be treated at the hospital if the heart rate was less than 150; Resident #2's discoloration and SOB had resolved and he was walking and talking at baseline; at the direction of EMS, the resident was not sent out to the hospital; he was tested for Covid due to congestion with negative results.

Review of a separate page of hand-written progress notes documented out of sequence from Resident #2's sequential progress notes revealed:
-On 03/09/24 at 2:00pm there was an entry the Medication Aide (MA) had reported to the Memory Care Coordinator (MCC) that Resident #2 complained of needing to cough up mucus, was overall not feeling well, and was informed to ensure Resident #2 was getting as needed cough medication.
-On 03/09/24 at 4:50pm there was a third entry Resident #2 was given cough medication; he was weak and unsteady when walking and continued to state he did not feel well; he refused to eat or drink at dinner time but ate a few bites with encouragement; he was congested and coughing up mucus; the MA was told to pass on the information to the next shift and to inform them to continue to administer cough medication.
-On 03/10/23 at 10:00am there was an entry Resident #2 ate 100% of his breakfast, looked better, and stated he felt better; he was given cough medication.

Review of Resident #2's electronic medication administration records (eMAR) for March 2024 revealed:
-On 03/09/24 Resident #2 was given one dose of Geritussin for cough and congestion and the results were documented as effective.
-On 03/10/24 Resident #2 was given one dose of Geritussin for congestion and the results were documented as effective.

Review of an audio recording of a 911 call from the facility on 03/08/23 revealed:
-At 4:24pm, a female called 911 and identified herself as calling from the facility.
-The female identified herself by name and was the DHW.
-She stated, "I have a resident who is having trouble breathing and he is asking to see a doctor."
-When asked by the 911 operator if the resident had seen a doctor or nurse in the last two hours, the DHW stated "I'm a nurse. I'm not with him now but I saw him for a minute, and he was having trouble breathing."

Review of an EMS electronic report of a facility visit dated 03/08/24 revealed:
-At 4:29pm EMS arrived at the facility.
-When EMS arrived, staff reported Resident #2 was pale and sitting up in bed.
-Upon evaluation, Resident #2 was described by EMS as a 90-year-old male sitting upright in bed, eyes open, oriented to sounds, and able to follow objects and interact.
-Resident #2's chief primary complaint was listed as chest discomfort.
-Upon evaluation, the written report stated the patient had "atrial fibrillation but was normal."
-All other vitals were within normal range.
-The final log of events stated, "Staff on scene states they are comfortable with a refusal" and "EMS obtained a refusal against medical advice."
-EMS departed the facility at 4:45pm

Review of a Refusal of EMS Service/Transport form dated 03/08/24 revealed:
-The refusal form read "The EMS Provider has recommended" and the box of options that applied was marked with X for "Ambulance transportation."
-The refusal form included a typed statement that read "I refuse the care that the attending EMS provider has recommended. I understand that my refusal may result in serious injury or death to the patient. I accept full

responsibility for this decision. I assume all risks and consequences resulting from my refusal of care. I will not hold the City, the Fire Department, its members, officers, agents, or employees responsible for any negative things that may happen to the patient because of my refusal. My signature below attests that I understand what has been recommended and what the consequences may be if that is not done, and I am still refusing the recommended treatment, evaluation, and transport."
-The refusal form included an additional typed statement that read, "You have not been evaluated by a doctor, and the doctor should be contacted immediately" followed by handwritten instructions to "Contact doctor about atrial fibrillation."
-The refusal form was signed by the DHW.

Telephone interview with an EMS Paramedic on 05/16/24 at 2:00pm revealed:
-She was one of the responders on 03/08/24 when EMS was dispatched to the facility for Resident #2.
-She pulled the records from the response call to refresh her memory and could see that EMS was called for Resident #2 having shortness of breath and upon arrival, the primary complaint was chest discomfort.
-Staff reported that before EMS arrived on the scene, Resident #2 was pale.
-Upon assessment by EMS, Resident #2's appearance was normal but he did have AF.
-If a patient had a history of AF, they typically did not treat AF unless the rate was over 150.
-"Yes it could" make a difference in how they responded if a person never had a history of AF but she did not remember what Resident #2's history was.
-She remembered Resident #2 was responding normally, and he felt ok.
-She informed the DHW that Resident #2 was having AF and that he could be transported to the hospital, but there was a chance the hospital would not treat the AF at that heart rate.
-She had been doing her job for 17 years and she had never in her career refused to take anyone to the hospital, especially a SCU resident.
-The DHW said she felt comfortable with Resident #2 not being taken to the hospital and she signed the refusal form.
-Anytime a resident was in the SCU, it was up to the supervisor on duty if the resident was transported to the

hospital.
-She would expect staff to inform the PCP of Resident #2's symptoms and the refusal form specifically indicated staff were to inform the PCP of Resident #2's AF.

Review of an audio recording of a 911 call from the facility on 03/10/23 revealed:
-At 2:06pm, a female called 911 and identified herself as calling from the facility.
-The female identified herself by name and was the MCC.
-She reported a resident (#2) was unresponsive.
-Resident #2 was "coming in and out of consciousness."
-Staff would meet EMS at the front of the building to let them into the locked SCU where the resident resided.
-As soon as the call ended, the MCC called back to provide notification that CPR was being performed on Resident #2.

Review of an EMS electronic report of a facility visit dated 03/10/24 revealed:
-At 2:10pm EMS arrived at the facility.
-EMS observed staff doing CPR and they reported Resident #2 had returned from the dining room after eating lunch, and was in his room eating a bowl of ice cream with a staff member present, when his eyes rolled back in his head and he went unconscious.
-Staff reported they laid Resident #2 down on the floor and saw him take his last breath, at which point they began CPR.
-EMS observed Resident #2 was pale in all extremities, had purple lips, no pulse, no blood pressure, and no oxygen level was detected.
-EMS interventions included CPR, assisted ventilation, and suctioning but resuscitation efforts were ceased after approximately 25 minutes from the start due to "obvious signs of death."
-Resident #2 was pronounced "Dead on scene."

Telephone interview with Resident #3's family member on 06/04/24 at 10:00am revealed:
-She was Resident #2's responsible party who signed all of Resident #2's admissions records to the facility.
-Resident #2 had a Power of Attorney (POA) but she was 85-years old and was really struggling with his death, so she asked that no one speak with the POA about the weekend of his passing.
-Any communication from the facility was always made to her phone and she always provided information to Resident

#2's POA as needed.
-The first time the family was contacted by the facility on the weekend of his passing was on 03/10/24, and they were told he stopped breathing and to come right away.
-The family arrived and were told EMS was performing CPR.
-The family was not allowed to enter Resident #2's room until almost an hour later.
-The family was never notified Resident #2 was not feeling well that weekend or that EMS had been called for Resident #2 on 03/08/24, and "this phone call" was when they learned of this.
-If they had known Resident #2 was having abnormal symptoms, they would have insisted he go to the hospital.

Telephone interview with a former Personal Care Aide (PCA) on 04/11/24 at 3:33pm revealed:
-She previously worked at the facility as a PCA but had resigned from her position because she was so upset about how the situation with Resident #2 was handled.
-She thought his death was likely a direct result of not getting the medical care he should have received when his symptoms started on Friday 03/08/24.
-She was the PCA working with Resident #2 on 03/08/24.
-She went into Resident #2's room and woke him from a nap to tell him it was time to go to the dining room for dinner.
-Resident #2 looked very tired and she noticed he "just wasn't right and did not act like himself."
-He stood up and he began to stumble, which was unusual for him.
-Resident #2 began holding his chest and looked at her and said, "I need a doctor".
-When Resident #2 told her he needed a doctor, he said it "as clear as day."
-She asked Resident #2 "What is wrong?" and patted her own chest to let him know she understood.
-Resident #2 responded and said, "I need a doctor. I hurt.", while still holding his chest.
-She helped Resident #2 sit down and called out for another PCA to come into the room.
-As soon as the second PCA came into the room and saw Resident #2, the PCA told her "Oh my Gosh. He's not right."
-The second PCA said she was going to get the DHW.
-It took the DHW what seemed like forever to come to the room, which concerned her greatly because she was afraid Resident #2 was "about to code".
-She wanted to give the DHW space to evaluate Resident #2,

so she left the room and began to attend to the needs of some of the other residents.
-She observed EMS coming into the SCU and entering Resident #2's room and within a few short minutes they were leaving.
-She saw that they were not taking Resident #2 with them.
-She could not remember who said it, but she heard a staff member say Resident #2 was having AF, so then she was "really confused about why EMS was leaving without him."
-She went to the DHW and asked what was happening and the DHW told her Resident #2 was in AF but he did not want to go to the hospital."
-She told the DHW that Resident #2 told her he needed to see a doctor and that if he was having AF and hurting in his chest, he needed to go to the hospital.
-The DHW said again that Resident #2 was not going to the hospital.
-She was "blown away" by the DHW's response and asked her would she rather be safe than sorry.
-She told the DHW she was going in to speak to Resident #2 and then the DHW's story changed and she said Resident #2 was not going to the hospital because EMS refused to take him.
-She told the DHW she had never heard of EMS refusing to take someone to the hospital, especially a SCU resident having chest pain and AF.
-She told the DHW "I know you are the nurse and I am the PCA, but I do not agree with this decision and do not understand why you would not send him out to be checked."
-That evening at dinner the DHW came into the dining room and said she wanted to test Resident #2 to make sure his symptoms of phlegm and chest pain were not due to COVID.
-The DHW did not notify the aides of the results of the COVID test so after a couple of hours, she went and asked her for the results.
-The DHW told her the results were negative and "he's fine."
-The PCA helped Resident #2 to bed that night and was still very concerned that he was not himself and did not act like he felt well.
-She worked as a PCA the next day, Saturday (03-09-24) and the MCC, who was working that day as the MA, told her she was going to give Resident #2 an as-needed medication for cough and congestion.
-Resident #2 told her he had gas several times that day and she reported it to the MA.
-Her thoughts at the time were that Resident #2 was obviously

still not himself and she said to several staff members it was not right and Resident #2 was not himself and should be sent out to be evaluated.
-The next day, Sunday (03/10/24) she started her work day as a PCA in the SCU and received a verbal change of shift report from night shift staff, she did not remember who, that Resident #2 did not seem to feel well.
-Resident #2's normal demeanor was that he was a funny and agreeable guy and he was steady on his feet.
-She did not remember if she reported this to anyone specifically but she had been reporting all weekend that Resident #2 was not himself.
-That morning when she took him to breakfast, he was quiet and unsteady on his feet.
-A short time after breakfast, she was pulled from the SCU to work on the Assisted Living (AL) side.
-She was not in the SCU when Resident #2 coded, but as soon as she heard a resident had just coded, she knew immediately that it was him.
-The Resident Care Coordinator (RCC) exited the SCU and came over to the AL and she observed he was sweating and upset.
-The RCC informed her he just had to do CPR on Resident #2.
-She asked if Resident #2 was okay and the RCC said he did not make it.
-She was "livid" and told the RCC "This should not have happened."
-She informed the staff on duty she needed a minute and she went outside to pull herself together.
-She spoke with the RCC later and she asked questions about everything that had occurred with Resident #2 since EMS came on Friday (03/08/24), and the RCC told her he had reviewed Resident #2's record and did not see anything about Resident #2 having symptoms on 03/08/24, about EMS being called, or about why he did not go to the hospital.
-The RCC did not know EMS had been called to the facility for Resident #2 on 03/08/24 until Sunday after Resident #2 died.
-She had a conversation with the DHW after Resident #2 died and told her she would not be returning to work because of how the situation with Resident #2 had been handled.
-The DHW told her EMS said his AF was 120 beats per minute and they refused to take him out if it was not at least 140 beats per minute.
-Before she resigned, she met with the Executive Director (ED) and told her how upset she was that Resident #2 had not been sent out to the hospital to be checked when EMS came

on 03/08/24.
-She informed the ED Resident #2 had asked to see a doctor on Friday night, said he was hurting in his chest, had AF, and was not himself the whole weekend.
-She was sorry for being so emotional recounting the story, but she had tried so hard to get Resident #2 sent to the hospital and she was still having a difficult time coming to terms with what happened.

Interview with a first shift MA on 04/10/24 at 1:57pm revealed:
-She worked with Resident #2 on Saturday (03/09/24) and Sunday (03/10/24).
-Resident #2 was congested on both days, and she administered an as-needed congestion medication to the resident one time each day.
-When she came into work on 03/10/24 she was informed by a staff, she did not remember who, that Resident #2 did not seem to be feeling well and she should keep an eye on him.
-EMS was called to the facility for Resident #2 on 03/08/24 but he did not go to the hospital to be evaluated.
-Resident #2 had dementia and could not have made that decision for himself.
-She had inquired with other staff about who told EMS not to take Resident #2 to the hospital and several staff members told her it was the DHW.
-After lunch on 03/10/24, Resident #2 was in his room eating a snack, she was sitting on his bed talking to him, and he suddenly blacked out and fell over onto her.
-She yelled out for the MCC to come and within a minute the RCC, who was also working that weekend, entered the room.
-It was apparent Resident #2 was not breathing and staff began CPR and continued until EMS arrived.
-If Resident #2 had AF and shortness of breath on 03/08/24, it was her opinion that he should have gone to the hospital to be evaluated.

Interview with the Memory Care Coordinator (MCC) on 04/10/24 at 2:14pm revealed:
-She worked with Resident #2 on 03/09/24 and 03/10/24.
-At some point during the weekend, she was informed by a staff member, she did not remember who, that EMS had been called for the resident on Friday (03/08/24) because he had

congestion and was not feeling well, but he did not go out to the hospital but she was not informed Resident #2 also had AF when EMS arrived and that he was having trouble breathing
-Resident #2 received cough medication on both Saturday and Sunday for cough and congestion.
-On Sunday (03/10/24) afternoon after lunch, Resident #2 was in his room and his MA was with him.
-He suddenly went limp and the MA had to catch him.
-She and the RCC were called to come to Resident #2's room.
-He was not breathing and was a full code, so staff began CPR and called 911.
-EMS arrived and continued CPR but it was not successful in saving the resident.
-The staff was very fond of Resident #2 and there had been a lot of questions asked about why Resident #2 did not go out to the hospital on 03/08/24 to be evaluated.
-She did not think the PCP had been notified of Resident #2 having AF because when she saw the PCP in the facility the following Thursday (03/14/24) the PCP stated she was not informed of Resident #2 having AF until after he died and was asking why she had not been notified he had AF and why he was not sent out to the hospital.
-She had asked the DHW why she did not send Resident #2 to the hospital and the DHW told her EMS informed her they could take him, but there was a chance the hospital would just send him back if his AF was not a rate of 140 or above.
-She told the DHW she should have sent him anyway.
-The proper procedure would have been to contact the PCP about Resident #2's symptoms and to get instructions.
-Resident #2's PCP office had 24/7 coverage by telephone because there was always a physician on call.
-The staff were to use the on-call number for all urgent situations.
-Anytime a telephone call was made to the PCP office, it should be documented in the resident's progress note and anytime a fax was submitted to the PCP office, the fax communication and confirmation page was to be saved in the resident record.
-She reviewed Resident #2's records that weekend, after Resident #2 died, but did not see anything in the record about the EMS visit, his symptoms, why he was not sent out to the hospital, or the PCP being notified.
-Based on her experience and training, if Resident #2 had AF and shortness of breath on 03/08/24, he should have gone to the hospital to be evaluated.

Interview with the RCC on 04/10/24 at 3:21pm revealed:
-When he arrived for work on the evening of 03/08/24, he was informed by the MA to "kind of keep an eye on" Resident #2 because EMS had been called for him earlier in the afternoon but did not take him to the hospital.
-He was not informed of why EMS was called or why Resident #2 was not taken to the hospital.
-Resident #2 seemed like he was not his normal self and seemed a little sluggish, but it still seemed like he was doing okay.
-He also worked on Saturday (03/09/24) and Sunday (03/10/24) and Resident #2 was walking around and seemed to be doing okay, other than receiving an as-needed cough medication for some congestion.
-Resident #2's PCP office had coverage 24 hours a day 7 days a week so the physician should have been contacted on 03/08/24 about Resident #2's symptoms.
-He was not 100% sure the PCP had been notified.
-Typically, the PCP would be called for urgent situations or the PCP would be emailed or faxed for non-urgent situations.
-If there was a telephone call to Resident #2's PCP about his symptoms on 03/08/24, it would be documented in his progress notes and if a fax was sent, there would be a fax confirmation in the record, but he was not able to locate any evidence of the PCP being contacted.
-If an email had been sent to the PCP, he would have been copied on it, but he checked his emails and he did not receive anything.
-On the afternoon of 03/10/24, he was called to Resident #2's room and when he entered the room, he saw the resident had shallow breathing and was lying against the MA.
-He put his head to Resident #2's chest to see if he heard any sounds of gurgling and he heard him take his last breath.
-He and other staff laid Resident #2 down and began CPR because he was a full code.
-The MCC "bagged him" and resuscitation efforts continued until EMS arrived.
-When EMS arrived, they asked him to continue CPR until they got set up.
-When EMS finished setting up, they began life-saving measures which included shocking the resident, but ultimately, Resident #2 could not be resuscitated.
-If he had been working when EMS came to the facility for Resident #2 on 03/08/24, based on what he now knew about Resident #2's symptoms that day, Resident #2 would have

been sent to the hospital.
-He was always quick to tell EMS workers that their job was to transport the resident and his job was to ensure they were transported.
-EMS workers were not physicians and did not know the residents, so the staff in charge should always enforce the rules that protected the residents, even if they received pushback from EMS.

Interview with the ED on 04/10/24 at 4:24pm revealed:
-She began working in her position as ED on 02/26/24.
-The following week, on 03/08/24, she saw EMS enter the SCU and then exit the SCU a few minutes later, but they did not have a resident with them on the stretcher.
-She thought it seemed odd, but she did not know who they had come to see, or what the circumstances were.
-That following Sunday (03/10/24) she received a telephone call from the RCC, and he told her CPR had been conducted on Resident #2 but efforts were unsuccessful.
-The next day (03/11/24) she received a telephone call from one of the PCAs who asked if she could come in and meet with her.
-About an hour later the PCA came into her office and even though she did not know all the staff yet, she recognized her right away and knew she was a dedicated hard worker.
-The PCA arrived at her office and began to speak with her privately about Resident #2.
-The PCA said she knew something was not right with Resident #2 the entire weekend of 03/08/24 and she kept trying to get people to listen.
-After she learned of this incident, she asked the DHW why Resident #2 did not go to the hospital on 03/08/24 and she was told EMS said Resident #2 was in AF at a rate of 120, but they "only deal with rates of 140 and above."
-After that, there was a conversation that involved the facility's regional nurse, and she asked the DHW when she started allowing EMS to decide of if a resident was to go out to the hospital.
- She had heard the DHW say on more than one occasion that it was a waste of time to send residents out to the local hospital.
-She told the DHW that the staff were the voice for the residents; when in doubt, send them out; if the hospital sent them back twice and they still thought they needed care, to send them back again.

-It was her expectation the PCP should have been immediately notified of Resident #2's symptoms on 03/08/24 and should have been involved in the decision of what evaluation and treatment he needed.
-If she had known about Resident #2's symptoms during the weekend of 03/08/24 through 03/10/24, she would have made sure Resident #2 received medical attention.

Interview with the DHW on 04/10/24 at 3:45pm revealed:
-On the afternoon of 03/08/24 she was called to Resident #2's room by his PCAs who said he was having shortness of breath and was discolored.
-Resident #2 did not look "that bad" when she saw him but since the aides "had claimed he was short of breath" and said he did not look good she decided to go ahead and call 911.
-When EMS arrived Resident #2 was his normal skin tone and he was not short of breath.
-EMS assessed Resident #2 which included taking vital signs and doing their normal workup.
-EMS said Resident #2 was "possibly in" AF but his pulse was probably not high enough at a rate of 120.
-EMS told her for Resident #2 to be treated at the hospital, his heart rate would have to be over a rate of 150, "so they said they could not take him."
-At that point, Resident #2's symptoms she had reported to 911 had resolved.
-Even though the aides had "claimed he had shortness of breath and discoloration", neither she nor EMS ever saw it.
-She did not recall telling the 911 operator she observed Resident #2 was short of breath.
-When EMS refused to take Resident #2 to the hospital, they required her to complete a service refusal form.
-She did not know what the refusal form said.
-Resident #2 did not refuse to go to the hospital and she would not allow a SCU resident to make that decision.
-She did not refuse to send Resident #2 to the hospital but since EMS required her to sign a service refusal form, she "just signed it."
-As far as EMS putting on the refusal form for the PCP to be contacted about the AF, she "felt like she would have told the doctor" and could not imagine that she would not have.
-If she contacted the PCP about Resident #2's symptoms on 03/08/24, including his AF, "it should be documented in the progress notes but if it was not, she did not know why."
-There was not a facility policy that specified when the PCP was to be notified, but she knew she was supposed to notify

the PCP of Resident #2's symptoms.
-The PCP was available during normal business hours and there was an after-hours on-call emergency line for the PCP office, but she did not think she had ever called it.
-She would usually send emails or faxes to the PCP, but after searching, she was unable to locate evidence of an email or fax being sent to Resident #2's PCP on 03/08/24.

Review of email and fax records of communication between staff and Resident #2's PCP from 03/08/24 through 03/10/24 revealed:
-On 03/08/24 there were no records of communication to the PCP.
-On 03/09/24 there were no records of communication to the PCP.
-On 03/10/24 at 1:20pm there was an email from the MCC to the PCP informing her of Resident #2 having coughing, congestion, and mucus and he was being given an as-needed cough medication; the resident was requesting medication for gas.
-On 03/10/24 at 1:29pm the PCP provided a fax order to staff for gas medication for Resident #2.
-On 03/11/24 at 1:10pm there was an email from the DHW to the PCP which read, "just wanted to inform you Resident #2 passed away; EMS was called for him on Friday afternoon due to shortness of breath but by the time EMS arrived his color had come back and his shortness of breath had resolved; EMS did not feel his symptoms warranted him going to the hospital; a COVID test was completed on 03/08/24 but it was negative; he had no complaints the rest of the evening; on Saturday (03/09/24) he had cough and congestion and was given an as needed cough medication; he was fine on Sunday (03/10/24) until he had an episode of unconsciousness; staff did CPR until EMS arrived; he passed on scene and EMS stated he may have aspirated."

Telephone interview with Resident #2's PCP on 04/12/24 at 9:29am revealed:
-The PCP office had 24-7 coverage and there was always a staff member available to speak with the facility.
-She did not receive any communication from the facility about Resident #2 on 03/08/24 or 03/09/24.
-On 03/10/24 at 1:29pm, she received an email from the MCC that stated it was just an "FYI update" on several residents,

which included Resident #2.
-The email said "Resident #2 had been coughing and was being given an as-needed cough medication; EMS was called on Friday 03/08/24 due to him having congestion and just overall not feeling well but he did not go out; a COVID test was completed on Friday and was negative; yesterday (03/09/24) congestion, coughing, and mucus continued along with overall not feeling well; today (03/10/24) he was still receiving cough medication and he looked overall better but he continued to ask if there was something they could give him for gas."
-There was no mention in the email about Resident #2's symptoms of chest pain, shortness of breath, or AF on 03/08/24 and she did not think the MCC had even been made aware of those symptoms at the time she sent her the email.
-Any serious symptoms with a resident would warrant the facility staff calling the PCP office during business hours or the on-call number after hours as opposed to faxing something in, but on 03/08/24, neither was done on behalf of Resident #2.
-She was pretty sure it was the day after Resident #2's death when she was informed he had died, but she was still not informed about the AF.
-It was not until she was in the facility the next Thursday (03/14/24) that she was informed by the DHW about Resident #2 having AF on 03/08/24.
-She asked the DHW why Resident #2 did not go to the hospital and she said EMS told her they could take Resident #2 to the hospital, but it was likely the hospital would not do anything since his heart rate was below 140.
-She told the DHW it was not true that the hospital would not have done anything and that if she had been informed, she would have made sure Resident #2 was transported to the hospital.
-There was no minimum threshold number she would have wanted to see for AF before she would have thought Resident #2 should have gone to the hospital, especially since Resident #2 did not have a prior diagnosis of AF.
-Despite the heart rate number, if Resident #2 was symptomatic, he should have gone to the hospital.
-Upon learning, during this telephone interview, that the time of day EMS was called on 03/08/24 was 4:24pm, the PCP stated that was normal business hours and she was in the office, so staff would not have even needed to contact an on-call physician.
-She did not know if EMS refused to take Resident #2 to the hospital, but if they were pushing back on taking him out, the

facility should have pushed back harder.
-If she had been contacted and told he was having AF, she would have gotten on the telephone with EMS and made sure Resident #2 was taken to the hospital.
-She was the one who completed Resident #2's death certificate, and she believed she documented the reason for death as cerebral vascular disease because at the time she thought perhaps he had a heart attack, but that was before she knew anything about the AF.
-After she learned about the AF, she thought he may have had "Afib with rapid ventricular response" and if Resident #2 had that and formed a blood clot, and his heart converted back to normal sinus rhythm, the clot may have caused him to have a stroke.
-"Will we ever know for sure? Probably not. Could the resident's death have been prevented? Maybe so."
-Resident #2 should have gone to the hospital to be evaluated when his symptoms began on 03/08/24.

The facility failed to notify Resident #2's PCP of his symptoms beginning on 03/08/24 of chest pain, shortness of breath, and discoloration. EMS was called and diagnosed the resident with atrial fibrillation, facility staff signed a refusal against medical advice form, and the resident was not sent to the hospital for evaluation. Resident #2 died at the facility 2-days later on 03/10/24. This failure resulted in serious physical harm and neglect and constitutes an A1 Violation.

The facility provided a Plan of Protection (POP) in accordance with G.S. 131D-34 received on 04/12/24.

THE CORRECTIVE DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED **07/07/24**.

6/26/24
L. Hardin

IV. Delivered Via:	Hand Delivered	Date: 06/07/24
DSS Signature:	Jamie Robin	Return to DSS By: **06/28/24**

V. CAR Received by:	Administrator/Designee (print name): X Laura Hardin	
	Signature: X Laura Hardin	Date: X 6/8/24
	Title: X Executive Director	

Facility Name:

VI. Plan of Correction Submitted by:	Administrator (print name): Laura Hardison
	Signature: Laura Hardison Date: 7/1/24

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: [signature]	Date: 7-1-24
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*