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	HAL021009	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

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EDENTON HOUSE	323 MEDICAL ARTS DRIVE EDENTON, NC 27932

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and followup survey and complaint investigation on April 15, 2025 and April 16, 2025.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure follow-up to meet the acute health care needs of 1 of 5 sampled residents (#3) related to failing to notify the correct hospice provider after the resident had a visible head injury. The findings are: Review of Resident #3's current FL-2 dated 05/13/24 revealed: -Diagnoses included Alzheimer's Disease, dementia, and hypertension. -She was constantly disoriented. -She was non-ambulatory. Review of Resident #3's Resident Register revealed she was admitted to the facility on 02/10/17. Review of Resident #3's Incident/Accident (I/A) report dated 03/07/25 revealed: -The incident date and time were documented as 03/07/25 at 4:14am. -The type of incident was documented as injury of unknown origin-bruising and swelling on the "left	D 273		

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frontal lobe".
-The location of the incident was documented as the resident's room.
-The incident was unwitnessed by staff.
-The incident was reported by a staff member.
-The description was documented as observed the resident laying in bed with bruising and swelling to her "left frontal lobe".
-The resident was unable to say what happened to due to cognitive impairment/dementia.
-The resident exhibited swelling.
-First Aid was documented as administered and described as ice pack applied.
-The resident was not sent to the emergency department (ED).
-The Administrator was notified, with no time documented.
-The county Department of Social Services (DSS) was notified via fax.
-The resident's hospice provider was notified at 11:13am.
-The resident's primary care provider (PCP) was documented as notified on 03/07/25 at 6:15am.
-The resident's responsible party (RP) was documented as notified on 03/07/25 at 6:23am.
-Vital signs were documented as temperature 97.5, pulse 75, respirations 17, and blood pressure 127/70 at 6:47am.
-The I/A report completed on 03/07/25 at 4:04pm by the Resident Care Coordinator (RCC).

Review of Resident #3's electronic progress notes dated 03/07/25 revealed:
-There was an entry at 6:17am by the medication aide (MA) that the PCP was notified that the resident had bruising and swelling to her left frontal lobe.
-There was an entry at 6:25am by the MA that the resident's RP was notified that the resident was found in bed, with bruising and swelling to her left

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D 273	Continued From page 2 frontal lobe. -There was an entry at 6:30am by the MA that she called a named hospice provider and they stated that the resident has not been a client of theirs for quite some time. -There was an entry at 11:30am by the RCC that hospice was notified of the resident's injury of unknown origin, and a nurse would be sent to assess. -There was a second entry at 11:30am by the RCC that noted the date and time of the incident at 03/07/25 at 4:14am, the type of incident was injury of unknown origin, the resident's PCP and hospice were notified as well as the resident's RP. Review of Resident #3's hospice skilled nurse as needed (PRN) visit note dated 03/07/25 revealed: -The visit time-in was documented as 5:45pm and the visit time-out was documented as 6:15pm. -The reason for the prn visit was documented as change in condition, -Her vital signs were documented as temperature 98.1, blood pressure 128/86, oxygen saturation 96% on room air, pulse rate 56, and respirations 16. -The resident did not require a higher level of care. -She was a high risk for falls due to muscle weakness. -She had poor skin turgor. -Her pain level as assessed at 0 indicating no pain. -There were no new orders for her plan of care. -The narrative notes included, she was seen today because the facility's staff reported a hematoma to her skull. -Facility staff were unaware of how this happened.	D 273		

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-Upon assessment, there was a slightly raised area to her left temporal area, the area was soft.
-She did not appear to be in any pain, no facial grimacing or guarding noted.
-The area was of normal skin color, no erythema (redness) and no bruising was observed.
-The resident did not appear to be in any distress at the time.
-Her vital signs were taken and documented in the chart and were within normal limits, with no fever, her lung sounds were diminished in all lobes, her heart sounds were irregular.
-Resident #3 appeared to be at her baseline cognitive function, despite information reported of the "large goose egg" to her skull.
-Staff were encouraged to call with any changes.

Interview with Resident #3's RP on 04/15/25 at 3:37pm revealed:
-She was notified on 03/07/25 at 6:22am that Resident #3 had a large goose egg on the left side of her head.
-She was told no one knew what caused the swelling on Resident #3's head but it had been discovered by staff on the 11:00pm to 7:00am shift.
-She was told hospice, and the Administrator had been notified.
-When she did not hear from hospice later that morning she drove to the facility and arrived around 11:00am.
-When she arrived, she found Resident #3 to have swelling, a knot, and an abrasion to the left side of her head.
-She had asked about the resident being sent to the ED but was told the hospice nurse would have to make that decision
-She asked the RCC when the hospice nurse would be coming to see the resident and was then told that the previous hospice provider had

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been contacted but not the current hospice provider and she asked the RCC to contact the current hospice provider.
-The RCC called the current hospice provider in her presence from Resident #3's room using her cell phone and had her on speaker phone, she and the RCC spoke with the hospice representative.
-The hospice nurse asked how the resident was doing and if she was eating and advised that it sounded as if the resident was stable and it would be later in the day when a nurse came out to assess Resident #3.
-Resident #3 has dementia and did not know what happened but said she was ok.
-She asked Resident #3 if anyone had hurt her, and she said no.
-She requested an ice pack for the resident and was able to get some of the swelling down,
-Resident #3 and her roommate were sisters, and she was unable to say what happened to Resident #3.
-She received a call from the hospice nurse around 7:30pm on 03/07/25, that she had seen Resident #3, and she felt there were no findings, but the resident would continue to be monitored.

Based on observations, record review, and interviews with staff, it was determined that Resident #3 was not interviewable.

Telephone interview with the Care Team Manager for Resident #3's hospice provider on 04/16/25 at 8:49am revealed:
-Resident #3 had been under their service since 07/03/24 for diagnoses of Alzheimer's Disease and dementia.
-Resident #3 received skilled nursing services twice a week, as well as Chaplain and Social Worker visits monthly.

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D 273	Continued From page 5 -A call came in to hospice on 03/07/25 about Resident #3, she thought between 12:00pm and 1:00pm, but she was in a meeting and asked another nurse to take the call but there was no documentation of exactly when the call came in. -She knew one of the hospice Registered Nurses (RN) saw Resident #3 later in the day on 03/07/25. -The facility was always to contact hospice first prior to sending a resident to the ED unless there was severe injury. Telephone interview with the hospice RN from Resident #3's hospice provider on 04/16/25 at 9:24am revealed: -She saw Resident #3 week at least weekly. -Resident #3 had contractures of the left arm and was very limited in movement. -She was contacted by Resident #3's RP on 03/07/25, she thought in the early afternoon and was notified that the resident had an unexplained knot on her head, that had been discovered by the night shift. -The hospice provider should have been contacted immediately. -After questioning, Resident #3 seemed stable and at her baseline and not in pain. -She advised that a hospice RN would be out later in the day on 03/07/25 to assess Resident #3. -The weekend on call RN saw Resident #3 in the late afternoon on 03/07/25 and Resident #3 was stable and was not sent to the local ED. Attempted telephone interview with the on-call weekend RN with Resident #3's hospice provider on 04/16/25 at 8:49am was unsuccessful. Interview with a personal care aide (PCA) on 04/15/25 at 4:05pm revealed:	D 273		

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D 273	Continued From page 6 -She worked the 3:00pm to 11:00pm shift. -The residents were checked every 2 hours for toileting, but she checked her residents every 30 minutes. -Resident #3 was a two person assist. -Resident #3 usually napped in the afternoon and would be gotten up for dinner. -She and another PCA got Resident #3 up for dinner on 03/06/25 and put her back to bed after dinner, probably around 5:30pm or 6:00pm. -The other PCA that assisted her with Resident #3 on 03/06/25 was no longer employed at the facility. -The 3:00pm to 11:00pm shift staff changed Resident #3 into her night clothes and the 11:00am to 7:00am shift staff performed her bath and morning care and changed her into her day clothes. -Resident #3 had contractures of her arms and dressing could be difficult but there was no problem changing Resident #3's clothes or getting her in and out of bed with the other PCA's assistance on her shift on 03/06/25. -She checked Resident #3 again at 8:00pm and 10:00pm and the resident did not have any marks, swelling or bruising on her head. -She said she received a call from the Administrator around 11:00am on 03/07/25, asking if anything happened with Resident #3 on her shift because she was found to have a knot on her head by staff on the 11:00pm to 7:00am shift and she told him there were no problems on her shift. Attempted telephone interview with the other second shift PCA that worked 03/06/25 on 04/16/25 at 8:31am was unsuccessful. Telephone interview with a second PCA on 04/16/25 at 8:33am revealed:	D 273		

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-She was a MA and worked as a PCA on some shifts.
-The residents were checked every two hours to make sure they were clean, dry, turned and re-positioned if needed and safe.
-If a resident had a fall, they were checked every hour.
-She worked the 11:00pm to 7:00am shift on 03/07/25.
-Resident #3 had to be turned and checked for incontinence every 2 hours.
-When she checked on Resident #3 at 12:00am and 2:30am, she only turned the bathroom light on so she could not fully see Resident #3's face and head but did not see anything unusual.
-At around 4:00am, she gathered supplies to provide morning care for Resident #3 and turned on the overhead light to wash the resident's face and noticed a goose egg size knot on the left side of Resident #3's forehead.
-She immediately contacted the MA to notify her of the knot on Resident #3's head.
-Resident #3 did not complain of pain or appear to be in pain.
-The MA immediately assessed Resident #3 and contacted the hospice provider, the resident's PCP and RP.
-The MA applied an ice pack to Resident #3's head.
-The 3:00pm to 11:00pm shift staff had not reported any injury or concerns for Resident #3 to her or the MA.

Interview with the MA on 04/16/25 at 9:40am revealed:
-She was currently the Business Office Coordinator (BOC) and had been in the BOC role for the past two weeks.
-She was previously a third shift MA.
-The residents were checked every 2 hours by

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the PCAs and/or MAs to make sure they were clean, dry, and repositioned if needed.
-If a resident had a fall or an injury, the MA did an assessment, checked vitals signs, called or texted the PCP, if the resident was under hospice care, hospice was notified, the resident's RP was notified, the RCC was notified, the Administrator was notified and an I/A report was completed.
-Resident #3 required total care and was a two-person assist, which meant 2 staff were required to get her in and out of bed.
-Resident #3 also received her morning care and grooming on the 11:00pm to 7:00am shift.
-On 03/07/25, she was in the nurse's station and received a phone call from the PCA, around 4:15am.
-The PCA called her from Resident #3's room and told her she was getting the resident ready for her bath and noticed the resident had swelling on the left side of her forehead.
-She immediately went to Resident #3's room and the resident had a knot on the left side of her head.
-Resident #3 did not seem to be in pain and could not say what happened to her.
-She placed an ice pack on Resident #3's head to help with swelling.
-She texted Resident #3's PCP, the RCC and the Administrator.
-The resident had a knot on the left of her forehead with maybe a little redness.
-Resident #3 did not appear to be in pain, after her bath, she and the PCA transferred Resident #3 to her chair.
-She contacted a hospice provider and was told Resident #3 was no longer under their care.
-She notified the RCC that she had contacted hospice but was told Resident #3 was no longer under their care.
-She was not sure if the RCC notified her of the

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correct hospice provider, but the RCC told her she would contact the correct hospice provider.
-She notified Resident #3's RP of the resident's injury and that they did not know what happened and the resident seemed to okay, and hospice would be contacted.

Interview with the RCC on 04/16/25 at 10:11am revealed:
-The residents were checked at least every 2 hours by the PCAs or MAs for toileting and to make sure they were feeling okay.
-If a resident had a fall or an injury, the MA was notified and an assessment done, the MA contacted the PCP and if the resident needed to be sent to the ED, then emergency medical services was contacted, and the resident's RP was contacted.
-If the resident received hospice services, hospice was contacted.
-Resident #3 was total care for feeding, bathing, dressing and was a two person assist.
-She was at home and received a call from the MA around 7:00am to notify her that Resident #3 had a contusion on the side of her head and that her PCP and hospice provider had been contacted.
-She arrived at the facility between 8:30am and 9:00am and saw that Resident #3 had an area of swelling and a small abrasion on the left side of her head.
-She contacted Resident #3's PCP around 9:00am and was told to check her blood pressure again to make sure her blood pressure had not dropped.
-Resident #3 did not appear to be in pain because she would grind her teeth when she was in pain.
-She was in Resident #3's room and her RP arrived around 11:00am and her RP asked her

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when the hospice nurse was coming, the day shift MA was at the resident's door also and she asked her when the hospice nurse was coming and the day shift MA told her the night shift MA had called hospice but was told Resident #3 was no longer in their care.
-She immediately called the correct hospice provider while in Resident #3's room in the presence of her RP on speaker phone.
-She was not made aware that the correct hospice provider had not been contacted until Resident #3's RP arrived and questioned her.
-She did not tell the night shift MA that she would contact the correct hospice provider because night shift MA did not inform her that she had contacted the wrong hospice provider for Resident #3.
-Had she known the night shift MA had contacted the incorrect hospice provider for Resident #3, she would have given her the correct hospice information for Resident #3.
-Resident #3's correct hospice provider should have been contacted immediately instead of 5 hours later.

Interview with the Administrator on 04/16/25 at 3:20pm revealed:
-The MAs and PCAs checked on the residents at least every two hours to make sure they are clean, dry, comfortable and safe.
-When a resident sustained a fall or injury, the MA assessed them, checked their vital signs, notified the PCP, RCC and RP.
-If a resident received hospice services, the hospice provider was notified immediately.
-Resident #3's correct hospice provider should have been notified in a timely manner and not hours later,
-He expected staff to be familiar with the appropriate providers for the residents and for the

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D 273	Continued From page 11 appropriate providers to be contacted. Telephone interview with Resident #3's PCP on 04/16/25 at 2:34pm revealed: -She was contacted by the MA on 03/07/25 that Resident #3 had a bump on the head. -She knew Resident #3 received hospice services and was told hospice was contacted. -She was not told that the incorrect hospice provider was contacted initially and that the correct hospice provider was not contacted until 5 hours later. -Ideally Resident #3's correct hospice provider should have been contacted immediately.	D 273		