Adult Care Home Corrective Action Report (CAR)

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

II. Date(s) of Visit(s): 06/25/25 and 07/07/25
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 07/29/25

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 .0901	☑ POC Accepted TR *DSS Initials*	
Rule/Statutory Reference: 10A NCAC 13F .0901 Personal Care and Supervision (c)Staff shall respond immediately in case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	ED/DHW/Designee has provided re-training for all care staff on fall policy and calling the physician immediately after a fall for further instruction. ED/DHW/Designee will provide a refresher course for all care staff on physician notification and use of on call hotline support. ED/DHW/Designee will continue to review quality assurance incidents and resident records in morning stand up meeting to assure physicians were immediately notified of a fall.	8/14/2025
Level of Non-Compliance: Type A1 Violation		
Findings: Based on interviews and record reviews, the facility failed to respond immediately and in accordance with the facility's policies and procedures following a fall incident for 1 of 5 sampled residents (#3), who resided in the Special Care Unit (SCU) and was found lying on her back after an unwitnessed fall. The findings are: Review of the facility's Falls Policy dated 06/11/24 revealed: -If a resident experienced a fall, they were to receive immediate care. -The Director of Health and Wellness (DHW) or Medication Aides (MA) on duty were allowed to assist the resident from the floor to a chair if it was known that the resident did not strike their head during a fall.		

-The MA staff were to evaluate residents who had fallen to determine if the resident could be assisted safely off the floor or if 911 needed to be called.
-The resident's physician was to be contacted immediately for further instructions.
-For forty-eight hours after a fall, the DHW or designee was to monitor the resident and make a brief chart entry on each shift.

Review of Resident #3's current FL dated 01/28/25 revealed:
-Diagnoses included Alzheimer's dementia without behavioral disturbance, essential hypertension, pure hypercholesterolemia, and chronic kidney disease.
-The resident was disoriented, ambulatory, and required assistance with bathing, feeding, and dressing.
-The recommended level of care was the SCU.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 01/31/25.

Review of Resident #3's current Assessment and Care Plan dated 01/17/25 revealed:
-The resident was confused and disoriented.
-The resident was independent with mobility and transfers.
-The resident did not have a history of falls.
-The resident required minimal assistance with showering, dressing, and grooming.

Review of Resident #3's electronic progress notes for June 2025 revealed:
-On 06/21/25 at 2:00pm there was an entry, Resident #3 was found on the floor in front of another resident's room, lying down; the resident did not seem to be in any duress; however, "it took some convincing to get up out of the floor (not due to pain)"; the resident's vital signs were taken.
-On 06/22/25 at 8:58am there was an entry, Resident #3 was in the dining room eating breakfast and showed no signs or symptoms of pain or distress.
-On 06/23/25 at 2:30pm there was an entry, Resident #3 had a bruise on the right side of her hip, possibly due to her previous fall and she favored her right leg; staff reported the resident was favoring her right leg before her fall; the PCP was notified, and an as-needed pain medication was requested.
-On 06/23/25 at 11:08pm there was an entry, Resident #3 was "sleeping so far tonight", had "not shown any behaviors", and staff would "continue to monitor."

-On 06/24/25 at 6:05am there was an entry, an order for as-needed Acetaminophen 325mg tablets for pain was faxed to the pharmacy.
-On 06/24/25 at 1:00pm there was an entry, Resident #3 was found very fatigued and she refused to eat or get out of bed or to get her blood pressure checked.
-On 06/24/25 at 2:20pm there was an entry, Resident #3 was found very fatigued and refused to eat; the MA attempted to take the residents vital signs but was only allowed to take her temperature (94.7); the MA called the Primary Care Physician (PCP) and left a message concerning the resident's condition; the PCP called back and spoke with the DHW and advised staff to send the resident to the emergency room (ER); Resident #1 was sent to the emergency room at 1:00pm.
-On 06/25/25 at 1:08am there was an entry, the hospital called to report Resident #3 had been admitted with a broken femur due to fall.

Review of the SCU handwritten shift change staff-to-staff reports from 06/21/25 through 06/24/25 revealed:
-On 06/21/25 during the 7:00am to 7:00pm shift, there was an entry under the "Other Issues/Concerns" section that noted Resident #3 was found lying on the floor; she was not feeling well but did not have a temperature.
-On 06/21/25 during the 7:00pm to 7:00am shift, there was an entry under the "Resident Refused" section that noted Resident #3 was refused her evening medication; she was not feeling well but did not have a temperature."
-On 06/22/25 during the 7:00am to 7:00 pm shift, there were no entries.
-On 06/22/25 during the 7:00pm to 7:00am shift, there was an entry under the "Incidents/Accidents" section that noted "Follow-up for fall"; no additional details were noted.
-On 06/23/25 with the shift time marked as "All" there was an entry under the "Incident/Accidents" section that noted "Follow-up fall" for Resident #3; no additional details were noted.
-On 06/24/25 during the 7:00am to 7:00pm shift at 1:00pm there was an entry under the "Residents to Hospital" section that noted Resident #3 was "Sent to the hospital for fatigue, refusing to leave bed, and refusing meals."; under the "Admitted" section, there was an entry "Admitted-Broken Femur."

Review of Resident #3's handwritten skin assessment dated 06/23/25 at 1:30pm revealed an entry that stated, "Big bruise on right hip area."

Review of a faxed handwritten physician communication form from the Special Care Unit Coordinator (SCUC) to Resident #3's PCP, electronically time-stamped on 06/23/25 at 1:41pm revealed:
-The reason for the fax was documented as right leg pain.
-Resident #3 was "favoring her right leg and had a bruise on her outside right hip, which was possibly from a previous fall; staff stated the resident's leg was bothering her before the fall"; a request was made for something for pain.
-The return section of the communication form had a signed physician's order for as-needed Acetaminophen 325mg 2 tablets to be given by mouth every 6 hours as needed for pain.
-There was a handwritten note at the top of the form that read, "Charted and faxed to pharmacy 06/24/25."

Request for Resident #3's June 2025 incident/accident reports on 06/25/25 at 3:05pm of Resident #3's revealed there were none available for review.

Review of Resident #3's handwritten accident/incident report received by fax on 06/25/25 at 4:20pm revealed:
-The date of the incident was entered as 06/24/25 at 1:00pm.
-The narrative entry read, "Resident sent to ER for change in condition. Bruising noted on right hip. Resident had a fall on 06/21/25. No complaints at that time."
-The date and time the Power of Attorney (POA) was notified was entered as 06/24/25 at 1:06pm.
-The report was dated as completed on 06/25/25.

Request for a fax confirmation or documentation of telephone notification of Resident #3's fall to her PCP on 06/21/25 revealed there was no fax confirmation or documentation of verbal notification available for review.

Request for any evidence of communication with Emergency Medical Services (EMS) on 06/21/25 after Resident #3's fall revealed there was none available for review.

Review of Resident #3's hospital admission records dated 06/24/25 through 06/25/25 revealed:
-On 06/24/25 at 1:44pm there was an entry, the resident was sent to the ER due to generalized weakness, worsening lethargy, and sleeping more during the past few days.
-The resident was disoriented to person, place, and time, and could not provide information about her history.
-On 06/24/25 at 7:20pm there was an entry, an initial examination revealed bruising on the resident's right vaginal

area and right hip; at 7:39pm it was confirmed through tests that the resident had a nondisplaced right hip fracture; at 8:49pm and 9:04pm hospital staff attempted telephone contact to the facility staff to discuss the findings, but received no answer; at 9:05pm the hospital staff made telephone contact with the resident's Power of Attorney (POA), who reported the facility informed the resident had an unwitnessed fall (date unknown).
-On 06/25/25 at 12:34am the hospital nurse made telephone contact with a facility staff member, informed her Resident #3 was being admitted to the hospital with a fracture, and requested information about the resident's fall; the staff member said she could not provide information about the fall but would locate the MA; the staff member was unable to locate MA so she took the ER contact number and a message for the MA to call the ER; at 1:08am the facility MA returned the call to the ER and was informed the resident was being admitted to the hospital with a right hip fracture, at which time the MA informed the hospital staff Resident #1 had a fall on 06/21/25; at 8:12am the hospital orthopedic consultation showed the resident's right lower extremity appeared somewhat shortened and externally rotated, and the resident was to remain non-weight bearing, to have nothing by mouth, and hip surgery was recommended.

Review of Resident #3's hospital operative report dated 06/26/25 revealed:
-Resident #3, who was noted as having severe dementia, had an unwitnessed fall at the facility in which she resided and sustained a right femoral neck fracture.
-A right hip hemiarthroplasty (A surgical procedure that replaces part of the hip joint with a prosthetic implant) was completed.

Interview with a hospital Registered Nurse Case Manager (RNCM) on 06/25/25 at 2:00pm revealed:
-Resident #3 was sent by the facility to the hospital on 06/24/25 due to increased weakness and excessive sleepiness.
-During the physical assessment, hospital staff discovered bruising on the right side of her vaginal area and right hip.
-The facility had not reported any fall, prompting hospital staff to begin calling the facility to try to get information about the origin of the bruises; however, before reaching anyone, the resident's POA informed them that facility staff had told him she had fallen a few days before she was transported to the hospital
- Further testing confirmed that the resident had a right hip

fracture and required surgery for repair.
-Resident #3 had advanced dementia and was extremely resistant to being touched, but she would attempt to persuade the resident to allow her right hip bruise to be viewed.

Observation of Resident #3 at a local hospital on 06/25/25 at 2:10pm revealed:
- She was lying in a hospital bed beneath the covers, with side rails raised and a bed alarm in place.
- The RNCM informed Resident #3 that she needed to check her bruise and gently removed her covers.
- The resident immediately flinched when the covers were removed and began resisting by pushing the RNCM's hands away, repeatedly saying "No. No. No.", while rambling incoherently.
- Before the covers were replaced, a brief view revealed a yellow and purple bruise encircling the entire circumference of her right hip.

Interview with the DHW on 06/25/25 at 2:00pm revealed:
-Resident #3 had an unwitnessed fall on 06/21/25.
-The resident was found by a staff member sitting on the floor in the hallway and was assessed by the MA on duty.
-The resident was found sitting in the hallway, had no complaints, and was functioning normally the rest of the day.
-She did not know if EMS was called to evaluate the resident after her unwitnessed fall, but the PCP was notified as soon as the resident fell.
-The PCP was probably notified by fax, and she would locate the fax confirmation and find out if EMS was called.
-On 06/23/25, during Resident #3's shower, a bruise was observed on her right hip; the resident had no complaints and was walking normally.
-Yesterday morning, 06/24/25, she was notified by the first shift MA that Resident #3 was not herself and refused to get up for breakfast; the decision was made to monitor the resident until lunch time to see if there were improvements, but when she continued to refuse to get up, the PCP was notified and the PCP recommended sending the resident to the hospital.

Telephone interview with the DHW on 09/26/25 at 9:25am revealed:
-She was not able to locate any evidence of EMS being called or the PCP being notified after Resident #3 fell on 06/21/25.
-Even if the staff had sent a fax to the PCP, she would not have received it because the office was closed.

-She believed the PCP had an on-call number staff could have called to provide immediate notification of the fall, but she was not sure.
-If the PCP's office had an after after-hours on-call contact number, her preference would have been for the staff to call the PCP when Resident #3 fell.
-If a SCU resident had an unwitnessed fall, especially if it was unknown if they hit their head, staff were supposed to respond immediately by calling EMS and notifying the PCP.
-She was not present when Resident #3 fell so she did not know the details of the fall; she came in two days after the fall, 06/23/25 and was told the resident had been found on the floor on 06/21/25, who the MA on duty was, that the resident "was fine and walking around, and that was kind of the end of it".
-When staff found Resident #3 on the floor, they should have called EMS to come and assess the resident and should have notified the PCP.

Telephone interview with Resident Care Coordinator (RCC) on 07/07/25 at 10:06am revealed:
- She worked as the Manager on Duty (MOD) on the Saturday that Resident #3 fell, 06/21/25.
- She entered the SCU to inform the SCU MA that she was leaving for the day, and as she approached the staff workstation, she saw Resident #3 lying on the floor, "flat on her back."
- She could see the SCU MA sitting at a table at the back of the dayroom and called out, "Hey, you have a resident on the floor, and at that point, the resident got up and walked away".
- The MA "kind of assessed her a little bit," but the resident "just stood up and walked away."
-Resident #3's fall on 06/21/25 was unwitnessed, so no one could know for sure whether she had hit her head when found lying on her back.
- A resident with dementia would not be a reliable source for reporting injuries, and staff should call EMS to evaluate SCU residents after an unwitnessed fall when there was any potential for a head strike or other injury.
- Staff would typically "send them out" if an SCU resident had an unwitnessed fall; she did not know why more was not done in response to Resident #3's fall.
- She and the MA did not discuss the appropriate response to the fall that day, and she did not make any recommendations.
- She did not assist the MA with assessing Resident #3 after the fall, but was nearby.
-The MA was unable to conduct much of a post-fall

assessment because the resident got up as soon as she was touched.
- She did not advise that the resident remain in place until a full evaluation could be completed because "she basically just got up."
- She did not notice Resident #3 limping as she walked away.
- She assumed the MA notified Resident #3's PCP at the time of the fall, but was informed by a telephone call from management last week, while she was attending an out-of-town training, that the PCP had not been notified of the fall on 06/21/25.
-After any fall, staff were expected to closely monitor the resident for related signs and symptoms and document their observations every shift, usually for 72 hours.
-She did not know if this monitoring and documentation occurred after Resident #3's fall on 06/21/25 but she observed the resident eating breakfast in the dining room the next morning, 06/22/25, and documented that she was doing well.
-She was pretty sure more frequent monitoring and documentation began a couple of days after Resident #3's fall, when the bruise was found on her hip.

Interview with a first shift MA on 06/25/25 at 3:08pm revealed:
-On 06/21/25, he was the MA working first shift in the SCU.
-The RCC was working as the MOD that weekend.
-The MOD entered the SCU that afternoon and observed Resident #3 lying on the floor.
-He was sitting at a table at the back of the SCU dayroom when the RCC called out and informed him that Resident #3 was on the floor.
-He went to the resident, who was "lying on the floor flat on her back", just outside the dayroom in front of the staff's workstation.
-The MOD left. and he went to Resident #3 and attempted to assess her, but she resisted.
-When he was touching her, she flinched, jerked away, and had facial grimacing, but "she always jumped no matter where she was touched", so he was not concerned.
-He did not see any obvious signs of injury, like bleeding, knots, or bruises.
-He could not know for sure if the resident hit her head, but she did not have a knot on the back of her head.
-"Ninety percent of the time" he "called EMS" for further assessment when SCU residents had unwitnessed falls, but he did not call EMS to come and evaluate Resident #3 after her fall.

-He guessed he did not call EMS because the resident denied feeling any pain.
-"It took a lot of persuading to get the resident to stand up, but she finally agreed to get up", and he assisted the resident off the floor.
-She was "walking pretty normally, except she had a slight limp."
-It seemed like maybe she had the limp before she fell that day.
-She "seemed fine except she seemed tired and sleepy over the next few days and had a slight limp."
-He did not contact Resident #3's PCP through the after-hours emergency on-call number, but he was "pretty sure" he sent a faxed notification to the PCP's office.
-The PCP's office was closed on weekends, but he guessed the PCP would have received the information when the office reopened.
-The protocol following a fall included placing the resident on increased supervision checks, usually once per hour for 72 hours, and initiating alert charting, requiring the MA to document a status update in the electronic documentation system at least once per shift; he was "pretty sure" these steps were followed.

Interview with a second first shift MA on 06/25/25 at 3:14pm revealed:
-On 06/24/25 she observed Resident #3 refused her medications twice and was lethargic.
-Resident #3's PCP office was notified, and staff were instructed to send the resident to the hospital.
-The hospital called early the next morning, at around 1:00am, and said the resident was being admitted to the hospital with a fracture.

Telephone interview with a first shift Personal Care Aide (PCA) on 07/08/25 at 2:18pm revealed:
-She was working in the SCU on 06/21/25 when Resident #3 had a fall.
-She was not present when Resident #3 fell because she had just gone on break, but the MOD came to where she was taking a break and informed her that she was leaving for the day, but wanted to let staff know Resident #3 was on the floor.
-After she was informed of the fall, she went to where the resident was, just outside the dayroom, and in front of the staff workstation, and observed the SCU MA and another PCA with the resident, who was lying flat on her back.

-She observed the MA taking the resident's vital signs and talking to her; she did not remember what was said.
-She and the other PCA waited for instructions from the MA, and after a brief time, he instructed them to go ahead and assist the resident off the floor.
-She, the other PCA, and the MA, all assisted Resident #3 up from the floor to a standing position.
-When the resident began walking, she was favoring her right side.
-She and the other PCA assisted the resident to the bathroom and did not see any marks or bruises resulting from the fall.
-The SCUC called her on 06/23/25 and asked if Resident #3 had fallen during the weekend; she confirmed the resident had a fall on 06/21/25 and told her she and another PCA had noticed before she fell that day that the resident did not really seem like herself, meaning she was usually social, chatty, and cheery, but she was quiet and seemed sluggish and tired; she did not seem sick or in pain, just not herself.
-They had mentioned it to the SCU MA and were continuing to watch her.
-The resident was not limping before she fell on 06/21/25.

Interview with the SCUC on 07/07/25 at 11:40am:
- Two PCAs were showering Resident #3 on 06/23/25 and informed her they observed a bruise on the resident's right hip; they noted the resident was favoring her right leg while walking, as though something was bothering her.
- One of the PCAs who discovered the bruise said she had heard Resident #3 had fallen during the previous weekend (06/21/25).
- She contacted one of the weekend PCAs, who confirmed that Resident #3 had an unwitnessed fall on 06/21/25; the PCA reported the resident had been "kind of favoring her right side and didn't seem to feel well" before the fall.
- She assumed the bruise on Resident #3's right hip was caused by the fall.
- She faxed the PCP to request as-needed pain medication, and notified the PCP of the fall on 06/21/25, however, she informed the PCP the pain was likely not related to the fall, as the heard the resident may have been showing signs of discomfort and favoring her right side beforehand; she told the PCP this based on the information she received from the PCA who worked on the day the resident fell.
- Typically, even for SCU residents with dementia, EMS was not called after a fall unless the resident specifically complained of pain.
- Staff did not send residents to the hospital after a fall if it

was unknown whether they had hit their head; however, if a head strike was witnessed by staff, EMS was called for further evaluation.
- If staff witnessed a resident hit their head or had an obvious injury like a protruding bone, staff would immediately call EMS, but not if there was no clear evidence of injury.
- She did not understand how Resident #3 had been "walking around for days with a hip fracture."
-The resident was confused and not reliable in reporting injuries.
- She suggested that the facility's falls policy might need to be updated to require staff to notify EMS to come and evaluate SCU residents after unwitnessed falls.
- She was unaware that the current falls policy stated a resident who fell should not be moved by staff if there was any possibility that they may have hit their head.
- Since Resident #3 was found on her back following an unwitnessed fall, it was unclear whether she had struck her head, and technically, staff should not have moved her.
-The MAs were responsible for assessing residents after a fall, which in Resident #3's case should have included checking her range of motion and for signs of pain, such as facial expressions.
- Staff were required to monitor residents closely for 48 hours after a fall and document observations in chart notes during each shift; she did not know why some shifts lacked documentation of monitoring for Resident #3 during the 48-hour period following her fall on 06/21/25.
- Staff members routinely faxed fall notifications to PCP offices, even after the physician's hours, but the MA on duty at the time of Resident #3's fall failed to send the notification.
-Resident #3's PCP did have an after-hours emergency call line.
- As a result of this incident, staff were now required to call the physician's after-hours emergency number for instructions and document the name of the person they spoke with; she was not aware the current falls policy specified that a written fax could only be used if there was no chance the resident had hit their head or if the resident was able to reliably report no injuries.

Interview with a first shift PCA on 07/07/25 at 11:51am revealed:
-She was the PCA who found Resident #3's hip bruise while she was preparing to shower her on 06/23/25.
-She would describe what she saw as "the whole right hip was black and blue."

-The resident was not complaining of pain, but she was limping.
-Staff could not rely on Resident #3 to say if she was hurting, because she was very confused, her routine response was always to say "I'm fine" when asked how she was feeling.
-When she found the bruise on 06/23/25, she informed the SCUC that she heard something about Resident #3 having a fall the previous weekend.

Telephone interview with Resident #3's POA on 07/08/25 at 10:25am revealed:
-He received a telephone call on 06/21/25 from a staff member, he did not remember who, but he was informed that Resident #3 had been found on the floor earlier that day and staff had "assisted her up, put her in bed, and were going to keep an eye on her."
-He was not informed that she was favoring her right side when she walked.
-He received a second call from a staff member on 06/24/25 saying she was not eating, and they needed to send her to the hospital.
-He could not visit Resident #3 like he wanted to because he was in poor health and had moved into a facility over two hours away, near other family members.
-Resident #3 was "definitely not reliable" to inform staff if she was injured, because she was "completely disoriented and had no idea what was going on."
-After Resident #3 was hospitalized with a hip fracture on 06/24/25, she had a right hip replacement and recently returned to the facility with the additional service of hospice care.

Interview with the Executive Director (ED) on 06/25/25 at 2:35pm revealed:
-She was the newly hired ED but was familiar with Resident #3 being sent out to the hospital yesterday, 06/24/25 because it had been discussed in a morning stand-up meeting.
-Resident #3 was sent to the hospital due to generalized decline but was admitted to the hospital due to a hip fracture.
-It was her understanding that Resident #3 had a fall on 06/21/25, but "got herself back up and was ok."
-She did not know if the fall was witnessed.
-If the resident got herself up from the floor, she did not know how the staff knew she had fallen.
-The details of the fall should be documented in the electronic documentation system.
-She was new to the facility and was still learning their

policies and procedures, but based on her previous experience, the PCP should have been notified of the fall, and the resident would have been monitored closely after her fall for any signs of injury.

Telephone interview with the ED on 06/26/25 at 1:16pm revealed:
-Being new to her position, she was not aware that Resident #3's PCP had an after-hours on-call line, but if that was an option, she would prefer that staff use the on-call number immediately if an accident occurred outside of routine business hours.
-Before Resident #3 fell on 06/21/25, she did not know if the expectation was for the staff to send a fax to the PCP's office after normal business hours, or if it was to call the on-call physician and notify someone immediately.
-When Resident #3 fell on 06/21/25, she got up from the floor on her own and was assessed by the MA, with no signs of anything being potentially wrong, so that would have been the same information that would have been provided to the PCP.
-There was a "likelihood in this type of situation, that the physician would have referred the resident for additional evaluation, like an X-ray."
-When in doubt, staff should make the call for further evaluation, but in this case, the resident was just found sitting on the floor, so there were probably no concerns of her hitting her head or possible further injury.
-She did not know Resident #3 was found lying on her back or that it took a while for the MA to persuade and assist her from the floor; she did not know the resident was reacting negatively to being touched.
-She had just received a copy of the falls policy that day (06/26/25), and agreed that it indicated the PCP was to be informed immediately after an accident, and that residents should have close monitoring after the accident, as indicated by a chart entry on each shift.
-She had not been able to read through the policy completely and did not know that it
specified that a resident with even the possibility of a head strike staff were not supposed to move the resident, and that the PCP fax communication form was only to be used if there was no possibility of a head strike.

Telephone interview with Resident #3's PCP on 06/26/25 10:41am revealed:
- She was not notified on 06/21/25, either by fax or via the after-hours on-call line, regarding Resident #3's fall.

-The first time she became aware of the fall was on 06/23/25 at 1:41 p.m., when she received a fax from the SCUC requesting an as-needed pain medication for the resident; the fax stated that Resident #3 had a bruise on her right hip, was favoring her right leg, and appeared to be feeling discomfort.
-The SCUC indicated the resident was having general discomfort before she fell.
-Since the staff did not call her directly or indicate any urgency in the fax, she assumed the resident was experiencing mild soreness, so she prescribed her an as-needed pain medication and added her to the list of residents to be seen during her routine facility visit scheduled for 06/26/25.
-On 06/24/25, when staff called to report that the resident was lethargic and refusing her medications, the PCP immediately directed them to send her to the hospital for evaluation, and she later learned that Resident #3 was admitted with a pelvic fracture.
-She had repeatedly informed facility staff, particularly those in the SCU, that no one was in in her office during non-business hours, and as such, faxes sent after hours were not reviewed until the office reopened; staff had been reminded numerous times to use the after-hours on-call line, which had a physician available during all non-business office hours.
-If staff had immediately contacted the on-call physician on 06/21/25 following Resident #3's fall, they would have been guided through an assessment checklist that included evaluating for leg shortening and rotation, both of which were identified at the hospital three days later; while it could not be stated with certainty, earlier identification of the fracture may have been
possible had this assessment guidance occurred at the time of the fall.
-If there was even a chance the resident hit her head, the on-call physician would have automatically recommended sending her to the hospital.
-If Resident #3 was found lying flat on her back, and it was an unwitnessed fall, there would be a high likelihood that she hit her head, and the on-call physician would have automatically recommended sending the resident to the hospital.
-Most residents like Resident #3 with dementia were not reliable in reporting pain.
-She always tried to talk the staff through post-fall assessments by telephone before deciding to move the resident and to help determine if EMS should be called.
-There was certainly a chance that Resident #3's injury worsened because staff failed to respond immediately after her fall.

-Resident #3 should not have been walking around after she fractured her hip.
-"An untreated hip fracture could significantly increase the risk of death, especially in an older adult."

The facility failed to immediately respond Resident #3, who resided in the SCU and hand an unwitnessed fall, by not calling EMS to evaluate her or providing immediate notification to the PCP. When the resident flinched, jerked away, and had facial grimacing during a staff member's attempted post-fall assessment, staff persuaded and assisted her to stand and walk, observed her limping and appearing unwell. Resident #3's condition declined over the next three days as staff noted a large right hip bruise, requested an as-needed pain medication order, and observed the resident refusing food and medications, remaining in bed, and becoming lethargic, until she was sent to the hospital three days after her fall and diagnosed with a right hip fracture requiring surgery. The facility's failure resulted in serious neglect of the resident and constitutes a Type A1 Violation.

The facility provided a Plan of Protection (POP) in accordance with G.S. 131D-34 received on 06/26/25.

THE CORRECTIVE DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED **08/28/25**

IV. Delivered Via:	Hand Delivered	Date: 07/29/25
DSS Signature:	Jamie Robins	Return to DSS By: **08/19/25**

V. CAR Received by:	Administrator/Designee (print name): X Nichole Wood, CO	
	Signature: X NAWood, P	Date: X 7/29/2025
	Title: X Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Nichole Wood, CO	
	Signature: NAWood, CO	Date: 8/2/2025

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted* | By: | Date:

Comments:

Facility Name:

☑ *POC Accepted*	By: Jannie Robeson	Date: 08-04-25
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.*