Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018032	A. BUILDING: _____ B. WING _____	R-C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS OF CATAWBA	2010 29TH AVENUE DRIVE NE HICKORY, NC 28601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Catawba County Department of Social Services conducted a follow up survey and complaint investigation on September 30, 2015 and October 1, 2015. The complaint investigation was initiated by the Catawba County Department of Social Services on September 25, 2015.	{D 000}	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies: The Plan of Correction is prepared solely as a matter of compliance with State Law. Prior to the facility inspection certain programs were already in place and measures taken in an effort to satisfy a 7/17/15 survey. *** Immediately upon the ED's installation the facility began a tracker for falls. Data gathered included Date, Time of Day, Shift and Supervisor. This was done in an effort to identify needs for intervention and training, with the understanding that people fall and no reasonable intervention will eliminate all falls.	8/7/15 Ongoing
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure 1 of 5 sampled residents (Resident #2) was adequately supervised in accordance with the resident's assessed needs. The findings are: Review of Resident #2's current FL2 dated 7/21/15 revealed: -The resident's diagnoses included vascular dementia, end stage renal disease on maintenance dialysis, chronic ischemia heart disease, hypertension, and hyperlipidemia. -Recommended level of care was special care unit. -The resident was documented incontinently	D 270		

Approved By: Charity Steele
Date Approved: 11/05/15

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D 270	Continued From page 1 disoriented -The resident was documented a wanderer, verbally abusive, and injurious to others. -Ambulatory Review of Resident #2's record revealed: -The resident was admitted to the facility on 3/5/15. -The resident was moved to the special care unit in the facility on 7/21/15. Review of Resident #2's Care Plan dated 9/23/15 revealed: -In the mental health and social history section the resident was documented as wandering and verbally abusive. -In the Ambulation/Locomotion section the resident was documented as having "No Problems." -In the orientation section the resident was documented as sometimes disoriented. -In the risk management section under Safety Measures to Implement there was a note which read, "Ensure Resident Safety on Unit " Interview with Resident #2's Family Member at 12:00pm on 9/25/15 revealed: -Resident #2 had walked away from an outpatient dialysis clinic on two occasions. -The most recent occasion was 9/23/15. -Resident #2 had walked away from the facility on two occasions before he was moved to the facility special care unit. -The elopements from the dialysis clinic had occurred during the time when he was in the waiting room prior to his dialysis appointment. -Sometimes the transportation provider would drop him off to dialysis clinic 30 minutes or more prior to his appointment. -The Family Member had a meeting with the	D 270	It is this Community's policy to provide for the safety and security of each resident. To that end, each entry/exit door is equipped with a mag lock system and key pad. Codes are managed by staff and management and are changed periodically as needed to provide for the security of the residents. The Community requires each individual to sign the visitor book upon entry and exit to the Community. The Community contracts with the NC Project Lifesaver to provide training to staff on preventive measures to assure resident safety and the procedure for missing residents. Staff is also trained to use the NCPL Manual.	

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D 270	Continued From page 2 facility about the need for a staff person to sit with Resident #2 during the time prior to dialysis, but the facility Administrator had stated he didn't have staff available to go sit with Resident #2. Interview with the Transportation Provider Supervisor at 12:30pm on 9/25/15 revealed: -The transportation policy stated that an individual could be picked up within 1 hr of the appointment time. -The driver was trying to get the drop off time for Resident #2 as close to the actual dialysis appointment time as possible, but due to the drivers needing to pick up/drop off other clients, it wasn't always possible. -The drivers are not able to stay and supervise Resident #2 prior to his dialysis appointment. -He had discussed the situation with Resident #2's family. Review of Resident #2's "Care Notes" revealed: -On 7/3/15, a note was written that the resident stated to a staff member " I will get out this weekend. " -A second note on 7/3/15 documented that the facility received a call from someone asking if they were missing Resident #2. The person then brought Resident #2 back to the facility in her car, and staff had to talk Resident #2 into coming back into the facility. The family was notified of the incident and requested that someone be with Resident #2 if he goes outside of the facility. -A note dated 7/17/15 documented Resident #2 got upset during the supper meal and then went outside and was attempting to leave the facility. Staff followed him and tried to get him to come back into the facility, and then the resident hit the staff across the head. Eventually staff were able to talk the resident into coming back into the facility.	D 270	10A NCAC 13F (.0901(b) Personal Care and Supervision Following the exit conference on September 30, 2015 the following considerations were made: ***The facility arranged for a staff member to deliver Resident#2 to dialysis, sit in waiting room for 4 hours while Resident #2 receives treatment and return Resident #2 back to the facility upon completion of his treatment. ***While Resident #2 continues to receive dialysis treatments and is a resident of Springs of Catawba, the facility will provide oversight to all dialysis treatments. ***The facility has currently upgraded Resident #2's status to Skilled Nursing and is seeking placement.	9/30/15 Ongoing 10/2/15

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D 270	Continued From page 3 -A note dated 8/31/15 at 5pm documented that the facility received a call from a nurse at the dialysis clinic stating that the resident needed more monitoring during his time at dialysis due to his early arrival. -A note dated 9/23/15 at 5pm documented Resident #2 had tried to give a staff person money to let him out. -A note dated 9/24/15 at 11:30am documented Resident #2 tried to give a staff person money to let him out, or he would jump the fence. Interview with a Nurse from the outpatient dialysis clinic on 9/30/15 at 2:30pm revealed: -Resident #2 had walked away from the dialysis clinic 3 times. -The first time happened in August, but she wasn't sure exactly what date because she wasn't involved in the incident. -The second time was 9/23/15, and Resident #2 was at the tree right next to the road (where the driveway to the dialysis clinic is) when she caught up to him. -He did not actually go out into the road on 9/23/15, but stated he wanted to go home -She was easily able to redirect him to return inside the clinic. -Resident #2 had walked away from the dialysis clinic today also (9/30/15). -He made it onto the road in front of the dialysis center, and turned left and was walking up the hill towards the railroad tracks. -The resident stated he was going "to hit" the railroad to go home. -The resident refused to go back inside and kept walking up the road until the nurse returned to the dialysis clinic and called the police. -After she caught up with him again on the road and told him she had called the police, he agreed to return to the dialysis clinic.	D 270	***Immediate training will occur with facility staff covering Resident Supervision and Fall Management including outside appointments and MD notifications. ***Care Managers will review shift change reports daily for 4 weeks and then PRN ***ED will then review shift change reports weekly for 4 weeks and then PRN	10/1/15 10/1/15 Ongoing 10/8/15 Ongoing

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D 270	Continued From page 4 -The nurse stated that she had called and talked with the Special Care Unit Coordinator at the facility on at least one occasion to express the need for Resident #2 to have supervision when he was dropped off early at the dialysis clinic. -The nurse stated that the staff at the dialysis clinic could not supervise the resident, because they have other patients to care for. Interview with a second staff person at outpatient dialysis clinic at 10:25am on 10/1/15 revealed: -The first incident of Resident #2 walking away from dialysis was on 8/17/15. -The first time he only made it to the bushes which line the parking lot by the road. -There was also an incident on 7/20/15 where Resident #2 attempted to leave, and became very irate when staff prevented him from leaving. -During the incident on 7/20/15, the police and the family had to be called because the resident was refusing to get into the car with Medicaid transportation to go back to the facility. -Resident #2 eventually rode back to the facility with family after the police talked him into going. Observation of the surrounding area outside the dialysis clinic on 9/30/15 at 5:15pm revealed: -The road leading into the driveway of the dialysis clinic was a two lane road. -Turn left out of the driveway onto the road you will go up a hill past several industrial buildings, cross another two lane road, walk through a parking lot, and on to the railroad tracks (about .2 miles). -Tuurn right out of the driveway onto the road it is approximately 292 ft down a hill to a major four lane divided highway. Interview with the Special Care Unit Coordinator at 3:22pm on 9/30/15 revealed:	D 270		

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D 270	Continued From page 5 -Resident #2 had no issues when at the facility except he sometimes got agitated when his family visited. -Dialysis had called each time he had walked away from the facility. -The most recent time was earlier that day. -She got a call back after the first incident from dialysis requesting assistance with supervision. -The family had refused to provide someone to ensure supervision when he was dropped off at dialysis early. -She had conversations with the Primary Care Provider today to evaluate if Resident #2 might be better served in skilled care. Interview with the Executive Director at 4:05pm on 9/30/15 revealed: -Resident #2 had walked off from dialysis three times, and the police had found him and brought him back. -The problem seems to happen when Resident #2 had been dropped off at dialysis earlier than his scheduled appointment. -He has met with Resident #2's family and asked them to provide a sitter, or family member to provide the supervision needed and they had refused. -He can't afford to have a staff member sit with Resident #2 for the entire 3 hrs the resident was at dialysis. -As far as he knew, dialysis had not called the facility to ask for extra supervision. -Other than the issue with walking off from dialysis, Resident #2 was a good resident with no problems at the facility. -He had talked to so many people about this issue, he couldn't remember if he discussed the issue with anyone at his corporate office. Interview with Resident #2 at 4:50pm on 9/30/15	D 270		

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D 270	Continued From page 6 revealed: -Resident hated living "locked up like a dog." -He had tried to go home from the dialysis clinic earlier in the day, but had been unable to get home because the dialysis staff had made him go back to the dialysis clinic. Confidential interviews with three staff revealed: -Resident #2 was mostly no problem as long as he was taken out to smoke and given snacks. -Sometimes Resident #2 would ask staff to let him out, and even offer to pay them money, and would get angry if staff refused. -Resident #2 had walked off from dialysis a couple times. Interview with the Primary Care Provider at 11:25am on 10/1/15 revealed: -She had talked with the Special Care Unit Coordinator on 9/30/15 about Resident #2 walking away from dialysis. -Resident #2 was not safe to walk away from the dialysis clinic due to his mental status. -Resident #2's family was not supportive in helping to provide the supervision necessary. -Resident #2 may no longer be appropriate for his current level of care and may be better served at the skilled nursing level. --- A Plan of Protection was provided by the facility on 9/30/15 and included: -Facility has arranged staff member to accompany the resident to dialysis treatment on 10/2/15 and will stay with the resident until he goes back into treatment area. -While resident continues to receive dialysis treatments, and is a resident of the facility, the facility will provide oversight to all dialysis treatments.	D 270		

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D 270	Continued From page 7 -Facility currently looking to upgrading the resident to skilled care. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.	D 270		
{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: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to notify the physician concerning 3 of 5 sampled residents related to elopement (Resident #2), bruising and swelling of a resident's forearm (Resident #3), and a resident needing a higher level of care (Resident #4). The findings are: A. Review of Resident #2's current FL2 dated 7/21/15 revealed: -The resident's diagnoses included vascular dementia, end stage renal disease on maintenance dialysis, chronic ischemia heart	{D 273}		

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{D 273}	Continued From page 8	{D 273}		

disease, hypertension, and hyperlipidemia.
-The recommended level of care was special care unit.
-The resident was documented intermittently disoriented
-The resident was documented a wanderer, verbally abusive, and injurious to others.
-Ambulatory

Review of Resident #2's record revealed:
-The resident was admitted to the facility on 3/5/15.
-The resident was moved to the special care unit in the facility on 7/21/15.

Review of Resident #2's Care Plan dated 9/23/15 revealed:
-In the mental health and social history section the resident was documented as wandering and verbally abusive.
-In the Ambulation/Locomotion section the resident was documented as having "No Problems."
-In the orientation section the resident was documented as sometimes disoriented.
-In the risk management section under Safety Measures to Implement there was a note which read, "Ensure Resident Safety on Unit "

Interview with Resident #2's Family Member at 12:00pm on 9/25/15 revealed:
-Resident #2 had walked away from an outpatient dialysis clinic on two occasions.
-The most recent occasion was 9/23/15.
-Resident #2 had walked away from the facility on two occasions before he was moved to the facility special care unit.
-The elopements from the dialysis clinic had occurred during the time when he was in the waiting room prior to his dialysis appointment.

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{D 273}	Continued From page 9 -Sometimes the transportation provider would drop him off to dialysis clinic 30 minutes or more prior to his appointment. -The Family Member had a meeting with the facility about the need for a staff person to sit with Resident #2 during the time prior to dialysis, but the facility Administrator had stated he didn't have staff available to go sit with Resident #2. Review of Resident #2's "Care Notes" revealed: -A note dated 7/3/15 documented that the facility received a call from someone asking if they were missing Resident #2. The person then brought Resident #2 back to the facility in her car, and staff had to talk Resident #2 into coming back into the facility. -A note dated 7/17/15 documented Resident #2 got upset during the supper meal and then went outside and was attempting to leave the facility. Staff followed him and tried to get him to come back into the facility, and then the resident hit the staff across the head. Eventually staff were able to talk the resident into coming back into the facility. Interview with a Nurse from the outpatient dialysis clinic on 9/30/15 at 2:30pm revealed: -Resident #2 had walked away from the dialysis clinic 3 times. -The first time happened in August, but she wasn't sure exactly what date because she wasn't involved in the incident. -The second time was 9/23/15, and Resident #2 was at the tree right next to the road (where the driveway to the dialysis clinic is) when she caught up to him. -He did not actually go out into the road on 9/23/15, but stated he wanted to go home -She was easily able to redirect him to return inside the clinic.	{D 273}		

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{D 273}	Continued From page 10 -Resident #2 had walked away from the dialysis clinic today also (9/30/15). -He made it onto the road in front of the dialysis center, and turned left and was walking up the hill towards the railroad tracks. -The resident stated he was going "to hit" the railroad to go home. -The resident refused to go back inside and kept walking up the road until the nurse returned to the dialysis clinic and called the police. -After she caught up with him again on the road and told him she had called the police, he agreed to return to the dialysis clinic. -The nurse stated that she had called and talked with the Special Care Unit Coordinator at the facility on at least one occasion to express the need for Resident #2 to have supervision when he was dropped off early at the dialysis clinic. -The nurse stated that the staff at the dialysis clinic could not supervise the resident, because they have other patients to care for. Interview with a second staff person at the outpatient dialysis clinic at 10:25am on 10/1/15 revealed: -The first incident of Resident #2 walking away from dialysis was on 8/17/15. -The first time he only made it to the bushes which line the parking lot by the road. -There was also an incident on 7/20/15 where Resident #2 attempted to leave, and became very irate when staff prevented him from leaving. -The incident on 7/20/15 the police and the family had to be called because the resident was refusing to get into the car to go back to the facility. -Resident #2 eventually rode back to the facility with family after the police talked him into going. Interview with Resident #2's Primary Care	{D 273}		

LED

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{D 273}	Continued From page 11 Provider (PCP) at 11:25am on 10/1/15 revealed: -She was aware of the incident where Resident #2 had walked away from the dialysis center on 9/30/15, because the Special Care Unit Coordinator had called her and reported it to her -The only other issue at dialysis she had been made aware of by the facility was an incident that had happened right before the resident was moved to the special care unit. Interview with the Special Care Unit Coordinator at 3:55pm on 10/1/15 revealed: -Resident #2 moved to the special care unit on 7/21/15. -She had made Resident #2's PCP aware of the incident of when the resident had walked away from the facility on 9/30/15, because they had discussed moving Resident #2 to a skilled level of care. -She was "pretty sure" she had talked with the PCP after the first time Resident #2 had walked off from dialysis, because that's when she started him back on Exelon (a medication to treat dementia). -She thought she had spoken with the PCP after the second incident. Interview with the Executive Director at 4:05pm on 9/30/15 revealed: -Resident #2 had walked off from dialysis three times, and the police had found him and brought him back. -The problem seems to happen when Resident #2 had been dropped off at dialysis earlier than his scheduled appointment. -Other than the issue with walking off from dialysis, Resident #2 was a good resident with no problems at the facility. Interview with Resident #2 at 4:50pm on 9/30/15	{D 273}		

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{D 273}	Continued From page 12 revealed: -Resident hated living "locked up like a dog." -He had tried to go home from the dialysis clinic earlier in the day, but had been unable to get home because the dialysis staff had made him go back to the dialysis clinic. Interview with the Primary Care Provider at 11:25am on 10/1/15 revealed: -She had talked with the Special Care Unit Coordinator on 9/30/15 about Resident #2 walking away from dialysis. -Resident #2 was not safe to walk away from the dialysis clinic due to his mental status. -Resident #2 may no longer be appropriate for his current level of care and may be better served at the skilled nursing level. B. Review of Resident #3's current FL2 dated 8/27/15 revealed: -The resident's diagnoses included Alzheimers, anxiety, arthritis, and hypertension. -The resident was documented intermittently disoriented. -The resident was documented semi-ambulatory. -The resident was documented verbally abusive. -The resident was documented injurious to self and others. Review of Resident #3's Care Plan dated 9/1/15 revealed: -The resident was documented verbally abusive. -The resident was documented physically abusive. -The resident was documented as resists care. -The resident was documented as having disruptive behavior and socially inappropriate. -The resident was ambulatory with aide or device. -The resident was documented as always disoriented.	{D 273}	***ED completed a 24 Hour Report and Faxed to HCPR on 10/1/15 prior to the conclusion of the exit interview ***ED will review with Care Management Staff appropriate times to complete 24 Hour and 5 Day Reports and notify HCPR ***ED will review all Incident Reports to ensure completion of HCPR notification ***Management will discuss with staff, any injuries of unknown origin during the next stand-up meeting to determine the most effective plans of intervention.	10/1/15 10/1/15 Ongoing Ongoing

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{D 273}	Continued From page 13 Observation of Resident #3 on 9/30/15 at 9:22am revealed: -The resident was sitting in a wheelchair at a table in the living room of the special care unit (SCU). -The resident's right forearm was in a cast. Review of Resident #3's Care Note entries dated 8/31/15 revealed: -"Resident refused breakfast and all morning meds. Was trying to hit [Resident Assistants] and [Medication Aide]. [Family member] came in and was unable to calm [the resident] down." -"Resident has been agitated on this shift. Refusing dinner, refusing all meds. Resident has hit, slapped, kicked, punched, and tried to trip staff. Resident also bit this [Medication Aide] and also trying to spit on staff...." -"Resident also was biting self..." Review of Resident #3's Care Note entry dated 9/1/15 revealed: -"Resident has a bruise on [right] wrist..it is swollen. Contacted [power of attorney and Primary Care Provider (PCP)]." -"Resident is still refusing to eat. [Physician] has been contacted, [PCP] saw resident today." -"Also resident is very combative to staff." Review of Resident #3's Care Note entries dated 9/3/15 revealed: -"Resident was observed lying in the floor beside her bed..." -The resident's blood pressure was 160/90 and pulse was 100. -"[Emergency Medical Service (EMS)] came to evaluate resident and said that the [resident] didn't have any visible injuries. [EMS] contacted [family member] to ask if [family member] would	{D 273}		

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{D 273}	Continued From page 14 like [resident] to be sent out." -Family member asked for Resident #3 to be sent to the local emergency department for evaluation and get an xray of the right wrist due to it being "swollen and bruised." -"[Right] wrist isn't swollen or bruised because she fell today. Wrist was reported swollen/bruised on 9/1/15." -"Resident came back from hospital with a diagnosis of a ulnar fracture. Residents [sic] arm is in a cast and a sling." Review of Resident #3's visit summary from a local emergency department dated 9/3/15 revealed: -Presenting complaint: Right wrist deformity -Diagnosis: ulnar fracture Confidential interview with a Personal Care Aide revealed: -On 9/1/15, "I saw [Resident #3's name] arm was bruised... That same day, I pulled [Resident #3's name] up to the breakfast table and she had a hard time lifting her arm up" to eat. -Resident #3 had complained of pain in the arm "just at breakfast" and the resident "didn't want to lift up her arm to eat." -"A good part of [the Resident's] wrist was bruised. I can't remember about swelling." Confidential interview with a second Personal Care Aide revealed: -On 9/1/15 at breakfast, she noticed Resident #3 had a "reddish, purplish" bruise approximately 4 inches in length on her right forearm and it was swollen. -"I didn't remember seeing it the day before." -"If we raised [the Resident's] arm [the Resident] would say it hurt." -The Personal Care Aide reported the bruising of	{D 273}		

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{D 273}	Continued From page 15 Resident #3's arm to the Medication Aide covering that shift. -When the Personal Care Aide had asked staff from third shift about what had happened to Resident #3's arm, "They said they didn't know either what had happened to her arm." Confidential interview with a third Personal Care Aide revealed: -She had worked second shift on the evening of 8/31/15 and she had not seen any bruising on Resident #3's arms when she helped the resident get into her pajamas for bed. -The next day on 9/1/15, Resident #3's right forearm "was swollen and she complained of pain." -"When we touched her arm, she would complain about the pain." Confidential interview with a Medication Aide revealed: -"I honestly don't know how [Resident #3] broke her arm." -Resident #3 "didn't complain to us about pain in her arm. She doesn't tell me when she's in pain. She will tell her [family member], but not us." -"I didn't see the bruise. I just came in one day and it was wrapped-hadn't been casted yet." Interview with the Special Care Coordinator on 10/1/15 at 10:36am revealed: -On 9/1/15, Resident #3 had a face to face visit with her PCP at the facility. -She was "pretty sure" Resident #3's PCP was made aware at the 9/1/15 visit Resident #3's right forearm was bruised. -"If [PCP's name] saw swelling she would have ordered an xray." -"[PCP's name] and [family member] and I met that day and talked about [Resident #3's]	{D 273}		

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{D 273}	Continued From page 16 medications." -The family member had not seen "anything" amiss with the Resident's arm either. -Staff had not reported to her Resident #3 had experienced pain when the Resident lifted her right hand. -She had not asked her staff what had caused the bruising on Resident #3's arm. -She had assumed the Resident had sustained the bruising on her arm because the Resident had been "hitting the table with her arm" on 8/31/15. -She had known Resident #3 was "abusive to staff" and had worked with the family and PCP to "get her meds changed." Review of PCP face-to-face encounter note for Resident #3 dated 9/1/15 revealed: -No documentation of an assessment of resident's right arm for bruising. -Continued treatment for the resident's urinary tract infection was documented. -An order for a hospital bed with contour mattress. Telephone interview with Resident #3's Primary Care Provider on 10/1/15 at 11:15am revealed: -Facility staff had not reported Resident #3's complaints of pain and bruising to the Resident's right forearm during her face-to-face visit with the Resident on 9/1/15. -"[Resident #3's] was up in the wheelchair with me talking with her. I didn't know anything about bruising." -She remembered meeting with Resident #3's family member on 9/1/15, however the family member had not mentioned to her anything about bruising on the Resident's right forearm. Telephone interview with Resident #3's family	{D 273}		

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{D 273}	Continued From page 17 member on 10/1/15 at 11:45am revealed: -The Special Care Coordinator had notified the family member by phone on 9/1/15 at 11:09am about the bruising on Resident #3's right arm and that staff were unaware how it had occurred. -The family member had visited Resident #3 "later in the day to look at the wrist and it was obviously bruised." -Resident #3 "was holding [the arm]" during her visit. A second interview with the Special Care Coordinator (SCC) on 10/1/15 at 12:20pm revealed: -Staff had reported to her on 9/1/15 a "small area of bruising on [Resident #3's] right forearm" but "didn't say anything about swelling." -A Medication Aide had reported the injury to her and an incident report had been completed by the Medication Aide. -"I guess I thought [the PCP] had seen everything" while she was here on 9/1/15 doing the face to face visit. -When the PCP was on site for face-to-face visits with residents, she was given a list of residents to be seen, however she did not round with the PCP as she saw residents. -The Medication Aide who had reported the injury to her had stated "The resident had been hitting the table with her arm and swatting at staff...there you go." -The fall that had occurred on 9/1/15 happened in the evening. -She did not question staff regarding what happened "leading up to the bruise" on Resident #3's arm. Review of Resident #3's record revealed there were no documented Accident and Injury Report dated 9/1/15 for the Resident.	{D 273}	***Steps are underway to find a Skilled Nursing facility for Resident #3 ***Training on the appropriate method for Incident Reporting was conducted and staff was reminded of the importance of timely and accurate reporting practices. The Who, What, When, Where and How incident was discovered was discussed at the training. *** Hot Box Training and Proper Documentation Training was provided to staff. Discussed was the importance for timely and accurate follow up checks over the 72 hours after a fall occurs. ***A Falls Protocol Instruction sheet was placed on each Med Cart, at the Nurses Stations and at the Time Clock.	Ongoing 10/1/15 10/2/15 8/7/15

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{D 273}	Continued From page 18 Review of Resident #3's Accident and Injury Report dated 9/3/15 revealed: -"Resident was observed lying in the floor beside her bed." -Type of injury: bruising -Resident was taken to the local emergency room for evaluation on 9/3/15 at 5:30pm. -Diagnosis: ulnar fracture -The family member was contacted on 9/3/15 at 6:10pm. -A message was documented as left with the PCP on 9/3/15 at 6:15pm. Interview with the Administrator on 10/1/15 at 12:45pm revealed: -"I vaguely remember [SCC's name] going to look at [Resident #3's name] before her arm was casted." -The SCC had informed him she had "seen bruising" on the Resident's arm and had reported it to Resident #3's PCP and family. -"I thought the [PCP's name] did a full assessment [of Resident #3] and then met with [Resident #3's family member]." C. Review of Resident #4's current FL2 dated 9/30/15 revealed: -Diagnoses included: Alzheimer's, dementia, atrial fibrillation, hypertension, cerebral vascular accident, and generalized muscle weakness. -The Resident was constantly disoriented and semi-ambulatory with a wheelchair. Review of Resident #4's record revealed: -She had six documented falls from 8/20/15 to 9/30/15. -She had slid out of her wheelchair on 9/12/15 and 9/27/15. -Fall interventions included:	{D 273}	***Staff has received Fall Prevention Training through the National Fall Prevention website entitled "What Makes Us Fall" which covers Environmental and Physiological reasons for falling. ***An in-service was done on September 30, 2015, the day of this inspection, that covered Resident Rights. Terry Spencer, MSW, LCSW at Smoky Mountain Center conducted this training. Mr. Spencer is the Geriatric and Adult Mental Health Specialty Team Manager. ***An in-service was conducted on October 7, 2015 by Dr Lesassier dealing with Resident Rights ***Resident Rights Handouts were disseminated to Staff. Resident Rights are still a topic of discussion.	9/1/15 Ongoing 9/30/15 10/7/15 8/7/15 Ongoing

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{D 273}	Continued From page 19 7/07/15 bed/chair alarm 7/15/15 discontinued aspirin 7/15/15 hospital bed with contour mattress 9/04/15 Physical Therapy (PT) consult Review of Resident #4's Care Plan dated 9/27/15 revealed: -No changes in behavior. -Two person assist at all times for toileting. -Assistance needed for all transfers. -Ambulatory with wheelchair. -PT was completed for strengthening. -Inability to follow directions. -Use of bed/chair alarm to prevent falls. Review of Resident #4's Licensed Health Professional Support evaluation dated 9/10/15 revealed: -The resident was wheelchair bound due to generalized weakness and was unable to propel herself due to confusion. -The resident required 2-4 people with hands on assist for all transfers. -The number of staff required for assistance depended on the alertness of the resident. -The resident had been assessed for PT due to recent falls. Review of Resident #4's Care Notes entry dated 8/20/15 at 9:00am revealed "Resident fell in the sun room. EMS were called out. Resident was taken to [name of local emergency department]." Review of Resident #4's Accident and Injury Report dated 8/20/15 at 8:50am revealed, "Resident was sitting on the floor in the sunroom beside wheelchair." Review of Resident #4's visit summary from a local emergency department dated 8/20/15 at	{D 273}	***Resident #4 has been upgraded to Skilled Nursing and is no longer a resident at Springs of Catawba	10/8/15

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{D 273}	Continued From page 20 10:08am revealed: -Presenting complaint: fall, injury to back -Diagnosis: fall against object, right shoulder abrasion Review of Resident #4's Care Notes entry dated 8/23/15 at 10:00am revealed, "Resident fell in sunroom today trying to get up. EMS was called, resident took to [name of local hospital]." Review of Resident #4's Accident and Injury Report dated 8/23/15 at 10:05am revealed: -"Resident laying on floor on her back." -Type of injury: left arm abrasion Review of Resident #4's visit summary from a local emergency department dated 8/23/15 at 11:31am revealed: -Presenting complaint: fall -Diagnosis: fall, bilateral hip pain, right shoulder pain, small abrasion on left forearm Review of Resident #4's Care Notes entry dated 9/04/15 at 1:00am revealed "Resident was found lying on the floor on her right side by her bed. Called EMS, took to [name of local hospital]." Review of Resident #4's Accident and Injury Report dated 9/04/15 at 1:03am revealed: -"Resident was found lying on her right side next to her bed." -Type of injury: none present Review of Resident #4's visit summary from a local emergency department dated 9/04/15 at 5:55am revealed: -Presenting complaint: fall -Diagnosis: fall, no injury Review of Resident #4's Care Notes entry dated	{D 273}	***The Ombudsman is scheduled to present on Resident Rights on December 22, 2015 ***A Power Point Presentation entitled "SUPERVISION" is scheduled for 11/6/15 Items covered in presentation will be: 1. What is Supervision 2. The Difference Between Rounds 3. What Supervision is Required 4. Why is Supervision Of Residents Important 5. Where Supervision May Be Needed 6. Taking A Closer Look At Supervision 7. Supervision and Behaviors 8. Supervision and Wandering 9. Supervision and Smoking	12/22/15 11/6/15

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{D 273}	Continued From page 21 9/07/15 revealed, "Resident was observed sitting in the floor of her bedroom. EMS was called and evaluated resident. Called [HCPOA] and she stated that she didn't want resident to be took out." Review of Resident #4's record revealed there was no documented Accident and Injury Report dated 9/07/15 for the resident. Review of Resident #4's Care Notes entry dated 9/26/15 revealed, "Resident was found sitting on the floor in the day room. EMS took to [name of local emergency department]." Review of Resident #4's Accident and Injury Report dated 9/26/15 at 6:10am revealed: -"Resident was found sitting in the floor in the day room." -Type of injury: left hand skin tear Review of Resident #4's visit summary from a local emergency department dated 9/26/15 at 09:24am revealed: -Presenting complaint: fall, back pain, abdominal pain -Diagnosis: fall, back pain, abdominal pain Observation of Resident #4 on 9/30/15 at 3:05pm revealed: -She was sitting in her wheelchair waiting to use the restroom. -There was one Personal Care Aide (PCA) standing within one to two feet of the resident's wheelchair. -She fell face first, out of her wheelchair, and landed on her left side in the doorway leading into the restroom. Review of Resident #4's Care Notes entry dated	{D 273}		

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{D 273}	Continued From page 22 9/30/15 at 3:05pm revealed, "Resident found on floor. Sent to [name of local emergency department]. Unable to obtain vitals." Review of Resident #4's record revealed there was no documented visit summary from the local emergency department dated 9/30/15 for the resident. Review of Resident #4's Accident and Injury Report dated 9/30/15 at 3:05pm revealed: -"Resident was laying on left side in doorway of bathroom." -Type of injury: bruising, abrasion, and skin tear to left arm -Diagnosis: Urinary tract infection Further review of Resident #4's Care Notes entries revealed: -On 8/21/15, "Resident agitated today, trying to get up and walk." -On 8/26/15, "Resident very agitated this morning, would not stay in chair of dining room. Screaming out and trying to hit [staff], gave PRN." -On 8/30/15 at 10:15pm, "Resident continues to try to get out of her chair and bed. Very hard to redirect." -On 8/31/15, "Resident very agitated this morning. Crying and screaming, 3rd shift [staff] gave PRN, was effective." -On 8/31/15 at 8:30pm, "Resident has been hard to redirect at times, will not stay in chair." -On 9/05/15, "Resident has been fighting, yelling out loud to staff members. Very agitated when trying to assist with any care. Spitting, very hard to redirect. Gave PRN medication this morning." -On 9/09/15, "Resident yelling out loud when staff tries to assist resident, it takes 3 or more [staff] to assist resident with any care." -On 9/10/15, "Resident receiving physical therapy	{D 273}		

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{D 273}	Continued From page 23 due to recent falls, Family notified of need to discuss resident care following completion of [physical] therapy." -On 9/12/15, "Resident slip out of her wheelchair in the sun room. Resident has a small abrasion on left hand." -On 9/22/15, "Resident very agitated, keeps trying to stand up. [Staff] have to stay with her most of the time." -On 9/27/15, "Resident slid out of her wheelchair to the floor. No acute injuries due to the fall.". -On 9/30/15 at 7:45am, "Resident has bruising around 2nd and 3rd toes on left foot." Review of PCP Face to Face Encounter Note for Resident #4 dated 9/1/15 revealed: -No documentation of an assessment of the resident's right shoulder or left arm abrasions. -The resident had numerous falls in the past several weeks with no noted injuries. -The resident was wheelchair bound and had a chair alarm. -The resident was hard of hearing and "required repeated, slow, repetitive instructions." -The resident had difficulty standing or rolling over in bed without assistance. -The resident had a hospital bed with contour mattress. -The resident required one plus assistance to leave the facility due to increased fall risk and required 24 hour supervision due to Alzheimer's dementia. -The PCP will consult PT if the resident continues to fall. Review of Resident #4's PT Care Notes entries revealed: -Resident #4 received six PT visits from 9/09/15 to 9/23/15. -Resident #4 was discharged from PT on 9/23/15	{D 273}		

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{D 273}	Continued From page 24 due to "no significant progress made, cognitive deficits are greatest barrier to further progress." Telephone interview with Resident #4's PCP on 10/1/15 at 11:15am revealed: -She had been notified of all falls and behaviors that were documented for Resident #4. -The falls were a result of the increase in signs/symptoms of dementia. -The facility had implemented all interventions to prevent her from falling. -Resident #4 had been upgraded to a higher level of care on 9/30/15 and the facility was seeking placement. Interview with the Memory Care Coordinator (MCC) on 9/30/15 at 10:10am revealed: -Resident #4 had multiple falls. -She was trying to find placement for Resident #4 in a skilled facility. Confidential interviews with staff revealed: -The staff checked on residents every 15 to 30 minutes. -There was not enough staff to take care of the residents. -"We keep [Resident #4] with us most of the time." -The facility had implemented the use of the bed/chair alarm for Resident #4 in July 2015. "If [Resident #4] is in a good mood she can walk a few steps with 1 person assist, if not she requires 2-3 people." A second interview with the MCC on 10/1/15 at 3:00pm revealed: -She had notified the HCPOA on 9/10/15 regarding the need to discuss Resident #4's care following the completion of physical therapy. -She realized that Resident #4 needed to be	{D 273}		

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	HAL018032	A. BUILDING: _____ B. WING _____	R-C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS OF CATAWBA	2010 29TH AVENUE DRIVE NE HICKORY, NC 28601

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{D 273}	Continued From page 25 upgraded to a higher level of care once PT had been completed on 9/23/15. -The first time she notified Resident #4's HCPOA of the need for a higher level of care was on 9/30/15. -Interventions implemented by the facility to reduce falls included: kept Resident #4 where staff could closely monitor during the day, used bed/chair alarm, performed 15 to 30 minute checks when Resident was in her room, and used contour mattress. Telephone interview with Resident #4's HCPOA on 10/1/15 at 4:01pm revealed: -The MCC had notified her by phone every time the Resident had a fall. -She had last visited Resident #4 approximately 3-4 weeks ago. -She stated, "the first time I heard about a higher level of care was on 9/30/15." -The HCPOA had asked staff about medications to help with memory and to decrease confusion, but never received a response from the facility. _____ A plan of protection was provided by the facility on 10/1/15 and included: -Immediate training will occur with facility staff covering resident supervision/fall management including outside appointments and physician notification. -Care managers will review shift change reports daily for four weeks and then as needed. -Executive Director will then review with care managers shift change reports weekly times 4 weeks and as needed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.	{D 273}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS OF CATAWBA	2010 29TH AVENUE DRIVE NE HICKORY, NC 28601

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(D 438)	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to comply with G.S. 131E-256 and Rule 10A NCAC 13O.0102 by not reporting injury of unknown source to the Health Care Personnel Registry within 24 hours of an incident (Resident #3 had a fracture of the ulna with staff unaware how the injury occurred). The findings are: Review of Resident #3's current FL2 dated 8/27/15 revealed: -Diagnoses included: Alzheimers, anxiety, arthritis, and hypertension. -Intermittently disoriented -Semi-ambulatory -Verbally abusive -Injurious to self and others Observation of Resident #3 on 9/30/15 at 9:22am revealed: -The resident was sitting in a wheelchair at a table in the living room of the special care unit (SCU). -The resident's right forearm was in a cast. Review of Resident #3's "Care Note" entry dated	(D 438)		

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{D 438}	Continued From page 27 9/1/15 revealed: -"Resident has a bruise on [right] wrist..it is swollen. Contacted [power of attorney and Primary Care Provider (PCP)]." -"Resident is still refusing to eat. [The PCP] has been contacted, [PCP] saw resident today." -"Also resident is very combative to staff." Review of Resident #3's "Care Note" entries dated 9/3/15 revealed: -"Resident was observed lying in the floor beside her bed..." -The resident's blood pressure was 160/90 and pulse was 100. -"[Emergency Medical Service (EMS)] came to evaluate resident and said that the [resident] didn't have any visible injuries. [EMS] contacted [family member] to ask if [family member] would like [resident] to be sent out." -Family member asked for Resident #3 to be sent to the local emergency department for evaluation and get an xray of the right wrist due to it being "swollen and bruised." -"[Right] wrist isn't swollen or bruised because she fell today. Wrist was reported swollen/bruised on 9/1/15." -"Resident came back from hospital with a diagnosis of a ulnar fracture. Residents arm is in a cast and a sling." Review of Resident #3's visit summary from a local emergency department dated 9/3/15 revealed: -Presenting complaint: Right wrist deformity -Diagnosis: ulnar fracture Confidential interview with a Personal Care Aide revealed: -On 9/1/15, "I saw [Resident #3's name] arm was bruised... That same day, I pulled [Resident #3's	{D 438}		

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{D 438}	Continued From page 28 name] up to the breakfast table and she had a hard time lifting her arm up" to eat. -Resident #3 had complained of pain in the arm "just at breakfast" and the resident "didn't want to lift up her arm to eat." -"A good part of [the resident's] wrist was bruised. I can't remember about swelling." Confidential interview with a second Personal Care Aide revealed: -On 9/1/15 at breakfast, she noticed Resident #3 had a "reddish, purplish" bruise approximately 4 inches in length on her right forearm and it was swollen. -"I didn't remember seeing it the day before." -"If we raised her arm she would say it hurt." -The Personal Care Aide reported the bruising of Resident #3's arm to the Medication Aide covering that shift. -When the Personal Care Aide had asked staff from third shift about what had happened to Resident #3's arm, "They said they didn't know what had happened to her arm." Confidential interview with a third Personal Care Aide revealed: -She had worked second shift on the evening of 8/31/15 and she had not seen any bruising on Resident #3's arms when she helped the resident get into her pajamas for bed. -The next day on 9/1/15, Resident #3's right forearm "was swollen and she complained of pain." -"When we touched her arm, she would complain about the pain." Confidential interview with a Medication Aide revealed: -"I honestly don't know how [Resident #3] broke her arm."	{D 438}	Resident Care Manager has set up refresher training for all PCAs, CNAs, and Med Techs. The LHPS Nurse will revisit Skills Check List with each employee.	10/7/15 Ongoing

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{D 438}	Continued From page 29 -Resident #3 "didn't complain to us about pain in her arm. She doesn't tell me when she's in pain. She will tell her [family member], but not us." -"I didn't see the bruise. I just came in one day and it was wrapped-hadn't been casted yet." Interview with the Special Care Coordinator on 10/1/15 at 10:36am revealed: -She had not asked staff what had caused the bruising on Resident #3's arm. -She had assumed the resident had sustained the bruising on her arm because the resident had been "hitting the table with her arm" on 9/31/15. Telephone interview with Resident #3's family member on 10/1/15 at 11:45am revealed: -The Special Care Coordinator had notified the family member by phone on 9/1/15 at 11:09am about the bruising on Resident #3's right arm and that staff were unaware how it had occurred. -The family member had visited Resident #3 "later in the day to look at the wrist and it was obviously bruised." -Resident #3 "was holding [the arm]" during her visit. A second interview with the Special Care Coordinator (SCC) on 10/1/15 at 12:20pm revealed: -Staff had reported to her on 9/1/15 a "small area of bruising on [Resident #3's] right forearm" but "didn't say anything about swelling." -A Medication Aide had reported the injury to her and an incident report had been completed by the Medication Aide. -The Medication Aide who had reported the injury to her had stated "The resident had been hitting the table with her arm and swatting at staff...there you go." -She did not question staff regarding what	{D 438}		

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{D 438}	Continued From page 30 happened "leading up to the bruise" on Resident #3's arm. Review of Resident #3's record revealed no documented "Accident and Injury Report" dated 9/1/15 for the resident. Review of Resident #3's "Accident and Injury Report" dated 9/3/15 revealed: -"Resident was observed lying in the floor beside her bed." -Type of injury: bruising -Resident was taken to the local emergency room for evaluation on 9/3/15 at 5:30pm. -Diagnosis: ulnar fracture -Family member was contacted on 9/3/15 at 6:10pm. -A message was documented as left with the PCP on 9/3/15 at 6:15pm. Interview with the Executive Director on 10/1/15 at 12:45pm revealed: -"I vaguely remember [SCC's name] going to look at [Resident #3's name] before her arm was casted." -The SCC had informed him she had "seen bruising" on the Resident's arm and had reported it to Resident #3's PCP and family. -He had not submitted a Health Care Personnel Registry report for injury of unknown source for Resident #3, because he was unaware there was a question as to how the injury had occurred. -He planned to complete and fax in a Health Care Personnel Registry 24 Hour Initial Report for the injury of unknown source for Resident #3 immediately upon completion of our interview. _____ A plan of protection was received from the facility	{D 438}		

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{D 438}	Continued From page 31 on 10/1/15 and included: -The Executive Director completed a 24 Hour Report and faxed to Health Care Personnel Registry 10/1/15 regarding injury of unknown source. -The Executive Director will review with Care Management Staff appropriate time to complete 24 Hour/5 day report and notify Health Care Personnel Registry. -Executive Director will review all incident reports to ensure completion of Health Care Personnel Registry notification. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2015.	{D 438}	***The Ombudsman is scheduled to present on Resident Rights on December 22, 2015	12/22/15
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from neglect related to failure to provide supervision of a resident with dementia leading to elopement; notifying physician of elopement occurrences; notifying physician of bruising and pain for an injury of unknown origin, notifying a physician of a resident needing a higher level of care after failure of interventions to prevent repeated falls; and investigating and reporting an injury of unknown source to the Health Care Personnel Registry. The findings are:	{D914}	***An in-service was done on September 30 2015, the day of the inspection, that covered Resident Rights. Terry Spencer. MSW, LCSW at Smoky Mountain Center conducted this training. Mr. Spencer is the Geriatric and Adult Mental Health Specialty Team Manager. ***An in-service was conducted on October 7, 2015 by Dr. Lesassier dealing with Resident Rights. ***Resident Rights handouts were disseminated to staff. This topic of discussion is ongoing.	9/30/15 10/7/15 8/7/15 Ongoing

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{D914}	Continued From page 32 A. Based on observation, interview, and record review, the facility failed to assure 1 of 5 sampled residents (Resident #2) was adequately supervised in accordance with the resident's assessed needs. [Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision, (Type A2 Violation).] B. Based on observation, interview, and record review, the facility failed to notify the physician concerning 3 of 5 sampled residents related to elopement (Resident #2), bruising and swelling of a resident's forearm (Resident #3), and a resident needing a higher level of care (Resident #4). [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care, (Type A2 Violation).] C. Based on observation, interview, and record review, the facility failed to comply with G.S. 131E-256 and Rule 10A NCAC 13O.0102 by not reporting injury of unknown source to the Health Care Personnel Registry within 24 hours of an incident (Resident #3 had a fracture of the ulna with staff unaware how the injury occurred). [Refer to tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry, (Type B Violation).]	{D914}		

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