STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060154	A. BUILDING: _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTON HOUSE	4910 HARRIS WOODS BOULEVARD CHARLOTTE, NC 28269

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on July 2-3, 2018.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to respond to an incident in accordance with the facility's established policy and procedures for 1 of 3 residents sampled (Resident #5) as evidenced by failing to send resident (#5) to the hospital for medical evaluation after fall resulting in a head injury. The findings are: Review of Resident #5's current FL2- dated 04/13/18 revealed diagnoses included dementia, coronary artery disease (CAD), cerebrovascular accident (stroke), atrial fibrillation and hypertension. Interview on 07/02/18 at 11:10 am with the first shift MA revealed Resident #5 had fallen around 10:45 am, Resident #5 had been outside on the	D 271		

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patio and had fallen out of his wheel chair and hit his head.

Observation on 07/02/18 between 12:00 pm and 1:20 pm in the dining room area revealed:
-Resident #5 had a dressing to his forehead which appeared to be a gauge wrapped around the top of his head with extra gauge padding to the left side of his forehead.
-Resident #5's POA was present with the lunch meal.
-Resident #5 continued to lean to the right side during the lunch meal and the POA would assist him to an upright position.

Survey team requested on 07/02/18 at 11:15 am from the Director Resident #5's incident report and the notes for the fall that occurred on 07/02/18.

Survey team requested on 07/02/18 at 2:50 pm from the Director Resident #5's incident report and the notes for the fall that occurred on 07/02/18.

Survey team requested on 07/02/18 at 3:18 pm from the Director Resident #5's incident report and the notes for the fall that occurred on 07/02/18.

Survey team requested on 07/02/18 at 4:15 pm from the Director Resident #5's incident report and the notes for the fall that occurred on 07/02/18.

Interview on 07/02/18 at 4:40 pm with the facility director revealed:
-She was aware Resident #5 had fallen and hit his headed on 07/02/18.
-She was aware Emergency Medical Service

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(EMS) had applied the dressing to Resident #5's head.
-She was also a Registered Nurse and had not assessed the head injury to Resident #5 on 07/02/18.
-She relied on the MAs to assess Resident #5's head injury and to call EMS.
-The first shift MA had left the facility without completing the incident record or documenting in Resident #5 record the incident that occurred on 7/02/18.
-The facility policy was incident reports were to be completed when the incident had occurred.

Interview on 07/02/18 at 4:45 pm with the Assistant Director revealed:
-The Assistant Director and the Director were both in the facility when Resident #5 had fallen.
-She had notified the Director via text when Resident #5 had fallen and hit his head.
-The MA contacted EMS for Resident #5 after he had fallen.
-"We felt he [Resident #5] did not need to be seen by a doctor".
-The facility policy was incident reports are to be completed when the incident occurred.

Telephone interview on 07/02/18 at 4:55 pm with the Administrator revealed:
-"Our policy is, if a resident fall they are to be sent out to the ER for an evaluation."
-Incident reports are to be completed when an incident occurred.
-She was not aware Resident #5 was not sent to the ER to be evaluated after falling and hitting his head.
-She was not aware Resident #5 had a dressing to his head.

Review on 07/03/18 of an Accident/Incident

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Report for Resident #5 dated 07/02/18 revealed:
-The date and time of the incident was documented as 070/2/18 at 10:45 am.
-Documentation the diagnoses Alzheimer / dementia were the contributed to the incident.
-Documentation vital signs were obtained and EMS was contacted.
-Documentation the physician was contacted on 07/02/18 at 10:55 am.
-Documentation Resident #5's Power of Attorney (POA) was contacted on 07/02/18 at 10:55 am.
-The description of the incident included documentation Resident #5 was observed on the patio ground by the Medication Aide (MA) and the Personal Care Aide (PCA). Resident #5 had an abrasion to his forehead. First aid had been administered by EMS to the injury. Resident #5's Power of Attorney (POA) had refused transport to the ER per EMS. The facility staff would continue to monitor.
-Documentation first aide was administered on 07/02/18 at 11:17 am by EMS "wrap around his head."
-The Accident/Incident Report was signed by a Medication Aide on 07/02/18 and the facility Director on 07/03/2018.

Review of Resident #5's record revealed:
-There was a note dated 07/02/18 at 10:45 am as follows:
Resident #5 was observed on the patio ground by the MA and 2 PCAs. Resident #5 was assessed for an abrasion to his forehead. EMS was notified of the incident. Vitals signs were obtained by the facility staff. "EMS proceeded to instruct the MA on the next step." The POA and the facility physician were both notified. The POA refused for the resident to be transported to the hospital for an evaluation. EMS provided first aide to the injury. Resident #5 continued to sit

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unsteady in the wheelchair, staff transferred Resident #5 to a reclining chair for safety. Staff will continue to monitor and report changes.
-There was a late entry note one dated 07/03/18 at 8:00 am signed by the MA; Resident had been sitting at the table for lunch with the POA and acted appropriately to conversation. The Resident was transfer via two person assist from wheelchair to a reclining chair. Will continue to monitor [Resident #5] for level of consciousness.
-Another late entry on 07/03/18 at 8:45 am was written and signed by the Director; the PCA had informed her she and the MA were both outside on the patio with the residents on 07/02/18. The PCA had been transferring the residents to the outside patio. The MA had left the outside patio to get a medication for a resident. The MA passed the PCA in the doorway. When the PCA turned the corner Resident #5 was observed on the ground.

Telephone interview on 07/02/18 at 11:40 am and at 4:40 pm with Resident #5's POA revealed:
-The facility contacted her on 07/02/18 in regard to Resident #5 "falling and hitting his head".
-The facility had told her, "It was not bad."
-The POA said she told the facility staff "you tell me what to do?"
-She told the facility staff she would see Resident #5 at lunch.
-She relied on the facility staff to tell here if Resident #5 needed to be transported to the ER for evaluation.

Interview on 07/02/18 at 12:50 with Resident #5's POA revealed:
-The POA said Resident #5 was "not himself today".
-"He looked worse today."
-She was not aware of the dressing to Resident

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#5's forehead until she arrived at the facility on 07/02/18.
-She said Resident #5 had fallen a lot at a previous facility but only once at the current facility.

Interview on 07/02/18 at 3:40 pm with a second shift MA revealed:
-"When a resident falls the MAs are to do vital signs, call the family, and the physician."
-If the resident falls and hits their head they are to be sent out to the ER for an evaluation.
-EMS can assess the resident to see if the resident needed to go to the ER for an evaluation.
-If the family refused to send the resident to the ER then EMS will contact the family too and verify they are not to be transported to the ER.
-When the incident occurs you are to complete an incident report and give it to the director.

Interview on 07/03/18 at 8:20 am with a first shift MA revealed:
-She was not working on 07/02/18 but was aware Resident #5 had fallen and hit his head on 07/02/18.
-She was unsure why Resident #5 had not been transported to the ER for an evaluation.
-When an incident occurred an incident report is to be completed when it occurred.
-The facility policy is "If a resident falls and hit their head they are to go to the ER."

Interview on 07/03/18 at 1:00 pm with a Personal Care Aide (PCA) revealed:
-She had worked on 07/02/18 when Resident #5's had fallen.
-She had not been outside on the patio, but had stayed in the facility to clean the dining room tables.
-Another PCA had transported the residents

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outside "To get fresh air".
-The MA was outside in the patio area watching the residents.
-She heard someone yell, "Someone has gone down."
-She and two other staff had assisted Resident #5 off the floor.
-Resident #5 had hit his head and had an abrasion on the left side of his forehead.
-She stayed with Resident #5 while the MA called EMS.
-She heard the MA tell the EMS team the POA did not want Resident #5 sent out to the ER for evaluation.

Telephone interview on 07/03/18 at 1:35 pm with a MA revealed:
-She had worked as a MA on 07/02/18 when Resident #5 had fallen and hit his head.
-The PCA's had brought the residents outside on the patio and she was outside with them.
-A resident requested a medication so she had gone back into the facility to get the medication.
-One PCA had been in the dining room area cleaning the tables, and the other was turning the corner to go outside on the patio.
-The MA told the PCA that was going outside "I needed to get a medication for one of the residents."
-When the MA returned to the patio area, Resident #5 was on the ground.
-She yelled for help and two PCA's came and assisted Resident #5 up in the chair.
-The MA had known Resident #5 had hit his head when she had seen a red abrasion on the left side of his forehead.
-She had contacted Resident #5's POA and the physician.
-She told the physician Resident #5 had "scrapped his head" from the fall, the physician

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D 271	Continued From page 7 said she would see him on 07/03/18. -She contacted Resident #5's POA and informed her Resident #5's had fallen and hit his head. -"The POA wanted to know my opinion, I described what I saw to [Resident #5's] forehead". -The facility policy was to send a resident to the ER for evaluation if they had fallen and hit their head. -The POA said she would see Resident #5 at lunch on 07/02/18. -She informed EMS when they arrived at the facility the POA had refused for Resident #5 to be sent for evaluation to the ER. Attempted telephone interview on 07/03/18, 07/06/18 and on 07/16/18 with the local EMS were unsuccessful. Review of Resident #5's record revealed a care note by the regional Registered Nurse on 07/03/18 which included the following: Abrasion noted on left side of forehead. No drainage, no redness, no signs of infection. Vital signs were obtained, B/P 138/68, Pulse 62, Respiration 14, temperature 98.3. Resident #5 was at his normal baseline.	D 271		