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): 02-20-23, 03-07-23, 03-21-23
Purpose of Visit(s): Monitoring
Exit/Report Date: 04/12/23

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 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 facilities policies and procedures. Level of Non-Compliance: Type A1 Violation Findings: This rule is not met as evidenced by: Based on interviews and records reviews, the facility failed to respond immediately to a fall accident in accordance to their policies and procedures for 1 of 5 sampled residents (#2), a resident of the memory care unit (MCU), including moving the resident who was reporting pain, failing to call for emergency medical services or to provide immediate notification to the physician, resulting in the resident remaining in the facility for 10 hours before she was transferred to the hospital and diagnosed with a right hip fracture. The findings are: Review of the facility's Falls Management Policy dated 06/2022 revealed: -For the purposes of the policy, it was considered a fall when	☐ POC Accepted _____ *DSS Initials*	

a resident had any unplanned descent to the floor.
-Fall management was an important part of resident care and safety.
-After a fall, staff were to assess the resident for injury.
-If the resident had pain, the staff were not to move the resident and were to wait for a medical professional.
-If the resident had pain, staff were to call 911 to request emergency medical services (EMS).
-Staff were to immediately notify the residents physician of injury and provide information about assessment findings.

Review of Resident #2's current FL-2 dated 08/18/22 revealed:
-Diagnoses included Alzheimer's disease, atrial fibrillation, osteoporosis, and hypertension.
-Resident #2 required placement in the MCU.
-The resident was constantly disoriented, total care, and ambulated with a walker.

Review of Resident #2's Assessment and Care Plan dated 11/18/22 revealed the resident had limited mobility and balance issues.

Review of Resident #2's Accident/Incident Report dated 02/10/23 revealed:
-On 02/10/23 at 7:25pm Resident #2 had an unwitnessed fall.
-When staff found her, she was sitting on the floor beside her bed.
-The resident was complaining of pain on her bottom.
-There was an entry of no bruising, skin tears, or lacerations.
-There was an entry of a voicemail was left for the responsible party at 7:30pm and a fax being sent to the primary care provider (PCP) office at 9:42pm.

Review of Resident #2's 911 call log and audio recording dated 02/11/23 revealed:
-On 02/11/23 at 5:58am a facility Medication Aide (MA) called and requested EMS to come for a 92-year-old resident (#2) who "fell the night before around 7:30pm."
-The MA reported the resident's fall was unwitnessed and the resident started complaining of pain when she fell.
-The staff "got her up on her bed" because "we thought the resident was complaining of pain on her bottom because she had been sitting on the floor too long".
-The resident was now "screaming in agony".
-At 7:12am EMS arrived at the facility and the resident was transported to the hospital.

Review of Resident #2's electronic Medication Administration Record (MAR) dated February 2023 revealed:
-There was an entry for Acetaminophen 325mg 2 tablets by mouth to be administered every four hours as needed for pain or fever.
-Acetaminophen was documented as administered on February, 02/10/23 at 7:37pm, the only time it was administered in that month.
-The MAR "Notes" section stated the Acetaminophen was given to the resident for pain.

Review if Resident #2's handwritten progress notes dated February 2023 revealed:
-On 02/10/23 at 7:25pm, there was an entry Resident #2 had an unwitnessed fall.
-The resident was found sitting on the floor beside her bed, complaining of pain on her bottom.
-The residents vital signs were taken by staff.
-At 9:42 pm a fax was sent to the resident's PCP.
-On 02/11/22 at 6:00am, staff call EMS due to Resident #2 complaining of pain and the resident was transported to the hospital.
-On 02/12/23 Resident #2's family notified the staff that the resident had a right hip fracture.
-On 02/13/22 Resident #2's family notified the staff the resident was having hip surgery and would be going to a rehabilitation facility post-surgery.

Review of Resident #2's hospital discharge summary dated 02/17/23 revealed:
-On 02/11/23 Resident #2 was transported to the hospital by EMS.
-The 91-year-old resident was reported to have been found by staff on the ground the night before (02-10-23) after she had an unwitnessed fall.
-Resident #2 was admitted with a diagnosis of right femur intertrochanteric fracture and nonorganized hemorrhage within the adjacent soft tissue and musculature.
-Slightly more focal hemorrhage was present in the right lateral thigh.
-Resident #2 had orthopedic surgery for "fixation" of her right hip on 02/13/23 and was discharged to a rehabilitation facility on 02/17/23.

Interview with the Resident Care Director Registered Nurse (RCD RN) on 02/20/23 at 11:50am revealed:
-On 02/10/23 Resident #2 was found by staff sitting on her

bottom in her room.
-She was complaining of pain in her bottom
-The shift supervisor, the MA, and the Personal Care Aide (PCA) stood the resident up and walked her to her bed.
-The put her to bed and gave her Tylenol for her pain.
-The staff did not see any obvious signs of injury, so they did not call EMS.
-The resident was "complaining of pain" when she fell but she was not "crying out in pain" until the next morning.
-On the morning of 02/11/23 just before 6:00am, staff stood the resident up, got her out of bed, and began to walk her to the bathroom, at which time she began crying in pain.
-Staff only called for EMS when there was obvious injury or if it was known that a resident hit their head.
-Obvious signs of injury would be screaming in pain, blood, protruding bones, or if they saw bruising where a resident hit their head.
-There was nothing to indicate Resident #2 had a serious injury after her fall.
-Resident #2 always shuffled when she walked so even if staff had observed her shuffling when she walked, it would not have been an indicator of a problem for her.
-Sometimes residents might routinely say they have pain, so just because they might say that after a fall, did not mean that staff were to call EMS, because it had to be determined if it was a new pain or an old pain.
-As far as she knew, Resident #2 was not a resident that routinely reported pain.
-It was the decision of the shift SUPV and MA to determine if EMS should be called after a fall.
-The shift SUPV was also a MA.
-The staff did not call the physician's office to provide notification of the accident due to the physician preferring to receive information by fax.
-As far as she knew, the fax sent to the Resident #2's PCP office during the evening shift would not have been viewed until the PCP office reopened the morning after the fall.

Telephone interview with a MA on 02/22/23 at 9:06am revealed:
-On 02/10/23, the night of Resident #2's fall, she was working as an MA for the 7:00pm to 7:00am shift.
-She was passing medications at the time of Resident #2's fall.
-Two of the evening shift PCA's called out to her and told her to come because Resident #2 fell.

-She went to the Residents #2's room and found her on the floor.
-She started assessing the resident for injuries and when she rubbed her hand across the resident's hip and buttocks area, the resident said it hurt.
-The training she had on assessing for injury after a fall was to look for signs of something obvious and if they found symptoms like bleeding or if the resident hit their head, staff were to call EMS.
-She asked the Resident #2 if she hit her head and the resident said "No."
-She took the residents vitals and she and the two PCA staff assisted the resident up from the floor.
-The resident "didn't holler when we got her up, but she did say she was hurting."
-The resident took a few steps backward toward her bed and the MA "assumed she was kind of stumbling because of her bottom hurting."
-When she would rub her hand over the resident's bottom, she would say "owie" and "ouch"
-A PCA got the ready for bed and helped her lay down.
-The MA administered Tylenol to Resident #2 to help with her pain before she went to sleep.
-The resident had a routine of getting up and walking around during the night, but she stayed in bed that night.
-When PCA staff went in early that morning to get the resident up and dressed, she started hollering in pain.
-It was the responsibility of the MA to assess residents after a fall.
-She did not know what the falls policy stated about moving injured residents after a fall.
-Staff did not need anyone's permission to move them after a fall.
-Staff always provided notice of falls to the PCP by fax, even after hours.
-She had never gotten a response back from a PCP during evening shift, so if the physician responded, it was the next day during first shift.

Telephone interview with a PCA on 2/22/23 at 10:00am revealed:
-On 02/10/23 he worked the 7:00pm to 7:00am shift and he and another PCA found Resident #2 sitting on the floor beside

her bed around 7:30pm.
-She just "slipped off her bed and barely bumped the floor when she fell."
-"No one witnessed the fall but that's what I think happened."
-He and the other PCA called the MA and the shift supervisor to come to the resident's room.
-While the resident was still on the floor, she said she was hurting on her buttocks but "we didn't really think anything of it."
-Staff got the resident up from the floor and put her in her bed.
-It was the decision of the MA and the shift supervisor on duty to decide if it was ok to move the resident after she fell.
-Staff usually only called EMS for "head lacerations or if something could be broken."
-He was pretty sure staff checked the resident's vital signs and gave her something for pain.
-Resident #2 tried to get up about an hour later and just sat on the edge of her bed, which was not like her.
-Staff "recognized that every time the resident lifted off the bed she was crying out in pain."
-It was the resident's normal routine to walk around at night, but she didn't that night.
-She woke up about an hour after she went to sleep and she was in pain, but then she went back to sleep.
-The staff started thinking something might be wrong and were going to tell the morning shift to look out for her.
-He did not know what was in the facility's falls policy but it was "probably to call EMS if a resident hit the floor."

Interview with a PCA on 02/20/23 at 11:30pm revealed:
-MA's were responsible for resident assessments after falls unless it was during first shift, when the facility RCD RN was there and could do them.
-For an unwitnessed fall in the MCU staff did not do anything different than they would for a fall in Assisted Living Unit.
-For all falls, staff looked for obvious signs of injuries like blood, a head injury, protruding bones, back pain, or if it was unknown if the resident hit their head, and in these cases staff would call EMS.
-Notification of falls, with or without injury, was always provided to the PCP by fax, even if the PCP office was closed.
-She did not know what was in the falls policy but there was

probably a policy book in the RCD RN's office.

Interview with the Health Care Coordinator (HCC) on 3/7/23 at 1:52pm revealed:
-She and the facility's RCD RN were responsible for completing fall assessments when they were on duty.
-They were not working on the evening of 02/10/23 when Resident #2 fell, so the MA and shift supervisor on duty were responsible for Resident #2's fall assessment.
-When any resident had a fall, staff were to determine if anything looked out of place, if the resident was in pain, if they hit their head or suspicion or hitting their head, and if anything was red or bleeding.
-If they saw these obvious signs, they were to call EMS.
-After Resident #2's fall, staff faxed the PCP's office to provide notification the resident had fallen.
-Resident #2's PCP had an on-call after hours number, with someone always available, so there was no reason why staff should have been faxed the PCP's office instead of calling to report an injury.
-When Resident #2 was found on the floor, the PCA's on duty called for the MA to come to assess her.
-Any injury that called for anything besides first aid, the staff were not to treat, and they were to call EMS.
-Anytime a resident had a fall and there was any evidence they were having pain, EMS was to be called, "so yes, if the resident (#2) was hurting, EMS should have been called."
-The local EMS was known to "push back" about staff calling them frequently which might have caused some staff to have reservations about calling them.
-The staff should have called them to come and assess Resident #2 on the night of her fall (02-10-23).

Telephone interview with Resident #2's PCP Office Assistant on 03/15/23 at 3:15pm revealed:
-She worked as an assistant to Resident #2's PCP.
-The PCP's practice had an after-hours telephone number and all physicians rotated being available through the on-call service.
-The facility had been informed of the on-call number and that a physician was always available to them any time after the PCP's office closed.
-Based on her fax receipt, the facility faxed notification of Resident #2's fall to the PCP office on 02/10/23 at 10:51pm

and the office was closed.
-The faxed handwritten notification stated Resident #2 had an unwitnessed fall, was found on the floor beside her bed at 7:30pm, had no bruising, skin tears, or lacerations, and was "c/o of pain."
-She did not know what "c/o" meant unless it meant complaining of pain.
-On 02/10/23 between the hours of 5:00pm and 8:00am, an on-call PCP would have been available for the staff to speak with.
-If Resident #2 was hurting, the staff should have done something immediatelly instead of sending a fax to the closed office.

Telephone interview with Resident #2's PCP on 3/15/23 at 3:43pm revealed:
-She did not know a lot about what happened to Resident #2 on the evening of 02/10/23 when she was found on the floor, but staff had kind of filled her in later.
-Her office always had an after-hours on-call physician, sometimes it was her and sometimes it was other physicians, but there was always a physician available through the on-call center for urgent needs.
-If the on-call physician did not answer immediately for the call center, the call center would go down the list until they made contact with a physician.
-She had told the facility staff before, "If you don't know what to do about a situation with a resident, you can always call the on-call number."
-A physician definitely would have been available on the evening of 02/10/23 if the staff had called the on-call number.
-If Resident #2 had an unwitnessed fall and was having pain in her hip area, or any type of pain, she would want staff to notify her or the on-call physician.
-Besides the fact that the resident was experiencing the pain of a hip fracture that night, the staff's failure to respond immediately to get care for Resident #2's fracture, could have led to more serious medical complications such as internal bleeding.

Interview with the Executive Director (ED) on 02/20/23 at 12:30pm and 1:15pm revealed:
-She did not know what the facility falls policy was, but she would find out.

-She could get a copy of it from her corporate office.
-She preferred to review a copy of the falls policy before she commented on what her expectation of staff was for responding to unwitnessed falls in memory care.
-Staff always faxed notices to the physician's office, even in emergencies or if the PCP office was closed, because the PCP referred to receive notifications this way.
-MA's were responsible for injury assessments after an accident.
-The RCD RN could speak on what the staff were trained to look for during assessments.

Telephone interview with the ED on 03/15/23 at 11:32am revealed:
-She had received a copy of the falls policy from her corporate office.
-She had reviewed the policy and the information was being shared with staff.
-At the time of Resident #2's fall, staff did not immediately call the physician or EMS because they did not really think the resident was hurt, but they were now being in-serviced by the RCD RN and HCC of the policy requirements to do so if a resident had a fall and reported pain.
-On the night Resident #2 fell, (02-10-23), the reason the staff faxed the PCP office instead of calling was because the PCP preferred this, but now they were to call the on-call number to provide immediately notification and then fax the information to the PCP office.

Attempted telephone interviews with Resident #2's Power of Attorney (POA) revealed the telephone number was disconnected.

Attempted telephone interviews with the shift supervisor revealed she was not available for interview.

The facility failed to immediately respond to Resident #2's fall by immobilizing the resident who was reporting pain, calling EMS to come and evaluate, or providing immediate notification to the PCP of the fall with injury. Staff facilitated getting the resident up from the floor to stand and walk, gave her an as need pain medication, and placed her in bed, failing to respond to her needs until over 10 hours later, when the

resident was reported to be screaming in agony and was transported to the hospital where she was diagnosed with a right hip fracture. The facility's failure resulting 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 03/07/23. THE CORRECTIVE DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 05/12/23.		

IV. Delivered Via:	Certified mail and electronic mail	Date: 04/12/23
DSS Signature:	Jennifer Robinson	Return to DSS By: **05-03-23**

V. CAR Received by:	Administrator/Designee (print name): Ann Worley	
	Signature: X	Date:04/12/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

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

☐ *POC Not Accepted*	By:	Date:
Comments:		
☐ *POC Accepted*	By:	Date:
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.*