Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Seasons at Southpoint
Address: 1002 East Highway 54 Durham NC 27713
County: Durham
License Number: HAL-032-109

II. Dates of Visits: 8/21/23, 8/28/23, 9/11/23
Purpose of Visits: Complaint Investigation
Exit/Report Date: 10/9/2023

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 (C) Personal Care and Supervision Rule/Statutory Reference: (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. Level of Non-Compliance: A1 Violation **This rule is not met as evidenced by:** **Based on observations, interviews, and record reviews the facility failed to ensure 1 of 5 sampled residents who had a fall and related to a resident who had a fall and sustained a fractured left hip and was not sent to the hospital in a timely manner.** The findings are: Review of the facility's fall policy dated 05/01/23 revealed: -The initial evaluation conducted by the first responding associate, or designee, for possible injury, including obtaining vital signs, evaluating for pain, responsiveness, and movement. -911 or emergency personnel may be called when obvious deformity, the resident has hit her/his head during the fall	☐ POC Accepted _____ *DSS Initials*	

regardless of hospice status, the resident and/or their responsible party requests emergency assistance, staff believe that calling emergency personnel would be in the resident's best interest, or uncontrolled bleeding.

Review of Resident #1's FL2 dated 05/03/23 revealed:
-Diagnoses included urinary tract Infection (UTI), depression, anxiety, hypertension, hyperlipidemia, dementia, and falls.
-Resident #1 was ambulatory.
-Resident #1 was constantly disoriented.

Review of the facility incident form for Resident #1 dated 08/06/23 revealed:
-The blood pressure, (BP), pulse, and respiration was checked on 08/06/23 at 9:16 p.m.
-BP was 112/74, pulse 68 and respiration was 18.
-Description of incident states: Hospice Social Worker came to the facility to visit with the resident. Resident #1 was noted to be on the floor by her bed. The Hospice Social Worker assessed the resident, no injury was noted.

Review of the Emergency Medical Services records revealed:
- Resident #1 had fallen off the bed and was under it.
-The staff reported Resident #1 was stuck there until staff helped her out and placed her on the bed.
-The resident #1 had a hematoma to the left temporal of her head and had complained of hip pain.
-Call was received at 1:04 a.m. on 08/07/23.
-Call was dispatched at 1:06 a.m. on 08/07/23.
-EMS was on scene at 1:10 a.m. on 08/07/23.
-EMS arrived at the patient at 1:15 a.m. on 08/07/23.
-EMS transported Resident #1 to the hospital at 1:43 a.m. on 08/07/23.

Review of Resident #1's hospital discharge summary dated 08/07/23 revealed:
-She was admitted to the hospital on 08/07/2023.
-An X-Ray of left hip was completed on 08/07/23 at 3:48 a.m.
-Resident #1 had a fractured left femur near the hip.
-The decision was not to pursue surgical intervention but to focus on symptom management.
-She was discharged to inpatient hospice on 08/09/23 for ongoing management of pain and agitation.

Interview with a Hospice Social Worker on 08/21/23 at 10:31 a.m. about the incident on 08/06/23 revealed:
-She made a visit after 5:00 p.m. on a weekend to the facility to see Resident #1 and other residents.
-She took her personal car key, turned the latch on the door

knob, and unlocked Resident #1's door which was locked.
-Resident #1 was on the floor with only her pull-up on.
-Her head was under the mattress and her hair was stuck in the metal frame.
-She did not witness any bruises.
-Staff could not tell her how long Resident #1 was there.
-Resident #1 made facial expressions that looked like she was in pain.
-Resident's #1 body was shaking.
-She called the on-call hospice nurse and informed her of the fall.
-She was not informed by the on-call hospice nurse to send Resident #1 to the hospital.
-She waited until Resident #1 was picked up off the floor and placed into the bed before she left.
-Resident #1 was falling asleep in the bed when she left.
-She got a call later that night that Resident #1 was sent to the hospital because she was still in pain.

Interview with the Wellness Director on 08/21/23 at 1:09pm revealed:
-There was no video surveillance in the facility.
-The policy was for staff to check on residents every 2 hours.
-Residents could lock their door from the inside of the room and come and go as they pleased.
-She was told that Resident #1 complained of pain after her fall on 08/06/23.

Interview with the Licensed Practical Nurse (LPN) on 08/24/23 at 4:00 p.m. revealed:
-She "laid eyes" on Resident #1 between 10:30p.m.-11:00 p.m. on 08/06/23 to provide incontinence care.
-She could not provide incontinence care to Resident #1 because she was stating that she was in pain.
-Resident #1 was given Morphine (used to treat moderate to severe pain) around 11:00 p.m.
-Resident #1 was still in pain after 30 minutes of being given Morphine, so the hospice nurse, Emergency Medical Services and Resident #1's family member were called.
-She observed that Resident #1 had a protrusion of the left hip
-She may have called 911 at 1:04 a.m. in the morning of 08/07/23 instead of the time she reported prior and 1:04 a.m. sounds like a more accurate time.

Interview with a Lead Personal Care Aide (PCA) on 08/24/23 at 4:30 p.m. revealed:
-She went into Resident #1's room at 5:45pm and the resident was in bed and had her eyes closed.
-Hospice Social Worker told her that Resident #1 had fallen.

-She found Resident #1 on 08/06/23 between 6:30 p.m. and 6:45 p.m. under the bed, was on her back with her knees up, and half her body was under the bed.
-She had to lift the bed to get Resident #1out from under the bed and her hair was between the holes of the spring.
-She pushed her hair through the holes, but it was not tangled in the springs.
-She was not sure if the Resident #1's door was locked.
-Resident #1 said that her back was hurting after they sat her up.
-She got a Medication Aide (MA) to assist the resident off the floor and she went and took care of other residents.

Interview with a PCA on 08/24/23 at 5:00 p.m. revealed:
- The MA was angry because the PCA did not tell her that Resident #1 was on the floor.
-She observed Resident #1's hematoma and bone of her left hip protruding after she was found.
-Resident #1 complained about hip pain in the past and she expressed that she was in constant pain.
-She would tell other staff about Resident #1 expressing that she was in pain, but staff members said that Resident #1 always complained of pain.
-She did not work on that hall that night and she did not know who picked Resident #1 off the floor or called for help.

Interview with a Lead MA on 08/24/23 at 8:00 p.m. revealed:
-When she got to work at 7:00 p.m., Resident #1 was sitting up on the floor alone in her room and the Hospice Social Worker was visiting another resident.
-She got Resident #1 off the floor and put her into the bed.
-After she put Resident #1 in the bed, she left the room and was working with other residents.
- Resident #1 said that she had back pain after the incident.
-She observed the knot on the Resident #1's head after the incident.
-She rubbed Resident #1's left hip, and she felt the bone protrusion later that night when Resident #1 was complaining of pain.
-She informed the facility LPN to come and evaluate Resident #1.
-The LPN called hospice, the family, and 911.

Interview with a second LPN on 08/25/23 at 10:30 a.m. about the incident on 08/06/23 revealed:
-The hospice Social Worker came and told her about Resident #1 being on the floor in her room.
-She went into the room and observed Resident #1 in the bed.
-She took vital signs at 9:16 p.m.

-She did not observe any injury at that time.
-She attempted to contact a family member.
-She did not call Resident #1 primary care provider since the hospice Social Worker contacted their nurse on call.

Interview with a second PCA on 08/25/23 at 11:12 a.m. revealed:
-The incident had already occurred when she arrived at work at 7:00 p.m. on 08/06/23.
-She observed Resident #1 in bed, a knot on Resident #1's head, and she saw a protrusion on the side of her left hip.
-The hospice social worker was in the room when she arrived.
-She did not report because she thought other staff handled the situation.

Interview with the Wellness Director on 08/28/23 at 4:00 p.m. revealed:
-She was not aware of the time frames and response times of the staff for Resident #1.
- Interventions for frequent falls were to add PT/OT, use high low mats, and the hospice nurse could determine if the resident needed interventions.
-The PCP should be notified with every fall.

Interview with Director of Operations on 09/08/23 at 9:00 a.m. revealed:
-Resident #1 was admitted to hospice on 05/07/23.
-The reason for admission was diagnoses of senile degeneration of the brain, muscle weakness, and history of urinary tract infections.
-The hospice Social Worker contacted the Clinical Manager at the scene about a fall on 08/06/23.
- The facility staff did not call the nurse with hospice because the hospice Social Worker had already called and told her of the situation on 08/06/23.

A second interview with the LPN on 09/08/23. revealed:
-Staff came and got her and said Resident # 1 was screaming and crying in pain.
-She went to Resident #1's room between 11:30 p.m. – 12:00 a.m.
-Resident #1 was in bed and was in physical pain.
-She saw the protrusion of the left hip when Resident #1 kicked the sheets off of her.
-She gave Resident #1 Morphine around 11:30 p.m. – 12:00 a.m.
-After 30 to 45 minutes. There was no relief in Resident #1's level of pain.
-She called the on-call hospice nurse and called 911.

-She did not know why the staff did not call 911 sooner and she would have called earlier if it was her.
-Other staff thought the hospice Social Worker was a nurse.

A second interview with Lead MA on 09/08/23 at 10:00 p.m. revealed:
-She did not know why Resident #1 was still on the floor when she came into the room.
-She assumed the hospice Social Worker was a nurse.
-She rubbed Resident #1's leg and back because of her pain and felt the bone of her left hip.
-She observed a hematoma on her head.
-Resident #1 was acting differently, and she went and got a nurse.
-There was a lot of missed communication that day of the incident.
-Other staff said they checked on Resident #1, and she looked okay.
-Resident #1 verbalized that she was in pain.
-She did not remember the time the morphine was given or when 911 was called because the LPN called 911.

A second interview with the Operations Manager on 09/11/23 at 3:00 p.m. revealed:
-The hospice Social Worker stated that she observed Resident #1 ten minutes prior to calling the Clinical Manager.
-It was documented that the hospice Social Worker called the Clinical Manager at 7:36 p.m. and there were no notes about sending Resident #1 to the emergency room.
-The hospice Social Worker noted Resident #1 had her hair tangled in the bed frame and she was in pain.
-The hospice Social Worker noted that Resident #1 had a red mark above her butt area.

A third interview with the Operations Manager on 09/14/23 at 4:00 p.m. revealed:
- The family wanted the hospice doctor to be notified about any falls or incidents and not her PCP.
-Facility staff called the hospice triage number at 11:00 p.m. saying that there was a fall, and they were sending Resident #1 to the hospital.

Review of the hospice records for Resident #1 revealed:
-Resident #1 was admitted to inpatient hospice on 08/09/23.
-Resident #1 had a recent fall in which she sustained a left hip intertrochanteric fracture.
-The decision by family was not to pursue surgery and to focus on comfort measures.
-The resident passed away on 08/13/23.

Facility Name:

Review of the death certificate for Resident #1 on 08/29/23. revealed: -The date of death was 08/13/23. -The cause of death was from complication of a hip fracture. _____ The facility failed to send Resident #1 to the hospital after a fall. Resident #1 had an unwitnessed fall on 08/06/23 between 5:45p.m. and 7:26 p.m., had a visible hematoma on her forehead, left hip protrusion, and she verbalized to staff that she was in pain. The facility staff did not call 911 until 1:04 a.m. on 08/07/23, resulting in a delay in medical treatment for a left femur hip fracture for Resident #1. This failure resulted in serious harm and death which constitutes a Type A1 violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/28/23 for this violation.		

IV. Delivered Via:	Hand Delivered	Date: 10/9/23
DSS Signature:	Erin Perez *Erin Perez*	Return by: 10/27/23

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

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:		

Facility Name:

☐ ***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.*			