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 07/17/2015

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 biennial, follow-up survey, and complaint investigation from 07/14/15 to 07/15/15, with an exit conference via telephone on 07/17/15.	D 000		
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: TYPE A1 VIOLATION Based on record review and interviews the facility failed to assure referral and follow-up for one of four sampled residents with falls, (Resident #6), by not sending the resident out for medical evaluation after an unwitnessed fall. The findings are: Review of Resident #6's current FL2 dated 01/06/15 revealed: - Resident #6 had diagnoses that included Alzheimer's disease. - The resident was intermittently disoriented. - The resident was independent with ambulation and used a walker. Review of Resident #6's profile on admission to the Special Care Unit on 01/06/15 revealed: - The resident was independent with walking and	D 273		

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D 273	Continued From page 1	D 273		

transfers but used a walker.
- No history of falls.

Review of Resident #6's quarterly Licensed Health Professional Support evaluation dated 05/07/15 revealed the resident ambulated without difficulty using a walker.

Review of the resident's quarterly care plan, updated 06/30/15, revealed no change in ambulation or transfer abilities.

Review of an Accident/Injury Report dated 07/06/15 at 2:30am revealed:
- Resident #6 was found "on bottom sitting against bed".
- Unwitnessed.
- The resident was helped back to bed.
- Vital signs: BP-160/70, pulse-52, and respirations-18.
- No injuries present.
- No first aid.
- "left message" was checked for notification of physician and family member.
- Name of person preparing report [Staff A], (Medication Aide/Supervisor).

Review of an incident report dated 07/06/15 at 5:20am revealed:
- Resident #6 was "found in bed unresponsive and vomiting".
- No injury present.
- Resident was transported to a local hospital.
- "left message" was checked for notification of physician and family member.
- Name of person preparing report [Staff A].

Review of the hospital Admission and Discharge summary dated 07/06/15 revealed:
- Resident #6 was unresponsive and admitted for

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D 273	Continued From page 2 further evaluation. - The resident had mild dyspnea (labored breathing), regular heart rate and rhythm. - A computed tomography scan (an imaging test that creates detailed images) of the brain showed: "huge left hemispheric parenchymal hemorrhage; midline shift of brain due to hematoma." - The resident was placed on comfort measures and expired 07/07/15 at 3:35am. A telephone interview conducted on 07/15/15 at 3:00pm and 07/16/15 at 11:45am, respectively, with Staff B (Personal Care Aide who had discovered Resident #6 had fallen) revealed: - Staff B found the resident "sitting up on the floor, towards the foot of the bed... close to a chair ...kind of slumped over". - The resident said "she was OK... talked to us...said she just fell". - Staff B said she informed the supervisor (Staff A, who was in charge that night). - Staff A came in the room and asked the resident if she was OK, told Staff B to put the resident back to bed and check vital signs. - Staff B checked the resident and "she seemed fine". - Staff B stated Staff A found Resident #6 later that morning around 5:30am, in bed, unresponsive and had called 911. - The resident "had vomited some...was breathing/gurgling some". - The resident was rolled onto her side and her clothes were changed while waiting for EMS to arrive. - Staff B stated the facility's fall protocol was to never move a resident, get the Supervisor (who was supposed to check the resident), then proceed as directed.	D 273		

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D 273	Continued From page 3 A telephone interview conducted on 07/16/15 at 11:30am with Staff C (Personal Care Aide who worked the night of Resident #6's fall) revealed: - Staff C had only worked at the facility "about 2 weeks" as a Personal Care Aide. - Resident #6 was ambulatory and was not known to fall. - Staff C had not witnessed the fall but had been called to the resident's room by Staff B around 2:30am. - Staff C stated Resident #6 was on the floor, lying on her right side/hip and said "I am trying to get up." - The resident "sat up and we went and got [Staff A]". - "[Staff A] told us to check the resident's vital signs and put her back to bed". - The resident "grabbed her walker...stood on her own... we checked her over...no visible injures....then I saw a bruise on her right side/rib area... she was coherent." - Later around 5:30am, Staff C overheard Staff B saying something about Resident #6 and 911 having been called. By the time she got to the resident's room, the resident was "gurgling...clammy and cold...labored breathing....looked like she had vomited." - Staff C stated they rolled the resident on her side and the resident vomited more. - Staff C stated the facility's protocol for falls was to never move a resident until the Supervisor had checked the resident for injuries, if the fall had not been witnessed, 911 should be called and the resident "automatically sent out". Numerous attempts were made to reach Staff A by telephone, all were unsuccessful. Review of the facility's Fall Policy (no date) revealed in part:	D 273		

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D 273	Continued From page 4 - Assess the resident. - If injury is apparent or possible, do not move the resident. - Call 911, if necessary. Joint interview with the Administrator and the Regional Director of Operations (RDO) on 07/15/15 at 9:30am revealed: - Staff were expected to automatically send residents out for medical evaluation for any head injury, anytime a resident's head was hit during a fall, or any unwitnessed fall. - All staff were expected to know to send a resident out when a fall was unwitnessed because this information was received upon hire, during orientation and discussed routinely every two weeks during stand up meetings. - Staff A had not followed the facility's fall protocol and failed to send Resident #6 out as the fall was unwitnessed. - Neglect was not considered, just a "bad decision" on Staff A's part. - Staff A had been removed from the Supervisor position immediately after the incident and had left employment soon thereafter. - Per the facility's Employee Safety Responsibilities, a resident should never be moved until evaluated by a nurse or Emergency Medical Person. Review of Employee Safety Responsibilities revealed in part: - When a fall occurs, no one should help him/her get up until a nurse or an EMT (Emergency Medical Technician from a 911 call) has assessed for injuries. - Staff A had signed and dated the Employee Safety Responsibilities on 01/12/15 verifying he had read and understood the rules listed above.	D 273		

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D 273	Continued From page 5 Random interviews were conducted with numerous staff on all three shifts both days of the survey. All staff verbalized the correct protocol regarding facility's fall policy. A Plan of Protection was submitted by the facility on July 15, 2015 that included: - Staff A was immediately removed from the Supervisor position after the incident and was no longer employed at the facility. - On July 07, 2015, all staff were inserviced on the Falls Policy regarding calling 911 for all unwitnessed falls or witnessed falls resulting in injury requiring more than first aide. - The Fall Policy will be reviewed daily at stand up meetings on each shift. - All falls must be reported to the ED or Care Manager immediately. - The Ombudsman will be scheduled regarding Resident's Rights Training and an inservice covering falls in the elderly will be completed. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 16, 2015.	D 273		
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: Based on interviews the facility failed to comply with G.S. 131E-256 and Rule 10A NCAC 130	D 438		

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D 438	Continued From page 6 .0102 by not reporting neglect by a staff member to the Health Care Personnel Registry within 24 hours of an incident. (Staff A neglected to send Resident #6 out for medical evaluation after an unwitnessed fall). The findings are: Review of an Resident #6's current FL2, dated 01/06/15, revealed: - Resident #6 had diagnoses that included Alzheimer's disease. - The resident was intermittently disoriented. - The resident was independent with ambulation and used a walker. Review of an Accident/Injury Report dated 07/06/15 at 2:30am revealed: - Resident #6 was found "on bottom sitting against bed". - Unwitnessed. - The resident was helped back to bed. - Vital signs: BP-160/70, pulse-52, and respirations-18. - No injuries present. - No first aid. - Message left with family member and physician. - Name of person preparing report [Staff A], (Medication Aide/Supervisor). Review of an incident report dated 07/06/15 at 5:20am revealed: - Resident #6 was "found in bed unresponsive and vomiting". - No injury present. - Resident was transported to the local hospital. - Name of person preparing report [Staff A]. Review of the hospital Admission and Discharge summary dated 07/06/15 revealed:	D 438		

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D 438	Continued From page 7 - Resident #6 was unresponsive and admitted for further evaluation. - The resident had mild dyspnea (labored breathing), regular heart rate and rhythm. - A computed tomography scan (an imaging test that creates detailed images) of the brain showed: "huge left hemispheric parenchymal hemorrhage; midline shift of brain due to hematoma." - The resident was placed on comfort measures and expired 07/07/15 at 3:35am. Review of the facility's Fall Policy (no date) revealed in part: - Assess the resident. - If injury is apparent or possible, do not move the resident. - Call 911, if necessary. Interviews with the Administrator and the Regional Director of Operations (RDO) on 07/15/15 at 9:30am and 3:30pm respectively, revealed: - Staff were expected to automatically send residents out for medical evaluation for any head injury, anytime a resident's head was hit during a fall, or any unwitnessed fall. - All staff were expected to know to send a resident out when a fall was unwitnessed because this information was received upon hire, during orientation and discussed routinely every two weeks during stand up meetings. - If a fall was not witnessed, EMS (Emergency Medical Service) needed to check the resident and determine whether they need treatment. - Staff A had not followed the fall policy and failed to send Resident #6 out as the fall was unwitnessed. - Neglect was not considered, just a "bad decision" on Staff A's part and had not been	D 438		

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D 438	Continued From page 8 reported to the HCPR for neglect.	D 438		
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 interview and record review, the facility failed to assure that Resident #6 was free from neglect related to residents' rights and failed to send the resident out for medical evaluation after an unwitnessed fall per the facility's fall protocol. The findings are: Based on record review and interviews the facility failed to assure referral and follow-up for one of four sampled residents with falls, (Resident #6), by not sending the resident out for medical evaluation after an unwitnessed fall. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care Referral and Follow-up (Type A1 Violation).]	D914		