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	345160	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

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E 000	Initial Comments A recertification survey and complaint investigation was conducted on 08/01/22 through 08/09/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # QLX011.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 08/01/22 through 08/09/22. Event ID # QLX011. The following intakes were investigated: NC00187053, NC00191426, NC00187264, NC00186908, NC00189522, and NC00191832. 2 of the 13 complaint allegations were substantiated with deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 scope and severity (J). Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy for F689 began on 07/12/22 and was removed on 08/06/22. An extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		8/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/26/2022

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with facility staff, Physician, Psychiatric Physician's Assistant (Psych PA), and observations, the facility failed to protect a resident with severe cognitive impairment from a hazardous environment when a resident wrapped a call light cord around her neck and tied the cord in a knot on three separate occasions (04/29/22, 07/12/22 and 07/22/22) for 1 of 7 residents reviewed for accidents (Resident #11). This deficient practice placed Resident #11 at risk for asphyxiation (deprivation of oxygen) which can result in loss of consciousness, brain injury, or death. Immediate Jeopardy began on 7/12/22 when Resident #11 was observed with the call bell cord wrapped loosely around her neck and tied in a knot. The Immediate Jeopardy was removed on 8/6/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring systems are education put into place are effective. The findings included: Resident #11 was admitted to the facility on 11/18/21 with diagnoses to include dementia without behavioral disturbance, mild intellectual disabilities, and depression. Review of the electronic medical record (EMR) for Resident #11 revealed she was admitted to Hospice services on 4/11/22 with a diagnosis of	F 689	Davis Healthcare Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Davis Healthcare Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Davis Healthcare Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F689 Resident #11 is in a private room. Call bell was immediately removed by the Social Worker upon identification by surveyor on 8/3/22. Room assessment was completed on 8/4/22 at 115 pm to identify any other potential accident hazards in room. This included modification of all other cords in room (bathroom cord and bed control cord) to ensure ability to use with a length short enough to prevent ability to wrap around neck. No other hazard beyond the cords were observed during the assessment. This task was completed on	

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F 689	Continued From page 2 senile dementia. Further review of Resident #11's EMR revealed she had a fall on 4/19/22 and was diagnosed with a left and right sinus fracture. Review of Resident #11's quarterly Minimum Data Set assessment dated 7/18/22 revealed she was severely cognitively impaired. She required extensive assist of 1 staff with activities of daily living (ADL). Resident #11 required extensive assistance of 1 staff with bed mobility, and toilet use. She required limited assistance of 1 staff for mobility and was occasionally incontinent of urine. a. A nurse progress note dated 4/29/22 at 5:01 PM by Nurse #1 revealed she was called to Resident #11's room by a nurse aide (NA). She observed Resident #11 with the call bell cord loosely wrapped around her neck with 2 knots in it. The call bell cord was removed from the room and an alternate call bell was provided. Review of the electronic medical record (EMR) revealed a physician's order dated 5/4/22 to obtain a psych consult. A psychiatric evaluation for Resident #11 was conducted on 5/5/22 by the Psych PA. The Psych PA assessment revealed Resident #11's suicidal ideation was now resolved however had suicide attempt over the weekend without true intention to harm herself. She indicated Resident #11 was in a secured nursing facility, with licensed clinical staff so no safety concerns were identified. The Psychiatric PA recommended antidepressant, antianxiety medication, and antipsychotic medication changes and she would follow-up in 2-4 weeks as needed. Review of the care plan (last reviewed on	F 689	8/4/22 at 130 pm. An audit was conducted on 8/4/22 to identify residents who triggered for severe cognitive impairment on the current MDS 802. 73 residents were identified as having severe cognitive impairment. The audit was conducted by the administrator and Director of Nursing. The resident environments were assessed by the Nurse Educator, staff nurse and social worker and was completed by end of business day 8/5/22. The community Nurse educator initiated training on identifying and removing hazards in the environment of cognitively impaired residents. Education included supervision of residents to avoid accidents and hazards and extended to 100% employees against payroll. The majority of employees were educated by the end of business day August 5, 2022 and contract and PRN staff were educated at or prior to reporting to next work shift. An audit has been put in place to identify potential accidents/hazards in resident rooms. Five residents identified as being cognitively impaired per day are being audited by DON, Administrator, or designee daily for three weeks and then weekly for three weeks. The results of this audit will be reviewed by the QA committee for further action.	

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7/30/22) for Resident #11, revealed a plan of care dated 5/10/22 for resident unsafe with call bell, wraps cord around neck at times with one intervention: to provide resident with manual bell for call bell usage and ensure manual bell is within reach.

A psychiatric periodic evaluation for Resident #11 was conducted on 5/19/22 by the Psych PA. The Psych PA indicated the call bell cord was still removed from Resident #11's room. The Psych PA's mental status examination revealed Resident #11 had poor judgement and was no longer having suicidal ideations. The Psych PA indicated in the recommendations that she would allow Resident #11 to have her call bell cord back at this time.

A psychiatric periodic examination was conducted on 5/31/22 by the Psych PA. The Psych PA indicated Resident #11 was very happy to have her call bell cord back. The Psych PA revealed that the facility nursing staff reported Resident #11 used her call bell frequently and there had been no issues with it. The Psych PA indicated Resident #11 was not experiencing suicidal ideations anymore. The Psych PA revealed in the recommendations that she would allow Resident #11 to have her call bell back at this time.

b. A nurse progress note dated 7/12/22 at 6:50 AM by Nurse #2 revealed she had observed the call bell was wrapped loosely around Resident #11's neck and tied in a knot when she entered the room. Nurse #2 indicated she had telephoned the Psych PA and they agreed Resident #11 was displaying attention-seeking behaviors and was not at risk of self-harm at this time. The call bell cord was not removed from Resident #11's room

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by Nurse #2. There were no new interventions initiated to monitor Resident #11 more closely by the facility or the Psych PA.

A psychiatric periodic evaluation was conducted by the Psych PA on 7/12/22. The Psych PA's history of present illness indicated Resident #11 had placed the call bell cord around her neck that morning. The Psych PA revealed Resident #11 denied any suicidal ideations and denied she had made any attempts on taking her own life. The Psych PA further revealed that Resident #11 continued to have very loose and vague suicidal threats, that she uses for attention seeking. The Psych PA indicated in the recommendations that she did not feel that Resident #11 needed any suicide monitoring or precautions at this time, and she felt these were attention seeking behaviors and there was no danger to self at the time.

c. A nursing progress noted dated 7/22/22 at 6:27 PM by Nurse #1 revealed Resident #11 was observed with the call bell cord loosely wrapped around her neck with a knot in it. Resident #11 was also observed with the bathroom call cords wrapped around her neck. Nurse #1 revealed she had received a telephone order from the Hospice Physician to administer Resident #11 an antianxiety medication by injection. Nurse #1 indicated in the progress note that Resident #11 had been inconsolable all day and needed to see someone about her trying to kill herself. The call bell cord was removed by the Director of Nursing (DON) and replaced with a manual call bell.

An interview with the DON on occurred on 8/4/22 at 8:55 Am. She stated that she had removed the call bell cord from Resident #11's room on 7/22/22. She stated that she had removed the call

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bell cord from the room because it was on a Friday, and she thought that was the best thing to do over the weekend.

A psychiatric periodic evaluation was conducted by the Psych PA on 7/26/22. The Psych PA indicated she had once again been asked to see Resident #11 due to continued behaviors that appear to be suicide attempts. The Psych PA indicated Resident #11 was continuing to wrap the call bell cord around her neck, and then remove when staff entered the room. The Psych PA notes revealed Resident #11 at first denied that she was trying to kill herself by wrapping the call bell cord around her head, but later made a comment that she wished she was dead. The Psych PA indicated that Resident #11 reported she no longer plans to use the cord, and was told if she does, it will be taken away. The Psychiatric PA's assessment revealed Resident #11 continues to make suicidal comments, but no plan, for attention mostly. The Psych PA's recommendation for Resident #11 indicated that she did not need any suicide monitoring or precautions at this time because she felt this was attention seeking behavior and there was no danger to herself at this time. The DON removed the call bell from Resident #11's room and replaced it with a manual bell.

An observation of Resident #11 on 8/3/22 at 8:55 AM revealed an approximately 6-foot-long call bell cord in her bed within reach. The cord for the electric bed control was noted beside bed and within reach of Resident #11. Resident #11's bathroom was observed to have an emergency cord in it and a shower cord.

An interview with Nurse #1 was conducted on

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8/3/22 at 09:20 AM. She stated she knew Resident #11 and her family and that these behaviors were attention seeking. She stated Resident #11 had other attention seeking behaviors such as hollering and shaking the bed rails. She stated the call bell cord had been removed from the room on 4/29/22 and 7/22/22 and replaced with a manual call bell. She further stated she didn't know who had given Resident #11 the call bell cord back. She indicated on 7/22/22, Resident #11 was saying she wanted to die, and she wished the place would burn down or she would have a heart attack. She stated Resident #11 was able to wheel herself into the bathroom and transfer on to the toilet. She further stated Resident #11 required assistance with transferring back to the wheelchair.

A telephone interview was conducted the Psych PA on 8/3/22 at 10:50 AM. She stated she had not given Resident #11 her call bell cord back. She stated when she saw Resident #11 on 7/26/22 the call bell cord was already back in her room. She further stated Resident #11 was not suicidal when she interviewed her. The Psych PA indicated Resident #11 was attention seeking and she didn't think she would harm herself. She stated it was up to the facility to decide if the call bell cord should remain in Resident #11's room.

A telephone interview was conducted on 8/3/22 at 11: 10 AM with a Physician in Resident #11's primary care physician's office. The Physician stated Resident #11's primary care physician was on vacation this week. The Physician indicated she was familiar with Resident #11 and had seen her twice. She stated she had been on call for one of the incidents involving the call bell cord. She stated that Resident #11 had severe

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dementia and poor judgement. She further stated the facility and Psych PA should not have depended on the Resident to make good decisions or trusted her judgment. She further stated that removing the call bell cords from the room was the facility's decision because they knew Resident #11 the best.

An observation and interview with Resident #11 on 8/3/22 at 11:32 revealed she was sitting on the toilet in the bathroom with the wheelchair beside her. Resident #11's speech was difficult to understand because she has had a stroke and she is edentulous (no teeth). She indicated that she had gotten herself to the bathroom and transferred to the toilet by herself.

An interview with Nurse #2 occurred on 08/4/22 at 11:55 AM. She stated that she had observed Resident #11 with a call bell cord wrapped loosely around her neck with a knot in it. She further stated that she had immediately untied the cord and removed it from her neck. She indicated that Resident #11 had not had any bruising or red marks on her neck. She stated that she just had a feeling these behaviors were just attention seeking. She further stated that she had not removed the call bell cord from Resident #11's room on July 12, 2022.

The Administrator, DON, and the Clinical Services Administrator were notified of the Immediate Jeopardy on 8/4/22.
F689

On 8/6/22 the facility provided the following credible allegation of Immediate Jeopardy Removal
1. Identify those recipients who have suffered, are

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likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to protect a resident from a hazardous situation when the resident wrapped a call light cord around her neck on three separate occasions (Resident #11).

The residents at risk are those with severe cognitive impairment. There were 73 residents identified on the most recent 802. The 802 is a roster sample matrix used to identify pertinent care categories for all residents.

2.Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when action is complete.

Resident #11 was in a private room. The call bell was immediately removed by the Social Worker upon identification by the surveyor on 8/3/22. Room assessment was completed on 8/4/22 at 1:15 pm to identify any other potential accident hazards in room. This included modification of all other cords in the room (bathroom cord and bed control cord) to ensure ability to use with a length short enough to prevent ability to wrap around neck. No other hazard beyond the cords were observed during the assessment. This task was completed on 8/4/22 at 1:30 pm.

An audit was conducted on 8/4/22 to identify residents who triggered for severe cognitive impairment on the current MDS 802 (Resident Roster). Their environments are to be assessed to identify and remove any potential hazards. The audit was conducted by the Administrator and Director of Nursing. The resident environments

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will be assessed by the Nurse Educator, staff (MDS) nurse, and the Social Worker to be completed by the end of business day 8/5/22.

Training: On 8/4/22 the facility Nurse educator-initiated training on identifying and removing hazards in the environment of cognitively impaired residents. Education will include supervision of residents to avoid accidents and hazards and will extend to 100% against payroll. The majority of work will be completed by end of business day 8/5/22 and all other staff including contract prior to or at the beginning of the next work shift.

Completion date: 08/06/22

The Licensed Nursing Home Administrator is responsible for ensuring the removal plan had been implemented and completed.

The facility alleges Immediate Jeopardy was removed 08/06/22.

On 8/9/22 the Immediate Jeopardy removal plan was verified by onsite validation. A sample of staff that included nurses, nursing assistants, and housekeeping staff were interviewed regarding in-servicing related to the deficient practice. All staff interviewed stated they received Inservice training including in person education and written materials regarding identifying and removing hazards in the environment of cognitively impaired residents. All staff verbalized understanding of the in-services that were presented. A review of all documents developed to correct the deficient practice was completed. Facility policies and procedures that were revised to address the deficient practice were reviewed.

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F 689	Continued From page 10 The audit forms that were developed to monitor that the systems put in place were effective were also reviewed. An observation of Resident #11's room revealed: that there was a manual call bell; the bed cord was zip tied under the bed where she could not reach it; and the bathroom emergency call bell cord was shortened to a length that would not wrap around her neck. The facility's Immediate Jeopardy removal date was validated to be 8/6/22.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store the hand-held plastic scoops outside of 3 of 3 dry food bins holding breadcrumbs, flour, and sugar which were	F 812	Scoop holders were ordered and arrived on August 17,2022 and were installed and put in to operation August 18, 2022.	8/23/22

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F 812	Continued From page 11 observed during the initial tour of the kitchen. Findings included: An observation was made on 08/01/22 at 12:05 PM of the flour, sugar, and bread-crumb bins with the scoops stored directly in the food item. During an interview with the Dietary Manager (DM) on 08/02/22 at 12:00 PM and 08/05/22 at 2:50 PM, he stated it was his expectation that scoops be stored in a closed container outside of each bin. During an interview with the Administrator on 08/05/22 at 2:15 PM revealed it was her expectation that the dietary staff follow the sanitation guidelines taught by the facility.	F 812	100% of kitchen staff were educated on the proper storage and cleaning of Bulk Dry Bin Scoops on 8/23/22. An audit of Bulk Dry Bin Scoop Storage was initiated on August 18, 2022 and is completed by the Dining Services Director or a designee. This audit will be done daily for three weeks and then weekly for three weeks. The results of this audit will be reviewed by the QA committee for any further action.	