STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacGregor Downs Health Center by Harborview	2910 MacGregor Downs Road Greenville, NC 27834

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50404 Based on record review, and resident, family and staff interviews, the facility failed to ensure a copy of the resident's advanced directive was included in the resident's record and failed to provide written advance directive information and/or an opportunity to formulate an advance directive (Residents #105 and #114). This was for 2 of 4 residents reviewed for advance directive. The findings included: A review of the facility's policy titled Residents' rights Regarding Treatment and Advance Directives dated 3/1/22 and reviewed/revised on 3/1/24 revealed it is the policy of this facility to support and facilitate a residents' right to formulate an advance directive. On admission the facility will determine if the resident has executed an advance directive, and if not determine whether the resident would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 1. Resident # 105 was admitted to the facility on [DATE]. A review of Resident #105's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. Resident #105's care plan last revised on 12/3/24 indicated the resident's code status was full code. There was no documentation in the record for education regarding the formulation of advanced directives and /or an opportunity to formulate advanced directives. An interview was held with Social Worker #3 on 2/10/25 at 11:35 AM and she revealed she did not discuss advance directives. She stated the admission nurse or Social Worker # 2 would have been responsible for that task. In an interview with Social Worker #2 on 2/10/25 at 11:45 AM, she stated she had only been employed at the facility for two months and did not have to deal with advance directives. If there was a request for help with advance directives she would help them. She further stated the admission nurse was responsible for advance directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Admission Nurse #1 on 2/11/25 at 3:45 PM who admitted Resident #105 revealed if a resident had advance directives in place upon admission, the document was downloaded into the system by the Administrative Ambassador. If a resident did not have advance directives in place she did not initiate a conversation to educate or formulate advance directives. She went on to state she thought the Admissions Director was responsible for that task. An interview with the Admissions Director was conducted on 2/11/25 at 4:00 PM at which time she stated she did not discuss advance directives with families or residents. She indicated that would be the admission nurse's responsibility. An interview was completed with the Administrator and the Director of Nursing on 2/11/25 at 4:10 PM. The DON indicated the social worker assigned to each resident was tasked to speak with and educate the resident and the resident's responsible party about advance directives. 41009 2. Resident #114 was admitted to the facility on [DATE] with a diagnosis of left leg fracture. A review of Resident #114's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. A review of Resident #114's medical record did not reveal any documentation of a discussion to determine whether or not Resident #114 had formulated any advanced directives such as a living will or a health care power of attorney or would like to formulate one. Additionally, there were no copies of such documents in Resident #114's medical record. On 2/12/25 at 8:33 AM in a telephone interview Resident #114's family member stated she did not recall anyone at the facility having a conversation with her regarding the formulation of advanced directives. She stated Resident #114 had both living will and a health care power of attorney documents. She reported she could not recall anyone from the facility asking her to bring copies of the documents to the facility, and she had not done so. On 2/12/25 at 9:42 AM an interview with Admissions Nurse #2 indicated she did not have conversations with residents or their family regarding advanced directives such as a living will or a heath care power of attorney during her admissions process. She stated she only discussed code status. On 2/12/25 at 9:52 AM an interview with the Admissions Director indicated she spoke with resident's and their family members regarding advanced directives such as living wills or health care powers of attorney during the admissions process and asked them to bring copies of any documents they had already formulated. She stated she did not document these conversations anywhere, and she could not recall whether Resident #114 or his family member reported having a living will or a health care power of attorney to her. The Admissions Director stated she didn't see anything in his medical record. On 2/12/25 at 11:28 AM an interview with Social Worker #2 indicated she did not recall ever having a conversation with Resident #114 or his family member regarding advanced directives such as a living will or a health care power of attorney. She stated typically if a resident had a living will or a health care power of attorney the resident or a family member would bring her a copy. She stated she did not see either of these documents in Resident #114's medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 11:33 AM an interview with Social Worker #3 indicated she did not know whether or not Resident #114 had a living will or a health care power of attorney. She stated typically if a resident had either of these documents, they would bring a copy in for the medical record. She reported the only thing with regards to advanced directives she could see in Resident #114's medical record was the desire to be a full code status. Social Worker #3 stated if a resident or a family member brought up the desire to formulate other advanced directives at the care plan meeting, she would have a discussion with them at that time, but Resident #114 had not had a long-term care plan meeting yet. On 2/13/25 at 8:09 AM an interview with the Director of Nursing indicated that when a resident was admitted to the facility, the Admissions Director would get any copies of advanced directive paperwork such as a living will or a health care power of attorney a resident had. She reported if someone needed assistance with formulating an advanced directive, the SW would assist with this. On 2/13/25 at 9:44 AM an interview with the Administrator indicated the facility should have a process in place for determining whether a resident had or would like to formulate advanced directives such as a living will or a health care power of attorney.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review, and resident, staff, and physician interviews, the facility failed to provide care in a safe manner when Resident #42 rolled out of bed during care and sustained a skin tear to the left forearm, skin tear to the right upper arm, and hematoma (bruise) to the left hip and when Resident # 92 was rolled out of bed during care and sustained a right arm skin tear this was for 2 of 6 residents reviewed for accidents. (Resident #42 and Resident #92) Findings included: 1. Resident #42 was admitted to the facility on [DATE]. Her active diagnoses included anemia, heart failure, hypertension, diabetes, and respiratory failure. Review of the care guide posted in Resident #42's closet door dated 1/7/25 revealed she was extensive 1 person assistance with transfers and activities of daily living. Review of Resident #42's Minimum Data Set assessment dated [DATE] revealed she was assessed as cognitively intact. She required partial/moderate assistance with the ability to roll from lying on back to left and right side, and returning to lying on back on the bed. Resident #42 was on blood thinner medication. Review of Resident #42's care plan dated 1/9/25 revealed Resident #42 was care planned to be at risk for falls related to deconditioning, back pain, history of falls, impaired balance, gait, and mobility. The interventions included to anticipate and meet the resident's needs, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. She was care planned to require assistance by staff to turn and reposition in bed as necessary. Review of a progress note dated 1/13/25 noted as a fall note written by Nurse #1 revealed Resident #42 was being changed by the Nurse Aide #2 and slid to the floor. Upon assessment, Resident #42 had a skin tear on her right upper arm and a small skin tear on her left forearm. She also had a bruise on her left hip on the backside that was blackish blue. She was transported to the emergency department. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 3:06 PM Nurse Aide #2 stated she was changing Resident #42 and standing on the side of the bed towards the door changing her brief. She unstrapped the brief and then went to the window side and using the draw sheet, pulled towards herself to turn the resident to face the door. The resident kept rolling which was not something she normally did and her bottom half slid off the side of the bed. When she saw this, she lowered the bed and the resident slid down to a sitting position on the floor with her back against the bed. She stated the resident did not hit the ground hard as she had been able to lower the bed as she was sliding out of it. Her skin would easily bruise and bleed and she was on a blood thinner. She immediately got Nurse #1 and the nurse assessed the resident and it was decided to send the resident to the hospital. She stated she stayed with Resident #42 until the ambulance came to the facility to take her to the hospital. She stated she had been trained when turning a resident to turn them towards herself instead of facing away from herself. She stated she did not know why she turned the resident away from herself that day. She concluded after the resident left in the ambulance, Nurse #1 reeducated her in regards to turning residents towards herself so that her body would be in front of the resident and prevent the resident from continuing to roll. During an interview on 2/10/25 at 11:33 AM Nurse #1 stated she usually worked with Resident #42 and knew her well. She required limited assistance with dressing and one person assistance with turning and repositioning as well as transfers. Nurse #1 stated Resident #42 was at this functioning level since she started working at the facility the beginning of November 2024. She stated Nurse Aide #2 was trying to change Resident #42's brief and instead of rolling the resident towards herself she rolled the resident in the opposite way (the other side of the bed from where the nurse aide was standing) and Resident #42 continued to roll, and her legs fell off the side of the bed. This caused Resident #42 to begin to slide off the bed. Nurse Aide #2 started lowering the bed as the resident slid to the floor. The nurse aide then came and got the nurse who did an assessment. She saw that Resident #42's right leg was bent oddly, and she had two skin tears. One skin tear on each forearm. It wasn't fast or heavy bleeding but it was enough they had to hold pressure to her arms. She also had a bruise on her left hip that was blackish blue. From there she got Admission Nurse #1 (who was the unit manager at the time) and they got an order to send the resident to the hospital. Resident #42 did not want to go but the Responsible Party wanted her to go to the hospital and because the Responsible Party wanted her to go to the hospital she agreed to go. The resident was sent directly to the hospital, and she did not provide the resident with any pain medication at that time as Resident #42 had indicated to her she did not want pain medication. The resident stated she had pain but kept stating she was fine and did not want to go to the hospital until the nurse informed the resident that her Responsible Party wanted her to go to the hospital. She stated she then reeducated Nurse Aide #2 to ensure she turned residents towards herself and not away from herself when providing activities of daily living care. Review of the hospital discharge summary dated 1/30/25 revealed Resident #42 had sustained an accidental fall which resulted in a left hip hematoma. A CT (Computed Tomography) scan of the head and a CT scan of the cervical spine for Resident #42 were negative for acute intracranial abnormality. A CT scan of the abdomen and pelvis were noted to have hematoma within the subcutaneous tissues of the left lateral lower abdominal wall and hip. Resident #42 was hospitalized for unrelated health concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/25 at 11:44 AM Resident #42 stated two weeks ago she fell in her room but did not really remember the details. Resident #42 stated her left hip had pain, and she sustained a large bruise as a result of the fall. Resident #42 stated a nurse aide was providing care to her at the time but did not remember the nurse aide's name or the time of day. Resident #42 stated the nurse aide placed her on the edge of the bed, and she fell to the floor. The nurse aide was upset and got a nurse. The nurse told the resident she should go to the hospital. Resident #42 stated she told the staff she was fine and did not need any pain medications and just needed to be put back in bed, but they worried her Responsible Party, and he wanted her to go to the hospital. She stated she was in pain following her bottom hitting the floor and estimated the pain was an 8 out of 10 and did not remember if she got pain medication. The pain did not last long and got much better before she arrived at the hospital. She could not remember what all happened at the hospital or how long she was there. She stated it was an accident and did not have anything else to add about the fall. During an interview on 2/12/25 at 7:53 AM Admission Nurse #1 stated she was the unit manager at the time of Resident #42's fall. Staff yelled for help and when she arrived, Nurse #1 was concerned the resident might have broken her hip, but Resident #42 kept stating she was okay, did not want to go to the hospital, and was not in pain. The physician was called, and the Responsible Party was called, and they were trying to convince the resident to go to the hospital, which she did finally agree to when they told her that her Responsible Party wanted her to go as well as the physician. Because the resident was stating she did not have pain and just asking staff to put her back in bed, they did not provide any pain medication at that time. Emergency Medical Services arrived quickly, and they took her out to the hospital, and she did not have any fractures, just a large bruise on her left hip and skin tear to both arms. She stated she then spoke to Nurse Aide #2 separately and re-educated the nurse aide to always turn residents towards herself instead of away from herself to prevent accidents like this. During an interview on 2/11/25 at 11:01 AM the Physician stated it sounded like Nurse Aide #2 thought she was providing care correctly and then was educated later after the incident by nursing how to appropriately turn residents. The nurse aide should have turned the resident towards herself in order for the nurse aide's body to prevent the resident from continuing to roll off the bed so the reeducation was appropriate. She stated the outcome for Resident #42 was a skin tear to each forearm and a hematoma to the left hip. She stated the resident did not hit her head so she felt there were no other outcomes that could have resulted from this incident for the resident or other residents. During an interview on 2/10/25 at 3:28 PM the Director of Nursing stated a resident should never sustain a fall during care and she was notified when Resident #42 sustained her fall. She stated Nurse Aide #2 should have turned the resident towards herself in order for her body to prevent the resident from rolling further. She stated this was how staff were trained to turn and reposition residents. During a follow up interview on 2/13/24 at 8:10 AM the Director of Nursing stated upon review of the documentation regarding Resident #42's fall, the facility did not complete 100% in-services of all nurses and nurse aides in the facility following the fall. She further stated they reviewed three residents following the incident and did not complete a 100% audit of all residents who could have been affected. 41009 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #92 was admitted to the facility on [DATE] with a diagnosis of heart failure. A review of Resident #92's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. She had functional impairment in range of motion on one side of her upper extremities and both sides of her lower extremities. She required substantial assistance to roll from left to right in bed. She was always incontinent of bladder. She had no falls since her prior assessment. A review of a nursing progress note for Resident #92 dated 12/5/24 at 8:11 PM written by Nurse #1 indicated Resident #92 experienced a fall from bed at 6:00 PM that day. Nurse Aide (NA) #1 was present during the fall and provided Nurse #1 with a full statement of the incident. NA #1 had been attempting to change Resident #92's bed sheets, turned Resident #92 away from herself, pulled on the bed sheets, and Resident #92 fell off the bed onto her right side. Resident #92 had not hit her head. A full body assessment and vital signs were done. Resident #92 any pain. Resident #92 had a right arm skin tear which was cleaned, and a dry dressing was applied. Her family member and physician were notified. A review of a written statement by Nurse #1 dated 12/5/24 revealed NA #1 had been educated on how to change a resident with one assist. NA #1 was instructed that when changing a resident with one assist, she should turn the resident towards herself and not away from herself. When using a turn sheet, she should be mindful of how light or heavy the resident was and how fast or slow she was pulling the sheet with consideration to where the resident's body was positioned in bed. On 2/12/25 at 3:43 PM an interview with NA #1 indicated she recalled Resident #92's fall on 12/5/24. She stated when she went into Resident #92's room that day, Resident #92's sheets had been wet. She went on to say Resident #92 had been positioned more toward the right side of her bed and when she pulled on the draw sheet to bring Resident #92 closer to herself to turn Resident #92, instead of coming towards her, Resident #92 had rolled off the right side of her bed. She reported Resident #92's bed had been approximately 3 feet from the floor at the time, and Resident #92's upper body had gone off the bed first followed by Resident #92's legs. She stated Resident #92 had not said anything, and she could see that Resident #92 did not hit her head during the fall. NA #1 went on to say she immediately called for Nurse #1 who came to assess Resident #92. She stated although Resident #92 needed only one person to assist with bed mobility, she thought because her bed had been wet the use of the draw sheet had not gone as planned. She reported she had received education after the incident, and in the future would get another person to assist her if a resident's bed was wet. On 2/12/25 at 8:02 AM an interview with Nurse #1 indicated she recalled Resident #92's fall on 12/5/24. She stated when NA #1 notified her she immediately went to assess Resident #92. She reported Resident #92's bed had been positioned approximately 2 feet from the floor and Resident #92 had been lying on the floor beside her bed on her right side. Nurse #1 went on to say she completed a full body assessment of Resident #92 and took her vital signs. She stated Resident #92 had denied any pain, denied hitting her head during the incident and had not seemed upset at the time but was just asking them to get her up. She reported Resident #92 had a skin tear to her right arm which she cleaned and dressed. She went on to say she had notified Resident #92's family member and physician of the fall, and after getting a full statement of the event from NA #1, had notified Admission Nurse #1 who had been her supervisor at the time. Nurse #1 stated she provided immediate education to NA #1 after the incident that NA #1 should always roll residents towards herself when turning them in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order for Resident #92 dated 12/6/24 indicated to clean her right arm skin tear with normal saline and apply a non-adherent gauze dressing every Monday and Friday for skin tear. On 2/12/25 at 7:56 AM an interview with Resident #92 indicated she did not recall ever having fallen from bed during care. She stated she had no concerns with the way NAs provided care to her, and she always felt safe during care. On 2/12/25 at 8:15 AM an interview with Admissions Nurse #1 indicated she did not think she had been present in the facility when Nurse #1 notified her of Resident #92's fall on 12/5/24, and after Nurse #1 notified her by telephone, she notified the Director of Nursing (DON). On 2/12/25 at 8:22 AM an interview with the DON indicated she had been notified of the circumstances of Resident #92's fall on 12/5/24 and immediate education had been provided to NA #1 regarding always turning residents towards herself when turning them in bed. She went on to say she thought an in-service had also been provided to all staff regarding this after the incident. On 2/13/25 at 8:09 AM a follow-up interview with the DON indicated 100 percent staff education had not been completed after Resident #92's fall on 12/5/24. On 2/12/25 at 12:28 PM a telephone interview with Resident #92's Physician indicated Resident #92 had not experienced any major injury as a result of the fall that occurred on 12/5/24. She reported Resident #92 would have been at risk for any injury that could occur as a result of a fall. She stated a fall from bed would not be an anticipated outcome during the provision of care and it must have been a frightening experience for both Resident #92 and NA #1. On 2/13/25 at 9:44 AM an interview with the Administrator indicated Resident #92 should not have sustained a fall during the provision of care. On 2/12/25 a review of an in-service training record dated 12/11/24 provided by the Staff Development Coordinator (SDC) revealed the attached procedure titled: Turning a Resident on His/her Side Away From You which included in part the following: Steps in the Procedure: 5. Slide both your arms under the resident's back to his/her far shoulder. 6. Slide the resident's shoulders towards you on your arms. 7. Slide both your arms (as far as you can) under the resident's buttocks. 8. Slide the resident's buttocks towards you. 9. Slide both arms under the resident's feet and ankles. 10. Slide the resident's feet towards you. On 2/12/25 at 10:44 in an interview the SDC stated she provided an in-service training on the proper procedure for turning a resident on their side away from you in bed to nurses and nurse aides on 12/11/24 in response to Resident #92's fall from bed during care on 12/5/24. She reported that while the in-service did not specifically address the use of a draw sheet, it was standard practice to use a draw sheet when repositioning residents.