STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060111	A. BUILDING: _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(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 conducted a follow-up survey and complaint investigation on February 23, 2022 and February 24, 2022.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 4 of 5 sampled residents (Residents #1, #2, #4 and #5), including nail care, bathing and skin assessments (Resident #1), and nail care (Residents #2, #4 and #5). The findings are: 1. Review of Resident #1's current FL2 dated 02/22/22 revealed: -Diagnoses included dementia with behaviors. -The recommended level of care was a Special Care Unit (SCU). Review of Resident #1's care plan dated 01/11/22 revealed she required assistance as needed with grooming and personal hygiene.	D 269		

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D 269	Continued From page 1 Review of Resident #1's "Who I Am and What I Need" sheet that outlined personal care needs for residents revealed: -The document did not have a date. -Resident #1 required extensive assistance with socks, shoes, buttons and zippers. -Resident #1 required limited assistance in the shower with back, feet, legs and skin care. -There was no documentation staff should check and provide care for resident's fingernails and toenails. Telephone interview with Resident #1's family member on 02/21/22 at 4:00pm revealed: -She and a friend took turns visiting Resident #1. -On 02/08/22 Resident #1's friend noticed that she had very long nails with dirt under most of her fingernails. -After Resident #1's friend visited, Resident #1's family member dropped off nail clippers at the facility. -She was not aware of the last time Resident #1's fingernails were trimmed. a. Observation of Resident #1's fingernails on 02/23/22 at 9:15am revealed: -All 10 of Resident #1's fingernails were approximately 1/4 inch to 1/2 inches beyond her fingertips. -Her thumb nail and ring finger nail on her right hand were broken and the nails were jagged. -The nail on her right pointer finger was discolored. Observation of Resident #1's toenails on her right foot on 02/24/22 at 9:00am revealed: -The toenails on the first and second toes were raised, discolored and had multiple broken layers. -The toenail on the third toe was entirely a	D 269		

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white/yellow color and raised at the end of the nail above the tip of the toe and nailbed.
-The toenails on the fourth and fifth toes extended approximately 1/4 inch past the tip of the toes.

Review of Resident #1's physician notes revealed:
-She saw the podiatrist on 05/27/21 to have her toenails trimmed.
-There was no documentation of a visit with a provider to trim her toenails from 05/28/21-02/24/22.

Review of the activity log for Resident #1 revealed her fingernails were filed on 11/16/21 and 12/03/21 by the former Activity Director (AD).

Review of the shower schedule on 02/24/22 revealed Resident #1 was scheduled to shower on Monday, Wednesday and Friday during 2nd shift.

Interview with Resident #1 on 02/23/22 at 9:15am revealed:
-She did not remember the last time her fingernails were trimmed or filed.
-She had not asked anyone to trim her fingernails.
-She would trim her own fingernails but she did not have anything to trim them with.

Interview with a first shift personal care aide (PCA) on 02/23/22 at 11:45am revealed:
-Staff were responsible for completing a skin assessment, which included an assessment of the residents' fingernails and toenails, after each shower.
-The residents' fingernails were usually trimmed during activities but she was not sure who

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trimmed the residents' toenails.
-She did not remember the condition of Resident #1's fingernails or toenails.

Interview with a first shift medication aide (MA) on 02/23/22 at 1:36pm revealed:
-She clicked "done" under nail care for Resident #1 on 02/15/22 but did not perform any nail care.
-She clicked "done" so the task would stop popping up on the computer screen.
-One of the PCAs at the facility was responsible for residents' nail care.

Interview with a second 1st shift MA on 02/23/22 at 2:30pm revealed:
-Some of the PCAs would trim the residents' fingernails or the AD would trim them on manicure days.
-She was not aware of who trimmed the residents' toenails.

Interview with a 2nd shift PCA on 02/23/22 at 3:15pm revealed:
-She tried to trim the residents' fingernails when she noticed that they were long.
-She did not always have time to trim residents' fingernails.
-She had not trimmed Resident #1's fingernails recently.
-The AD could also help trim residents' fingernails.
-She thought a podiatrist was responsible for trimming the residents' toenails but was not certain.

Interview with another 1st shift MA on 02/24/22 at 10:07am revealed:
-A provider came into the facility to cut the residents' toenails.
-When she observed residents with long toenails

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she put them on a list.
-She gave the list of residents with long toenails to the Resident Care Coordinator (RCC).

Interviews with three 2nd shift PCAs and one 2nd shift MA on 02/24/22 from 2:45pm to 3:05pm revealed:
-No one recalled the last time they assisted Resident #1 with a shower.
-No one recalled recently looking at Resident #1's fingernails or toenails.

Review of the Observation Detail List Report related to showers that was requested on 02/24/22 at 12:15pm revealed Resident #1 did not have documentation of a skin assessment from 01/01/22 to 02/24/22.

Telephone interview with the facility's contracted physician on 02/24/22 at 10:55am and 4:20pm revealed he was not aware of the state of Resident #1's fingernails and toenails.

Refer to interview with the Resident Care Coordinator (RCC) on 02/23/22 at 2:00pm.

Refer to interview with the RCC on 02/24/22 at 11:26am.

Refer to telephone interview with the facility's contracted physician on 02/24/22 at 10:55am and 4:20pm

Refer to interview with the former Administrator on 02/24/22 at 11:45am.

Refer to interview with the Administrator on 02/24/22 at 3:15pm.

Attempted telephone interview with the facility

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D 269	Continued From page 5 contracted podiatrist on 02/23/22 at 10:16am was unsuccessful. b. Observation on 02/24/22 at 11:10am revealed: -Resident #1 was sitting on the side of her bed with slippers and white ankle socks on both feet. -Staff removed her slippers and upon removing her socks she grimaced and stated there was an area on her feet that was uncomfortable, "but it's alright". -On the front of both feet, at ankle height, there was a darkened area the size of a fifty cent piece. -On the right foot, in the center of the discolored area was a quarter size opening exposing an underlying reddened area. -The white ankle length sock that had been removed by staff showed dried blood staining in the area of the opening. -On the left foot, in the center of the discolored area, there was a nickel size opening, with blackened skin surrounding the opening and no drainage . -The ankle socks were approximately fitted at the site of the open areas on both feet. -No footwear was observed in the room that were fitted at the ankle area. Review of Resident #1's care plan dated 01/11/22 revealed she required assistance as needed with grooming and personal hygiene as well as dressing. Review of Resident #1's "Who I Am and What I Need" document that outlined personal care needs for residents revealed: -Resident #1 required extensive assistance with socks, shoes, buttons and zippers. -Resident #1 required limited assistance in the shower with back, feet, legs and skin care. -The document did not have a date.	D 269		

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D 269	Continued From page 6 Review of the shower schedule on 02/24/22 revealed Resident #1 was scheduled to shower on Monday, Wednesday and Friday during 2nd shift. Review of the Observation Detail List Report related to showers that was requested on 02/24/22 at 12:15pm revealed Resident #1 did not have documentation of a skin assessment from 01/01/22 to 02/24/22. Review of the Skin Care Assessment sheets for Resident #1 from 01/01/22 through 02/24/22 revealed: -On 01/27/22 there was a skin assessment form documenting there were no concerns with skin care. -No additional skin care assessments were documented in the resident's record, electronic progress notes or Skin Assessment binder. Interview with a first shift personal care aide (PCA) on 02/23/22 at 11:45am revealed: -Staff were responsible for completing a skin assessment on each resident, which included an assessment of any areas of skin breakdown, skin tears or bruising, with every shower. -She did not recall seeing any skin breakdown on Resident #1's feet when she provided personal care to the resident. -She could not recall the last time she showered Resident #1 since she was scheduled for a shower on second shift. Interviews with 3 second shift PCAs and 1 second shift medication aide (MA) on 02/24/22 from 2:45pm to 3:05pm revealed no one recalled the last time they assisted Resident #1 with a shower.	D 269		

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D 269	Continued From page 7 Telephone interview with a MA on 02/24/22 at 3:40pm revealed: -She did not typically give showers to residents but she did remember helping Resident #1 with a shower about one and one half months ago. -She did not remember Resident #1 having any skin tears or wounds on her feet. Telephone interview with Resident #1's primary care provider (PCP) on 02/24/22 at 10:55am and 4:20pm revealed: -He did not routinely check residents' skin for wounds or skin breakdown since the facility was supposed to regularly assess the residents' skin integrity. -He expected the facility to notify him if a resident had a new wound so he could form a treatment plan. -He was not aware of the wounds on Resident #1's feet. -If a wound was left untreated it could get infected and lead to sepsis. Interview with the Resident Care Coordinator (RCC) 02/24/22 at 11:26am revealed: -The PCA's and the MAs were to report to him if any of the residents were observed to have skin breakdown. -He would assess the skin breakdown and notify the PCP. -He was not informed Resident #1's had open areas on the top of each foot parallel to the ankle. Interview with the Administrator on 02/24/22 at 3:15pm revealed: -She was not aware Resident #1 had open areas and skin breakdown on the top of both feet. -The MAs or the PCAs who dressed and showered her should have notified the RCC or	D 269		

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the Administrator.
2. Review of Resident #2's current FL2 dated 02/22/22 revealed:
-Diagnoses included dementia without behaviors and congestive heart failure.
-There was no information documented under patient information on the FL2 for bowel, bladder or skin assessment.

Review of Resident #2's current care plan dated 11/12/22 revealed:
-The resident was occasionally incontinent.
-He required extensive assistance with toileting, dressing and grooming.
-He required limited assistance with bathing and was independent with ambulation.

Review of Resident # 2's "Who I Am and What I Need" form dated 04/26/21 that outlined the personal care needs of residents revealed:
-Resident # 2 required extensive assistance with toileting, all hygiene and briefs needed, shower and dressing.
-Resident #2 required limited assistance with feeding.

Observation on 02/23/22 at 9:47am revealed:
-The resident walked out of his bathroom with a trail of toilet paper hanging from the back of his pants.
-Resident had sneakers on both feet with a bedroom slipper over the top of his right sneaker.

Interview with Resident #2 on 02/23/22 at 9:47am revealed:
-Resident stated that his right foot hurt.
-Resident stated that the staff were too busy to help him.

Observation of Resident #2's feet on 02/24/22 at

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D 269	Continued From page 9 9:18am revealed: -When the personal care aide (PCA) removed the sock on the right foot the resident made a facial grimace and complained his foot hurt. -The resident's toenails on both feet were overgrown, thick and discolored. -Resident's right big toenail was curled upwards approximately ½" above base of nail bed. Interview with a first shift PCA on 02/24/22 at 9:19am revealed: -She assisted Resident #2 with his showers on shower days providing verbal prompting and assistance with bathing resident's back. -She did not know Resident #2 was experiencing pain in his right foot. -She did not report or document that resident's toenails were overgrown, thick or discolored. -She stated that if there were any skin issues or concerns, she would report to the MA and document on the electronic progress notes under shower skin assessment. Interview with second shift PCA on 02/24/22 at 3:40pm revealed: -He sometimes assisted Resident with showers. -Resident #2 complained of right foot pain. -He knew the resident's toenails needed to be cut. -Staff were allowed to trim fingernails and toenails, if the resident was not a diabetic. -He was planning to trim the resident's toenails however he became busy and by the time he was available, the resident was in bed. -He did not report or document that the resident's toenails were overgrown, thick or discolored. -If there were areas of concern that needed to be addressed, he reported to the medication aide (MA), completed the shower skin assessment form and documented on the electronic progress	D 269		

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D 269	Continued From page 10 notes under shower skin assessment. Review of Resident #2's Shower Skin Assessment Report dated 01/20/22 through 02/24/22 revealed: the skin assessment observation details indicated Resident #2's toenails did not need to be cut. Review of Resident #2's progress notes dated 01/20/22 through 02/24/22 revealed there was no documentation in the progress notes of any concerns with Resident #2's nails. Review of Resident #2's provider notes on 02/24/22 revealed: -Resident was seen by the facility contracted podiatrist on 05/27/21. -There was no other documentation of a follow up appointment or consultation. Refer to interview with the Resident Care Coordinator (RCC) on 02/23/22 at 2:00pm. Refer to interview with the RCC on 02/24/22 at 11:26am. Refer to telephone interview with the facility's contracted physician on 02/24/22 at 10:55am and 4:20pm Refer to interview with the former Administrator on 02/24/22 at 11:45am. Refer to interview with the Administrator on 02/24/22 at 3:15pm. 3. Review of Resident #4's FL2 dated 02/22/22 revealed: -Diagnoses included dementia without behaviors, atherosclerotic heart, pulmonary hypertension	D 269		

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and hyperlipidemia.
-She required assistance with bathing and dressing.
-She was intermittently disoriented.

Review of Resident #4's current Care Plan dated 01/11/22 revealed:
-Resident #4 was sometimes disoriented and needed reminders.
-She required limited assistance for bathing and dressing.
-She required extensive assistance with grooming and personal hygiene.

Observation of Resident #4 revealed her toenails on both feet extended above the tips of her toes.

Interview with Resident #4 revealed:
-"My toenails look really bad."
-"My toenails push against my shoes and it is painful".

Review of Resident #4's Admission/Readmission Skin Assessment dated 01/09/22 revealed the resident's toenails did not need to be cut.

Review of Resident #4's progress notes 01/09/22 revealed there was no documentation in the electronic progress notes of any concerns with Resident #4's toenails.

Interview with a medication aide (MA) on 02/24/22 at 10:07am revealed:
-She noticed Resident #4's toenails were long about 2 weeks ago and put her on a list to get her toenails trimmed.
-She gave that list to the Resident Care Coordinator (RCC).
-The facility brought someone in to cut the residents' toenails.

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D 269	Continued From page 12 Refer to interview with the Resident Care Coordinator (RCC) on 02/23/22 at 2:00pm. Refer to interview with the RCC on 02/24/22 at 11:26am. Refer to telephone interview with the facility's contracted physician on 02/24/22 at 10:55am and 4:20pm Refer to interview with the former Administrator on 02/24/22 at 11:45am. Refer to interview with the Administrator on 02/24/22 at 3:15pm. 4. Review of Resident #5's FL2 dated 02/22/22 revealed: -Diagnoses included dementia with behavior, primary insomnia and major depressive disorder. -She required assistance with bathing and dressing. Review of Resident #5's current care plan dated 01/11/22 revealed: -She required limited assistance with eating, toileting, ambulation, bathing, dressing and grooming. Review of Resident #2's record on 02/24/22 revealed: -Skin assessment observation form detailed resident's toenails did not need to be cut. -There was no documentation in the progress notes reporting any concerns with Resident #5's toenails. Review of Resident # 5's "Who I Am and What I Need" form dated 04/26/21 for personal care	D 269		

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needs of residents revealed the resident required limited assistance with toileting, hygiene and brief, showers, all lower and upper bathing needs, dressing with upper and lower dressing needs and feeding.

Observation of Resident #5's feet on 02/24/22 at 9:32am revealed:
-Her on both feet extended approximately 1/4" to 1/2" above the tips of toes.

Interview with personal care aide (PCA) on 02/24/22 at 9:34am revealed it had been months since Resident #5 had been seen by podiatry.

Review of Resident #5's record on 02/24/22 revealed:
-Resident was seen by the facility contracted podiatrist on 05/27/21.
-There was no other documentation of a follow up appointment or consultation.

Refer to interview with the Resident care Coordinator (RCC) on 02/24/22 at 11:26am.

Refer to telephone interview with the facility's contracted physician on 02/24/22 at 10:55am and 4:20pm

Refer to interview with the former Administrator on 02/24/22 at 11:45am.

Refer to interview with the Administrator on 02/24/22 at 3:15pm.

Interview with the RCC on 02/24/22 at 11:26am revealed:
-The facility generated a temporary list of activities of daily living (ADLs) for a new resident,

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	HAL060111	A. BUILDING: _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(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
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based on their initial assessment prior to admission by a facility contracted RN.
-The resident was re-assessed in a month by the RN for staff assistance in completing ADLs and a"Care List " was electronically generated and used by the staff to document the the completion of daily and weekly ADLs as part of their assignment.
-Before or after each shower, staff observed the resident's skin for breakdown, bruising, skin tears or any other exceptions.
-The staff also observed the condition of the resident's fingernails and toenails.
-The staff documented the skin integrity of the residents and the condition of their fingernails and toenails on the "Skin Assessment" form, which was filed in a binder and kept in the medication room.
-It was also documented electronically on the Point of Care history.
-If any of these areas required further attention, the staff was to verbally report to the RCC in addition to documenting on the Skin Assessment form and the Point of Care, since the RCC did not review this documentation weekly.
-The medication aides (MAs) or personal care aides (PCAs) were responsible for trimming fingernails and toenails unless the the resident was a diabetic.
-He was not informed by the staff of any resident needing their fingernails or toenails to be trimmed by a podiatrist.

Telephone interview with the facility's contracted physician on 02/24/22 at 10:55am and 4:20pm revealed:
-He did not always assess the residents' nails when he visited the facility.
-He expected the facility to schedule a podiatry provider to trim the residents' toenails and for the

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D 269	Continued From page 15 RCC to alert him of which residents needed to see a podiatrist for nail care. -Toenails that were not trimmed regularly could lead to ingrown toenails and become infected. -Long toenails or fingernails increased the risk of trapping moisture and/or bacteria under them which could lead to a fungal infection. -He did not routinely check residents' skin for wounds or skin breakdown since the MAs and PCAs were supposed to regularly assess the residents' skin integrity. -He expected the facility to notify him if a resident had a new wound so he could form a treatment plan. -He was not aware of the wounds on Resident #1's feet. -If a wound was left untreated it could get infected and lead to sepsis Interview with the former Administrator on 02/24/22 at 11:45am revealed: -The podiatrist would come every 3 months to trim all of the residents' toenails. -PCAs or the former Activities Director (AD) would trim fingernails, however, the resident was allowed to refuse having their fingernails trimmed. -She expected staff to assess residents' nails after every shower. -She reviewed the skin assessments daily and if anything was reported she would personally assess the resident. -Staff were expected to clean under the resident's fingernails when a problem was identified. -If a nail issue could not be resolved in the facility then she expected staff to alert the physician. -She was not sure of the last time a Podiatrist was in the facility since the RCC scheduled the visits. -She would not allow residents to trim their own fingernails or toenails.	D 269		

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D 269	Continued From page 16 Interview with the current Administrator on 02/24/22 at 3:15pm revealed: -The staff were made aware of the personal care needs of every resident through shift to shift verbal reports and the "Who Am I and What I Need" binder. -The resident's form completed in the "Who Am I and What I Need" binder was a modified documentation of the their service plan, which in turn generated their plan of care and activities of daily living. -The care staff should look at this information before beginning their shift each day to provide the appropriate care for each resident. -The RCC or lead MA entered the information on the "Who Am I and What I Need" form for new residents and updated the information as needed on current residents. -New staff trained with seasoned staff for 3 to 4 days and were also informed through their training on the specific needs of each resident. -There was a facility contracted podiatrist that came to the community and provided nail care to the residents on a quarterly basis or as needed. -She had to cancel scheduled visits of the podiatrist due to COVID out breaks in the facility. -The last visit scheduled podiatry visit on 10/29/22 was cancelled due to a COVID outbreak at the facility, but she was not sure. _____ The facility failed to ensure residents' personal care needs were met which resulted in a resident expressing pain in his right foot, great toe (Resident #2), and residents expressing discomfort due to their toenails pushing against their footwear, and jagged sharp fingernails which if not trimmed regularly could lead to ingrown toenails and become infected (Residents #1, #4 and #5). This failure was detrimental to the	D 269		

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D 269	Continued From page 17 residents' health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/24/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2022.	D 269		
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: A2 VIOLATION Based on observations, interviews and record review, the facility failed to contact the primary care provider for 1 of 5 sampled residents (#1) who had skin breakdown on top of both feet. The findings are: 1. Review of Resident #1's current FL2 dated 02/22/22 revealed: -Diagnoses included dementia with behaviors. -The recommended level of care was a Special Care Unit (SCU). Review of Resident #1's care plan dated 01/11/22 revealed she required assistance as needed with grooming and personal hygiene as well as dressing.	D 273		

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D 273	Continued From page 18 Review of Resident #1's "Who I Am and What I Need" document that outlined personal care needs for residents revealed: -Resident #1 required extensive assistance with socks, shoes, buttons and zippers. -Resident #1 required limited assistance in the shower with back, feet, legs and skin care. -The document did not have a date. Observation on 02/24/22 at 11:10am revealed: -Resident #1 was sitting on the side of her bed with slippers and white ankle socks on both feet. -Staff removed her slippers and upon removing her socks she grimaced and stated there was an area on her feet that was uncomfortable, "but it's alright". -On the front of both feet, at ankle height, there was a darkened area the size of a fifty cent piece. -On the right foot, in the center of the discolored area was a quarter size opening exposing an underlying reddened area. -The white ankle length sock that had been removed by staff showed dried blood staining in the area of the opening. -The left foot, in the center of the discolored area, there was a nickel size opening, with blackened skin surrounding the opening without drainage. -The ankle socks were approximately fitted at the site of the open areas on both feet. -No footwear was observed in the room that were fitted at the ankle area. Review of the shower schedule on 02/24/22 revealed Resident #1 was scheduled to shower on Monday, Wednesday and Friday during 2nd shift. Review of the Observation Detail List Report related to showers that was requested on 02/24/22 at 12:15pm revealed Resident #1 did	D 273		

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not have documentation of a skin assessment from 01/01/22 to 02/24/22.

Review of the Skin Care Assessment sheets for Resident #1 from 01/01/22 through 02/24/22 revealed:
On 01/27/22 there was a skin assessment form documenting their were no concerns with skin care.
-No additional skin care assessments were documented in the resident's record, electronic progress notes or Skin Assessment binder.

Interview with a first shift personal care aide (PCA) on 02/23/22 at 11:45am revealed:
-Staff were responsible for completing a skin assessment, which included an assessment of any areas of skin breakdown, skin tears or bruising.
-She did not recall seeing any skin breakdown on Resident #1's feet when she provided personal care to the resident.
-She did not recall the last time she showered Resident #1 since she was scheduled for showers on second shift.

Interviews with 3 second shift PCAs and 1 second shift medication aide (MA) on 02/24/22 from 2:45pm to 3:05pm revealed no one recalled the last time they assisted Resident #1 with a shower.

Telephone interview with a MA on 02/24/22 at 3:40pm revealed:
-She did not typically give showers to residents but she did remember helping Resident #1 with a shower about one and one half months ago.
-She did not remember Resident #1 having any cuts or wounds on her feet.

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Telephone interview with Resident #1's primary care provider (PCP) on 02/24/22 at 10:55am and 4:20pm revealed:
-He did not routinely check residents' skin for wounds or skin breakdown since the facility was supposed to regularly assess the residents' skin integrity.
-He expected the facility to notify him if a resident had a new wound so he could form a treatment plan.
-He was not aware of the wounds on Resident #1's feet.
-If a wound was left untreated it could get infected and lead to sepsis.

Interview with the Resident Care Coordinator (RCC) on 02/24/22 at 11:26am revealed:
-Before or after each shower, staff observed the resident's skin for breakdown, bruising, skin tears or any other exceptions.
-The staff documented the skin integrity on the "Skin Assessment" form, which was filed in a binder and kept in the medication room.
-It was also documented electronically on the Point of Care history.
-If any of these areas required further attention, the staff were to verbally report to the RCC in addition to documenting on the Skin Assessment form and the Point of Care, since the RCC did not review this documentation weekly.
-He relied on the staff to inform him of any skin breakdown on the residents' skin when they provided showers or personal care.
-He did not round on residents unless he was alerted to a problem.
-He was not informed by the staff Resident #1 had open areas and skin breakdown on the top of both feet.
-If he had been informed, he would have notified Resident #1's PCP and followed his

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D 273	Continued From page 21 recommendations and orders. Interview with the Administrator on 02/24/22 at 11:40am revealed: -She was not aware Resident #1 had open areas and skin breakdown on the top of both feet. -There was no documentation on the electronic progress notes or the Skin Assessment forms that indicated she had skin breakdown. -The MAs or the PCAs who dressed and showered her should have notified the RCC or the Administrator. -The RCC would have reached out to the PCP for assessment and treatment orders. The facility failed to ensure Resident #1's physician was notified of the nickel size wounds on the top of both feet which delayed treatment and could have developed into an infection and sepsis. This failure resulted in substantial risk of serious neglect to Resident #1 and constitutes a Type A2 Violation. The facility to provide a plan of protection in accordance with G.S. 131D-34 on 02/24/22 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 26, 2022.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 22 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 4 of 5 sampled residents (Residents #1, #2, #4 and #5), including nail care, bathing and skin assessments (Resident #1), and nail care (Resident #2, #4 and #5). [Refer to Tag D - 0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation).]	D912		
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 observations, interviews, and record review, the facility failed to ensure 1 of 5 sampled residents (#1) was free of neglect as related to health care. The findings are:	D914		

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D914	Continued From page 23 Based on observations, interviews, and record review, the facility failed to contact the primary care provider for 1 of 5 sampled residents (#1) who had skin breakdown on top of both feet. [Refer to Tag D - 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]	D914		