STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RECEIVED
APR 05 2021
ADULT CARE LICENSURE SECTION
RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 with an onsite visit on 02/09/21 - 02/10/21 and a desk review survey on 02/11/21 - 02/12/21 and 02/15/21, a virtual observation on 02/15/21, and a telephone exit on 02/15/21.	{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: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 5 residents sampled (#2) received personal care assistance with foot care. The findings are: Review of Resident #2's current FL-2 dated 01/14/21 revealed: -Diagnoses included diabetes, diabetic foot ulcer, peripheral vascular disease (PVD), hypertension (HTN), and memory impairment. -The resident was intermittently disoriented, semi-ambulatory with the use of a wheelchair and/or straight cane, incontinent of bowel and bladder, and required staff assistance with bathing and dressing. Review of Resident #2's current care plan dated 01/14/21 revealed:	{D 269}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Britt L Bennett

TITLE: Administrator

(X6) DATE: 3/24/21

STATE FORM 6899 ZXNG12

Reviewed and Accepted OAK 4/23/21

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{D 269}	Continued From page 1 -The resident required extensive assistance with ambulation, bathing, grooming, and dressing. -The resident required limited assistance with transfers. -The resident was forgetful and sometimes disoriented. -The resident had limited range of motion of the upper extremities and had limited ability to ambulate requiring the use of a walker/cane/wheelchair. -The resident's skin was documented within normal limits. Review of Resident #2's personal care log for February 2021 revealed: -From 02/01/21 - 02/08/21 the resident was documented as independent with applying and removing socks on 1st, 2nd, and 3rd shifts. -The resident was independent with applying and removing socks during 1st shift on 02/09/21. -From 02/01/21 - 02/08/21 the resident was documented as independent with skin care to include foot care on 1st, 2nd, and 3rd shifts. -The resident was independent with skin care to include foot care during 1st shift on 02/09/21. -There was no documentation of nail care. Observation of Resident #2's feet on 02/09/21 at 4:05pm revealed: -The left 2nd and 3rd toes were absent. -There was thin cream colored scaly, flaking skin to the missing toe space, on top of the remaining left toes, and scattered to the soles of his foot. -The left 1st, 4th, and 5th toe nails were thick and the 4th toenail curved with the tip of the toe; the 5th toenail grew upwards. -Between the left 4th and 5th toes, there was a thick light brown colored substance with flaking skin. -On the bottom of the left foot between the 2nd	{D 269}	Wilson AL's policy is for staff to provide all necessary personal care for all residents. To assist with any personal care needs residents may be unable to do for themselves including foot care. Staff should assist resident with washing their feet and should inspect the feet and toenails at that time. Any areas of concern should be documented and reported to Med Tech. Med Tech will inform RCC/MCC for follow-up. PCP will be contacted when necessary. Staff are oriented on assessments upon hire and at LHPS check-off. In-house podiatry clinics are	

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{D 269}	Continued From page 2 and 3rd toe space was a linear area of thick, yellow, peeling skin approximately 3 inches (in) long. -The left heel and ankle were dry, cracked, and flaking. -There was white to cream colored flaking skin scattered across the bottom of the right foot, and toes; the tip of the 1st toe was dry and scaly with thick yellow flaking crusty skin around the nail bed and on the toe joint. -There was thick, yellow to cream colored flaking skin between the right 1st - 4th toes. -There was a brown to yellow colored thick elevated patch of skin on the inside of the right 5th toe. -There was thick yellow and flaking skin around the nail beds of the right 1st - 5th toes. -The right heel and ankle were dry, cracked, and flaking. -The right 1st - 5th toenails were thick, elevated and jagged; the right 3rd toenail extended past the tip of the toe approximately 1 millimeter (ml). Interview with Resident #2 on 02/09/21 at 4:08pm revealed: -Sometimes he needed staff assistance washing his feet because it was difficult to reach the bottoms of his feet and between his toes. -Staff did not perform foot care or assist with washing his feet. -Staff never offered or helped him wash his feet and/or perform foot care. -He would accept help from staff with foot care and washing his feet if they offered. -He did not ask staff for help with foot care and washing his feet because staff would do as little as they had to do. -His feet or toes did not hurt. Interview with Resident #2's Primary Care	{D 269}	scheduled quarterly. RCC/MCC or designee will monitor monthly for compliance.	3/17/21

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{D 269}	Continued From page 3 Provider (PCP) on 02/10/21 at 11:40am revealed: -She did not know if the resident could independently perform foot care and/or wash his feet. -It was expected staff assist the resident with washing his feet if needed. -When staff performed foot care it was expected staff examine the feet for any skin break down and dirty feet especially for residents who had diabetes because they were at more risk for skin integrity issues. -Staff were to check resident's feet for skin integrity such as opened areas of skin, wounds and bruising. Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 12:15pm revealed staff initials in the "dressing" section of the personal care (PC) log meant residents feet were checked by the personal care aide (PCA). Interview with a medication aide (MA) on 02/10/21 at 12:40pm revealed: -Resident #2 would complain to her of dry skin on his feet. -Resident #2 asked her to look at his feet this morning (02/10/21) because of dry skin. -Before today, 02/10/21, she last checked Resident #2's feet 1 week ago. -The resident had a diabetic wound to the bottom of his left foot when she checked 1 week ago. -PCAs were supposed to check residents' feet for skin tears, scratching, bruising, or wounds with every shower/bath. -If skin integrity issues were discovered the PCAs were to document their findings on the skin assessment sheet then tell the MA. The MA would check the resident then call to report to the PCP.	{D 269}		

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{D 269}	Continued From page 4 Interview with a PCA on 02/10/21 at 12:30am revealed: -Resident #2 required staff assistance with bathing/showering and dressing. -She would physically wash Resident #2's feet because he could not wash them himself. -She had not provided foot care and/or washed Resident #2's feet in 2 weeks because of her work schedule/assignment. Interview with a PCA on 02/10/21 at 12:59pm who documented on Resident #2's February 2021 personal care log revealed: -Resident #2 was independent with bathing/showering and foot care. -She would help Resident #2 put on his socks and pants. -She knew what type of staff assistance Resident #2 needed because of observations and providing personal care to the resident. -PCAs were supposed to inspect residents' feet and between their toes when applying lotion and putting socks on the resident's feet. -Resident #2 had flaky dry skin and thick toenails to both feet. -She last rubbed lotion on Resident #2's feet on 02/09/21. -On 02/09/21, Resident #2 had flaking skin to the feet and thick yellow toenails. She did not tell the MA, RCC, or PCP. -She would look between Resident #2's toes when she applied lotion to the resident's feet. -She did not see the area between Resident #2's left 4th and 5th toes or right inner 5th toe on 02/09/21.	{D 269}		
{D 273}	10A NCAC 13F .0902(b) Health Care	{D 273}		

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{D 273}	Continued From page 5 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 2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 5 of 5 residents sampled (#1, #2, #3, #4, #5) for podiatry referral (#1, #,2, #3, #5); dermatology, physical and occupational therapy referral (#1); home health skilled nursing referral, delay in notification of wounds (#2); orthopedic, speech and physical therapy referral (#4); and laboratory and dental services (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 01/14/21 revealed: -Diagnoses included diabetes, diabetic foot ulcer, peripheral vascular disease (PVD), hypertension (HTN), and memory impairment. -The resident was intermittently disoriented, semi-ambulatory with the use of a wheelchair and/or straight cane, incontinent of bowel and bladder, and required assistance with bathing and dressing. Review of Resident #2's previous FL-2 dated 09/14/20 revealed: -Diagnoses included diabetes, diabetic foot ulcer, peripheral vascular disease, hypertension, and memory impairment. -The resident was ambulatory and required assistance with bathing and dressing.	{D 273}	Wilson Assisted Living is committed to ensuring referral and follow up for every resident to meet their healthcare needs. Referrals are received by RCC and a "Referral Form" is completed. Transporter receives a copy to make the appointments. Form is completed with appointment dates/information, copied and one copy returned to RCC for follow-up. If referral appointments cannot be scheduled in a timely manner, PCP will be notified. Monthly audits of resident charts will be conducted by RCC/MCC or designee to ensure follow-up timeliness and accuracy.	3/17/21

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{D 273}	Continued From page 6 Review of Resident #2's current care plan dated 01/14/21 revealed: -The resident required extensive assistance with ambulation, bathing, grooming, and dressing. -The resident required limited assistance with transfers. -The resident was forgetful and sometimes disoriented. -The resident had limited range of motion of the upper extremities and had limited ability to ambulate requiring the use of a walker/cane/wheelchair. -The resident's skin was within normal limits. Review of Resident #2's skin assessment sheets dated from 10/02/20 - 02/06/21 revealed: -There were instructions to document "any red/open areas, skin tears, rashes, cuts, etc", circle the body area on the picture, then submit the sheet after signing to the supervisor in charge and/or the Resident Care Coordinator. -There was no documentation of red/open areas, skin tears, rashes, cuts, etc. -There was no circled area on the body diagrams. a. Review of Resident #2's Primary Care Provider (PCP) visit note dated 12/30/20 revealed: -The resident was diagnosed with diabetes, diabetic foot ulcer, peripheral vascular disease, and peripheral neuropathy. -The resident was seen as a follow up for a diabetic foot ulcer. -The resident had been treated by home health (HH) status post a partial left foot amputation. -HH had since discharged the resident due to wound healing. -The resident had developed a new wound to the top of the left foot. -HH was ordered to evaluate and treat the wound to the left foot.	{D 273}		

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{D 27 }	Continued From page 7	{D 273}		

Interview with a Registered Nurse (RN) for Resident #2's HH provider on 02/11/21 at 11:00am revealed:
-Resident #2 was open for HH from 08/01/19 - 12/28/20 for wound care to the left 3rd toe area and post-surgical amputation.
-The resident was discharged from HH on 12/28/20 because the left foot wound was healed.
-On 12/28/20 the resident had "redness" to the top of the left foot, but the skin was closed and intact.
-Resident #2's 12/30/20 HH order to evaluate a new wound to the top of the resident's left foot was never received by the agency.
-It was important for the facility to have sent the resident's order for HH to evaluate the wound to the left foot because the resident was a diabetic and prone to delayed wound healing that could have led to infection and possible amputation.
-If the HH agency would have received the HH order a RN would have made a new assessment even though the resident was discharged from HH services on 12/28/20 because it was a new wound and there was a physician's order.

Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 11:15am revealed:
-It was her responsibility to process all orders for residents on the Assisted Living (AL) side.
-It was the responsibility of the Administrator to ensure resident orders were not missed.

A second interview with the RCC on 02/11/21 at 11:30am revealed:
-She did not remember sending Resident #2's 12/30/20 order for HH to the HH agency.
-She did not remember seeing Resident #2's 12/30/20 visit note.
-PCP visit notes were not kept in the resident's

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{D 273}	Continued From page 8 facility record. She did not know why. -PCP visit notes were received upon request from the facility. -If the PCP wanted residents referred to another provider the PCP would document on a handwritten visit note or fax the referral to her for processing. -Orders were to be placed in a box in her office or faxed from the referring provider to a fax machine located in her office. -The MA or Special Care Coordinator (SCC) were responsible to process referrals in her absence. Telephone interview with Resident #2's PCP on 02/15/21 at 9:56am revealed -Resident #2 had diabetes and was at increased risk for skin break down and delayed wound healing. -She expected the facility to have forwarded the residents order for HH to the agency on 12/30/20 so the wound could have been assessed and treated by licensed staff. -Increased skin break down could lead to infection or worsening of the resident's wound. -She did not know the order for HH was not sent to the HH agency. Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -She expected all orders to have been sent to the referral agency within the next business day. -She expected the ordering provider to have been notified if there was a delay in referring a resident to a referral agency. -The RCC was ultimately responsible for all orders on the Assisted Living (AL) side. -In the absence of the RCC, the Special Care Coordinator (SCC) was responsible to process physician orders unless the RCC had made other arrangements for the medication aide (MA) to	{D 273}		

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{D 273}	Continued From page 9 assume responsibility. b. Observations of Resident #2's feet, ankles, and leg on 02/09/21 at 4:05pm revealed: -Resident #2's top left mid foot had a red opened area approximately 2 x 2 centimeters with the skin peeled back. The perimeter was bright pink to light red in color -There were more than 3 scabbed areas in various stages of healing on the outer ankle. -The left 2nd and 3rd toes of the left foot were absent. -Between the left 4th and 5th toes were a thick light brown colored substance with flaking skin. -There was a black circular area approximately 2 millimeters (mm) x 2mm on the bottom of the right 1st toe. -There was a black circular area approximately 3mm x 3mm to the right tip of the right 1st toe. -There was a purple to black colored circular area approximately 2mm x 2mm to the outer right 2nd toe at the nailbed -There was an abrasion with a scab and a light red perimeter to the top of the right foot. -There was a scabbed area to the out right ankle. -There were 3 open, red abrasions to the right outer leg. The perimeters were bright red in color. -There were 3 scabs of various stages to the right outer knee. Interview with Resident #2 on 02/09/21 at 4:08pm revealed: -He did not know how the skin tear on his left foot occurred. -The skin tear on the top of his left foot had not been treated by HH. -The sores on his legs were from bumping into things. -He did not know how long he had the sores to	{D 273}		

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{D 273}	Continued From page 10 his legs. -He had not seen a provider for the sores to his legs or skin tear to the top of his left foot. -He was not being treated by HH for wounds to his feet, ankles, or legs. Interview with Resident #2's Primary Care Provider (PCP) on 02/10/21 at 11:40am revealed: -Resident #2 previously had left toe amputations and the surgical sites were healed. -Resident #2 wore a diabetic cradle shoe with a band on the top of the foot. -She did not know Resident #2 currently had a new "skin tear" to the top of the left foot. -The black areas to the resident's right toes looked like calluses. -She did not expect staff to tell her Resident #2 had a blackened area to his toes or dry skin. -From the description of Resident #2's feet, the resident had "athletes' foot" and probably needed a prescription medication to treat athletes' foot. -She was "worried" about the skin tear on top of Resident #2's foot because it was open, and the resident was a diabetic placing the resident at a risk for delayed wound healing and increased risk for infection. -She did not know about the wounds to Resident #2's right leg. -She expected staff to have told her of the wounds to Resident #2's right leg so she could have evaluated the wounds. -Resident #2 could have a delay in wound healing and was prone to infection because he was a diabetic. -Open wounds in diabetics placed the resident at increased risk of infection which could lead to antibiotics and a potential need for amputation from delayed wound healing. -She would evaluate Resident #2 today, 02/10/21.	{D 273}		

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{D 273}	Continued From page 11 Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 12:15pm revealed: -The personal care aides (PCAs) were to document skin integrity issues (wounds or bruising) on the skin assessment sheet with every shower and when noted during personal care. -The PCAs were to tell the medication aides (MAs) when skin integrity issues were discovered. -The MAs were to check the skin integrity issue, call the resident's PCP, then tell the RCC. -Resident #2 had a wound to his right foot but it was healed in December 2020. -Resident #2 did not currently have any wounds that she knew of. -She expected staff to have checked Resident #2's feet and legs during showers and personal care, document the skin assessments, and tell the provider so the residents wounds could have been evaluated. Interview with a MA on 02/10/21 at 12:40pm revealed: -The MAs were supposed to check Resident #2's left foot every week to be certain the wounds were not oozing or bleeding. -She last looked at Resident #2's left foot today, 02/10/21, per the residents request due to dry skin. -Before today, 02/10/21, she last checked Resident #2's feet 1 week ago. -The resident had a diabetic wound to the bottom of his left foot when she checked 1 week ago. -The wound to the bottom of Resident #2's left foot was being treated by home health. -Resident #2 complained to her today, 02/10/21, that he had dry skin on his feet. -Resident #2 would pick at the dry skin on his feet causing sores. -She had not told Resident #2's PCP about the	{D 273}		

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{D 273}	Continued From page 12 resident picking at his skin causing sores because she did not think it needed to be reported. -If Resident #2 had new wounds or wounds oozing or bleeding, she would report it to the resident's PCP. -She would not document dry skin, feet wounds, or wounds that were oozing or bleeding. -She would not report "scratches" to the PCP because they were not considered "bad" wounds. -She would report a skin tear to the PCP because skin tears were a step above scratches. -She did not know Resident #2 had a skin tear to the top of his left foot until this morning, 02/10/21. -She had not reported any wounds to Resident #2's PCP. -She had added Resident #2 to the PCP's list of residents to be evaluated today, 02/10/21, because of the skin tear on the top of the left foot. Interview with a PCA on 02/10/21 at 12:59pm who documented on Resident #2's February 2021 personal care log revealed: -She last saw wounds to Resident #2's left foot on 02/09/21. -She did not tell anyone about the wounds to Resident #2's left foot because she forgot. -She did not see any other wounds to the resident's feet or legs on 02/09/21. -She should have told the MA about the wounds to Resident #2's left foot. A second interview with Resident #2's PCP on 02/10/21 at 1:30pm revealed: -She assessed the resident's feet today, 02/10/21. -The sores on the resident's right leg were from bumping his leg on the wheelchair. -The new sore on top of the left foot was from the resident's shoe rubbing on the skin.	{D 273}		

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{D 273}	Continued From page 13 -She had ordered triple antibiotic ointment for the wound on the residents left foot and the right leg wounds. Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -All resident wounds were to be documented on the skin assessment sheet when discovered. -The process for wound notification was for the PCA to tell the MA who would tell the RCC who was responsible for calling the residents PCP when wounds were discovered. -The resident's PCP should have been informed of wounds when discovered so the resident's needs could have been met by a licensed provider. c. Review of a comprehensive foot exam performed by Resident #2's first Primary Care Provider (PCP) on 12/02/20 revealed: -The resident was diagnosed with diabetes type 2, peripheral neuropathy, and peripheral vascular disease. -The resident's skin was thin, fragile, shiny, and hairless. -There were no calluses. -There were signs of pre-ulceration. -The resident was high risk because of loss of protective sensation, history of foot ulcer, and previous amputation. -The resident did not wear appropriate footwear. Review of Resident #2's physician's order dated 12/08/20 revealed: -The order was a podiatry referral. -The resident was diagnosed with onychomycosis of the toenails (a fungus that causes thick, brittle, crumbly, or ragged nails). Review of a Podiatry progress note for Resident	{D 273}		

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{D 273}	Continued From page 14 #2 dated 09/18/20 revealed: -The resident was treated for diabetic foot care and had an amputation of the left 2nd and 3rd toes with sutures intact at the left 2nd toe amputation site. -The resident's right and left pedal and tibial pulses were not palpable. -The residents left 1st toenail was incurvated. -The resident's left 1st and 4th - 5th toenails were thick, discolored, and crumbly. -The resident's right 1st - 5th toenails were thick, discolored, and crumbly. -The resident was to follow up with podiatry in 2 - 3 months. Observation of Resident #2's feet on 02/09/21 at 4:05pm revealed: -The left 1st, 4th, and 5th toe nails on the left foot were thick and the left 4th toenail curved with the tip of the toe; the left 5th toenail grew upwards. -On the right foot, there was thick yellow and flaking skin around the nail beds of the right 1st - 5th toes. -On the right foot, the right 1st - 5th toenails were thick, elevated and jagged; the right 3rd toenail extended past the tip of the right 3rd toe. -On the right foot, there was thick, yellow, flaking, crusty skin around the right 1st toe nail bed. Interview with Resident #2 on 02/09/21 at 4:08pm revealed: -He had a podiatrist but had not seen the podiatrist in over 3 months. He did not know why. -He wanted to see a podiatrist for foot and nail care. -He was not currently seeing a provider for his feet. -He had no pain in his feet or toes. Telephone interview with Resident #2's first PCP	{D 273}		

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{D 273}	Continued From page 15 on 02/15/21 at 10:15am revealed: -She wrote the order for Resident #2 to see podiatry for nail trimming. -She expected Resident #2's podiatry order to be sent to the podiatrist when written. -Resident #2 was at increased risk for poor wound healing and infection which could require an antibiotic and eventually lead to amputation from diabetes and peripheral vascular disease. -If she had known the podiatrist would not have made a facility visit until March 2021, she would have requested a sooner podiatry appointment for the resident. Interview with Resident #2's second PCP on 02/10/21 at 11:40am revealed: -She thought podiatry visited the facility every 6 months. -Resident #2 previously had left toe amputations and the surgical sites were healed. -She knew Resident #2 had "thick toenails". -Resident #2 had not been seen by podiatry since around September 2020 or October 2020. -Resident #2 needed to be seen by podiatry to evaluate the feet and nails. She did not state when. Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 12:15pm revealed: -The podiatrist made facility visits every 6 months. -The next podiatrist visit would be in March 2021. -She thought the last podiatrist visit was in September 2020 or October 2020. -She did not know when Resident #2 was last seen by podiatry. Interview with a personal care aide (PCA) on 02/10/21 at 12:59pm who documented on Resident #2's February 2021 personal care log	{D 273}		

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{D 273}	Continued From page 16 revealed: -Resident #2 had thick toenails on both feet. -She last rubbed lotion on Resident #2's feet on 02/09/21. -On 02/09/21, Resident #2 had flaking skin to the feet and thick yellow toenails. She did not tell the MA, RCC, or PCP because she didn't think about it. A second interview with the RCC on 02/11/21 at 11:30am revealed: -Resident #2's podiatry order dated 12/08/20 was not sent to the podiatrist because podiatry only made scheduled every 6-month visits to the facility. -When she received Resident #2's podiatry referral order dated 12/08/20 she told the ordering PCP the podiatrist would see the resident at the next scheduled facility visit which was March 2020. -The ordering PCP was okay with Resident #2 waiting until March 2020 to be seen by the podiatrist. -She did not document the conversation with the PCP. -It was not expected to send podiatry orders to the podiatrist because it was known the podiatrist would see the residents at the 6-month facility visits. Telephone interview with a representative of the facility's contracted podiatrist on 02/12/21 at 9:50am revealed: -The last podiatry visit for the facility was September 2020. -The RCC called on 02/11/21 to schedule a facility podiatry visit. -The next facility podiatry visit was scheduled for 03/12/21. -She did not know when the last communication	{D 273}		

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{D 273}	Continued From page 17 was between the facility and podiatry from September 2020 - February 2021 when the RCC called to schedule a facility podiatry visit. -The facility would normally call to schedule the podiatry visits. -She did not know why there were no facility podiatry visits made after September 2020. -If there were documentation in the podiatry visit resident notes that indicated a 2 - 3-month podiatry follow up visit the visit should have been scheduled. -If a referral had been received, the podiatry office would have tried to schedule a facility visit for all the podiatry residents. -If a visit for all the podiatry residents could not have been made, the podiatrist would have made a visit for the residents with referrals. -They did not receive a December 2020 podiatry referral for Resident #2. Telephone interview with the podiatrist on 02/12/21 at 10:30am revealed: -Podiatry would make facility visits every 2 - 3 months and as often as needed. -Podiatrist specialized in the foot and ankle and expected to have been informed of any resident with foot and ankle concerns to include wounds. -It was expected the facility to have sent podiatry referrals when obtained so the residents could have been evaluated by a podiatrist. -A referral for nail and diabetic foot care was often an urgent visit. -Resident #2 could have been evaluated within 1 - 2 weeks if needed. -Diabetics required routine nail and foot care because of being at increased risk for complications. -If diabetics did not have routine nail care it would place them at risk for nail and skin infections, pain and discomfort, and cellulitis around the nail.	{D 273}		

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{D 273}	Continued From page 18 -Diabetics who had wounds and ulcers were at more risk of amputation. -Podiatry had been open to facility visits throughout the COVID-19 pandemic. -Podiatry would have made facility visits even if the facility had residents who were diagnosed with COVID-19. -She did not know why podiatry had not been at the facility since September 2020. -If notified by the facility of the need to evaluate and/or treat residents, a podiatry visit would have been made at any point and time during the COVID-19 pandemic. Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -She thought podiatry visits were made at the facility every 6 months. -She did not know when podiatry was last at the facility. -She expected all orders to have been sent to the referred providers and processed within the next business day. -She expected the ordering provider to have been notified if there was a delay in referring a resident to a referral agency. -The RCC was ultimately responsible for all orders on the Assisted Living (AL) side. -In the absence of the RCC, the Special Care Coordinator (SCC) was responsible to process physician orders unless the RCC had made other arrangements for the MA to assume respon sibility. -She did not know if podiatry had been asked not to make visits to the facility because of the COVID-19 pandemic. -She expected the 12/08/20 podiatry order to have at the least been sent to the podiatrist to allow the podiatrist to have made the decision to see or not see Resident #2.	{D 273}		

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{D 273}	Continued From page 19	{D 273}		

Telephone interview with the RCC on 02/15/21 at 9:50am revealed:
-She did not know podiatry made facility visits every 2 - 3 months.
-The previous SCC told her podiatry visits were to be every 6 months.

2. Review of Resident #4's current FL-2 dated 09/30/20 revealed:
-Diagnoses included hypertension, congestive heart failure, degenerative joint disease, and undiagnosed dementia.
-The resident was intermittently disoriented, ambulatory, and required assistance with bathing and dressing.

Review of Resident #4's current care plan dated 09/30/20 revealed:
-The resident was sometimes disoriented, forgetful needing reminders, ambulatory with aide or device, had limited strength of upper extremities, and occasional bowel and bladder incontinence.
-The resident required limited assistance with tolleting, ambulating, dressing, grooming, and transfers.
-The resident required extensive assistance with bathing.

a. Review of Resident #4's physician order dated 10/14/20 revealed:
-There was a handwritten order for Speech Therapy (ST) consult.
-There was documentation the resident had dysphagia (difficulty swallowing foods or liquids) and trouble swallowing pills.

Review of Resident #4's physician, therapy, and progress notes revealed:

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{D 273}	Continued From page 20 -There was no documentation that indicated Resident #4 was evaluated by ST. -There was no documentation Resident #4's Primary Care Provider (PCP) was informed the resident was not evaluated by ST. Interview with the facility's contracted Rehabilitation Director on 02/11/21 at 10:58am revealed: -Resident #4's ST referral order was never received from the facility. -ST would have evaluated Resident #4's swallowing ability in the facility or may have referred the resident to a hospital for a more formal swallowing study. -Resident #4 could have aspirated or choked on meals, liquids, or mediations as a result of dysphagia or difficulty swallowing medications. Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 11:15am revealed: -It was the responsibility of the RCC to process all orders. -She did not know anything about Resident #4's ST order dated 10/14/20 because she was out of the facility at that time. -The previous Special Care Coordinator (SCC) would have been responsible for processing orders at that time. Interview with Resident #4's PCP on 12/10/21 at 11:40am revealed: -She ordered ST for the resident to assess for swallowing problems. -She thought the resident was having problems swallowing a potassium pill. The potassium pills were bigger than a normal pill. -She changed the potassium pill to a capsule. -The resident did not have problems swallowing afterwards.	{D 273}		

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{D 273}	Continued From page 21 -She did not have concerns regarding Resident #4's ST order not being given to therapy because the resident was no longer experiencing swallowing problems. Interview with Resident #4 on 02/10/21 at 12:40am revealed: -She sometimes had difficulty swallowing medications. -She did not have problems swallowing food or beverages. Interview with the medication aide (MA) on 02/10/21 at 12:45pm revealed Resident #4 did not have difficulty swallowing. Interview with a personal care aide (PCA) on 02/10/21 at 12:59pm revealed: -Sometimes Resident #4 would tell her she had problems swallowing foods. -She had observed Resident #4 have difficulty swallowing food and would spit out the food in the past. -The last time she saw Resident #4 have difficulty swallowing food and spit it out was 02/09/21. -She had never told anyone Resident #4 had difficulty swallowing or had spit out food because she forgot. Second telephone interview with Resident #4's PCP on 02/10/21 at 5:10pm revealed: -She did not know Resident #4 was having difficulty swallowing food. -She did not know Resident #4 had difficulty swallowing on 02/09/21. -She did "not" expect to be informed of the resident having difficulty swallowing on 02/09/21. -She did expect to be told if the resident "choked" because choking was different than the inability to swallow.	{D 273}		

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{D 273}	Continued From page 22 -She would re-order ST to evaluate the resident. Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -The previous SCC was responsible for ensuring Resident #4's 10/14/20 ST order was given to the therapy department because the RCC was out of the facility at that time. -She expected all orders to have been sent to the referral agency within the next business day. -In the absence of the RCC, the SCC was responsible to process physician orders unless the RCC had made other arrangements for the MA to assume responsibility. Attempted telephone interview with Resident #4's family member on 02/15/21 at 11:07am was unsuccessful. b. Review of Resident #4's fall risk assessment dated 12/11/20 revealed: -The resident had a total score of 20. -A score of 10 or more indicated a high risk for falls. -There was an order for Physical Therapy. -It was signed by the resident's PCP on 12/11/20. Review of Resident #4's physician order dated 12/15/20 revealed: -There was an order for Physical Therapy to evaluate and treat for generalized muscle weakness. -The order was electronically signed on 12/17/20 by the resident's PCP. Interview with the facility's contracted Rehabilitation Director on 02/10/21 at 10:58am revealed: -Resident #4 was ordered PT on 12/11/20. -PT did not begin for Resident #4 until 01/14/21	{D 273}		

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{D 273}	Continued From page 23 because of lack of therapy staff. -Resident #4 was being treated by PT 5 days a week because she was a fall risk per the December 2020 fall risk assessment. Interview with the Resident Care Coordinator (RCC) on 12/10/21 at 11:15am revealed: -It was the responsibility of the RCC to process all orders. -It was left up to the therapy department to determine when they would start therapy services on a resident. -Two weeks or more would be considered a delay in start of care of therapy services. -The therapy department would tell the RCC if there would be a delay in starting therapy services and the RCC would tell the PCP. -She did not know there was a delay in starting PT for Resident #4. -She did not tell Resident #4's PCP there would be a delay in PT start of care because she did not know Resident #4 was ordered PT services. -It was the therapy departments responsibility to tell her if there would be a delay in start of care. -She did not know what happened with the delay in start of care with PT for Resident #4 because she had just returned full time. -The previous Special Care Coordinator (SCC) may have known about Resident #4's PT delay in start of care. Interview with Resident #4's PCP on 12/10/21 at 11:40am revealed: -She ordered PT for Resident #4 on 12/11/20 because of muscle weakness and wanted PT to increase the resident's strength. -She expected the resident to have been seen by PT within 1 week of ordering PT. -The faculty did not tell her Resident #4 was going to have a delay in PT start of care.	{D 273}		

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{D 273}	Continued From page 24 -She expected the facility to have told her if PT could not have treated the resident within 1 week from the date of the order to ensure coordination of care. -She did not think the resident had fallen between 12/11/20 - 01/14/21. -If the resident did not have falls, she was okay with the delay in PT start of care. Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -A delay in PT start of care for Resident #4 should have never happened. -It was the responsibility of the RCC/SCC to stay in contact with the therapy department to ensure there was not a delay in resident care. -She expected the ordering provider to have been notified by the RCC/SCC if there was a delay in start of care to ensure continuity of care. Attempted telephone interview with Resident #4's family member on 02/15/21 at 11:07am was unsuccessful. c. Review of Resident #4's local Emergency Department (ED) discharge instructions dated 02/07/21 revealed: -Resident #4 was treated in the ED for a fall. -The resident sustained a head injury. -The resident sustained a contusion to the left eye. -The resident complained of knee pain. -The resident was to follow up with an orthopedic surgeon on 02/08/21. -It was electronically signed by the ED provider. Interview with Resident #4's Primary Care Provider (PCP) on 02/10/21 at 11:40am revealed: -The facility told her Resident #4 was treated in the ED for a fall.	{D 273}		

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{D 273}	Continued From page 25 -She had not seen Resident #4's 02/07/21 ED discharge notes yet. -She did not know the ED provider wanted Resident #4 to follow up with an orthopedic surgeon on 02/08/21. -The ED providers order for Resident #4 to follow up with an orthopedic surgeon on 02/08/21 was "unrealistic" and "would never happen" because an orthopedic surgeon would not see the resident that fast without a fracture diagnosis. -She did not expect the facility to contact an orthopedic surgeon on 02/08/21 for an appointment that day because it was not feasible for an orthopedic surgeon to see the resident on that day. Telephone interview on 02/10/21 at 1:40pm with an office assistant with the Orthopedic Surgeon Resident #4 was referred to from the ED on 12/07/21 revealed: -Resident #4 had an appointment scheduled for 02/23/21. -The facility transporter called today, 02/10/21, to schedule the appointment. -The facility transporter told her she needed to schedule a "2-week hospital follow up appointment" for Resident #4. -She was not told the ED provider wanted Resident #4 seen on 02/08/21. -If told today, 02/10/21, the ED provider wanted Resident #4 seen on 02/08/21 the resident would have been scheduled for an appointment on 02/11/21 at 3:00pm. -The orthopedist was not in the office on 02/08/21. -If the facility called on 02/08/21 to schedule a 02/08/21 orthopedic appointment for Resident #4 the resident would have been worked in on 02/09/21.	{D 273}		

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{D 273}	Continued From page 26 interview with the transporter on 02/10/21 at 2:00pm revealed: -The Resident Care Coordinator (RCC) gave her a note on 02/09/21 at the end of her shift to make an orthopedic appointment for Resident #4. -The RCC told her Resident #4 needed a hospital follow up appointment with an orthopedist for right knee pain. -She did not know Resident #4 was treated in the ED. -She did not see Resident #4's ED discharge paper work. Review of a note provided by the transporter on 02/10/21 identified as the note given to her by the RCC revealed: -There was handwritten documentation Resident #4 needed an appointment with an orthopedic surgeon. -The reason was for right knee pain. -There was no documentation that indicated the urgency of the appointment. Interview with the RCC on 02/10/21 at 2:40pm revealed: -She was not in the facility Monday, 02/08/21. -The MA or the Special Care Coordinator (SCC) was responsible for checking her box for hospital paperwork and referrals. -She saw Resident #4's hospital paperwork on Tuesday, 02/09/21. -She placed a note in the transporter's box on 02/09/21 to schedule an appointment with the orthopedic surgeon. -The transporter would not know how soon Resident #4 needed to be seen unless she asked. -She verbally told the transporter to schedule the appointment for Resident #4 as soon as possible.	{D 273}		

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{D 273}	Continued From page 27 Interview with a medication aide (MA) on 02/10/21 at 2:45pm revealed: -The RCC and the MA were responsible for reviewing residents' hospital paperwork to check for orders. -In the absence of the RCC, the responsibility would fall on the SCC or MA. -The MA was not working Monday, 02/08/21. Interview with the Administrator on 02/10/21 at 2:50am revealed: -She did not know Resident #4 was treated in the ED on 02/07/21. -She did not know Resident #4 was to follow up with an orthopedic surgeon on 02/08/21. -It was the responsibility of the RCC to review hospital paperwork for orders. -The RCC would tell the transporter when appointments needed to be scheduled. -In the absence ofthe RCC, the MA and SCC would be responsible for checking the RCC box for hospital paperwork and any orders to ensure appointments were scheduled. Interview with the SCC on 02/10/21 at 4:35pm revealed: -She was not working when Resident #4 went to the ED on 02/07/21. -If the RCC was not working, she usually checked the RCC's box to for any pending orders or referrals needed to be made. -On Monday, 02/08/21, she did not check the RCC's box because she had seen the RCC in the facility that morning, but she did not realize the RCC left and was off that day. -She did not see Resident #4's hospital discharge orders because she did not check the RCC's box. -She was not aware the resident had a referral to see an orthopedic surgeon.	{D 273}		

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{D 273}	Continued From page 28 Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -She expected the orthopedic surgeon to have been contacted on Monday, 02/08/21, to make an appointment for Resident #4. -The orthopedic surgeon should have been contacted on 02/08/21 to ensure Resident #4's needs were met per referral of the ED provider. -She expected the RCC, SCC, and MA to communicate to ensure resident orders were not missed. -Usually when the RCC was out of the facility, the SCC would fill in and check the box for orders. Attempted telephone interview with Resident #4's family member on 02/15/21 at 11:07am was unsuccessful. 3. Review of Resident #3's current FL-2 dated 01/15/21 revealed: -Diagnosis included cerebral palsy. -The resident was intermittently disoriented, semi-ambulatory with the use of a wheelchair, and incontinent of bowel and bladder. Review of Resident #3's current care plan dated 01/12/21 revealed the resident was totally dependent upon staff for bathing, grooming, dressing, toileting, transfers, and eating. Review of Resident #3's physician order dated 12/10/20 revealed: -The resident was diagnosed with an unspecified acquired deformity of an unspecified lower leg. -The resident was referred to podiatry for right foot bony deformity, onychomycosis (thick, yellow, jagged toenails), and calluses. -There was documentation to send to an outside podiatrist.	{D 273}		

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{D 273}	Continued From page 29 Virtual observation of Resident #3's feet on 02/15/21 at 10:15am revealed: -The resident had callus formation to the top of the right ankle and left inner ankle where the foot and ankle join. -The toenails on the resident's right foot extended past his toes and had flaking skin around the nail beds. -The toe nails on the residents' left foot extended past his toes. -The left great toenail was jagged, the left 2nd toenail was curved in towards the 1st toe, the 4th toenail was thick and dark gray in color. -The outside of the left 5th toe was black in color approximately half the length of the 5th toe where the toe and foot join. -There was a circular area approximately dime size that was darker in color with the center open located on the left outer ankle, there was no drainage. -There were two abrasions to the left outer ankle. -There was flaking cracked dry skin to both heels. -There were 3 dark brown round shaped areas to the left outer edge of the foot and 1 to the bottom of the heel that were similar to bruises. Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 12:15pm revealed: -The podiatrist made facility visits every 6 months. -The next podiatrist visit would be in March 2021. -She thought the last podiatrist visit was in September 2020 or October 2020. A second interview with the RCC on 02/11/21 at 11:30am revealed it was not expected to send podiatry orders to the podiatrist because it was known the podiatrist would see the residents at the 6-month facility visits.	{D 273}		

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{D 273}	Continued From page 30 Telephone interview with a representative of the facility's contracted podiatrist on 02/12/21 at 9:50am revealed: -The last visit for the facility was September 2020. -The Resident Care Coordinator (RCC) called on 02/11/21 to schedule a facility podiatry visit. -The next facility podiatry visit was scheduled for 03/12/21. -She did not know when the last communication was between the facility and podiatry from September 2020 - February 2021 when the RCC called to schedule a facility podiatry visit. -The facility would normally call to schedule the podiatry visits. -She did not know why there were no facility podiatry visits made after September 2020. -If there were documentation in the podiatry visit resident notes that indicated a 2 - 3-month podiatry follow up visit the visit should have been scheduled. -If a referral had been sent by the facility the podiatry office would have tried to schedule a facility visit for all the podiatry residents. -If a visit for all the podiatry residents could not have been made, the podiatrist would have made a visit for the residents with referrals. -They did not receive a December 2020 podiatry referral for Resident #3. Telephone interview with the podiatrist on 02/12/21 at 10:30am revealed: -Podiatry would make facility visits every 2 - 3 months and as often as needed. -Podiatrist specialized in the foot and ankle and expected to have been informed of any resident with foot and ankle concerns to include wounds. -It was expected the facility to have sent podiatry referrals when obtained so the residents could have been evaluated by a podiatrist. -Podiatry had been open to facility visits	{D 273}		

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{D 273}	Continued From page 31 throughout the COVID-19 pandemic. -Podiatry would have made facility visits even if the facility had residents who were diagnosed with COVID-19. -She did not know why podiatry had not been at the facility since September 2020. -If notified by the facility of the need to evaluate and/or treat residents, a podiatry visit would have been made at any point and time during the COVID-19 pandemic. Telephone interview with the Administrator on 02/12/21 at 3:07pm revealed: -She thought podiatry visits were made at the facility every 6 months. -She did not know when podiatry was last at the facility. -She expected all orders to have been sent to the referred providers and processed within the next business day. -She expected the ordering provider to have been notified if there was a delay in referring a resident to a referral agency. -The RCC was ultimately responsible for all orders on the Assisted Living (AL) side. -In the absence of the RCC, the SCC was responsible to process physician orders unless the RCC had made other arrangements for the MA to assume responsibility. -She did not know if podiatry had been asked not to make visits to the facility because of the COVID-19 pandemic Telephone interview with Resident #3's PCP on 02/15/21 at 10:25am revealed: -She ordered podiatry for Resident #4. -Resident #4 used his feet to self-ambulate in the wheelchair. -She could not remember anything specific about the podiatry referral for Resident #4.	{D 273}		

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{D 273}	Continued From page 32 4. Review of Resident #1's current FL-2 dated 10/07/20 revealed: -Diagnoses included dementia with behavior disturbance, benign prostatic hyperplasia involving the lower urinary tract, sleep pattern disturbance, seizures, cerebrovascular accident, chronic obstructive pulmonary disease, and memory loss. -The resident was intermittently disoriented -The resident was semi-ambulatory with a walker -The resident was incontinent of bladder and bowel. -The resident was legally blind. -The resident needed assistance with bathing and dressing. Review of Resident #1's current assessment and care plan dated 10/06/20 revealed: -The resident was ambulatory with a wheelchair and no problems were documented with his upper extremities. -The resident was sometimes disoriented with significant memory loss and required redirection. -The resident's vision was very limited, and he was noted to be legally blind. -The resident required extensive assistance with toileting, ambulation, transferring, grooming, bathing and dressing. -The resident required supervision with eating. a. Review of Resident #1's accident/injury reports, primary care provider (PCP) communication/notification notes, PCP visit notes, and hospital emergency department (ED) records revealed: -The resident had 7 falls in a 4-month period from 10/09/20 - 02/02/21. -The resident had documented falls on 10/09/20, 10/20/20, 11/05/20, 12/04/20, 01/20/21, 01/22/21,	{D 273}		

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{D 273}	Continued From page 33	{D 273}		

and 02/02/21.
-The resident went to the ED for evaluation for 5 of 7 falls.
-The resident's injuries included traumatic hematoma of the head, head injury, back contusion, contusion of the head, and skin tear to the right arm.

Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 09/21/20:
-The resident used a wheelchair for mobility and used his feet to self-propel.
-The resident ambulated in his room but had to hold on to objects because he was not stable.
-The resident needed assistance in transferring, toileting, bathing and personal care.
-Bruising was noted to the resident's right lower arm and elbow; resident stated he fell at home.
-The LHPS nurse recommended a physical therapy (PT) evaluation for the resident.

Review of Resident #1's PCP visit note dated 10/21/20 revealed an order for PT and occupational therapy (OT) evaluation and treatment status post fall.

Review of Resident #1's quarterly Fall Risk Assessment by the PCP dated 12/03/20 revealed:
-The resident had a history of falls with at least 1-2 falls in the past 3 months.
-The resident's fall score was 26.
-A fall score of 10 or more meant that the resident was at high risk of falls.
-Interventions ordered included following the facility policy and a referral order to for PT.

Review of Resident #1's provider visit notes and progress notes revealed there was no documentation the resident had received any

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{D 273}	Continued From page 34 PT/OT evaluations or services. Interviews with Resident #1 on 02/09/21 at 10:37am and 3:55pm revealed: -He sometimes had falls and he could fall "anywhere". -He had a hard time getting out of bed. -He fell 3 times last week trying to get out of bed. -He had trouble coordinating his feet and he needed assistance at times. -He denied any serious injuries from falls, just bruises. -He was able to roll his wheelchair independently. -He did not know if he received any PT or OT services. -He could not get out bed by himself unless his wheelchair was close enough to the bed. -His ankles and knees would not support his weight. Interview with the facility's contracted Rehabilitation Director on 02/10/21 at 12:31pm revealed: -Resident #1 had insurance issues and would need to pay a co-pay to do PT/OT. -She screened Resident #1 in December 2020 and he would be appropriate for PT services. -She attempted to get in touch with Resident #1's power of attorney (POA) but had no response and no documentation regarding the attempted contact or when the attempt was made. -She was unable to provide any documentation of Resident #1's PT screening. Telephone interview with Resident #1's POA on 02/12/21 at 2:30pm revealed: -Resident #1 had dementia with good days and bad days and his mobility and balance were more "off" on bad days. -When the resident was first admitted to the	{D 273}		

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facility around October 2020, the facility got an order for the resident to be evaluated by PT.
-She did not know if the PT evaluation was done.
-No one at the facility or the therapy provider had contacted her about PT since the resident was admitted.
-She was in the middle of trying to get insurance for Resident #1.
-Resident #1 had fallen 6-7 times since his admission to the facility in September 2020.
-If PT was warranted due to his falls, she would have approved it to be done.

Telephone interview with the Resident Care Coordinator (RCC) on 02/15/21 at 12:21pm revealed:
-There was no update on the PT referral for Resident #1, but she believed the delay to be a financial issue.
-She had not discussed the PT referral with Resident #1's POA.
-She had not discussed or addressed the PT referral for Resident #1 prior to 02/12/21.
-She thought the previous RCC had completed all December 2020 referrals.

Telephone interview with the Special Care Coordinator (SCC) on 02/15/21 at 12:21pm revealed:
-There was no update on the PT referral for Resident #1, but she believed the delay to be a financial issue and would follow up on when therapy would start.
-She had not discussed the PT referral with Resident #1's POA.
-The in-house PT provider told her the delay was due to insurance issues on 02/12/21.
-She had not discussed or addressed the PT referral for Resident #1 prior to 02/12/21.
-She thought the previous RCC had completed all

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{D 273}	Continued From page 36 December 2020 referrals. Interview with Resident #1's PCP on 02/10/21 at 11:14am revealed: -She last saw Resident #1 on Friday, 02/05/21, after an ED visit for a fall where he was also diagnosed with a urinary tract infection. -Resident #1 was a frequent faller and he slid off the bed at times. -Resident #1 liked to be independent and fell getting into his wheelchair from the bed because he forgot to lock the wheels due to cognition deficits. -Resident #1 had not received any significant injuries from his falls including broken bones, stitches, or staples. -To her knowledge, Resident #1 had not received PT or OT services due to issues with his insurance. Telephone interview with the Administrator on 02/15/21 at 4:10pm revealed: -It was the responsibility of the RCC or SCC to make sure orders were forwarded to in-house therapy services and followed up to ensure they had been completed. -The medication aides (MA) could also do this task if the RCC or SCC was unavailable. b. Review of Resident #1's Basic Foot Examination by the primary care provider (PCP) dated 12/04/20 revealed: -Resident #1 was assessed to have thick, elongated or, ingrown toenails. -Resident #1 was assessed to have hammertoes. -There was a referral order for Resident #1 to see a podiatrist. Review of Resident #1's PCP visit note dated 12/04/20 revealed:	{D 273}		

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{D 273}	Continued From page 37 -Resident #1 was seen for a foot exam. -Resident #1's toenails were thick and long. -Resident #1 had diminished posterior tibial pulses noted bilaterally. -Resident #1 had abnormal gait and stance. -Resident #1 had onychomycosis (a fungus causing thickened, brittle, crumbly, or ragged nails) of toenails. -There was an order for a referral to see the in-house podiatrist in January 2021. Review of Resident #1's bath sheet skin assessment dated 01/15/21 revealed: -A personal care aide (PCA) noted that Resident #1's toenails were long and needed cutting. -A medication aide (MA) signed off as supervisor on the personal care log. Observations on 02/10/21 at 1:15pm revealed: -Resident #1 had long, thick, yellowed, and jagged toenails bilaterally. -The resident had dry skin to both feet and around the toenails. Interview with Resident #1 on 02/10/21 at 1:15pm revealed: -His toenails touched the end of his shoes and "sometimes they hurt". -His feet had "been that way for years" and he could not remember the last time his toenails were trimmed. Telephone interview with a MA/PCA on 02/15/21 at 1:13pm revealed: -He signed Resident #1's bath skin assessment sheet on 01/15/21 and noted the resident's toenails needed cutting. -He did not trim the resident's toenails because they were too thick. -He did not report it to anyone.	{D 273}		

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(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 273}	Continued From page 38 -He last saw Resident #1's feet yesterday, 02/14/21, while providing care. -Resident #1's toenails were "not too long but could be trimmed". -The skin on the resident's feet was dry but not flaky. -PCAs could perform toenail trimming, but Resident #1 would not let him do it because the resident was used to a family member caring for his toenails. Telephone interview with a PCA on 02/15/21 at 1:36pm revealed: -He assisted Resident #1 routinely with dressing, bathing, and toileting. -He bathed Resident #1 today, 02/15/21, and his toenails needed clipping. -Resident #1's toenails had needed clipping for 1 ½ months. -If the resident refused care, he did not document that; he would tell the Resident Care Coordinator (RCC). -He reported Resident #1's long toenails to Resident Care Coordinator (RCC) two weeks ago. Telephone interview with a second PCA on 02/15/21 at 1:50pm revealed: -She assisted Resident #1 with all activities of daily living and care except feeding. -The resident resisted some type of care every day. -She last saw Resident #1's feet last week. -The resident's toenails were long and needed trimming, but she was not allowed to cut residents' toenails. -She would let the MAs know if the resident needed foot care verbally and the MA would "handle it".	{D 273}		

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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{D 273}	Continued From page 39 Interview with the RCC on 02/10/21 at 12:59pm revealed: -The podiatry provider was due to come to the facility in March 2021 and came to the facility every 6 months. -She did not know if Resident #1 was on the list to see the podiatrist in March 2021. Telephone interview with Resident #1's power of attorney (POA) on 02/12/21 at 2:30pm revealed: -The resident needed help with all grooming to include bathing, toileting and foot care. -The resident would not let staff touch his toenails most of the time because he was ticklish. -She cared for his feet prior to admission and had to soak his feet his for a long time in warm water to be able to get his toenails soft enough to trim. -She could only do window visits, so she had not seen his toenails since his admission to the facility in September 2020. -The resident had not complained about his toenails being too long to her. -She did not know if the resident had been referred to podiatry but she would expect to be notified if the resident needed to see a podiatrist. Telephone interview with Resident #1's PCP on 02/15/21 at 10:30am revealed: -She referred resident to podiatry on 12/04/20 per assessment of thick, elongated and overgrown toenails. -The resident had hammertoes, diminished pulses, abnormal gait and stance, and onychomycosis. -She would have expected for Resident #1's podiatry referral to be done in January 2021 as ordered. -She thought that in-house podiatry came to the facility every 3 months and she was told by the previous RCC that podiatry was coming in	{D 273}		

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{D 273}	Continued From page 40 January 2021. -If she had known the podiatry provider was not coming until March 2021, she would have asked the facility to have them come sooner. -She had not been notified that Resident #1 had pain from his toenails pressing against the tips of his shoes. -She expected to be contacted regarding any issues with resident's feet. -Lack of follow up with podiatrist could lead to issues such as toenails cutting into the skin and having an open wound. Telephone interview with the RCC on 02/15/21 at 12:20pm revealed: -She was told by the previous RCC, who left in December 2020, that the in-house podiatry provider came to the facility every 6 months and they last came in September 2020. -She thought the previous RCC took care of all December 2020 referral orders including podiatry. Telephone interview with the Special Care Coordinator (SCC) on 02/15/21 at 12:20pm revealed: -She looked at Resident #1's feet on 02/12/21 but when asked to provide a description of what his feet looked like, she could recall the details to provide one. -None of the staff had brought up concerns concerning Resident #1's feet. -She was responsible for reviewing resident bath skin assessment sheets, but she had not had time to review Resident #1's bath sheet dated 01/15/21 noting his toenails were long and needed trimming. -She would expect staff to verbally notify her if residents had needs such as toenail trimming. -She was not aware of any foot pain due to Resident #1's long toenails.	{D 273}		

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{D 273}	Continued From page 41	{D 273}		

Telephone interview with a representative of the facility's contracted podiatrist on 02/12/21 at 9:50am revealed:
-The last visit for the facility was September 2020.
-The RCC called on 02/11/21 to schedule a facility podiatry visit.
-The next facility podiatry visit was scheduled for 03/12/21.
-She did not know when the last communication was between the facility and podiatry from September 2020 - February 2021 when the RCC called to schedule a facility podiatry visit.
-The facility would normally call to schedule the podiatry visits.
-She did not know why there were no facility podiatry visits made after September 2020.
-If there were documentation in the podiatry visit resident notes that indicated a 2 - 3-month podiatry follow up visit the visit should have been scheduled.
-If a referral had been sent by the facility the podiatry office would have tried to schedule a facility visit for all the podiatry residents.
-If a visit for all the podiatry residents could not have been made, the podiatrist would have made a visit for the residents with referrals.
-The RCC called on 02/11/21 to schedule a podiatry visit for Resident #1.
-Resident #1 would be seen by podiatry as a new patient on 03/12/21.
-They did not receive a December 2020 podiatry referral for Resident #1.

Telephone interview with the podiatrist on 02/12/21 at 10:30am revealed:
-Podiatry would make facility visits every 2 - 3 months and as often as needed.
-The podiatrist specialized in the foot and ankle and expected to have been informed of any

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{D 273}	Continued From page 42 resident with foot and ankle concerns to include wounds. -It was expected the facility to have sent podiatry referrals when obtained so the residents could have been evaluated by a podiatrist. -Podiatry had been open to facility visits throughout the COVID-19 pandemic. -Podiatry would have made facility visits even if the facility had residents who were diagnosed with COVID-19. -She did not know why podiatry had not been at the facility since September 2020. -If notified by the facility of the need to evaluate and/or treat residents, a podiatry visit would have been made at any point and time during the COVID-19 pandemic. Telephone interview with Administrator on 02/15/21 at 4:10pm revealed: -It was the responsibility of the RCC or SCC to make sure orders were forwarded to the in-house services, including podiatry, and follow up to ensure they had been completed. -The MAs could also do this task if the RCC or SCC were unavailable. -Sometimes the facility's contracted nurse or PCP would address toenail issues but if there was a risk of harm then podiatry would do it. c. Review of Resident #1's Head to Toe skin exam by the primary care provider (PCP) dated 12/10/20 revealed: -The resident had several moles and skin tags present with one larger skin tag on his upper left back. -There was an order for a dermatology referral to be performed on our around 12/29/20. Telephone interview with a personal care aide (PCA) on 02/15/21 at 1:13pm revealed:	{D 273}		

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{D 273}	Continued From page 43 -Resident #1 had some moles present on his back, but they looked "regular". -Resident #1 did not have any reddened or inflamed areas on his back or any skin tags that got caught in his clothing. -Resident #1 did not complain or scratch at any areas on his back. Telephone interview with a second PCA on 02/15/21 at 1:36pm revealed Resident #1 had moles on his back, including one that was large and stuck out; but it did not get caught on the resident's clothing. Telephone interview with the Special Care Coordinator (SCC) on 02/12/21 at 9:41am revealed: -She started working as the SCC in January 2021, so she did not know if Resident #1 had been seen by dermatology. -She would check with the facility's Transporter. Telephone interview with Resident #1's power of attorney (POA) on 02/12/21 at 2:30pm revealed: -She spoke with the RCC a few weeks ago and was notified they were going to refer the resident to a dermatologist. -The RCC asked if she would accompany the resident to a dermatology appointment. -The facility's Transporter was supposed to schedule the appointment, but she had not heard back from the facility. Telephone interview with the SCC on 02/15/21 at 12:20pm revealed: -The facility's Transporter was waiting for Resident #1's dermatology office to fax information back to facility for an appointment date and time. -Dermatology did not come to the facility, so	{D 273}		

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{D 273}	Continued From page 44 residents must be scheduled to go out to the dermatology office. Telephone interview with the facility's Transporter on 02/15/21 at 2:05pm revealed: -She called the dermatology office on 12/21/20 but they were not accepting any patients from long term care facilities at that time. -She called back in January 2021, but the dermatology office needed family approval because the resident had dementia. -She called the dermatology office three times last week and they needed a resident face sheet and insurance information. -The SCC called the resident's POA last week to try and get information for approval. -She did not know if the previous SCC tried to contact the POA in January 2021 to get approval. -She sent all required paperwork to dermatology office on 02/11/21 and was waiting for a fax back from them today with the appointment date and time. Telephone interview with the receptionist at Resident #1's dermatology office on 02/15/21 at 4:00pm revealed: -Resident #1 had an appointment scheduled for 04/06/21 at 11:45am. -The appointment was made on 02/12/21 by the facility. -There was no documentation of any previously scheduled or missed appointments for Resident #1. -The dermatology office had been seeing patients during the COVID-19 pandemic and they had no restrictions seeing patients from long term care facilities. Telephone interview with Resident #1's PCP on 02/15/21 at 10:30am revealed:	{D 273}		

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{D 273}	Continued From page 45 -She had ordered a dermatology referral on 12/10/20 for a large skin tag on the resident's back. -She expected facility staff to call and set up the appointment on or around 12/29/20 as ordered. -The skin tag was large and catching on the resident's clothes and she wanted it looked at by a dermatologist. Telephone interview with the Administrator on 02/15/21 at 4:10pm revealed Resident #1's dermatology referral had been overlooked by the facility but was on the Transporter's desk now to be addressed. 5. Review of Resident #5's current FL-2 dated 12/22/20 revealed: -Diagnoses included dementia with hallucinations, Alzheimer's, congestive heart failure, coronary artery disease, diabetes mellitus type 2, hypertension, history of colon cancer, acute renal failure, and metabolic acidosis. -The resident was intermittently disoriented. -The resident was semi-ambulatory with a walker. -The resident was incontinent of bladder and bowel. -The resident needed assistance with bathing and dressing. Review of Resident #5's current assessment and care plan dated 12/22/20 revealed: -The resident needed limited assistance with eating, ambulation and transferring. -The resident required extensive assistance with toileting, bathing, dressing and grooming. -The resident was ambulatory with a walker and had limited strength in his upper extremities. -The resident had daily incontinence of bowel and bladder. -The resident was sometimes disoriented with	{D 273}		

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{D 273}	Continued From page 46 forgetfulness requiring reminders. a. Review of Resident #5's Podiatry Services Progress Note dated 09/18/20 revealed: -The resident was seen for diabetic foot care. -Pigment changes were noted to the right foot and both feet were noted to be dry. -He had decreased tibial pulses and absent pedal pulses were noted to both feet. -His toenails were noted to be incurvated, dystrophic, crumbly, discolored and thickened. -The resident was to follow up with podiatry again in 2-3 months. Review of Resident #5's primary care provider (PCP) visit note and Comprehensive Diabetic Foot Exam form dated 12/04/20 revealed: -Resident #5 was seen for diabetic foot exam. -His past medical history included diabetes type 2, peripheral neuropathy, neuropathy, congestive heart failure, hypertension, and hyperlipidemia, diabetes with neuropathy, congestive heart failure, hypertension and hyperlipidemia on the visit note. -The resident had thick, long, ingrown or fungal toenails and bunions. -The resident had dryness to both feet. -There were decreased tibial pulses in both feet and absent pedal pulses in both feet. -The resident had bunions but wore well-fitting shoes at the time of the exam. -The resident's feet were warm, but he had extra dry skin. -The resident had a small callous/lesion to the right heel with decreased sensation present. -The resident's feet and toes had deformity with nail changes. -He had diminished or absent sensation with peripheral neuropathy, loss of protective sensation to pain, temperature, tactile touch, and	{D 273}		

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{D 273}	Continued From page 47 vibration to sole of both feet. -There was an order to refer to in-house podiatry in January 2021 for treatment. -The resident's callous on heel was to be monitored for any worsening changes to include blood, discharge on socks and cracking of the skin. Observation of Resident #5 on 02/10/21 at 1:07pm revealed: -The resident's first toenail on his left foot was very long and thick and it curved over the top of his toe. -The resident's first toenail on his right foot was broken and jagged. -The resident's toenails were long, yellowed, thick, and scaling. -The resident had dry peeling skin on his right heel. Interview with Resident #5 on 02/10/21 at 11:07am revealed the resident denied any pain with his feet or toes. Interview with the Resident Care Coordinator (RCC) on 02/10/21 at 12:59pm revealed: -The facility's podiatry provider would come to the facility in March 2021. -She thought the podiatrist provider came to the facility every 6 months. -She did not know if Resident #5 had seen the podiatrist. -The Special Care Coordinator (SCC) knew how they compiled the list of residents to be seen when the podiatrist came to the facility. Interview with a personal care aide (PCA) on 02/10/21 at 1:20pm revealed: -She could not remember the last time the podiatrist came to the facility.	{D 273}		

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{D 273}	Continued From page 48 -She was unsure when podiatry was scheduled to come again. -The PCAs could not provide foot care to residents if the residents were diabetic or had thick nails Telephone interview with a second PCA on 02/15/21 at 1:13pm revealed: -He assisted Resident #5 with bathing and dressing when the resident could not do it on his own. -He last saw the resident's toenails yesterday, 02/14/21, and they were long and needed trimming. -The facility contracted nurse should trim the resident's toenails because the resident was diabetic. -He would tell the facility's contracted nurse, who came to the facility twice per week, when the resident needed toenail trimming. Telephone interview with a third PCA on 02/15/21 at 1:30pm revealed: -He assisted Resident #5 with bathing, toileting, and dressing and the resident never refused care. -He last saw the resident's skin and toes this morning; they were dry, and the toenails needed cutting so he put lotion on them. -The toenails had needed cutting for the last two weeks but "weren't too bad". -The resident was diabetic so podiatry would have to cut the resident's toenails. -He would document the need for toenail trimming on the bath skin assessment sheet then turn it in to the medication aide (MA). -He told the SCC on 02/15/21 that the resident's toenails needed cutting but did not receive any further instruction from her regarding the issue. Interview with the RCC on 02/10/21 at 2:42pm	{D 273}		

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(D 273)	Continued From page 49 revealed: -She thought the podiatry provider did not come in January 2021 because of the highly positive rate of COVID-19 in their county. -The podiatry provider was coming in March 2021, but she did not know an exact date yet. -All residents were seen by podiatry if they signed up for the service upon admission. Telephone interview with Resident #5's PCP on 02/15/21 at 10:30am revealed: -She expected the resident's podiatry visit to be set up in January of 2021 as ordered since the resident was diabetic. -Diabetics were at risk of concerns such as toenails cutting into the skin or open wounds if they don't have follow up podiatry care. Telephone interview with the RCC on 02/15/21 at 12:20pm revealed: -She thought previous RCC took care of all December 2020 referrals, including podiatry. -The previous RCC told her the podiatrist came to the facility every 6 months and were due to come again in March 2021. Telephone interview with the SCC on 02/15/21 at 12:20pm revealed: -She thought the podiatry provider was supposed to come to the facility every 6 months. -She was not aware of Resident #5's follow-up order from his last podiatry visit in September 2020 to return in 2-3 months. -She was not aware that Resident #5's order from December 2020 for a podiatry referral to be completed in January 2021 had not been scheduled or completed. -She had not seen Resident #5's feet recently but had not received any concerns from staff about his feet.	(D 273)		

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{D 273}	Continued From page 50 -Resident #5 now had a podiatry appointment in March 2021. Telephone interview with a representative of the facility's contracted podiatrist on 02/12/21 at 9:50am revealed: -The last visit for the facility was September 2020. -The RCC called on 02/11/21 to schedule a facility podiatry visit. -The next facility podiatry visit was scheduled for 03/12/21. -She did not know when the last communication was between the facility and podiatry from September 2020 - February 2021 when the RCC called to schedule a facility podiatry visit. -The facility would normally call to schedule the podiatry visits. -She did not know why there were no facility podiatry visits made after September 2020. -If there were documentation in the podiatry visit resident notes that indicated a 2 - 3-month podiatry follow-up visit the visit should have been scheduled. -If a referral had been sent by the facility the podiatry office would have tried to schedule a facility visit for all the podiatry residents. -If a visit for all the podiatry residents could not have been made, the podiatrist would have made a visit for the residents with referrals. -Resident #5 had not been seen by podiatry since 09/18/20. -They did not receive a December 2020 podiatry referral for Resident #5. Telephone interview with the podiatrist on 02/12/21 at 10:30am revealed: -Podiatry would make facility visits every 2 - 3 months and as often as needed. -The podiatrist specialized in the foot and ankle and expected to have been informed of any	{D 273}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILS[illegible] ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) 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 273}	Continued From page 51 resident with foot and ankle concerns to include wounds. -It was expected the facility to have sent podiatry referrals when obtained so the residents could have been evaluated by a podiatrist. -Podiatry had been open to facility visits throughout the COVID-19 pandemic. -Podiatry would have made facility visits even if the facility had residents who were diagnosed with COVID-19. -She did not know why podiatry had not been at the facility since September 2020. -If notified by the facility of the need to evaluate and/or treat residents, a podiatry visit would have been made at any point and time during the COVID-19 pandemic. Telephone interview with the Administrator on 02/15/21 at 4:10pm revealed: -It was the responsibility of the RCC or SCC to make sure orders were forwarded to in-house services and followed up to ensure they had been completed. -The MAs could also do this task if the RCC or SCC was unavailable. -Sometimes the facility's nurse or PCP would address toenail issues but if there was a risk of harm then podiatry would do it. -Resident #5 would need to see podiatry because he was diabetic and at risk for infection and injury. b. Review of Resident #5's Comprehensive Diabetic Foot Exam by the primary care provider (PCP) dated 12/04/20 revealed: -The resident's past medical history included diabetes type 2, peripheral neuropathy, neuropathy, congestive heart failure, hypertension, and hyperlipidemia. -There was an order for the resident to get an	{D 273}		

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{D 273}	Continued From page 52 updated Hemoglobin A1C. (Hemoglobin A1C is a blood test used to determine how well a diabetic's blood sugar has been controlled for the last 2-3 months. Review of Resident #5's PCP visit note dated 12/04/20 revealed: -Resident #5 was seen for diabetic foot exam. -His history included diabetes with neuropathy, congestive heart failure, hypertension and hyperlipidemia. -The resident's last Hemoglobin A1C lab was 6.0 in February 2020. Review of Resident #5's lab work dated 01/30/20 revealed that resident's Hemoglobin A1C was 6.0 and flagged as above high normal (lab reference range was less than 5.7%). Interview with Resident #5 on 02/09/21 at 9:52am revealed: -He was a diabetic and his blood sugars were checked once per day. -His blood sugars were good, and he couldn't remember if he still took insulin. Telephone interview with Resident #5's PCP on 02/15/21 at 10:30am revealed: -She expected orders to be carried out as written for the resident. -Lack of follow up care for diabetic risks were always a concern to her due to potential complication risks. Telephone interview with the Special Care Coordinator (SCC) on 02/15/21 at 12:20pm revealed: -She was unaware of Resident #5's order dated 12/04/20 to have his Hemoglobin A1C checked. -She had just started her position as SCC in	{D 273}		

STATI :N OF DEFICIENCIES AND i N JF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 53 January 2021 and thought the previous Resident Care Coordinator (RCC) had completed all previous orders prior to her taking the SCC role. Telephone interview with the RCC on 02/15/21 at 12:20pm revealed: -She was also unaware of Resident #5's order dated 12/04/20 to have his Hemoglobin A1C checked. -She thought the previous RCC took care of all December 2020 orders. Telephone interview with the facility's Transporter on 02/15/21 at 2:05pm revealed: -She had not taken Resident #5 to any appointments in the last 6 months. -She was not responsible for scheduling laboratory appointments because the lab usually came to the facility to draw residents' blood. -It was the RCC or SCC's responsibility to schedule in-house orders and referrals. -If a resident needed to go off-site for lab work, she would transport them to the appointment. Telephone interview with the SCC on 02/15/21 at 4:35pm revealed: -She was unable to locate the updated Hemoglobin A1C for Resident #5 as ordered on 12/04/20. -The Hemoglobin A1C had not been done. -She was not the SCC at the time of it was ordered so she did not know why the lab work was not done. -She was currently working on getting the lab work set up to be completed. Interview with the Administrator on 02/15/21 at 4:10pm revealed: -The facility was unable to locate an updated Hemoglobin A1C for Resident #5.	{D 273}		

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{D 273}	Continued From page 54 -The previous RCC or SCC should have scheduled the lab to be drawn at the time the order was written. -The current RCC and SCC were working on getting the Hemoglobin A1C completed as soon as possible. -The RCC or SCC were responsible for calling the lab provider to come to the facility when a lab order was received. -The lab provider usually came to the facility the same day to draw labs when they were notified of the order. c. Review of Resident #5's primary care provider (PCP) visit note dated 12/15/20 revealed: -The resident was seen for a routine oral exam and screening. -The resident had poor dentition with missing and broken teeth. -The PCP ordered a dental referral at the earliest given appointment around COVID-19 precautions to be on or around 12/30/20. Telephone interview with a personal care aide (PCA) on 02/15/21 at 1:36pm revealed: -Resident #5 was diabetic and he assisted the resident with oral care every morning when he worked. -The resident brushed his teeth with supervision. -The resident had his own teeth, but there were some missing teeth on both the top and bottom of his mouth. -The resident had not complained of mouth or tooth pain. Telephone interview with the Special Care Coordinator (SCC) on 02/15/21 at 12:20pm revealed: -She was unsure if Resident #5 had seen the dentist as ordered by the PCP on 12/15/20.	{D 273}		

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{D 273}	Continued From page 55 -The residents were usually seen by a dentist at a local dental clinic. -She thought the facility's Transporter was setting up that appointment. Telephone interview with the facility's Transporter on 02/15/21 at 2:05pm revealed: -She had not transported Resident #5 to any appointments in the last 6 months. -Resident #5 had a dentist appointment coming up on 04/07/21. -She made the dentist appointment today, 02/15/21. -She had not seen the order for Resident #5's dental referral until today, 02/15/21, because it was hidden under other papers on her desk. -She had never taken Resident #5 to the dentist before. Telephone interview with the receptionist at Resident #5's dentist office on 02/15/21 at 2:30pm revealed: -Resident #5 had an appointment scheduled for 04/07/21 that was made today, 02/15/21. -That was the first appointment that had ever been scheduled for Resident #5 and he had never been to that clinic before. -Their office would not have delayed an appointment for Resident #5 due to COVID-19 or due to him being a long-term care resident. Telephone interview with Resident #5's PCP on 02/15/21 at 10:30am revealed: -She could not recall the specifics of the resident's oral exam. -As a diabetic, if the resident did not receive oral care, she would worry about delayed wound healing should the resident have ulcerations or other complications. -She expected the resident to be seen by a	{D 273}		

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{D 273}	Continued From page 56 dentist as ordered. Telephone interview with the Administrator on 02/15/21 at 4:10pm revealed: -Resident #5's dental appointment was overlooked. -The facility Transporter scheduled Resident #5's dental appointment today, 02/15/21. -Outside referrals were put in the Transporter's box so she could make the appointment. -The RCC and SCC were responsible for checking behind the facility's Transporter. The facility failed to ensure Resident #2 who was a diabetic had a home health (HH) referral for a new wound to a foot with a history of diabetic ulcers and a history of toe amputations as ordered by the primary care provider (PCP) and the PCP was notified of multiple scattered wounds to both legs, and failed to make a podiatry referral for diabetic nail care placing the resident at risk for infection and further amputation; Resident #1 who sustained 7 falls in a 4-month period obtained physical therapy/occupational therapy (PT/OT) services, podiatry services for thick, elongated toenails and dermatology services for a large skin tag on the back; Resident #5 who was a diabetic with incurvated, long, thickened toenails received podiatry services, lab work to determine how well the blood sugar was controlled, and dental services for broken and missing teeth. Resident #4 who had difficulty swallowing food and medication received a referral to speech therapy (ST) placing the resident at risk for aspiration and choking. The facility's failure resulted in substantial risk of serious harm, serious injury, and neglect to the residents and constitutes a Type A2 Violation.	{D 273}		

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{D 273}	Continued From page 57 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/15/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 17, 2021.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents sampled (#1, #5) including errors with an antibiotic for infection (#1) and an inhaler used to treat symptoms of chronic lung disease. The findings are: 1. Review of Resident #1's current FL-2 dated 10/07/20 revealed diagnoses included dementia with behavior disturbance, chronic obstructive pulmonary disease, cerebrovascular accident, memory loss, sleep pattern disturbance, benign prostatic hypertrophy with lower urinary tract, and	{D 358}		

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{D 358}	Continued From page 58 seizures. Review of Resident #1's emergency room (ER) visit form dated 01/08/21 revealed: -The resident was seen for pneumonia of both lungs. -The resident was to return to the ER for worsening shortness of breath, chest pains, or other concerns. -The resident was given a prescription for an antibiotic. Review of Resident #1's ER prescription dated 01/09/21 revealed an order for Augmentin 875mg take 1 tablet twice a day for 10 days. (Augmentin is an antibiotic used to treat infections.) Observation of Resident #5's medications on hand on 02/10/21 at 4:39pm revealed there was no Augmentin on hand for the resident. Review of Resident #1's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Augmentin 875mg take 1 tablet twice a day for 10 days (20 doses) with scheduled administration times of 8:00am and 8:00pm. -The first dose documented as administered was at 8:00am on 01/12/21. -Augmentin was documented as administered twice a day for 6 days from 01/12/21 - 01/17/21, for a total of 12 doses. -On 01/18/21 at 8:00am, the Augmentin order was documented as expired. -There were 12 of 20 ordered doses of Augmentin documented as administered. Review of Resident #1's handwritten Antibiotic Count Sheets for Augmentin revealed:	{D 358}	It is Wilson AL's policy for staff to administer medications and treatments as ordered. Any medication not given must be documented and reason given. Orders for antibiotics are sent to pharmacy upon receipt by Med Tech. If after hours or weekends, Med Tech should request medication come from back-up pharmacy. All new orders are initialed and copied by Med Tech and one copy is placed in RCC/MCC box for follow-up and to ensure timely compliance. Cart/medication audits are done weekly by Med Tech, RCC/MCC or designee so ensure compliance and verify accuracy.	3/12/21

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{D 358}	Continued From page 59 -The first antibiotic count sheet had documentation of 4 Augmentin 875mg tablets being received from the back up pharmacy on 01/09/21. -The 4 tablets of Augmentin from the back up pharmacy were documented as administered on 01/09/21 at 8:00am and 8:00pm and 01/10/21 at 8:00am and 8:00pm. -The first antibiotic count sheet documented a total of 4 doses being administered leaving a balance of zero. -The second antibiotic count sheet documentation of 20 Augmentin 875mg tablets being received from the facility's contracted pharmacy on 01/11/21. -The first dose documented as administered was on 01/11/21 at 8:00am. -There were 16 doses documented as administered from 01/11/21 at 8:00am through 01/18/21 at 8:00pm. -There was 1 dose documented as wasted on 01/14/21 at 8:00pm with no reason for wasting the dose documented. -After the last dose was documented as administered on 01/18/21 at 8:00pm, the remaining balance was 3 tablets. Review of Resident #1's pharmacy dispensing records for Augmentin from the back up pharmacy revealed 4 Augmentin 875mg tablets were dispensed on 01/09/21. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/12/21 at 1:59pm revealed: -The pharmacy received the Augmentin prescription from the facility on Saturday, 01/09/21, at 3:00am. -The pharmacy staff entered the Augmentin order into the eMAR system on 01/09/21 at 4:37pm.	{D 358}		

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{D 358}	Continued From page 60 -When the pharmacy entered an order into the eMAR, a facility supervisor had to approve and activate the order in the eMAR system in order for it to be active on the eMAR. -He was unable to determine when the facility activated the Augmentin order in the eMAR system. -For weekends, if the facility needed a medication immediately, such as an antibiotic, the facility would have to call the pharmacy's on-call service and request the order to be called into the back-up pharmacy. -According to current pharmacy records, the facility did not request the pharmacy to call the Augmentin order into the back up pharmacy on 01/09/21. -If the facility had requested back up services, the pharmacy would have noted on the prescription that it was sent to back up for a temporary supply and then they would have only dispensed the remainder needed after the temporary supply was dispensed by the back up pharmacy. -They had no documentation of a temporary supply being sent by the back up pharmacy so they dispensed the full quantity of 20 Augmentin 875mg tablets on Monday, 01/11/21. -If a facility obtained medications through the back up pharmacy without going through the contracted pharmacy, they expected the facility to notify them so the pharmacy would not double bill the resident's insurance company or send more tablets than prescribed. -The Augmentin was scanned into the pharmacy tote for delivery on 01/11/21 at 6:00pm. -The pharmacy tote with the Augmentin was received and signed for by a facility MA on 01/12/21 at 1:00am. -He was unable to determine if any Augmentin had been returned to the pharmacy since a partial supply was not usually credited back to the	{D 358}		

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{D 358}	Continued From page 61	{D 358}		

account.

A second telephone interview with a pharmacist from the facility's contracted pharmacy on 02/12/21 at 4:14pm revealed:
-The back up pharmacy sent the contracted pharmacy dispensing information to the contracted pharmacy today, 02/12/21, for Resident #1's Augmentin order.
-The back up pharmacy dispensed 4 Augmentin 875mg tablets on 01/09/21.

Review of Resident #1's eMARs, antibiotic count sheets, and pharmacy dispensing records revealed:
-The facility received 4 Augmentin 875mg tablets for Resident #1 on 01/09/21 from a back up pharmacy.
-Those 4 tablets were documented as administered from 01/09/21 at 8:00am - 01/10/21 at 8:00pm.
-The next supply of 20 Augmentin 875mg tablets were received on 01/12/21 at 2:00am.
-Two of those 20 tablets were documented as administered on 01/11/21 at 8:00am and 8:00pm but no tablets would have been available to administer on 01/11/21.
-There were 14 other doses of Augmentin 875mg documented as administered on the antibiotic count sheet for the supply received on 01/12/21.
-One tablet was documented as wasted and 3 tablets were documented as destroyed.
-There were 18 of 20 doses of Augmentin 875mg documented as administered as ordered.
-The resident did not receive at least 2 doses as ordered.

Review of Resident #1's primary care provider (PCP) visit note dated 01/20/21 revealed:
-The reason for visit was to follow up on

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{D 358}	Continued From page 62 pneumonia. -The resident was status post Augmentin and had no complaints of chest pain or shortness of breath. -The resident continued to have a chronic cough. -The PCP noted the resident's pneumonia was improving. Interview with Resident #1 on 02/10/21 at 1:14pm revealed: -He did not recall what medications he took. -He denied any current breathing problems, cough, or shortness of breath. Telephone interview with the Special Care Coordinator (SCC) on 02/12/21 at 9:22am revealed: -An antibiotic should be started as soon as possible. -When they received an order for an antibiotic on the weekend, the medication aide (MA) on duty was supposed to fax and call the contracted pharmacy to let them know they needed the medication from the back up pharmacy. -If the facility Transporter was not on duty, a MA would pick up the antibiotic from the back up pharmacy. -The contracted pharmacy usually entered the medication orders into the eMAR system. -The Resident Care Coordinator (RCC) or SCC had to approve the orders in the eMAR system before they became active. -The RCC or SCC could also enter orders into the eMAR system when they were on-site at the facility. -She did not know if the RCC or SCC could enter or approve orders in the eMAR system remotely. -The RCC and SCC would approve any weekend medication orders on Mondays, when they returned to the facility.	{D 358}		

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{D 358}	Continued From page 63 -They could not document administration of a medication in the eMAR system until the order was approved. -They did not have paper MARs they could document on when they were waiting for an order to be approved like on the weekends. -She thought Resident #1's Augmentin was pending until it was put in the eMAR system by the pharmacy on 01/12/21. -The MAs documented administration of Resident #1's Augmentin on a paper antibiotic count sheet until the order became active on the eMAR on 01/12/21. Telephone interview with a MA on 02/15/21 at 1:06pm revealed: -She administered the first dose of Augmentin 875mg to Resident #1 as documented on the antibiotic count sheet on 01/09/21 at 8:00am. -The Augmentin was already on hand when she started her shift that morning on 01/09/21. Telephone interview with a second MA on 02/15/21 at 1:13pm revealed: -Resident #1 returned to the facility from the ER during third shift around 2:00am on 01/09/21. -He faxed the prescription for Augmentin to the contracted pharmacy and he called the back up pharmacy. -He thought the back up pharmacy got in touch with the contracted pharmacy but he was not sure. -Another MA picked up 4 Augmentin tablets from the back up pharmacy on 01/09/21. -He did not administer any Augmentin on his shift because none was due to be administered on third shift. A second telephone interview with the SCC on 02/15/21 at 4:35pm revealed:	{D 358}		

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(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 358}	Continued From page 64 -There were 4 Augmentin 875mg tablets dispensed for Resident #1 on 01/09/21 from the back up pharmacy. -She was unsure why she documented that she administered Augmentin tablets to Resident #1 on 01/11/21 at 8:00am and 8:00pm if none would have been available in the facility at that time. -She did not borrow any Augmentin and she did not recall getting any other supply except the supply sent by the contracted pharmacy on 01/12/21. -She and another MA wasted the 3 left over tablets on the antibiotic count sheet because the order expired in the eMAR system 10 days after it was entered into the system. Telephone interview with the Administrator on 02/15/21 at 4:10pm revealed: -If an antibiotic was ordered on the weekends, the MAs should utilize the back up pharmacy to obtain the medication. -The MAs were expected to administer medications as ordered. 2. Review of Resident #5's current FL-2 dated 12/22/20 revealed: -Diagnoses included dementia with hallucinations, Alzheimer's disease, congestive heart failure, coronary artery disease, diabetes mellitus - type II, hypertension, history of colon cancer, acute renal failure, and metabolic acidosis. -There was an order for Combivent Respimat inhale 1 puff 4 times a day. (Combivent Respimat in an inhaler used to treat chronic obstructive pulmonary disease.) Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/12/21 at 10:16am revealed:	{D 358}		

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{D 358}	Continued From page 65 -One Combivent Respimat inhaler was dispensed for Resident #5 on 09/28/20, 10/22/20, 11/18,20, 12/10/20, and 01/19/21. -Each inhaler contained 120 metered doses which was a one-month supply at 1 puff 4 times a day. Review of Resident #5's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Combivent inhale 1 puff 4 times a day scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Combivent was documented as administered 4 times a day from 10/01/20 - 10/31/20 except on 3 occasions. -Combivent was documented as not being administered on 10/05/20 at 8:00am and 12:00pm due to the resident being in the hospital. -Combivent was documented as a missed dose on 10/12/20 at 8:00am with no reason for the missed dose indicated. Review of Resident #5's November 2020 eMAR revealed: -There was an entry for Combivent inhale 1 puff 4 times a day scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Combivent was documented as administered 4 times a day from 11/01/20 - 11/30/20. Review of Resident #5's December 2020 eMAR revealed: -There was an entry for Combivent inhale 1 puff 4 times a day scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Combivent was documented as administered 4 times a day from 12/01/20 - 12/31/20. Review of Resident #5's January 2021 eMAR	{D 358}		

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{D 358}	Continued From page 66 revealed: -There was an entry for Combivent inhale 1 puff 4 times a day scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Combivent was documented as administered 4 times a day from 01/01/21 - 01/31/21. Review of Resident #5's February 2021 eMAR revealed: -There was an entry for Combivent inhale 1 puff 4 times a day scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was a second entry for Combivent inhale 1 puff 4 times a day scheduled to be administered at 7:00am, 11:00am, 3:00pm, and 7:00pm. -Combivent was documented as administered as ordered from 02/01/21 - 02/10/21 at 11:00am. Observation of Resident #5's medications on hand on 02/10/21 at 4:39pm revealed: -There was one Combivent Respimat inhaler dispensed on 01/19/21. -The open date documented on the inhaler was 01/19/21. -According to the dose indicator, there was approximately 100 of 120 metered doses remaining, indicating a 5-day supply of medication had been used from 01/19/21 - 02/10/21, a 3-week time period. Telephone interview with a medication aide (MA) on 02/15/21 at 1:06pm revealed: -She dated Resident #1's Combivent Respimat inhaler when she administered the first dose from the inhaler. -She usually administered 1 puff to the resident. -The resident never refused the inhaler but if he did refuse, she would document it on the eMAR. Telephone interview with a second MA on	{D 358}		

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{D 358}	Continued From page 67 02/15/21 at 1:13pm revealed: -Resident #5 always took the Combivent Respimat inhaler and had not refused it. -He did not know why there was an oversupply of Combivent on hand. Telephone interviews with the Special Care Coordinator (SCC) on 02/15/21 at 12:19pm and 4:35pm revealed: -The facility's MAs documented the open date on Resident #5's Combivent Respimat inhaler when they administered the first dose from the inhaler. -They only opened a new inhaler once the previous one had been used. -No one had reported to her that the resident had refused Combivent Respimat at any time. -She expected the MAs to administer the inhaler as ordered and if the resident refused, it should be documented. -She did not know why there was an oversupply of Combivent on hand. -There should have been more than 20 doses used from the Combivent Respimat inhaler opened on 01/19/21. Telephone interview with the Administrator on 02/15/21 at 4:10pm revealed the MAs were expected to administer medications as ordered, including Resident #5's Combivent Respimat inhaler.	{D 358}		
{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.	{D914}		3/17/21

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{D914}	Continued From page 68 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect as related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 5 of 5 residents sampled (#1, #2, #3, #4, #5) for podiatry referral (#1, #,2, #3, #5); dermatology, physical and occupational therapy referral (#1); home health skilled nursing referral, delay in notification of wounds (#2); orthopedic, speech and physical therapy referral (#4); and laboratory and dental services (#5). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]	{D914}	It is the policy of Wilson Assisted Living to promote all of the NC Declaration of Residents Rights and ensure that all residents be free of mental and physical abuse, neglect and exploitation. All staff are in-serviced on these rights at hire and yearly thereafter.	