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| **WEST BLADEN ASSISTED LIVING** | **714 BLADEN STREET BLADENBORO, NC 28320** |

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D 000 Initial Comments — D 000

The Adult Care Licensure Section and the Bladen County Department of Social Services conducted an annual survey and complaint investigation on 10/20/21 - 10/22/21. The complaint investigation was initiated by the Bladen County Department of Social Services on 09/30/21. There was an additional complaint received on 10/22/21.

D 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings — D 079

10A NCAC 13F .0306 Housekeeping and Furnishings
(a) Adult care homes shall
(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews the facility failed to ensure the facility was free of hazards including in an unlocked storage and one common bath and shower room where personal care hygiene products, razor blades, lancets and an insecticide were left unsecure and unattended in the Special Care Unit with 18 residents residing.

The findings are:

Observation of the Special Care Unit (SCU) on 10/20/21 at 9:00 revealed:
-The last room on the left side of the hallway was labeled as an office.
-The office door was not locked, and entry was

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not impeded.
-This room appeared was used as a storage room.
-An unlocked wooden storage cabinet was inside the office storage room and it was easy to access the items within.
-There was a 16-ounce (oz) bottle of 70% rubbing alcohol.
-The rubbing alcohol bottle label included warnings that the product was for external use only, not get into eye, and if swallowed get medical help or contact a Poison Control Center right away.
-There were six 5.5 oz tubes of toothpaste, nine 2.9 oz tubes of toothpaste, eight 1.0 oz tubes of toothpaste, fifty-four 1.5 oz tubes of toothpaste, one 6 oz tube of toothpaste.
-The toothpaste box labels included a warning that if more the used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away.
-There was one 40 pack box of denture cleansing tablets.
-The denture cleansing tablet box label included cautions to not put tablets into mouth, do not use as a gargle or rinse, and in case of accidental ingestion, seek professional assistance or contact a Poison Control Center immediately.
-There were five 4 oz bottles of alcohol-free mouthwash.
-The mouthwash bottle labels included warnings to not use this product for patient with cystic fibrosis and a caution to seek professional assistance or contact a Poison Control Center immediately in case of accidental ingestion.
-There were two sticks of deodorant.
-There were forty 1.5 oz bottles of roll on deodorant.
-The deodorant stick and roll-on deodorant bottle labels included warnings to only use the product

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| D 079 | Continued From page 2<br>externally and as directed, do not use on broken skin, and to consult a physician before use if you have kidney disease.<br>- The deodorant labels also included a warning to get medical help or contact a Poison Control Center immediately.<br>-There was one bar of soap with no manufacturer's label.<br>-There were four 4 oz bottles of baby powder.<br>-The baby powder bottle labels included warnings to close bottle tightly, do not use on broken skin, avoid contact with eyes and avoid inhalation which can cause breathing problems.<br>-There were seventeen 1.5 oz cans of shaving cream, and twenty-seven 11 oz cans of shaving cream.<br>-The shaving cream labels included warnings to avoid spraying in eyes and to not puncture or incinerate because contents are under pressure.<br>-A 21.8 oz can of ant and roach insecticide was located on the bottom shelf wedged between packages of dressing gauze.<br>-The insecticide label included a precautionary statement of hazards to humans and domestic animals.<br>-The insecticides label cautioned that prolonged skin contact may cause allergic reactions in some individuals and to have the product container available when calling a Poison Control Center, a doctor, or going for treatment.<br>-An opened tube of skin protectant was laying on top of cardboard box.<br>-The skin protectant label included warnings the product was for external use only, do not get into eyes, and get medical help or consult a Poison Control Center right away if swallowed.<br>-There were eighteen boxes of 10 triple bladed razors.<br>-There were four nail clippers.<br>-Multiple boxes of lancets were scattered | D 079 | | |

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| D 079 | Continued From page 3<br>throughout the cabinet.<br><br>Observation of SCU common bath and shower room on 10/20/21 at 9:54am revealed:<br>-This room was mid-way down SCU hallway on the right side.<br>-Resident rooms were located on both sides of the common bath and shower rooms.<br>-The door to the room was unlocked and open.<br>-A plastic storage cabinet in the corner of this room was unlocked and partially opened.<br>-There were three 8 oz bottles of shampoo and body wash.<br>-The shampoo and body wash bottle labels included a caution the product was for external use only.<br>-There was one 11 oz bottle of dry skin lotion.<br>-The dry skin lotion bottle label included caution that the product was for external use only.<br>-There was one 4 oz tube of skin protectant.<br>-The skin protectant tube label included warnings the product was for external use only, do not get into eyes, and get medical help or contact a Poison Control Center right away.<br>-There were five 11 oz cans of shaving cream.<br>-The shaving cream labels included warnings to avoid spraying in eyes and to not puncture or incinerate because contents are under pressure.<br>-There was one 12 oz bottle of oatmeal lotion.<br>-The oatmeal lotion bottle label included warnings the product was for external use only, do not get into eyes, and get medical help or contact a Poison Control Center right away.<br>-There was one 8 oz bottle of aloe-vesta moisturizer.<br>-The aloe-vesta moisturizer bottle label included warnings the product was for external use only, do not get into eyes, and get medical help or contact a Poison Control Center right away.<br>-There was one 24 oz bottle of aloe lotion with | D 079 | | |

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approximately 1/4 of contents remaining.
-There were no warnings included on the aloe lotion container label.
-There was one 40 count box of denture cleansing tablets.
-The denture cleansing tablet box label included cautions to not put tablets into mouth, do not use as a gargle or rinse, and in case of accidental ingestion, seek professional assistance or contact a Poison Control Center immediately.
-An 8 oz bottle of shampoo and body wash with approximately 1/3 of the contents remaining was setting on the side of the walk-in tub.
-The shampoo and body wash bottle that was on the walk-in tub had a label that included cautions to only use externally and to discontinue use if irritation occurs.

Observation of the SCU hallway on 10/20/21 at 9:28am to 10:09am revealed:
-The hallway was not always physically supervised by a staff member.
-The resident from room #110 wandered down the hallway towards the office storage room and entered resident room #114 at 9:56am for approximately one minute before being redirected back to his room.
-At 10:05am the resident from room #110 wandered down the hall towards the office storage room and entered room #112. He exited the room independently at approximately one minute later.
-Staff was not supervising the hallway at 10:06am.

Interview with a personal care aide (PCA) on 10/20/2021 at 10:10am revealed:
-The office storage room should be locked when staff is not present in the room.
-The keys to the room door lock were stored by

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the medication aide (MA).
-The wooden storage cabinet in the office storage room should be locked if the room door was not locked.
-Storage rooms and cabinets with toiletries, personal hygiene care products and insecticides needed to be locked to keep residents from getting hurt or ingesting something harmful.

Interview with the Special Care Unit (SCU) Shift Coordinator on 10/20/212 at 10:22am revealed:
-The office storage room was not locked to allow staff easy access to the items stored within.
-The medications in the office storage room were back up stock for the medication carts.
-The wooden storage cabinet had a locked, but the key could not be located.
-She would "dummy lock" the cabinet so it would look like it was locked to the residents.
-The cabinet containing toiletries in the bathing room was unlocked when staff left because they were going to be right back in with another resident.
-Insecticides should be locked securely away from the residents.

Interview with the Resident Care Coordinator (RCC) on 10/20/21 at approximately 11:00am revealed:
-All special care unit residents were capable of wandering into unlocked rooms.
-It was expected that all storage areas containing any personal hygiene care products be locked when not directly supervised by staff.
- It was expected that all storage areas containing any insecticide be locked when not directly supervised by staff.
-She was not aware the key for the wooden storage cabinet was missing.
-She was not aware the office storage room was

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unlocked when unsupervised by staff.
-She was not aware the lock for the plastic storage cabinet in the common bathing room was missing.
-Cabinet locks were last updated approximately six months ago.
-She was not aware an insecticide spray was being stored in the office storage room.
-There was a concern the unsecured personal hygiene care products and insecticides would be harmful if ingested by a resident.

Interview with primary care provider (PCP) on 10/22/21 at 8:58am revealed:
-All personal hygiene care products and insecticides on the SCU were expected to be locked and kept secured from the residents.
-There was a concern for poisoning if a resident ingested an insecticide.
-There was a risk of injury if a resident sprayed the insecticide in their face and eyes.

Review of the facility's undated policy and procedures for the Hazard Communication Plan revealed the policy did not provide processes of how toiletries and chemicals were stored to protect the residents residing on the SCU.

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The facility failed to store chemicals in a safe and secure manner in the SCU, where 18 residents with dementia, other cognitive impairments, and wandering behaviors resided. The chemicals included hygiene products and an insecticide which placed the residents at risk for injury and poisoning if ingested. This failure was detrimental to the health, safety, and welfare of the residents who resided in the SCU and constitutes a Type B Violation.

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The facility provided a plan of protection in

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| D 079 | Continued From page 7<br>accordance with G.S. 131D-34 on 10/20/21 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2021. | D 079 | | |
| D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(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.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 6 sampled residents (#6) who required extensive staff assistance with bathing, grooming, skin care and foley catheter care.<br><br>The findings are:<br><br>Review of the facility's Special Care Unit (SCU) Disclosure Statement revealed residents should be able to benefit from a safe and secure environment which included scheduled and unscheduled help with activities of daily living.<br><br>Review of Resident #6's current FL-2 dated | D 269 | | |

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07/01/21 revealed:
-Diagnoses included vascular dementia, chronic kidney disease stage IV, uremia, acute metabolic encephalopathy, acute cystitis with hematuria, and benign prostatic hyperplasia with urinary retention.
-The resident was constantly disoriented.
-The resident had an indwelling urinary catheter.
-The resident resided in the SCU.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 07/01/21.

Review of Resident #6's current assessment and care plan dated 07/01/21 revealed:
-The resident required extensive staff assistance three times a week with bathing, dressing, toileting, and grooming.
-The resident had a urinary catheter.
-There was an entry the resident did not provide self-care for the urinary catheter.
-Staff assisted the resident with bathing three times per week and as needed.
-Staff assisted the resident with toileting every 2 hours and as needed.
-Staff assisted the resident with grooming and personal hygiene daily.

Review of Resident #6's progress notes revealed:
-On 09/16/21, there was an entry by the home health nurse the resident's foley bag was noted with blood tinged urine and the foley catheter was changed by the nurse during the visit.
-On 09/20/21, there was an entry by the home health nurse a visit was made with the resident. The resident's foley catheter was unobstructed, draining clear, yellow urine and the resident had no skin issues noted or reported.

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Review of Resident #6's nurse's notes dated 09/21/21 revealed:
-Around 8:00pm, "we" were changing the resident getting him ready for bed and found "blister", skin tears and "swelling on him" which was not on him at 5:00pm when "we" were feeding the resident.
-The resident's family member was contacted, and the resident was sent to a local hospital.

Review of an emergency department (ED) visit for Resident #6 dated 09/21/21 revealed:
-The resident came from the facility for evaluation of possible blisters, skin tears and falls.
-The resident's chief complaint was documented as a possible "arrigic" [sic] reaction.
-The resident had skin tears, abrasions and blisters over several parts of his body.
-There was evidence of trauma to the right forehead with a hematoma to the forehead.
-The resident's chest was nontender without a rash.
-There was noted abrasion and bruising on the right rib region that extended from the mid-spine to the side of his body.
-There was some slight bruising noted on the right upper abdomen with an abrasion.
-The resident had chronic contractures of his lower extremities and had pressure ulcers, in between his knees where his knees were touching on the middle section of both knees.
-The middle section of the resident's right knee appeared to have a blister that had popped with a very superficial pressure ulceration.
-There was some redness on the left side without actual blistering of the skin.
-There were some early grade 1 pressure ulcers on his feet. (A grade 1 is used to describe tissue injury with non-blanchable discoloration of the skin).
-There was no generalized blistering of the skin,

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no evidence of an autoimmune disease that caused blisters on the skin and mucous membrane throughout the body.
-The right upper extremity had bruising and swelling noted to the right shoulder, with an abrasion noted.
-There was some swelling of the right upper extremity from the elbow down to the hand with mild tenderness and bruising of the right elbow region.
-There was some bruising noted to the right hip with an abrasion.
-The resident complained of some pain on his head, but did not know if he had hit his head or not.
-The assessment/plan included a minor closed head injury, pressure ulcers of the skin of multiple sites and "falls frequently".
-The resident would be discharged from the ED back to the facility where there would be a request that they manage his pressure ulcers and provide soft materials, in between his legs and Neosporin to his small areas of pressure ulcers. (Neosporin is a topical antibiotic medication used for minor cuts and abrasions).

Interview with the SCU Shift Coordinator on 10/20/21 at 3:09pm revealed:
-On 09/21/21 at approximately 7:00pm, she checked on Resident #6 and observed him to have the following: swelling to his face, lips and right hand, an opened red spot above his right eye, an area on his right shoulder that was open and red, an opened red spot on his right hip, areas to both inner knees open and red in color, red open areas to the inside of both ankles, a skin tear in the middle of his shoulder about the size of a pinky and impaired speech.
-Resident #6's family member was made aware of the incident and he was transported to the ED

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for evaluation.
-She received a return call from Resident #6's family member who informed her of a previous allergy Resident #6 had to fresh fruits that the family forgot to inform the facility about.
-She instructed Resident #6's family member to contact the ED to inform them of the allergy.
-Resident #6 was evaluated in the ED and was released on the same date (09/21/21) with no treatment orders received.

Interview with the Resident Care Coordinator (RCC) on 10/21/21 at 1:05pm revealed:
-Resident #6 had no wounds until 09/21/21.
-Resident #6 developed blisters that covered his body on 09/21/21 and was sent to the ED for evaluation of the new onset of the blisters.

Review of Resident #6's record revealed there was no additional documentation in the progress notes, no entries on the September 2021 electronic medication records (eMARS), or personal care records regarding the resident's skin status, wounds or any care provided to the resident's bruises, abrasions and pressure ulcers.

Review of an emergency medical services (EMS) report for Resident #6 dated 09/28/21 revealed:
-At 9:41am, EMS was dispatched to the facility due to the resident having breathing problems.
-At 9:57am on arrival, the medics were met by facility staff and escorted to the resident's room.
-The resident was found unresponsive to voice, labored breathing at 40 breaths per minute (Normal range 12-20) and hot to touch.
-The resident was placed on 3 liters of oxygen with no improvement.
-The resident was placed in an upright position and an intravenous line (IV) was started, oxygen was increased to 6 liters by nasal cannula and an

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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 |
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IV bolus was started.
-The resident had a weak carotid pulse and defibrillator pads were placed on the resident.
-The resident had a white chunky saliva coming out of the mouth and suctioning was performed.
-The resident's acuity was critical.

Review of Resident #6's ED medical provider notes from a local hospital dated 09/28/21 revealed:
-The resident was brought into the ED with shortness of breath and was unresponsive.
-There was an entry in the ED medical provider's physical exam that the resident was ill-appearing and toxic-appearing.
-The resident's clinical impression was sepsis associated hypotension and the diagnosis management comments included pneumonia, sepsis and mental status change.
-An admission consult was done with the hospital medical provider for Resident #6.

Review of Resident #6's history and physical from the local hospital dated 09/28/21 revealed:
-The resident's prognosis was very poor.
-Discussion was done with the resident's power of attorney (POA) and family and comfort care measures for the resident was decided.
-The resident was also found to have a urinary tract infection.
-There was documentation in the physical exam section the resident had stage II decubitus ulcers on both hips. (A stage II decubitus ulcer was a term used to describe tissue damage with partial -thickness skin loss into but no deeper than the dermis layer of the skin.)
-The resident would be admitted to the intensive care unit (ICU).

Review of Resident #6's "Patient Care Timeline"

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from the local hospital dated 09/28/21 revealed:
-At 10:38am, the resident arrived at the ED.
-At 10:38am there was documentation by a registered nurse (RN), the resident was moved to an ED bed from the stretcher and moaned during the transfer.
-At 12:21pm, there was an entry the resident had a 7 cm by 10 cm ulcer with redness and eschar noted on the resident's right hip. (Eschar is a term used to describe a collection of dry, dead tissue within a wound bed).
-A report was given to an ICU nurse for the handoff care of the resident.
-At 8:00pm, there was an entry by the ICU nurse the resident hollered out when his extremities were moved and several wounds were noted all over the resident's body of varying sizes, shapes and stages of healing with none of the wounds draining and a few of the wounds were opened.
-The resident's foley was draining cloudy urine with sediments in it and a thick tan-colored drainage noted draining from the resident's torn opening of the penis with the penile head covered in mucus and reddened in color.
-The resident's penile head was split from the opening of the penis to underneath towards the scrotum.
-The resident's wounds were documented and photographed for the resident's record.

Review of Resident #6's wound descriptions on a hospital flow data sheet dated 09/28/21 at 8:00pm by the ICU nurse revealed:
-The resident's skin had several wounds and bruises noted all over with varying sizes and stages of healing.
-The resident had 17 wounds that were present on admission to the hospital.
-There were 9 wounds described as pressure injuries.

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| **WEST BLADEN ASSISTED LIVING** | **714 BLADEN STREET BLADENBORO, NC 28320** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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-A non-healing pressure injury to the right hip measuring 7 cm x 10 cm with redness and eschar and no drainage.
-A pressure wound with circular plum colored bruising to the left back section of the elbow.
-A pressure wound to the left, lower, back section of the head with a secondary wound type described as a skin tear.
-A pressure wound to the left front of the proximal hip described as redness.
-A pressure wound with pinkish-red colored skin to the coccyx with no break in the skin.
-A pressure wound with a secondary skin tear, opened with a tan and blackened tissue bed at the left middle knee and bruising.
-A pressure wound as several reddened wounds and bruises of varying sizes noted all around the right foot the middle and side of his right foot with a secondary wound described as a skin tear.
-A pressure wound as several reddened bruises of varying sizes noted along the middle and side of his left foot with a secondary wound as a soft tissue injury.
-A pressure wound to the back of the resident's penis with a secondary wound as soft tissue and a skin tear injury with a description that the penis was split from the opening of the penis down through the lower foreskin along the shaft towards the scrotum with several tears noted to different (upper and sides) of the foreskin.
-There were 8 other wounds.
-A soft tissue wound located at the right front, gluteal fold.
-Two circular-shaped bruises noted near the right dorsal elbow with no open area.
-An atypical wound with redness and a scab along part of the wound at the posterior right shoulder.
-A large plum-colored wound that extended along the middle to left section of the resident's back

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with an open area along the center described as a "traumatic" wound and a skin tear as a secondary wound.
-A wound on the left upper back.
-A wound described as a plum colored bruise on the left lower back.
-An irregular right wound in the middle of his shin with blackened and tan-colored tissue with no drainage and 3 areas of red-colored bruising described as a soft tissue wound on the right side of his knee.

Telephone interview with an Adult Protective Services (APS) Social Worker (SW) on 10/22/21 at 12:03pm revealed:
-The APS SW received a complaint regarding neglect for personal care and multiple wounds for Resident #6 and the complaint of neglect was confirmed.
-She had spoken with an ICU nurse who cared for Resident #6 on his admission (09/28/21).
-The ICU nurse reported Resident #6 came into the ED with his eyes and mouth "matted shut".
-The ICU nurse reported she had to put a "foam" soak on Resident #6's penis to remove the scabs and crust build-up.
-The ICU reported Resident #6 had "gunk" and dead skin build-up in his mouth that required the use of suction to prevent the resident from aspirating on the build-up in his mouth at least 4-5 times that night (09/28/21).
-The ICU nurse reported the resident had a foul body odor of urine and the resident had to be washed 3 times.
-She had spoken with a second ICU nurse who provided care for Resident #6 on 09/28/21 at the hospital.
-The second nurse reported Resident #6's penis was not visible due to a thick, white layer of purulent discharge and the resident's penis

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appeared to be infected.
-The APS SW saw Resident #6 on 09/30/21 at the local hospital and observed a white build-up on the resident's penis and asked the ICU nurse what it was.
-The nurse reported the white build-up on Resident #6's penis was also underneath the foreskin.
-The two nurses reported that the build-up on Resident #6's penis was caused by not being cleaned properly.
-The nurse reported Resident #6 had a body odor of urine, the resident was unkept, unwashed and had not received proper care upon arrival from the facility.
-The nurse reported Resident #6's legs were contracted and had wounds present on the inner part of the resident's knees from rubbing together and no pillow for support used.
-The second ICU nurse reported Resident #6 had several wounds that did not have any bandages on them. The resident's foley collection bag was so full with urine that the weight of the bag caused pressure on the resident's penis which could have caused the resident's penis to split which was observed upon admission.
-The APS SW interviewed facility staff who provided care to the resident at the facility who were not aware of all of Resident #6's wounds.

Telephone interview with the case manager discharge planner from the hospital on 10/22/21 at 9:38am revealed:
-Resident #6 was admitted to the hospital on 09/28/21.
-There was a referral completed for Resident #6 on 09/28/21 related to multiple wounds and neglect.
-She reviewed the ED records for Resident #6's admission on 09/28/21 and it was documented

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that he was unresponsive, had foul urine smell, blood pressure was 86/38, O2 saturation 87% on oxygen set at 15 liters per minute, respirations 40 breaths per minute, temperature 100.1 degrees Fahrenheit (F) and deep pitting edema to his right upper and right lower extremities.
-There were several tears of his penis with tan drainage from the opening of his penis, the penile head was red in color and covered with mucous.

Review of Resident #6's personal care records for September 2021 revealed:
-There were boxed spaces for each day of the month to document the resident's personal care with event codes, level of staff assistance and staff initials on 1st, 2nd and 3rd shift.
-There was documentation the resident was in the hospital from 09/01/21 - 09/03/21, 09/17/21, and 09/28/29.
-There were instructions for staff to document the type of bathing provided to the resident using the following event codes: S = shower, ST = shower/tub, BB = bed bath, SB = sponge bath.
-There was documentation the resident received a shower, on 09/04/21, 09/06/21, 09/08/21, 09/12/21 - 09/15/21, 09/17/21 and 09/27/21.
-There were 9 days from 09/18/21 - 09/26/21 staff initials were documented and a slanted line and/or blank spaces for bathing and staff assistance. There was no additional documentation for the resident's bathing assistance provided by staff from 09/18/21 - 09/26/21.
-There were instructions for staff to document the care provided for the resident's skin/hair/feet using the event codes "SC" when skin care was provided.
-There was documentation the resident received skin care on 09/08/21, 09/12/21 - 09/15/21, 09/17/21, and 09/27/21.

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-There were 9 days from 09/18/21 - 09/26/21 staff initials were documented with a slanted line and/or blank in the daily spaces for skin care and staff assistance. There was no additional documentation for the skin care assistance provided by staff.
-There were instructions to document toileting and incontinence care daily with event codes that included "R" for routine toileting and "CC" for catheter care
-There was documentation routine toileting was completed by on 09/04/21 - 09/04/21, 09/07/21, 09/08/21, 09/11/21 - 09/19/21, 09/22/21-09/22/21, 09/23/21 and 09/25/21 - 09/27/21, however there was no documentation staff provided catheter care to the resident for the month of September 2021.
-There were instructions to document personal hygiene daily to include mouth/oral/denture care by using an event code of "M" for mouth care.
-There was documentation mouth care was provided for the resident 09/04/21 - 09/06/21, 09/08/21, 09/08/21, 09/11/21 - 09/19/21, 09/22/21, 09/23/21, and 09/25/21 - 09/27/21.
-On 09/27/21, there was documentation the resident received a shower, skin care and shampoo on first shift by a personal care aide (PCA) and a bed bath and skin care on second shift by two medication aides (MAs) and mouth care on 1st shift by a PCA and on second shift by two MAs.

Telephone interview with Resident #6's home health nurse on 10/22/21 at 11:23am revealed:
-She provided home health services for Resident #6's foley catheter.
-She visited Resident #6 once a week and changed his foley catheter once a month and as needed.
-She had not completed a full skin assessment

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for Resident #6 and was not aware of impairments of skin integrity.
-She asked the staff, during her initial visit with Resident #6, if he had any wounds and none were reported.
-Resident #6 had a history of combative behaviors.
-Resident #6 had frequent ED visits related to foley catheter dislodgement.
-Resident #6 had a securement device on his leg to secure his foley catheter.
-She could not remember the date of her last visit with Resident #6, but she documented a progress note in the record after each visit.
-She did not observe any discoloration, blisters or opened areas to Resident #6's face, arms, legs or perineal area during her last visit.

Interview with the RCC on 09/30/21 at 3:30pm revealed:
-The PCAs assisted the residents with bathing and mouth care.
-The residents were bathed/showered three times per week and as needed and the residents' oral care was provided daily.
-Resident #6 would fight staff during care on some days.
-Resident #6 had a urinary tract infection and was on antibiotics. He pulled the catheter out.

Second interview with RCC on 09/30/21 at 3:57pm revealed:
-The SCU Shift Coordinator, two MAs, and a PCA provided bathing and oral care for Resident #6.
-The SCU Shift Coordinator completed full body checks.

Interview with a PCA on 10/06/21 at 11:41am revealed:
-She worked with Resident #6 weekly and she

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bathed him unless he fought her.
-She last saw Resident #6 before he was transported to the ED on 09/28/21.
-Staff bathed residents every other day and sometimes Resident #6 missed his bath because he would resist bathing.
-She did not see any tears or cuts on Resident #6's penis.
-Residents were provided incontinent care and checked on every two hours or less.
-She last saw Resident #6 up and walking during the month of September 2021.
-Resident #6 would get up out of bed and take off walking.
-She saw Resident #6 walk after he had the blisters on 09/21/21.
-Resident #6's legs were not contracted when he was sent out to the hospital on 09/28/21.
-She last observed Resident #6's skin on 09/28/21.
-She observed blisters or marks between his legs, there were quite a few of them.
-Resident #6's blisters were not bleeding and they looked like water blisters.
-Staff changed his shirt before he was sent to the hospital, but she did not remember seeing anything on his back or feet. There were no open sores.
-Staff kept his legs open for the most part and kept "medicine" on them, but she did not know what kind of medicine.

A second interview with the PCA on 10/20/21 at 8:35am revealed Resident #6 was dependent on staff for bathing, grooming and dressing.

Interview with a MA on 10/06/21 at 11:58am revealed:
-She was not working on 09/28/21 when Resident #6 was sent out to the hospital.

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-She last saw Resident #6 on 09/23/21.
-She did not see Resident #6 walking on 09/23/21.
-Staff cleaned Resident #6's catheter area and emptied his catheter bag twice a day. She did not like to see anything in the catheter bag.
-Resident #6's back was clear on 09/23/21. There was nothing on his chest area and one on his leg.

Telephone interview with a second MA on 10/21/21 at 11:23am revealed:
-She was not aware her initials were documented as providing a bed bath for Resident #6 on the resident's personal care record on 09/27/21 on 2nd shift with another MA.
-She did not provide bathing assistance to Resident #6 on 2nd shift on 09/27/21.

Interview with a third MA on 10/22/21 at 1:45pm revealed:
-On 09/23/21, she did not see any marks, blisters, or discolored areas on the resident's skin.
-She worked the weekend of 09/24/21 on the SCU; she did not observe any issues with Resident #6's skin and no blisters.

Telephone interview with a former staff on 10/20/21 at 11:32am revealed:
-Her job responsibilities were to provide personal care and to make sure the residents ate.
-She worked different shifts and her last work day was 09/20/21.
-She wrote the "facility" a note when she left letting them know that the residents were not getting the care they needed.
-Residents' baths were documented in a resident care book.
-Staff also documented in the resident care book when the residents' bathroom visits were completed and when staff provided oral care to

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the residents.
-She never saw staff in the SCU provide oral care to the residents.
-When she saw oral care in the resident care book, she started providing the resident's oral care, she was not trained or told to provide oral care for the residents.
-She did monitor residents' skin for changes.
-When she saw residents with any skin changes, she reported the changes to the MA who would report it to the SCU or (assisted living) AL Shift Coordinator.
-The only care she provided to skin wounds was Desitin. She changed bandages. Another staff showed her how to change bandages. (Desitin is a medication used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations caused from incontinence of the bowel or bladder).
-She remembered Resident #6, she emptied his catheter bag.
-Resident #6's catheter bag would be full when she worked behind some of the staff.
-She had shown one of the staff how to empty the resident's catheter bag.
-Resident #6 did not want to do a lot.
-Resident #6 kept pulling his urinary catheter out.
-Just before she left, Resident #6 had blood in his catheter bag.
-Her last day was 09/20/21 and Resident #6 had a strong urine odor when she left.
-She changed Resident #6's clothes when his urinary catheter leaked.
-Resident #6 was difficult to provide personal care on.
-She did not remember any sores on Resident #6.
-Resident #6 stayed in bed 2-3 days before she left and she did not see the resident up.

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Telephone interview with a MA on 10/21/21 at 12:02pm revealed:
-She began working at the facility around June 2020 and had currently worked in the SCU for about 2-3 months.
-She worked second shift.
-Showers/baths were given to residents every other day and sometimes every day and was documented in the flow sheets.
-Skin assessments were done when showering by the PCAs and MAs.
-If she saw any residents' with skin changes or abnormalities she reported those to the SCU Shift Coordinator.
-She typically reported orally to her supervisor.
-She did not typically report to the residents' primary care provider (PCP).
-She provided personal care assistance for Resident #6, but not after he had a skin reaction (09/21/21) and the resident only had bed baths after this occurred.
-The only marks that she saw on Resident #6 were red blisters.
-One of the sides of Resident #6's body was swollen especially his arm around 09/21/21.
-She did not remember how many blisters Resident #6 had.
-She remembered Resident #6 had one on his head, between his knees, and on his legs and arms, but not on his back.
-She assisted Resident #6 with his emptying his urinary catheter care.
-She made sure Resident #6's urinary drainage bag stayed emptied and she monitored the color of his urine, and performed peri-care for his catheter.
-There were no tears on Resident #6's penis.
-She found blood in Resident #6's urine before he got so sick (no date provided).
-Resident #6 was not walking after his allergic

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|---|---|
| WEST BLADEN ASSISTED LIVING | 714 BLADEN STREET BLADENBORO, NC 28320 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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reaction (09/21/21).

Interview with the SCU Shift Coordinator on 10/20/21 at 3:09pm revealed:
-Resident #6 was ambulatory without assistance upon admission to the facility in July 2021.
-Resident #6 did not require assistance from staff with turning and repositioning.
-Resident #6 was dependent on staff with bathing, dressing, incontinence care and foley catheter care.
-Resident #6 received a bath every other day and if he refused, it was offered at a later time during that shift.
-Staff documented Resident #6's personal care on the resident's personal care record.
-Resident #6 did have a leg band to secure his foley catheter but he would remove it.
-The staff attempted to reposition Resident #6's foley catheter so that it would be out of his sight.
-She was not aware of Resident #6 having penile trauma.
-The staff monitored Resident #6's foley catheter to ensure that there was output but did not document the output.
-Resident #6 stopped ambulating and required a wheelchair around 09/23/21.
-She did not see Resident #6's skin on 09/28/21, she last assisted the resident with a shower on 09/23/21.
-She was not aware of any issues with Resident #6's personal care.

Interview with the RCC on 10/22/21 at 4:18pm revealed:
-She expected staff to maintain the resident's hygiene and cleanliness.
-She was not sure why there would be reports Resident #6 was unkept and not clean when he arrived at the ED on 09/28/21.

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-She relied on and expected the MAs and the Shift Coordinators to ensure the residents' personal hygiene were always met.

Interview with Resident #6's PCP on 10/06/21 at 12:15pm revealed:
-He was unable to address the resident's penile tear as a home health nurse was providing care for Resident #6's catheter.
-If staff were not seeing the blisters on Resident #6's body front and back then staff were not doing their job.

A second interview by telephone with Resident #6's PCP on 10/22/21 at 8:55am revealed he expected the facility staff to meet the resident's personal hygiene needs.

Attempted telephone interview with one of the ICU nurses who provided care to Resident #6 on admission to the hospital ( 09/28/21) on 10/21/21 at 7:00pm was unsuccessful.

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The facility failed to provide personal care assistance to a resident, who was independent with ambulation upon admission in July 2021, became dependent on staff for bathing, grooming, oral care, and urinary catheter care and arrived to the emergency department on 09/28/21 short of breath and unresponsive with a foul body odor of urine, his eyes "matted shut", a build-up of debris in and around his mouth which required suction to prevent aspiration, lower extremity contractures, 17 wounds on various parts of his body which included pressure wounds, one with eschar, skin tears, soft tissue injuries and a split on his penis from the opening down through the lower foreskin along the shaft towards the scrotum; purulent drainage built up around the opening of the penis and a urinary

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| D 269 | Continued From page 26<br>catheter bag which was heavy and full of urine, and was admitted to the ICU with diagnoses that included a urinary tract infection and sepsis with a poor prognosis (Resident #6). This failure resulted in serious neglect and constitutes a Type A1 Violation.<br>_________________<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 10/22/21 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2021. | D 269 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 6 (#5) sampled residents related to a fall and acute hip pain immediately to the primary care provider (PCP) who was diagnosed with a hip fracture several days after the fall (Resident #5).<br><br>The findings are:<br><br>Review of Resident 5's current FL-2 dated 04/28/21 revealed:<br>-Diagnoses of cirrhosis of the liver, type II diabetes, hypertension, congestive heart failure, | D 273 | | |

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coronary artery disease, and confusion.
-The county department of social services was the resident's guardian.

Review of a care plan dated 04/12/21 revealed:
-The resident ambulated without problems.
-The resident was forgetful and needed reminding.
-The resident was oriented.
-The resident required extensive assistance with toileting.
-The resident transferred independently.
-The resident's skin was documented as normal.

A review of Resident #5's physician orders revealed an order dated 10/14/21 "for hospice to come in to evaluate due to constantly declining, if she qualifies may we have orders for her to on hospice".

a. Review of an accident/incident report dated 10/13/21 at 10:00am revealed:
-Resident #5 stood up from the bed and slid to the floor because she felt weak.
-The incident was not witnessed.
-The resident was not taken to the hospital.
-It was not necessary to notify the physician was documented.
-Unspecified first aid was provided to the resident.
-The report was written by the Assisted Living (AL) Shift Coordinator on 10/13/21 at 10:05pm.
-The report was signed and dated by the primary care provider (PCP) on 10/20/21.

Observation of Resident #5 on 10/22/21 at 1:22pm revealed:
-The resident complained of left hip pain when staff moved her left leg to examine her heel at the time of observation.

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-Her left leg was observed to be slightly rotated inward and she held her hand to her hip.

Interview of Resident #5 on 10/22/21 at 1:22pm revealed:
-The resident could not state when her hip pain started.
-The resident requested to not be moved.

Review of Resident #5's physician orders on 10/22/21 at1:53pm revealed:
-An order for a left hip x-ray was written and signed by the PCP on 10/20/21.
-The diagnoses were left hip pain and frequent falls.

Review of a radiology report provided on 10/22/21 at 1:53pm revealed an x-ray of the left hip was completed on 10/21/21 which indicated the resident had a transverse fracture.

Review of a facility telephone order dated for 10/22/21 revealed an order for an orthopedic consult was faxed to the PCP for signature.

Interview with the AL Shift Coordinator on 10/22/21 at 2:00pm revealed:
-She was aware of Resident #5's unwitnessed fall on 10/13/21; she wrote the incident report.
-She was aware the resident had hip pain when moved or repositioned, but she did not know when it started.
-She was not aware the resident had a left hip fracture because no one had notified her.
-Changes in the resident condition were expected to be reported to her immediately.

Interview with a first shift personal care aide (PCA) on 10/22/21 at 2:12pm revealed:
-She provided care to Resident #5 as needed

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during the first shift, except bathing.
-The resident was scheduled to be bathed on second shift.
-She had not worked in the previous 2 weeks.
-The resident was not complaining of hip pain 2 weeks ago.
-The resident complained of hip pain when transferring and repositioning for approximately one week.
-The resident had not requested any medication to manage her pain.
-She could not recall if she had reported Resident #5's complaint of pain to the medication aide (MA) in the past week or on 10/22/21.
-She was not aware Resident #5 had a hip fracture.

Interview with a second shift PCA on 10/22/21 at 4:28pm revealed:
-She bathed the resident on 10/21/21 during second shift.
-The resident needed assistance to transfer and reposition in bed for approximately one week.
-Repositioning assistance was offered every hour.
-She reported the resident's complaint of hip pain and request for pain medication to the MA last night on 10/21/21.
-She was unsure if the MA had given Resident #5 medication for pain.

Interview with Resident Care Coordinator (RCC) on 10/22/21 at 5:25pm revealed:
-Resident #5 was seen by the PCP on 10/20/21 during a routine visit.
-She was made aware of the resident's complaint of hip pain during a visit from the PCP on 10/20/21 when the order for a left hip x-ray was ordered.
-She was aware the accident/incident report was

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reviewed by the PCP on 10/20/21.
-The resident had not requested any medication to manage her pain.
-Changes in residents' condition were expected to be communicated to the PCP immediately by the RCC or Shift Coordinators.
-The x-ray results for Resident #5 were faxed to the PCP on 10/21/21 at approximately 2:30pm.
-The PCP called to order an orthopedic consult on 10/22/21 at 12:10pm.

Review of Resident #5's nurses notes revealed:
-There was no documentation related to the fall on 10/13/21.
-There was no documentation of the resident reporting hip pain when transferring or repositioning.
-There was no documentation of the resident's complaints being reported to the PCP.
-There was no documentation of the RCC contacting the PCP after the radiology results were faxed to his office on 10/21/21.
-There was no documentation of medical care provided to the resident relating to her hip fracture and pain.

Attempted telephone interview with Resident #5's PCP 10/22/21 at 5:30pm was unsuccessful.

Attempted interview with the Administrator on 10/22/21 at 7:15pm was unsuccessful.

b. Observation of Resident #5 on 10/22/21 at 1:22pm revealed:
-An approximately 2-3 inch oval shaped are of dark, crusty and firm tissue on the bottom of the right heel.
-An approximately 2-inch round fluid filled tissue was on the outside bottom of the left heel.
-There was a butterfly shaped area of reddened

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skin with pin-point excoriation proximal to the sacrum and no skin barrier was applied to the area.

Review of Resident #5's hospice nurse's notes revealed:
-The resident was admitted to hospice on 10/18/21.
-A stage II pressure sore to the sacrum was found on 10/18/21.
-Deep tissue injuries on both heels were found on 10/18/21.

Telephone interview with the hospice nurse on 10/22/21 at 11:20am revealed:
-An order was received for Resident #5 to be evaluated for hospice care on approximately 10/15/21 because of the resident "constantly declining".
-The hospice nurse completed the admission assessment on 10/18/21.
-A dime size, butterfly pattern, non-blanching stage II pressure sore (Stage II pressure sores are characterized by partial-thickness skin loss into but no deeper than the dermis) was observed at the sacrum.
-Barrier cream was applied to the area by the hospice nurse on 10/18/21.
-Silver dollar sized deep tissue injury with eschar to the resident's heels was observed.
-The resident's heels were placed on pillows and heel protectors were ordered.
-She was concerned about the pressure wounds; the sacral wound was very new, possibly within the last week.
-The deep tissue wounds on the heels had been there greater than two weeks in her professional opinion".
-She recorded her findings in the resident's record.

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-She reported her findings to the medication aide (MA) and Resident Care Coordinator (RCC).
-She provided instructions to continue barrier cream to the sacral area and placement of heels on pillow to the MA.

Telephone interview with Resident #5's primary care provider (PCP) on 10/22/21 at 8:58am revealed:
-The PCP was not aware the resident had any skin wounds, or pressure ulcers.
-It was expected that changes relating to skin breakdown be documented in the residents' chart and reported to the PCP.
-A hospice consult was ordered on 10/14/21 because the resident was generally declining.

Interview with Assisted Living (AL) Shift Coordinator on 10/22/21 at 12:35pm revealed:
-She was not aware of Resident #5 having a sacral wound or wounds on her heels.
-It was expected for staff to notify the shift coordinators and document it in the residents' record.
-She did not routinely check residents' skin unless an issue is reported.
-The PCAs and MAs were expected to report findings to the AL Shift Coordinator.
-The AL Shift Coordinator was expected to report findings to the RCC.
-The RCC was responsible for notifying the PCP of changes in condition, including skin breakdown.

Interview with Resident #5's guardian on 10/22/21 at 1:32pm revealed:
-She requested a hospice nurse consultation on around 10/13/21 due to the resident's weight loss.
-She was not aware the resident had wounds on her skin.

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-She expected the facility and PCP to notify her of changes in the resident's condition.

Interview with the second shift PCA on 10/22/21 at 4:28pm revealed:
-Resident #5 was scheduled for baths on Tuesdays, Thursdays, and Saturdays on second shift.
-The resident seldom refused bathing assistance.
-The PCA noticed blisters on the resident's heels approximately one week ago and thought that they were caused by the resident wearing shoes that were too big.
-The heel wounds were reported to the second shift MA when she first noticed them about one week ago.
-Resident #5 was able to reposition herself, but assistance to turn was offered by the PCA every hour.
-PCAs were expected to report skin changes to the MAs and document findings in the residents' records.

Interview with the MA on 10/22/21 at 5:00pm revealed:
-She was aware of Resident #5's skin wounds on her heels and sacrum as of 10/22/21.
-She did not remember if the PCA reported any wounds on the resident about one week ago.
-The MAs were expected to report findings to the AL Shift Coordinator.
-The staff member that found changes in the residents were expected to document the findings in the resident record.

Interview with the RCC on 10/22/21 at 5:25pm revealed:
-She was aware of Resident #5's skin wounds as of the 10/18/21 hospice nurse assessment and order to start hospice care.

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-PCAs and MAs were expected to report findings to the AL Shift Coordinators.
-The AL Shift Coordinator was expected to report findings to the RCC.
-The RCC was responsible for notifying the PCP, but she could not remember if she had notified the resident's PCP.
-Any changes in the resident's condition was expected to be documented in the resident's record.

Review of Resident #5's progress notes revealed:
-There was no documentation by a PCA, MA, AL Shift Coordinator, or RCC of changes to the resident's skin prior to or after 10/18/21.
-There was no documentation of the RCC contacting the PCP about the changes to the resident's skin.

Attempted interview with the Administrator on 10/22/21 at 7:15pm was unsuccessful.

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The facility failed to ensure referral and follow-up for 1 of 6 (#5) sampled residents by not immediately notifying the primary care provider of a resident's unwitnessed fall of 10/13/21, complaints of pain when she was moved or repositioned, and diagnosed with a left femur fracture on 10/21/21 and not reported to the PCP until 10/22/21. The facility's failure resulted in risk of neglect and constitutes a Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/21/21 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2021.

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| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure foods stored and served to residents were protected from contamination related to food stored on a storage rack not protected in a covered container in the walk-in refrigerator and a box of food stuck to the floor by a thick black and pink colored substance in the walk-in freezer.<br><br>The findings are:<br><br>Observation in the walk-in refrigerator on 10/21/21 at 7:41am revealed:<br>-There were 5 heads of cabbage stored directly on the bottom shelf of a metal tier-type storage rack and not in a covered container.<br>-The shelving was rusted with an orange colored substance on the surface of the shelf where the cabbage was stored.<br><br>Observation of the walk-in freezer on 10/21/21 at 7:47am revealed:<br>-There was a thick, black colored build-up on the floor at the entrance door of the freezer.<br>-The floor of the freezer had scattered black colored build-up areas of stains and debris on the floor. | D 282 | | |

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|---|---|
| **WEST BLADEN ASSISTED LIVING** | **714 BLADEN STREET BLADENBORO, NC 28320** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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-There was a sticky, black and tan colored heavy build-up substance with scattered debris embedded at the base of one of the storage rack legs on the left side of the freezer.
-There was a 50-count box of churros stored on the floor under the back side of the right storage rack that was stuck to the floor by a thick black, pink colored substance with scattered grime and debris embedded into the substance.
-The bottom of the churro box was stained by the build-up substance on the floor.
-There was a heavy build-up of frozen debris and matter that was pink, tan, and black colored along all the walls and corners of the floor of the freezer.
-There was a heavy build-up of thick gray, black and brown substance with frozen debris embedded on the flooring underneath the storage rack on the right side of the freezer.

Observation of the facility's Food Establishment Inspection Report dated 07/16/21 revealed:
-The score was 93.
-Foods protected from contamination was out of compliance due to food-contact surfaces.

Review of the facility's kitchen cleaning schedule for October 2021 revealed:
-There was a handwritten entry of one staff's initials with no date beside the cleaning task to keep the freezer and walk-in refrigerator "straight".
-There was a handwritten entry of one staff's initial with no date beside the cleaning tasks to wipe "fridge" inside and out.

Interview with the Dietary Manager (DM) on 10/21/21 at 12:23pm revealed:
-The build-up substance on the floor looked like something was spilled under the right storage

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rack and around the storage racks leg base.
-She was not aware of a box of churros in the corner under the storage rack on the right that was stuck to the floor.
-Food was not supposed to be stored on the floor.
-The food for the residents was delivered weekly to the facility on Tuesdays.
-One dietary staff was assigned to unload the food off the truck, place in the freezer and clean the freezer and floor.
-She had noticed some stains and build-up on the floor of the walk-in freezer a few weeks ago and had attempted to mop the areas; however, the stains would not come up.
-She had not seen the heavy build-up of matter on the walk-in freezer floor under the storage racks.
-A full box of cabbage was received from the food delivery supplier and the 5 heads of cabbage were all that remained from the shipping box; however, foods should not be directly stored on the storage racks.
-She was not aware there was a rust orange colored substance on the surface of the shelves on the storage rack where the cabbage was stored in the walk-in refrigerator.

Interview with a cook on 10/22/21 at 2:05pm revealed:
-She had not seen the box of churros underneath the storage shelf in the walk-in freezer.
-Kitchen staff did not clean the floor in the walk-in freezer.
-She had not seen the build-up matter under the storage racks in the walk-in freezer.
-The Resident Care Coordinator (RCC) walked through the entire kitchen at least weekly to monitor the general cleanliness of the kitchen.

Interview with the DM on 10/22/21 at 2:31pm

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revealed:
-She discarded the box of churros that was stuck to the floor of the walk-in freezer and removed the 5 heads of cabbage without a cover or box stored on the storage shelf in the walk-in refrigerator.
-A scraper had been purchased yesterday, 10/21/21 and the floor of the walk-in freezer was cleaned.
-The storage racks in the walk-in refrigerator were cleaned yesterday, (10/21/21).
-She and the dietary staff were responsible for keeping the walk-in refrigerator and freezer clean.

Observation of the walk-in refrigerator on 10/22/21 at 2:07pm revealed the cabbage had been removed.

Observation of the walk-in freezer on 10/22/21 at 2:10pm revealed:
-The thick build-up matter and substances had been removed and the box of churros had been removed from the walk-in freezer.
-Some of the scattered black colored stains and build-up remained at the entrance and along the corners and walls of the walk-in freezer floor.

Interview with the RCC on 10/22/21 at 4:18pm revealed:
-She monitored the general cleanliness of the kitchen but had not observed the floor under the storage racks closely in the walk-in freezer.
-Food should not be directly stored on a storage rack without a covering or container to protect the food from possible contamination.
-She expected all areas of the kitchen to remain clean to protect the residents' food and for dietary staff to perform a deep cleaning weekly.

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| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>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 (#7, #8) observed during the medication pass including errors with a medication to lower blood pressure (#7) and a medication to lower blood glucose levels (#8).<br><br>The findings are:<br><br>1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am/9:00am medication pass on 10/20/21.<br><br>a. Review of Resident #7's current FL-2 dated 10/08/21 revealed:<br>-Diagnoses included diabetes, cirrhosis, esophageal varices, hyperlipidemia, hypertension (HTN), joint pain, post-operative nausea and vomiting and sleep apnea.<br>-There was an order for Norvasc 10mg once a day. (Norvasc is a medication used to lower blood pressure.) | D 358 | | |

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Observation of the 8:00am/9:00am medication pass on 10/20/21 at 8:34am revealed the medication aide (MA) prepared Resident #7's medications for administration and administered Norvasc 5mg.

Observation of Resident #7's medication on hand on 10/20/21 at 8:35am revealed:
-There were 20 of 30 Norvasc 5mg tablets that remained from the supply dispensed on 10/08/21.
-There were 30 of 30 Norvasc 10mg tablets that remained from the supply dispensed on 10/12/21 located in a drawer at the bottom of the medication cart.
-The bottom of the medication cart was where they stored a resident's overflow of medication.

Review of Resident #7's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Norvasc 10mg once a day scheduled at 8:30am.
-Norvasc 10mg was documented as administered from 10/13/21 - 10/20/21.

Interview with the MA on 10/20/21 at 1:05pm revealed:
-She checked Resident #7's blood pressure prior to medication administration and was 132/64.
-Resident #7 has had no complaints of headaches or dizziness.
-She had not realized that Resident #7's order for Norvasc had changed and it was an oversight.

Interview with the Assisted Living (AL) Shift Coordinator on 10/20/21 at 1:07pm revealed:
-She was not aware that Resident #7's Norvasc order had been changed.
-It was the responsibility of the MA to read the eMARs, compare the eMARs with the medication

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labels and administer the medications as ordered.
-Resident #7's primary care provider (PCP) was in the facility at this time and she would notify him of the medication error.

Interview with the Resident Care Coordinator (RCC) on 10/20/21 at 1:43pm revealed:
-It was the responsibility of the RCC or AL Shift Coordinator to fax new orders to the pharmacy.
-It was the responsibility of the pharmacy to update the resident's eMARs with the new orders received from the facility.
-It was the responsibility of the RCC or AL Shift Coordinator to review and approve orders entered onto the eMARs by the pharmacy.
-It was the responsibility of the AL Shift Coordinator to remove discontinued medications from the medication cart.
-It was the responsibility of the MA to read the eMARs, compare the eMARs with the medication labels and administer the medications as ordered.
-It was the responsibility of the RCC to complete a medication error report when an error occurs and notify the PCP.

Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.

Refer to the Interview with Resident #7's PCP on 10/20/21 at 1:50pm.

b. Review of Resident #8's current FL-2 dated 09/08/21 revealed:
-Diagnoses included diabetes, dementia, muscle weakness, lack of coordination, cerebral palsy with chronic cognitive dysfunction, cervical spondylosis encephalopathy and hypertension

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(HTN).
-There was an order for Glipizide 5mg once a day. (Glipizide is a medication used to reduce blood sugar levels.)

Observation of the 8:00am/9:00am medication pass on 10/20/21 at 8:44am revealed the medication aide (MA) prepared Resident #8's medications for administration, crushed the Glipizide 5mg ER tablet and administered the medication in a nutritional supplement.

Observation of Resident #8's medication on hand on 10/20/21 at 8:45am revealed the directions on Resident #8's Glipizide 5mg ER medication label stated for medication to not be crushed.

Review of Resident #8's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Glipizide 5mg ER once a day scheduled at 8:30am.
-There were directions on the Glipizide entry for the medication to not be crushed.

Interview with the MA on 10/20/21 at 11:30am revealed:
-Resident #8 had difficulty swallowing her medications so they were crushed and administered with her nutritional supplement.
-There were standing orders for medications to be crushed but she was not sure if it was on Resident #8's eMAR.
-Information on how a resident takes their medications was discussed with other MAs during the change of shift report.
-She was aware of some medication labels with instructions to not crush however Resident #8's primary care provider (PCP) was aware that her medications had to be crushed.

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| D 358 | Continued From page 43<br><br>Interview with the Resident Care Coordinator (RCC) on 10/20/21 at 1:43pm revealed:<br>-Resident #8 had difficulty swallowing her medications and it was easier for her to consume them crushed.<br>-Resident #8's PCP was aware that her medications were crushed.<br><br>Interview with Resident #8's PCP on 10/20/21 at 1:53pm revealed:<br>-There were no concerns related to Resident #8's Glipizide 5mg ER being crushed prior to administration.<br>-Resident #8's last HgbA1C was drawn sometime last month and was 6.1.<br>Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable. | D 358 | | |
| D 378 | 10a NCAC 13F .1006 (b) Medication Storage<br><br>10A NCAC 13F .1006 Medication Storage<br><br>(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews the facility failed to ensure non-prescription medications were locked and | D 378 | | |

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secure when not under the direct supervision of staff in in the Special Care Unit with 18 residents residing.

The findings are:

Observation of the Special Care Unit (SCU) on 10/20/21 at 9:00 revealed:
-Room #114 was occupied by a sleeping resident; no staff were present in this room.
-The room beside resident room #114 was labeled as an office.
-The office door was not locked, and entry was not impeded.
-This room appeared was used as a storage room.
-An unlocked wooden storage cabinet was inside the office storage room and it was easy to access the items within.
-A shelf in the cabinet contained multiple bottles of varies non-prescription medications.
-There were 108 tablets, three bottles containing 36 tablets each, of low strength chewable aspirin 81mg. (Aspirin is a medication that helps prevent heart attack, clot related strokes, reduce pain, fever and inflammation)
-The chewable aspirin bottle label included a stomach bleeding warning stating the product may cause severe stomach bleeding.
-There were 700 tablets, seven bottles containing 100 tablets each, of enteric coated low dose aspirin 81mg. (Enteric coated aspirin used to prevent stomach ulcers and bleeding associated with use of aspirin used to prevent heart attack, clot related strokes and to reduce pain and fever.)
-The enteric coated aspirin bottle label included a stomach bleeding warning stating the product may cause severe stomach bleeding.
-There were 400 soft gel capsules, four bottles containing 100 soft gel capsules each, of

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docusate sodium 100mg. (Docusate sodium is a medication used as a stool softener to prevent or treat constipation)
-The bottle label on the docusate sodium included a warning to discontinue use if rectal bleeding is present and fail to have a bowel movement after use of a laxative as this may be a sign of a serious condition.
-There were 900 tablets, nine bottles containing 100 tablets each, of ferrous sulfate 325mg. (Ferrous sulfate is a supplement used to prevent iron deficiency)
-The iron supplement bottle label included a warning stating do not exceed the recommended dosage and it may cause constipation, diarrhea or black stools.
-The suggested use of the iron supplement for adults was to take one tablet daily with or after a meal.
-There was one bottle containing 1,000 tablets of acetaminophen 500mg. (Acetaminophen is a medication used to as a pain reliever and fever reducer)
-The acetaminophen bottle label included a warning stating the maximum daily dose is 6 tablets in 24 hours, severe liver damage may occur if more than 8 tablets in 24 hours are taken.
-The acetaminophen bottle label also included an allergy warning stating may cause severe skin reactions including skin reddening, blisters and rash.
-There was one 16 oz bottle of magnesium hydroxide 1200mg per 15ml. (Magnesium hydroxide is a medication used to reduces stomach acid and as a laxative)
-The magnesium hydroxide bottle label included a warning stating to ask a doctor before use if a magnesium-restricted diet, kidney disease, stomach pain, nausea, vomiting, or a sudden change in bowel habits the lasts over 14 days are

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present.
-There were 450 tablets, three bottles containing 150 tablets each, of chewable calcium carbonate 500mg. (Calcium carbonate is a medication that relieves heartburn and indigestion)
-The calcium carbonate bottle label included a warning stating antacids may interfere with certain prescription drugs.
-The aspirin, acetaminophen, magnesium hydroxide or calcium carbonate bottles were not equipped with safety caps and their seals were intact.

Observation of the SCU hallway on 10/20/21 at 9:28am to 10:09am revealed:
-The hallway was not always physically supervised by a staff.
-A personal care aide (PCA) entered the office storage room at 9:33am to retrieve incontinent briefs while a survey team member was in the room. She did not lock the door upon exiting.
-The Special Care Unit (SCU) Shift Coordinator checked all the rooms up to room #114 at 9:49am. She did not check the office storage room.
-The resident from room #110 wandered down the hallway towards the office storage room and entered resident room #114 at 9:56am for approximately one minute before being redirected back to his room.
-At 10:05am the resident from room #110 wandered down the hall towards the office storage room and entered room #112. He exited the room independently at approximately one minute later.
-Staff was not supervising the hallway at 10:06am.
-A PCA entered the office storage room to retrieve dressing sponges at 10:09am. She did not lock the door upon exiting the room at

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10:11am.

Interview with a PCA on 10/20/2021 at 10:10am revealed:
-The office storage room should be locked when staff is not present in the room.
-The keys to the room door lock were stored by the medication aide (MA).
-The wooden storage cabinet in the office storage room should be locked if the room door is not locked.
-Storage rooms with medications needed to be locked to keep residents from getting hurt or ingesting something harmful.

Interview with the SCU Shift Coordinator on 10/20/212 at 10:22am revealed:
-The office storage room was not locked to allow staff easy access to the items stored within.
-The medications in the office storage room were back up stock for the medication carts.
-The wooden storage cabinet had a locked, but the key could not be located.
-She would "dummy lock" the cabinet so it would look like it was locked to the residents.

Interview with the Resident Care Coordinator (RCC) on 10/20/21 at approximately 11:00am revealed:
-All special care unit residents were capable of wandering into unlocked rooms.
-It was expected that all storage areas containing any medication be locked when not directly supervised by staff.
-She was not aware the key for the wooden storage cabinet was missing.
-She was not aware the office storage room was unlocked when unsupervised by staff.
-Unsecure medications were a concern because residents would get medicines and possibly

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| **WEST BLADEN ASSISTED LIVING** | **714 BLADEN STREET BLADENBORO, NC 28320** |

| (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 378 | Continued From page 48<br>overdose.<br><br>Interview with primary care provider (PCP) on 10/22/21 at 8:58am revealed:<br>-All medications on the SCU were expected to be locked and kept secured from the residents.<br>-There was a concern for the ferrous sulfate, aspirin and acetaminophen due to risk of deadly overdose.<br><br>Review of the facility's policy and procedures for the process of medications storage to protect residents residing on the SCU revealed a photocopy of Rule # 10A NCAC 13F .1006.<br>______________________________<br>The facility failed to store medications in the safe and secure manner in the SCU where 18 residents with dementia, other cognitive impairments, and wandering behaviors resided. The medications included ferrous sulfate, aspirin and acetaminophen, which placed the residents at risk for a deadly overdose. This failure was detrimental to the health, safety, and welfare of the residents who resided in the SCU and constitutes a Type B Violation.<br>______________________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/20/21 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2021. | D 378 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are | D912 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL009025 | A. BUILDING: ______ B. WING ______ | C 10/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| D912 | Continued From page 49 | D912 | | |

adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, medication storage and housekeeping and furnishings.

The findings are:

1. Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 6 (#5) sampled residents related to a fall and acute hip pain immediately to the primary care provider (PCP) who was diagnosed with a hip fracture several days after the fall (Resident #5). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

2. Based on observations, interviews, and record reviews the facility failed to ensure the facility was free of hazards including in an unlocked storage and one common bath and shower room where personal care hygiene products, razor blades, lancets and an insecticide were left unsecure and unattended in the Special Care Unit with 18 residents residing. [Refer to Tag D0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

3. Based on observations, interviews, and record reviews the facility failed to ensure non-prescription medications were locked and

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|---|---|---|---|---|
| D912 | Continued From page 50<br>secure when not under the direct supervision of staff in in the Special Care Unit with 18 residents residing. [Refer to Tag D0378, 10A NCAC 13F .1006(b) Medication Storage (Type B Violation)]. | D912 | | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect as related to personal care.<br><br>The findings are:<br><br>Based on interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 6 sampled residents (#6) who required extensive staff assistance with bathing, grooming, skin care and foley catheter care. [Refer to Tag D0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. | D914 | | |