STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092144	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKE ASSISTED LIVING	2800 KIDD ROAD RALEIGH, NC 27610

(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 and the Wake County Department of Social Services conducted an annual and complaint investigation on 05/13/22- 05/14/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to meet the health care needs for 1 out of 5 sampled residents (#3) by failing to immediately send the resident to the emergency department when she presented with severe leg pain and was no longer ambulatory. The findings are: Review of Resident #3's current FL-2 dated 11/03/21 revealed: -Diagnoses included dementia, Parkinson's, hyperlipidemia and hypertension. -She was ambulatory. Review of Resident #3's current care plan dated 03/16/22 revealed: -She had no problems with ambulation. -She wandered around the hallways going from residents to residents' room. Telephone interview with a medication aide (MA) on 07/14/22 at 8:19am revealed:	D 273		

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-Resident #3 was always walking around in the facility.
-She was an MA, but she worked as a personal care aide (PCA) on Sunday, 04/24/22.
-When she went to Resident #3's room, during first shift on Sunday, 04/24/22, she was sitting in a wheelchair.
-She attempted to stand Resident #3, but her legs buckled, and she moaned in pain therefore, she sat her back in the wheelchair.
-She informed the MA on Sunday, 04/24/22, something was wrong with Resident #3 (could not remember who) and informed either the Administrator or the previous Resident Care Coordinator (RCC) (could not remember which one).
-Later that day, Sunday, 04/24/22, when she provided personal care to Resident #3, she was in severe pain. She was moaning and groaning.
-She did not call hospice or send Resident #3 out to the emergency department because although she was an MA, she was in a PCA role that day and she left it up to the persons in charge to determine what to do for Resident #3.
-The facility received an order on Monday, 04/25/22, for a portable x-ray.
-The PCA who cared for Resident #3 during second and third shift on Saturday, 04/23/22 no longer worked with the facility.

Interview with a personal care aide (PCA) on 07/14/22 at 8:45am revealed:
-The MA was assigned as both the MA and the PCA on Sunday, 04/24/22.
-She assisted the MA with Resident #3 on Sunday, 04/24/22.
-When they tried to dress her and attempted to walk with her, the resident kept saying 'aw' as if she was in pain.
-When she and the MA realized Resident #3

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could not walk, they placed her in a wheelchair.
-She kept telling the MA, Resident #3 needed to be sent out to the emergency department. She did not know why the resident was not sent.
-She notified the previous Resident Care Coordinator (RCC) or the Administrator (not sure which one), Resident #3 was in pain.
-A family member came in to visit Resident #3 and asked what happened to her.
-The facility informed the family member Resident #3 was in pain, could not walk and they did not know what happened.
-On Monday, 04/25/22, an x-ray was ordered for Resident #3's right leg.

Interview with a second PCA on 07/14/22 at 11:35am revealed:
-She worked during first shift on Saturday, 04/23/22, and did not remember any incidents or accidents that occurred with Resident #3.
-She worked with Resident #3 on Monday, 04/25/22 and attempted to stand her but she could not stand alone because her leg was hurting.
-She informed the MA Resident #3 was in pain.
-The MA called hospice.

Telephone interview with a family member on 07/14/22 at 9:52am revealed:
-She visited Resident #3 on Saturday, 04/23/22 and the resident was walking independently when she left between 6:30pm- 7:00pm.
-She visited Resident #3 on Sunday, 04/24/22 and she was sitting in a wheelchair in the dining room.
-The facility staff informed her Resident #3 was placed in the wheelchair because she could not walk. They did not call the Primary Care Provider (PCP) to get an order for an x- ray but they gave Resident #3 pain medication.

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-She was concerned because Resident #3 always walked but was not able to.
-When she returned on Monday, 04/25/22, Resident #3 was in severe pain. The facility staff informed her they gave her pain medication.
-She asked the facility staff (not sure who) had an x-ray been done and they replied no.
-She informed another facility staff (note sure who) something was wrong with Resident #3 and she thought she needed an x-ray.
-After the facility staff left the room and spoke to someone, the facility staff informed her an x- ray was ordered.
-Resident #3 was sent to the emergency department on Wednesday, 04/26/22 and was diagnosed with a right hip femur fracture.

Review of Resident #3's hospice note dated 04/25/22 at 11:30am revealed:
-The hospice nurse saw her for a routine visit.
-She was examined for right hip pain.
-The PCP verbally ordered a portable x-ray and to continue morphine as needed (PRN) for discomfort. (Morphine is used for pain).

Review of Resident #3's hospice note dated 04/26/22 revealed:
-She was lying in bed and not responding to staff.
-When her right leg was moved by staff, she was groaning indicating she was in pain.
-Use cold compress for her fever and administer morphine for pain.
-Hospice would follow-up with x-ray results and process with treatment.

Review of Resident #3's incident and accident report dated 04/26/22 revealed per hospice she was sent to the emergency department to have right leg evaluated due to pain.

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Review of Resident #3's emergency department records dated 04/26/22 revealed:
-She was brought in due to right hip pain since Sunday, 04/24/22.
-There was no report of her falling.
-The x-ray showed a right hip fracture due to unknown injury.

Review of Resident #3's hospice assessment and care plan dated 04/29/22 revealed she was sent to the emergency department on 04/26/22 due to a displaced femoral fracture of the right leg and was admitted to the hospital post-surgery on 04/27/22.

Interview with the Administrator on 07/14/22 at 9:15am revealed:
-She was not sure if hospice was notified or came to the facility on Sunday, 04/24/22.
-She was notified by the MA on Monday, 04/25/22, Resident #3 could not bear weight on her right leg.
-She informed the MA on Monday, 04/25/22 to notify hospice.
-The MA informed her on Monday, 04/25/22, hospice was notified, and they were sending a nurse to the facility.
-She worked third shift on Monday, 04/25/22 and assisted with personal care for Resident #3.
-She observed the resident was in pain when she was repositioned.
-She notified hospice on Tuesday, 04/26/22 and asked if the facility could send Resident #3 to the emergency department. Hospice informed her they were waiting on x- ray results.
-When hospice came out on Tuesday, 04/26/22 they wrote handwritten, care instructions for Resident #3.
-When facility staff noticed on Sunday, 04/24/22, Resident #3 was in severe pain, they should have

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D 273	Continued From page 5 sent the resident to the emergency department. -She would not expect facility staff to allow a resident to be in severe pain for 24 hours and not send them out. Attempted telephone interview with the PCP on 07/13/22 at 2:54pm was unsuccessful. _____ The failure of the facility to ensure referral and follow up to meet the acute health care needs of Resident #3 who was in severe pain and no longer ambulatory for more than 24 hours due to a right hip fracture resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/14/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 13, 2022.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or	D 344		

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clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#1) for a medication used to treat constipation.

The findings are:

Review of Resident #1's previous FL-2 dated 04/05/22 revealed:
-Diagnoses included constipation.
-There was an order for Senna 8.6mg 1 tablet at bedtime. (Senna is a laxative used to treat constipation.)

Review of Resident #1's current FL-2 dated 04/14/22 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, hyperlipidemia, essential tremor, anxiety, dementia, and insomnia.
-There was no order for Senna included on the current FL-2.

Review of Resident #1's physician's orders revealed no documentation the order for Senna had been clarified.

Review of Resident #1's May 2022 - July 2022 electronic medication administration records (eMARs) revealed:
-There was no entry for Senna 8.6mg tablets on the May 2022 - July 2022 eMARs.
-No Senna was documented as administered in May 2022, June 2022, or July 2022.

Observation of Resident #1's medications on

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hand on 07/14/22 at 2:43pm revealed:
-There was a supply of Senna 8.6mg tablets with 22 of 28 tablets remaining.
-The start date on the Senna medication card was 07/06/22.
-The instructions for Senna were to take 1 tablet at bedtime.

Interviews with a medication aide (MA) on 07/14/22 at 2:43pm and 4:03pm revealed:
-She had not noticed the medication card with Senna 8.6 mg tablets for Resident #1.
-She did not recall administering Senna to the resident but she usually worked first shift.
-She had not seen Senna on the eMAR when she administered the resident's morning medications.
-She did not see an order for Senna in the eMAR system.
-The resident reported having some diarrhea on Tuesday, 07/12/22, but the resident got better after she ate some food.
-She was not aware of the resident having any other issues with diarrhea or constipation.

Interview with a second MA on 07/14/22 at 3:40pm revealed:
-She usually administered one Senna 8.6mg tablet to Resident #1 every night.
-She thought the order "popped up" on the eMAR about 7:00pm but she was not sure.
-She was not sure how long she had been administering Senna to the resident.

Interview with Resident #1 on 07/14/22 at 3:00pm revealed:
-She was unsure what medications she received.
-She was not currently having problems with constipation or diarrhea.

Interview with the Administrator on 07/14/22 at

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D 344	Continued From page 8 3:28pm revealed: -The facility's contracted pharmacy provider usually entered medication orders into the eMAR system. -Facility staff approved orders in the eMAR system before they became active orders on the eMAR. -Either she or the Resident Care Coordinator (RCC) or the MAs had access to approve orders in the eMAR system. -She could not locate an entry for Senna on any of Resident #1's eMARs from March 2022 - July 2022. -The RCC would be responsible for faxing FL-2s to the pharmacy but the RCC in April 2022 was no longer at the facility and that position was vacant. -She did not know why the current FL-2 dated 04/14/22 did not get faxed to the pharmacy. -The RCC should have clarified the Senna order when it was not included on the current FL-2 dated 04/14/22. -If a medication was not listed on the eMAR but available on hand, the MAs should not administer the medication until clarification was received. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/14/22 at 3:47pm revealed: -The pharmacy had Resident #1's FL-2 dated 04/05/22 with an order for Senna 8.6mg 1 tablet at bedtime. -The pharmacy dispensed a 28-day supply of Senna 8.6mg tablets on 04/06/22, 05/04/22, 06/01/22, and 06/29/22. -The supply dispensed on 06/29/22 had a cycle start date of 07/06/22 (the current supply on hand at the facility). -The pharmacy did not have a copy of the most current FL-2 dated 04/14/22 with no order for	D 344		

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D 344	Continued From page 9 Senna. -If they had received the current FL-2 dated 04/14/22 with no order for Senna, they would have needed clarification to determine if Senna should continue to be administered. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/14/22 at 4:05pm was unsuccessful.	D 344		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5-day requirements for 1 of 1 sampled resident (#3) who sustained a right hip fracture from unknown origin. The findings are: Review of Resident #3's current FL-2 dated 11/03/21 revealed: -Diagnoses included dementia, Parkinson's, hyperlipidemia and hypertension. -She was ambulatory. Review of Resident #3's current care plan dated 03/16/22 revealed:	D 438		

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D 438	Continued From page 10 -She had no problems with ambulation. -She wandered around the hallways in the facility, going from residents to residents' room. Review of Resident #3's incident and accident report dated 04/26/22 revealed per the hospice provider she was sent to the emergency department to have her right leg evaluated due to pain. Review of Resident #3's emergency department records dated 04/26/22 revealed: -She was brought in due to right hip pain since Sunday, 04/24/22. -There was no report of her falling. -The x-ray showed a right hip fracture due to unknown injury. Interview with a personal care aide (PCA) on 07/14/22 at 8:45am revealed: -She assisted the (MA) with Resident #3 on 04/24/22. -When they tried to dress her and attempted to walk with her, she kept saying 'aw' as if she were in pain. -When she and the MA realized Resident #3 could not walk, they placed her in a wheelchair. -A family member came in to visit Resident #3 and asked what happened to her. -They informed her Resident #3 was in pain, could not walk and they did not know what happened. Interview with the Administrator on 07/14/22 at 10:49am revealed: -It was reported to her, when the facility staff attempted to move Resident #3 her legs buckled, and she complained of pain. -She did not know how Resident #3 obtained the right hip fracture.	D 438		

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D 438	Continued From page 11 -She was aware she needed to report an injury of unknown origin to the Health Care Personnel Registry (HCPR) and complete a 5-day investigation. -She was busy during the time she was notified by staff Resident #3 was in pain and could not walk and forgot to notify HCPR.	D 438		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure a resident was free of neglect. The findings are: Based on observations, interviews and record reviews, the facility failed to meet the health care needs for 1 out of 5 sampled residents (#3) by failing to immediately send the resident to the emergency department when she presented with severe leg pain and was no longer ambulatory. [Refer to Tag 273, NCAC 13F .0902 Health Care (Type A1 Violation)].	D914		