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AVENDELLE ASSISTED LIVING ON TRYON	6645 TRYON ROAD CARY, NC 27518

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 18, 2022 - August 19, 2022 with an exit conference via telephone on August 19, 2022	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider was notified of new wounds and a Home Health referral as ordered for 1 of 3 sampled residents (#3) in which the resident was to receive wound care every other day until a home health agency was able to assume wound care duties. The findings are: Review of Resident #3's current FL-2 dated 06/27/22 revealed: -Diagnoses included neoplasm of the skin, cellulitis of the lower extremity, diastolic heart failure, peripheral vascular disease, and hypertension. -There was an order for dressing changes to the right foot and right 1st toe. Review of Resident #3's current care plan dated 07/29/22 revealed: -The resident's skin conditions included redness, abrasions, and open areas.	C 246		

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C 246	Continued From page 1 -The right great toenail was removed, and the right lower leg had three reddened scabbed areas. -The resident had daily intermittent pain of the right lower leg. a. Review of Resident #3's primary care provider (PCP) visit note dated 06/29/22 revealed: -The resident was seen to establish care as a new patient. -The resident was non-ambulatory due to several lesions and open areas to the feet bilaterally, especially in the heels and toes. -The resident was in urgent need of a podiatry and home health wound care referral. -The resident's legs were cool to touch, with scattered dry scabs, skin tears to the upper and lower extremities, blanchable redness to both heels, and the right great toenail was missing and draining scant serosanguinous drainage. -There was an order to obtain a home health wound care referral. Review of Resident #3's progress note dated 07/05/22 revealed: -The resident was seen by the podiatrist in which he had a toe infection. -The podiatrist wrote an order for Keflex (antibiotic to treat infection). Review of Resident #3's PCP visit note dated 07/16/22 revealed: -The resident was seen at the facility's request due to the resident having a recent behavior change with increasing signs of agitations and restlessness. -The resident complained on persistent pain on his feet; especially his right big toe. -Podiatry had recently started him on Keflex 500mg twice daily.	C 246		

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-The resident had slight redness and pain to the right big toe and was diagnosed with cellulitis of the right toe.
-The resident's Keflex order was changed to 500mg four times daily to treat the infection with an order to continue would care as previously ordered.

Observation of Resident #3 on 08/18/22 at 8:56am and 5:29pm revealed:
-The resident had a bandage covering a wound to the left calf and right elbow.
-The resident had multiple open sores on both of his legs.
-The skin on the resident's hands was intact.
-The resident's feet and toes were reddened and swollen bilaterally and there was blanching to the top of the right foot.
-The resident was missing toenails to the right first and second toe in which the skin was blackened, yellow, and crusted over.
-There were dark purple/black areas that were closed to the bottom of both feet.

Interview with Resident #3 on 08/18/22 at 5:45pm revealed:
-He had issues with sores, scabs, and his toenails for years.
-His swelling and infection in his right toes were painful and it was difficult for him to walk.
-The staff knew about all of his wounds because they saw them when he received help with bathing.

Review of Resident #3's Hospice provider note dated 08/01/2022 revealed:
-The resident was seen to initiate hospice care.
-There was a wound observed to the right great toe that was noted to have been treated with Keflex 500mg four times daily from

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07/18/22-07/28/22.
-The wound/nail bed was dry with slight redness and the feet were cool to touch bilaterally with pitting edema (swelling).
-There was an order to cleanse the right great toe with wound cleanser normal saline, pat dry with gauze, and paint with betadine on Mondays and Thursdays leaving open to air.
-There was an order to notify the hospice nurse of any change or concerns and the hospice nurse would clean, measure, and assess the resident's wound weekly.

Review of Resident #3's PCP visit note dated 08/16/22 revealed:
-Both of the resident's legs were red, tender, swollen and cool to touch with pulses in the feet not able to be palpated due to the swelling.
-The resident was unable to move his toes on both feet.
-The right great toe was missing the toenail with scant drainage.
-There was blanchable redness to both heels.

Review of Resident #3's resident record revealed:
-There was no documentation that a Home Health nurse assessed wounds or provided wound care to the resident until 08/08/22.
-There was no documentation that the resident's PCP was notified that the Home Health referral had not been implemented until 08/01/22 when the resident was initially assessed by a hospice provider for hospice services.

Interview with Resident #3's first Home Health provider's Registered Nurse on 08/19/22 at 9:00am revealed:
-The home health agency never received a wound care referral for the resident on 06/29/22 or thereafter.

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C 246	Continued From page 4 -It was the facility's responsibility to follow up with the home health agency to ensure the wound care referral had been received and was able to be implemented as ordered. -If they had received the order to provide Resident #3 with home health wound care services as ordered, they would have been able to provide a registered nurse for wound care at the facility within 24-48 hours of receipt. Interview with Resident #3's second Home Health provider's Clinical Nurse Manager on 08/19/22 at 8:51am revealed: -The home health agency received a referral order for the resident to receive wound care on 06/30/22. -On 07/01/22, the home health agency attempted to have the facility clarify the wound care order to specify that a registered nurse needed to provide the wound care in order for the agency to provide home health wound care services to the resident as ordered. -There was no documentation that the facility followed up with them to provide a clarified order in order to implement home health wound care services to the resident at the facility as ordered. -If the facility had provided a clarified order as needed and requested, the home health agency would have been able to provide wound care services to the resident within 48 hours of receiving the order or sooner. -Without being able to personally assess Resident #3's wounds, it was hard to say what the risk to the resident was, but lack of wound care in general could lead to infection, sepsis, or amputation based on a resident's health comorbidities. -It was the facility's responsibility to follow up with the provider to obtain a clarified order to ensure that the resident's wound care orders were	C 246		

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implemented as expected by the resident's provider.

Interview with Resident #3's PCP on 08/19/22 at 8:13am revealed:
-She was not aware that home health wound care had not been implemented until 08/08/22 after the resident began hospice services on 08/01/22.
-The facility had not made her aware that they had not implemented the order to have a home health wound nurse to perform wound care as ordered.
-She expected to have been notified if there was an issue implementing the referral order to contract a home health wound care nurse as ordered.
-Not having wound care for the resident as ordered put the resident at risk of losing the function or the entire extremity in which he had wounds and possibly causing infection, sepsis (severe infection), or death.

Interview with the Operations Manager on 08/19/22 at 10:12am revealed:
-She had just assumed Operations Manager duties of the facility this week.
-She was not aware that the Home Health referral for Resident #3 dated 06/29/22 had not been carried out as ordered until it had been brought to her attention on the previous day, 08/18/22.
-It was the previous Operations Manager's responsibility to have followed up to ensure orders were implemented and to notify Resident #3's PCP that the orders had not been implemented as ordered.

Interview with the Clinical Operations Director on 08/19/22 at 10:42am revealed:
-She was not aware that Resident #3's Home Health wound care referral dated 06/29/22 had

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not been implemented as ordered until being made aware on the previous day, 08/18/22.
-It was the Operation Manager's responsibility to have notified Resident #3's PCP that the Home Health wound care referral had not been administered as ordered.
-If she had been aware that Resident #3 had not received Home Health as ordered, she would have provided wound care and notified the resident's PCP for further guidance.

Interview with the Administrator on 08/19/22 at 11:30am and 2:40pm revealed:
-It was the Operations Manager's responsibility to have implemented and followed up on Resident #3's Home Health referral order within 1-2 business days.
-She was not aware that the Operations Manager had not followed up on the home health referral as expected.
-She did not follow up or call the home health agency sooner because she thought the order had been implemented as expected.
-It was the Operation's Manager's responsibility to have notified the resident's PCP that the referral order had not been implemented as expected.
-There was no process in place for the facility to follow up and verify orders had been received by outside agencies and were being processed as expected.

b. Review of Resident #3's PCP visit note dated 07/16/22 revealed there was an order to continue to monitor the resident and to notify the provider of worsening signs of infection were observed.

Review of Resident #3's skin assessment sheets revealed:
-On 07/02/22, it was documented that the resident had redness to the right elbow, dryness

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to the right hand, and wounds to the right and left calf.
-On 07/05/22, it was documented that the resident had redness to the right elbow, dryness to the right hand, and wounds to the right and left calf and left foot.
-On 07/12/22, it was documented that the resident had redness to the right elbow, dryness to the right hand, and wounds to the right and left calf and left foot.
-On an illegible date in July 2022, it was documented that the resident had redness to the right arm, dryness to the right hand, and wounds to the right and left calf and left foot.
-On 08/02/22, it was documented that the resident had redness to the right arm, dryness to the right hand, and wounds to the right and left calf and left foot.
-On 08/10/22, it was documented that the resident had redness to his right arm/hand, dryness to his left and right arm, and wounds to his right and left calf and left foot.
-On 08/17/22, it was documented that the resident had redness to his right arm, dryness to his right hand, and wounds to his right and left calf and left foot.

Review of Resident #3's resident record to include progress notes, PCP communication notes, and PCP visit notes revealed there was no documentation that the resident's PCP was notified that the resident had new wounds to his calves and left foot.

Review of Resident #3's PCP visit note dated 08/16/22 revealed:
-There was an ulcer to the left outer calf with eschar notes along the wound bed with a small open area which was very tender to touch.
-There was a new ulcer on his right elbow as well.

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C 246	Continued From page 8 Interview with Resident #3's PCP on 08/19/22 at 8:13am revealed: -She last saw the resident on 08/16/22 and the wounds that he was admitted with on 06/29/22 had worsened and he had new wounds present. -The facility had not notified her that the resident had been developing new wounds. -She was only aware of new wounds when she assessed the resident's wounds herself. -The resident had a new ulcer on his left leg and in his right elbow since his admission on 06/29/22, which no one at the facility had notified her of prior to her assessment on 08/16/22 in which she identified it herself. -She expected to have been notified of any new ulcers or wounds or sores that developed on the resident, any changes in his skin assessments. -Not being notified that the resident had new and worsening wounds prior to her assessment on 08/16/22 put the resident at risk of losing the function or the entire extremity in which he had wounds and possibly causing infection, sepsis (severe infection), or death. Interview with the Operations Manager on 08/19/22 at 10:12am revealed: -She had just assumed Operations Manager duties of the facility this week. -She was not aware that the resident had developed any new wounds until it had been brought to her attention on the previous day, 08/18/22. -It was the previous Operations Manager's responsibility to have notified Resident #3's PCP that the resident had developed new wounds. Interview with the Clinical Operations Director on 08/19/22 at 10:42am revealed: -She was not aware that Resident #3 had new	C 246		

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C 246	Continued From page 9 wounds until being made aware on the previous day, 08/18/22. -It was the Operation Manager's responsibility to have notified Resident #3's PCP that the resident had developed new wounds. -If she had been aware that Resident #3 had new wounds she would have provided wound care and notified the resident's PCP for further guidance. Interview with the Administrator on 08/19/22 at 11:30am and 2:40pm revealed: -She was not aware that Resident #3 had developed new wounds. -It was the Operation's Manager's responsibility to have notified the resident's PCP of new wounds. The facility failed to notify Resident #3's primary care provider of new wounds and failed to ensure a referral for home health wound care for which placed the resident at increased risk for infection, sepsis, loss of function, and/or death. The failure of the facility was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 08/19/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 3, 2022.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from	C 249		

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a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure implementation of orders for 2 of 3 sampled residents (#2, #3) for orders in which a resident was to have daily circulation checks performed on an injured extremity (#2) and a resident who was to receive wound care every other day until a home health agency was able to assume wound care duties (#3).

The findings are:

1. Review of Resident #3's current FL-2 dated 06/27/22 revealed:
-Diagnoses included neoplasm of the skin, cellulitis of the lower extremity, diastolic heart failure, peripheral vascular disease, and hypertension.
-There was an order for dressing changes to the right foot and right 1st toe.

Review of Resident #3's primary care provider (PCP) visit note dated 06/29/22 revealed:
-The resident was seen to establish care as a new patient.
-The resident was non-ambulatory due to several lesions and open areas to the feet bilaterally, especially in the heels and toes.
-The resident was in urgent need of a podiatry and home health wound care referral.

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C 249	Continued From page 11 -The resident's legs were cool to touch, with scattered dry scabs, skin tears to the upper and lower extremities, blanchable redness to both heels, and the right great toenail was missing and draining scant serosanguinous drainage. -There was an order to obtain a home health wound care referral and for the facility to administer wound care to the resident's right great toe and right hand with Xeroform petrolat gauze every other day until home health wound care was initiated. Review of Resident #3's progress note dated 07/05/22 revealed: -The resident was seen by the podiatrist in which he had a toe infection. -The podiatrist wrote an order for Keflex (antibiotic to treat infection). Review of Resident #3's PCP visit note dated 07/16/22 revealed: -The resident was seen at the facility's request due to the resident having a recent behavior change with increasing signs of agitations and restlessness. -The resident complained on persistent pain on his feet; especially his right big toe. -Podiatry had recently started him on Keflex 500mg twice daily. -The resident had slight redness and pain to the right big toe and was diagnosed with cellulitis of the right toe. -The resident's Keflex order was changed to 500mg four times daily to treat the infection with an order to continue would care as previously ordered. -There was an order to continue monitor the resident and to notify the provider if worsening signs of infection were observed.	C 249		

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C 249	Continued From page 12 Review of Resident #3's current care plan dated 07/29/22 revealed: -The resident's skin conditions included redness, abrasions, and open areas. -The right great toenail was removed, and the right lower leg had three reddened scabbed areas. -The resident had daily intermittent pain of the right lower leg. Review of Resident #3's current license health professional support (LHPS) assessment dated 07/20/22 revealed there were no tasks for wound care. Observation of Resident #3 on 08/18/22 at 8:56am and 5:29pm revealed: -The resident had a bandage covering a wound to the left calf and right elbow. -The resident had multiple open sores on both of his legs. -The skin on the residents hands appeared to be intact. -The resident's feet and toes were reddened and swollen bilaterally and there was blanching to the top of the right foot. -The resident was missing toenails to the right first and second toe in which the skin was blackened, yellow, and crusted over. -There were dark purple/black areas that were closed to the bottom of both feet. Interview with Resident #3 on 08/18/22 at 5:45pm revealed: -He had issues with sores, scabs, and his toenails for years and this was not a new problem. -His swelling and infection in his right toes were painful and it was difficult for him to walk.	C 249		

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C 249	Continued From page 13 Review of Resident #3's hospice provider note dated 08/01/2022 revealed: -There was a wound to the right great toe that was treated with Keflex 500mg four times daily from 07/18/22-07/28/22. -The wound/nail bed was dry with slight redness and the feet were cool to touch bilaterally with pitting edema (swelling). -There was an order to cleanse the right great toe with wound cleanser normal saline, pat dry with gauze, and paint with betadine on Mondays and Thursdays leaving open to air. -There was an order to notify the hospice agency of any change or concerns and the hospice nurse would provide wound care and assess the resident weekly. Review of Resident #3's PCP visit note dated 08/16/22 revealed: -Both of the resident's legs were red, tender, and swollen and cool to touch with pulses in the feet not able to be palpated due to the swelling. -The resident was unable to move his toes on both feet and there was an ulcer to the left outer calf with eschar notes along the wound bed with a small open area which was very tender to touch. -The right great toe was missing the toenail with scant drainage. -The heels had blanchable redness and there was a new ulcer on his right elbow as well. Review of Resident #3's 06/01/22-06/30/22 electronic medication administration record (eMAR) revealed: -There was an entry for Xeroform gauze as needed (PRN) to the right hand and right every other day until seen by wound care. -There was no documentation of any Xeroform gauze wound care provided to the resident.	C 249		

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C 249	Continued From page 14 Review of Resident #3's 07/01/22-07/31/22 eMAR revealed: -There was an entry for Xeroform gauze as needed (PRN) to the right hand and right every other day until seen by wound care. -There was no documentation of any Xeroform gauze wound care provided to the resident. Review of Resident #3's 08/01/22-08/18/22 2022 eMAR revealed: -There was an entry for Xeroform gauze as needed (PRN) to the right hand and right every other day until seen by wound care. -There was no documentation of any Xeroform gauze wound care provided to the resident. Observation of Resident #3's medications on hand on 08/18/22 at 4:40pm revealed there was not any Xeroform gauze available for use on the resident's wounds. Review of Resident #3's skin assessment sheets revealed: -On 07/02/22, it was documented that the resident had redness to the right elbow, dryness to the right hand, and wounds to the right and left calf in which cream was applied and a wound to his left foot. -On 07/05/22, it was documented that the resident had redness to the right elbow, dryness to the right hand, and wounds to the right and left calf and left foot, no wound care was provided. -On 07/12/22, it was documented that the resident had redness to the right elbow, dryness to the right hand, and wounds to the right and left calf and left foot in which the wounds were sprayed and cream applied. -On an illegible date in July 2022, it was documented that the resident had redness to the right arm, dryness to the right hand, and wounds	C 249		

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to the right and left calf and left foot in which wound spray was applied.
-On 08/02/22, it was documented that the resident had redness to the right arm, dryness to the right hand, and wounds to the right and left calf and left foot in which wound care spray was applied.
-On 08/06/22, it was documented that the resident had redness to his right arm, dryness to his right hand, and a wound on his left food in which wound care spray was applied.
-On 08/10/22, it was documented that the resident had redness to his right arm/hand, dryness to his left and right arm, and wounds to his right and left calf and left foot in which wound care spray was applied.
-On 08/17/22, it was documented that the resident had redness to his right arm, dryness to his right hand, and wounds to his right and left calf and left foot in which wound care spray and cream were applied.
-None of the skin assessment sheet documentation indicated the resident received any wound care to his right foot or right hand with Xeroform dressing as ordered.

Review of Resident #3's hospice visit note dated 08/08/22 revealed:
-The resident had a scab to his right great toe with no drainage.
-Wound care was provided to the right great toe.

Review of Resident #3's resident record revealed:
-There was no documentation of any wound care to Resident #3's right hand or right toe until home health/hospice wound care was initiated on 08/08/22.
-There were 20 out of 20 opportunities that wound care was not provided as ordered every other day to the resident's right hand and foot as

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C 249	Continued From page 16 ordered on 06/29/22 based on skin assessment sheet and eMAR reviews. Interview with a medication aide (MA)/personal care aide (PCA) on 08/19/22 at 9:58am revealed: -She did not realize that there was an active order to perform wound care for Resident #3 every other day. -She had never performed wound care for Resident #3 and was not sure if anyone else had done so as she had never observed any other staff members performing wound care for Resident #3 either. -Wound care for Resident #3 should have shown up on the eMAR as a scheduled task and not as a PRN task on the eMAR in order for her to have known she was supposed to carry the task out. -Resident #3 had wound care supplies in his room, but she was unsure if it was the supplies that were ordered by his PCP. -Residents were to receive skin assessments weekly with their baths. -She had never provided Resident #3 with a bath and was unaware that he had any wounds. -If she had known that Resident #3 had wounds, she would have filled out a facility form notifying the Supervisor in Charge (SIC) and placed it in the resident's folder for the Clinical Operations Manager to review and notify the resident's PCP. Interview with a second MA/PCA on 08/19/22 at 1:42pm revealed: -She did not perform any wound care for Resident #3 when she worked because she did not know there was a task to do so. -She had never observed any other staff members performing wound care for Resident #3. Interview with a third MA/PCA on 08/19/22 at	C 249		

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C 249	Continued From page 17 1:54pm revealed: -He would perform wound care for Resident #3's wounds anytime he provided the resident with a bath. -He would use the supplies that were on hand in the resident's room, but he never recalled using Xeroform as ordered, only leaving the wound open to air after cleansing it. -Baths were provided to Resident #3 on Tuesdays, Thursdays, and Saturdays. -He did not provide wound care to Resident #3 if he was not providing the resident with a bath on his scheduled bath days. -He was not aware that there was a wound care order scheduled every other day for Resident #3. Interview with the Operations Manager on 08/19/22 at 10:12am revealed: -Resident #3's order for wound care was inaccurate on the eMAR as a PRN (as needed) task, instead of a scheduled task every other day as ordered. -She had just assumed Operations Manager duties of the facility this week; the previous Operations Manager resigned last week. -It was the previous Operations Manager's responsibility to ensure that the eMAR was accurate when orders were placed on the eMAR by the pharmacy. -It was the previous Operation's Manager's responsibility to ensure that the order for Resident #3's wound care had been implemented and carried out as ordered. -She was not aware that the wound care for Resident #3 was not being carried out as ordered until it had been brought to her attention on the previous day, 08/18/22. Interview with the Clinical Operations Director on 08/19/22 at 10:42am revealed:	C 249		

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C 249	Continued From page 18 -She has not been aware that Resident #3's wound care had not been implemented as ordered until being made aware on the previous day, 08/18/22. -It was the Operation Manager's responsibility to ensure that the wound care order appeared on Resident #3's eMAR accurately as a scheduled task every other day as ordered. -It was the responsibility of the person bathing Resident #3 or the MA to perform wound care, and it was the MA's responsibility to ensure wound care had been performed as ordered and documented on the eMAR accurately each day. -It was the Operation Manager's responsibility to have notified Resident #3's PCP that wound care had not been administered as ordered. -If she had been aware that Resident #3 was not getting wound care as ordered, she would have provided wound care and notified the resident's PCP for further guidance. -Not getting wound care as ordered put Resident #3 at risk of developing infection and delayed healing. Interview with the Administrator on 08/18/22 at 4:50pm revealed: -There was no documentation that wound care was performed for Resident #3 because staff did not have the Xeroform gauze dressing and would only use a wound cleanser but could not recall if they used any other kind of dressing. -She thought the issue in not having Xeroform gauze as ordered was because the pharmacy did not have it in stock. -She thought staff were performing wound care as ordered but was unable to find any other documentation that the wound care was performed for Resident #3 as ordered. Interview with the Administrator on 08/19/22 at	C 249		

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C 249	Continued From page 19 11:30am revealed: -It was the Operations Manager's responsibility to ensure that Resident #3's wound care order appeared accurately on the eMAR. -It was the Operations Manager's responsibility to ensure that wound care was being performed every other day as ordered. -She was not aware that Resident #3 had not receiving wound care as ordered. Interview with a Pharmacist at the facility's contracted pharmacy provider on 08/19/22 at 3:27pm revealed: -The pharmacy received an order for Resident #3 to have wound care every other day with Xeroform gauze dressing to his right hand and right great toe dated 06/29/22 until he was seen by Home Health for wound care. -The order was not written as PRN but was placed on the eMAR as PRN because the pharmacy did not know when Home Health would be initiated. -It was the facility's responsibility to review orders placed on a resident eMAR for accuracy and to obtain clarification or correction of the order prior to approving the order for use. -Resident #3 should have received wound care with Xeroform gauze dressing every other day as ordered until Home Health wound care had been initiated. -There was no shortage of Xeroform gauze, but the supplies were never sent to the facility because they had not been requested by the facility. -It was concerning that Resident #3 did not receive wound care every other day as ordered because it could have resulted in an infection and delayed healing. Interview with Resident #3's Podiatrist on	C 249		

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C 249	Continued From page 20 08/19/22 at 8:51am revealed: -She assessed the resident on 07/05/22. -The resident had an infection of his right foot in the great first toe and the second toe due to his wounds. -She instructed the facility to perform the wound care as ordered and provided an order for antibiotics to treat the infection. Interview with Resident #3's PCP on 08/19/22 at 8:13am revealed: -She last saw the resident on 08/16/22 and the wounds that he was admitted with on 06/29/22 had worsened and he had new wounds present. -When she assessed the resident's toes on his right foot, they were cool to touch, swollen, and reddened; the resident expressed severe pain during her assessment. -The resident had a new ulcer on his left leg and in his right elbow since his admission on 06/29/22, which no one at the facility had notified her of, prior to her assessment on 08/16/22 in which she identified it herself. -She expected the wound care for the resident to be implemented immediately as ordered, was not aware that wound care for the resident had not been implemented as ordered and expected to have been notified when the wound care had not been done. -When the wound care for the resident was initially ordered, she spoke with the facility's registered nurse, who assured her that the wound care could be carried out by facility staff as expected. -Not performing wound care for the resident as ordered was concerning because it put the resident at risk of losing the function or the entire extremity in which he had wounds and possibly causing infection, sepsis (severe infection), or death.	C 249		

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C 249	Continued From page 21 -She expected to have been notified of any new ulcers or wounds or sores that developed on the resident, any changes in his skin assessments, and the inability to perform wound care as ordered. -The facility had not made her aware that they were unable to get a home health wound nurse contracted to perform wound care as ordered. Refer to interview with the Operations Manager on 08/18/22 at 9:52am and 5:04pm. 2. Review of Resident #2's current FL-2 dated 07/04/22 revealed: -The resident was admitted to the facility on 07/12/22. -Diagnoses included dementia, unsteadiness, dysphagia, cognitive communication deficit, history of falls, depression, ulnar fracture, weakness, Parkinson's disease, Alzheimer's, and protein calorie malnutrition. -The resident was constantly disoriented and semi-ambulatory. Review of Resident #2's primary care provider (PCP) visit note dated 07/16/22 revealed: -The resident recently moved to the facility from a rehabilitation facility in which she was recovering from a break in her right hip and right arm. -The resident had a soft cast with ace wrap on her right arm from the mid-upper arm to the fingers. -There was an order to perform circulation checks to the right arm daily and notify the PCP of any abnormalities. Review of Resident #2's licensed health professional support (LHPS) evaluation dated 07/20/22 revealed: -The resident wore a cast to her right arm due to	C 249		

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having an elbow fracture from a previous fall.
-There was no assessment or task for circulation checks to the right arm as ordered by her PCP.

Review of Resident #2's 07/01/22-07/31/22 electronic medication administration record (eMAR) revealed:
-There was an entry for circulation checks to the right arm daily as needed.
-There was no documentation of any circulation checks having been performed.

Review of Resident #2's 08/01/22-08/18/22 eMAR revealed:
-There was an entry for circulation checks to the right arm daily as needed.
-There was no documentation of any circulation checks having been performed.

Review of Resident #2's resident record revealed there was no other documentation that circulation checks had been performed daily as ordered.

Observation of Resident #2 in 08/18/22 at 5:30pm revealed:
-She no longer had a cast to her right arm.
-She used her right arm less than her left arm, but the right arm appeared to have normal range of motion and coloring of the skin.

Interview with a medication aide (MA)/personal care aide (PCA) on 08/19/22 at 1:42pm revealed:
-Resident #2 had a cast on her right arm when she was admitted to the facility.
-She was not aware that there were any tasks or orders to perform circulation checks on Resident #2's right arm.
-She had never performed any circulation checks on Resident #2's right arm.
-She had never observed any other staff

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C 249	Continued From page 23 members perform circulation checks on Resident #2's right arm. Interview with a second MA/PCA on 08/19/22 at 1:54pm revealed: -He only knew that Resident #2 needed circulation checks on her right arm because he was present when her PCP assessed her and discussed placing the order. -He never saw an order for Resident #2's circulation checks, or an entry on the eMAR to perform the task daily, only PRN. -Because he knew it was important, he would perform circulation checks on Resident #2's right arm when he worked to ensure she had good blood flow and range of motion in that arm. Interview with the Operations Manager on 08/19/22 at 10:12am revealed: -Resident #2's order for circulation checks was inaccurate on the eMAR as a PRN (as needed) task, instead of a scheduled task as ordered. -She just assumed Operations Manager duties of this facility this week; the previous operations manager resigned last week. -It was the previous Operations Manager's responsibility to ensure that the eMAR was accurate when orders were placed on the eMAR by the pharmacy. -It was the previous Operation's Manager's responsibility to ensure that the order for Resident #2's circulation checks had been implemented and carried out as ordered. -She was not aware that the circulation checks for Resident #2 were not being carried out as ordered until it had been brought to her attention on the previous day, 08/18/22. Interview with the Clinical Operations Director on 08/19/22 at 10:43am revealed:	C 249		

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C 249	Continued From page 24 -Resident 2's order for circulation checks should have appeared as a scheduled task as ordered on her eMAR instead of a PRN (as needed) task. -It was the Operations Manager's responsibility to ensure orders were accurate on the eMAR and that orders were implemented accurately within 24-48 hours as ordered. -The MA was responsible to ensure Resident #2's circulation checks were performed and documented daily on the eMAR as ordered. -She was not aware that Resident #2's circulation checks had not been implemented as ordered. -Because Resident #2's circulation checks appeared inaccurately on the eMAR, the MAs would not have known to perform the circulation checks as a scheduled task daily. Interview with the Administrator on 08/19/22 at 11:30am revealed: -It was the Operations Manager's responsibility to implement orders within 1-2 business days and ensure that Resident #2's circulation checks appeared accurately on her eMAR and were being carried out daily as ordered. -She was not aware that Resident #2 had not been receiving her circulation checks as ordered. -It was the Operation Manager's responsibility to ensure that the PCP had been notified that circulation checks had not been performed as ordered. Interview with a Pharmacist at the facility's contracted pharmacy provider on 08/19/22 at 3:27pm revealed: -The pharmacy received an order to perform circulation checks for Resident #2 on 07/18/22. -The order was placed on Resident #2's eMAR as PRN in error. -It was the facility's responsibility to review orders for accuracy prior to making them active on a	C 249		

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resident's eMAR and contact the pharmacy to clarify and correct the order as needed.

Interview with Resident #2's PCP on 08/19/22 at 8:13am revealed:
-Circulation checks to Resident #2's right arm daily were ordered to ensure the resident had appropriate blood flow in the extremity due to a fracture and the arm having been in a cast.
-Circulation checks were expected to be implemented immediately and carried out daily as ordered with any abnormalities reported to her as needed.
-She instructed the facility to perform circulation checks by assessing the extremity's color, pallor, capillary refill, and pulses.
-She was unsure if unlicensed staff were able to carry out the circulation check task, but when she spoke with the registered nurse on staff at the facility, she was told there would be no problem performing the circulation checks by facility staff as ordered.
-She was not aware the circulation checks for the resident had not been completed as ordered.
-Not performing the circulation checks for the resident as ordered, put the resident at risk of possible loss of the extremity or function of the extremity.
-If the facility was not able to carry out the extremity checks for circulation as ordered for the resident, the facility was responsible to notify her that the order was unable to be implemented so she could provide an order for an alternate option.

Based on observations, interviews, and record reviews it was determine that Resident #2 was not interviewable.

Refer to interview with the Operations Manager

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C 249	Continued From page 26 on 08/18/22 at 9:52am and 5:04pm. _____ Interview with the Operations Manager on 08/18/22 at 9:52am and 5:04pm revealed: -The previous Operations Manager quit last week, and she was new to managing the facility as of this week. -It was the Operations Manager, Clinical Director, or Supervisor in Charge's responsibility to process orders. -Orders were faxed to the main office for management review to ensure the order was appropriate and did not require clarification. -Once orders were approved by management, the orders were faxed to the pharmacy by the Operations Manager, Clinical Director, or Supervisor in Charge. -The pharmacy entered orders into the electronic medication administration record (eMAR) and then the Operations Manager or Clinical Director were responsible to review the order on the eMAR for accuracy before approving the order for use and make it active. -The Operations Manager was responsible to perform weekly chart audits to catch oversights and errors with resident orders in which eMARs were to be compared to orders in the record, but there was no documentation of that process and she was unsure if the previous Operations Manager had been performing the audits as expected. _____ The facility failed to ensure orders were implemented for 2 of 3 sampled residents who required wound care every other day until a home health nurse could assume the wound care (#3) and who required circulation checks of an arm in a cast with a fracture (#2). The failure of the facility placed the residents at substantial risk of physical harm and constitutes a Type A2	C 249		

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C 249	Continued From page 27 Violation. _____ A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 08/19/22. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 18, 2022.	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1, #3) in which a blood pressure medication was administered outside of the ordered parameters and wound care was not provided as ordered (#3). The findings are: Review of the facility's medication administration policy dated 02/01/2010 revealed: -Medications were to be administered within one	C 330		

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hour before or after the scheduled administration time precisely as ordered.
-Vital signs were to be obtained as ordered prior to administered medications and the medication should be held if the result of the vital signs was outside ordered parameters.
-If two or more doses of medication were held due to vital signs outside of ordered parameters, the resident's primary care provider (PCP) should be contacted for follow-up.

1. Review of Resident #1's current FL-2 dated 01/18/22 revealed:
-Diagnoses included hypertension, congestive heart failure, hypothyroidism, and cognitive dysfunction.
-The resident was constantly disoriented.
-There was an order for Coreg 6.25mg (a medication used to lower blood pressure and treat heart failure) twice daily, hold for a systolic blood pressure (SBP) less than 100 and a heart rate (HR) less than 60.
-There was an order to check vital signs before blood pressure medications were administered and to hold blood pressure medication for an SBP less than 100, diastolic blood pressure (DBP) less than 60, and a HR less than 60.

Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Coreg 6.25mg to be administered at 8:00am and 8:00pm daily with parameters to hold the medication for an SBP less than 100 and a HR less than 60.
-There was an entry for vital signs before blood pressure medication was administered and to hold blood pressure medication for an SBP less than 100, a DBP less than 60, and a HR less than 60.

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-The Coreg was administered twice daily in July 2022 as ordered per parameters from 07/01/22-07/31/22 except on 07/22/22 at 8:00am, 07/25/22 at 8:00am, and on 07/29/22 at 8:00pm.
-On 07/22/22 at 8:00am, the resident's blood pressure was 112/51, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 07/25/22 at 8:00am, the resident's blood pressure was 118/59, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 07/29/22 at 8:00pm, the resident's blood pressure was 112/57, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-There were 3 of 62 opportunities when the Coreg was administered to Resident #1 when it should have been held.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for Coreg 6.25mg to be administered at 8:00am and 8:00pm daily with parameters to hold the medication for an SBP less than 100 and a HR less than 60.
-There was an entry for vital signs before blood pressure medication was administered and to hold blood pressure medication for an SBP less than 100, a DBP less than 60, and a HR less than 60.
-The Coreg was administered twice daily in July 2022 as ordered per parameters from 08/01/22-08/18/22 except on 08/09/22 at 8:00am, 08/11/22 at 8:00am, 08/12/22 at 8:00pm, 08/14/22 at 8:00am, 08/15/22 at 8:00pm, 08/16/22 at 8:00am, and 08/16/22 at 8:00pm.
-On 08/09/22 at 8:00am, the resident's blood pressure was 102/55, in which the DBP was less

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than 60, and the Coreg was administered when it should have been held.
-On 08/11/22 at 8:00am, the resident's blood pressure was 120/52, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 08/12/22 at 8:00pm, the resident's blood pressure was 108/51, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 08/14/22 at 8:00am, the resident's blood pressure was 132/49, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 08/15/22 at 8:00pm, the resident's blood pressure was 112/51, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 08/16/22 at 8:00am, the resident's blood pressure was 144/53, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-On 08/16/22 at 8:00pm, the resident's blood pressure was 103/49, in which the DBP was less than 60, and the Coreg was administered when it should have been held.
-There were 7 of 35 opportunities when the Coreg was administered to Resident #1 when it should have been held.

Interview with a Medication Aide (MA)/personal care aide (PCA) on 08/19/22 at 9:58am revealed:
-MAs were expected to perform vital signs prior to administering any blood pressure medication to Resident #1 as ordered.
-MAs were expected to hold Resident #1's blood pressure medications per ordered vital sign parameters.
-She did not realize that she had recurrently administered Resident #1's blood pressure

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medications outside of ordered parameters until it had been brought to her attention that day.
-She should have held the medication as ordered.
-She did not hold Resident #1's blood pressure medications per ordered parameters because she had not looked at the resident's vital signs and paid close attention.

Interview with a second MA/PCA on 08/19/22 at 1:42pm revealed:
-MAs were expected to administer medications as ordered and hold blood pressure medications for Resident #1 based on her vital sign parameter orders.
-She did not realize that she had administered Resident #1's blood pressure medication outside of ordered parameters because she overlooked the details of the parameters.
-If she had realized that she had made a medication error with Resident #1's blood pressure medication, she would have contacted the supervisor in charge (SIC) or Operations Manager and the resident's PCP.

Interview with a third MA/PCA on 08/19/22 at 1:54pm revealed:
-Resident #1's Coreg order had parameters to hold the medication if her SBP was less than 100, DBP was less than 60, or her heart rate was less than 69 and all MAs were expected to administer the medication accurately as ordered to ensure her blood pressure did not drop too low for her safety.
-If a resident had vital signs outside of ordered parameters, MAs were expected to notify the resident's PCP.

Interview with the Operations Manager on 08/18/22 at 5:04pm revealed:
-MAs were expected to administer medications

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as ordered per parameters.
-Resident #1's Coreg should have been held per parameters if her DBP was less than 60 per the vital signs order.
-She could see how the MAs could have overlooked holding the Coreg per ordered parameters because the DBP parameter was not attached directly to the Coreg order as it should have been on the eMAR, it was attached to the vital signs order.
-If the DBP parameter order had been directly attached to Resident #1's Coreg order on the eMAR the computer system would have alerted the MA to hold the Coreg per parameters when they entered the BP prior to administration.
-The previous Operations Manager should have caught the error that the DBP order was not attached to Resident #1's Coreg order when she approved the order after the pharmacy entered it into Resident #1's eMAR.

Interview with the Clinical Operations Director on 08/19/22 at 10:43am revealed:
-She expected MA's to administer medications per ordered parameters and as they had been trained upon hire.
-Because the DBP parameter order was not directly attached to Resident #1's Coreg order on the eMAR, the computer system would not have stopped the MA from administering the Coreg outside of ordered parameters for DBP.
-Resident #1's Coreg still should have been held per parameters if her DBP was less than 60 based on the vital signs order with parameters related to her blood pressure medications.
-It was the Operation Manager's responsibility to have ensured that Resident #1's Coreg order appeared accurately with all parameters on the eMAR to prevent medication errors.
-The Operations Manager should have clarified

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and corrected Resident #1's Coreg order with parameters on the eMAR to include the parameter for DBP for resident safety.
-It was the Operation Manager's responsibility to have performed weekly chart audits to ensure orders were accurate as written by a resident's PCP.

Interview with the Administrator on 08/19/22 at 11:30am revealed:
-She expected the MAs to administer Resident #1's blood pressure medication Coreg accurately per parameters for resident safety.
-It was the Operations Manager's responsibility to have faxed Resident #1's order for Coreg with parameters to the pharmacy, reviewed the order for accuracy prior to approving, and ensured the order was being implemented and carried out as ordered.
-The Operations Manager should have clarified the Coreg order with parameters to ensure that the DBP parameter was attached to the medication order on the eMAR for resident safety.

Interview with a pharmacist at the facility's contracted pharmacy provider on 08/19/22 at 3:27 PM revealed:
-The facility was expected to administer resident medications as ordered per ordered parameters.
-Any blood pressure medication was expected to be held if Resident #1's vital signs were outside of the ordered parameters to include her Coreg.
-It was the facility's responsibility to ensure Resident #1's Coreg order appeared accurately on the eMAR and obtain clarification from the resident's PCP as needed.
-Having administered Resident #1's Coreg outside of ordered parameters with a low DBP could have dropped her blood pressure even further.

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-If Resident #1 had multiple low DBPs outside of ordered parameters, he would have expected the facility to contact her PCP to notify them so they could evaluate and possibly adjust her medications as needed.

Interview with Resident #1's PCP on 08/19/22 at 8:13am revealed:
-She expected Resident #1's Coreg to be administered as ordered per the vital signs parameters order for blood pressure medications.
-When Resident #1 had a vital sign outside of ordered parameters, she expected the MA to hold the resident's medication for blood pressure and call her for further orders.
-If the blood pressure medication was administered when a DBP was low it could be detrimental to the health of the resident causing potential cardiac events, falls, or other adverse health outcomes.
-If there was ever any question on whether or not Resident #1's Coreg should be held per ordered vital signed parameters, the facility was responsible to call her or the resident's hospice provider for further clarification.

2. Review of Resident #3's current FL-2 dated 06/27/22 revealed:
-Diagnoses included neoplasm of the skin, cellulitis of the lower extremity, diastolic heart failure, peripheral vascular disease, and hypertension.
-There was an order for dressing changes to the right foot and right 1st toe.

Review of Resident #3's primary care provider (PCP) visit note dated 06/29/22 revealed:
-The resident was seen to establish care as a new patient.
-The resident was non-ambulatory due to several

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lesions and open areas to the feet bilaterally, especially in the heels and toes.
-The resident was in urgent need of a podiatry and home health wound care referral.
-The resident's legs were cool to touch, with scattered dry scabs, skin tears to the upper and lower extremities, blanchable redness to both heels, and the right great toenail was missing and draining scant serosanguinous drainage.
-There was an order to obtain a home health wound care referral and for the facility to administer wound care to the resident's right great toe and right hand with Xeroform petrolat gauze every other day until home health wound care was initiated.

Review of Resident #3's progress note dated 07/05/22 revealed:
-The resident was seen by the podiatrist in which he had a toe infection.
-The podiatrist wrote an order for Keflex (antibiotic to treat infection).

Review of Resident #3's PCP visit note dated 07/16/22 revealed:
-The resident was seen at the facility's request due to the resident having a recent behavior change with increasing signs of agitations and restlessness.
-The resident complained on persistent pain on his feet; especially his right big toe.
-Podiatry had recently started him on Keflex 500mg twice daily.
-The resident had slight redness and pain to the right big toe and was diagnosed with cellulitis of the right toe.
-The resident's Keflex order was changed to 500mg four times daily to treat the infection with an order to continue would care as previously ordered.

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C 330	Continued From page 36 -There was an order to continue monitor the resident and to notify the provider if worsening signs of infection were observed. Review of Resident #3's current care plan dated 07/29/22 revealed: -The resident's skin conditions included redness, abrasions, and open areas. -The right great toenail was removed, and the right lower leg had three reddened scabbed areas. -The resident had daily intermittent pain of the right lower leg. Review of Resident #3's current license health professional support (LHPS) assessment dated 07/20/22 revealed there were no tasks for wound care. Observation of Resident #3 on 08/18/22 at 8:56am and 5:29pm revealed: -The resident had a bandage covering a wound to the left calf and right elbow. -The resident had multiple open sores on both of his legs. -The skin on the residents hands appeared to be intact. -The resident's feet and toes were reddened and swollen bilaterally and there was blanching to the top of the right foot. -The resident was missing toenails to the right first and second toe in which the skin was blackened, yellow, and crusted over. -There were dark purple/black areas that were closed to the bottom of both feet. Interview with Resident #3 on 08/18/22 at 5:45pm revealed: -He had issues with sores, scabs, and his toenails for years and this was not a new	C 330		

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problem.
-His swelling and infection in his right toes were painful and it was difficult for him to walk.

Review of Resident #3's hospice provider note dated 08/01/2022 revealed:
-The resident was seen to initiate hospice care.
-There was a wound to the right great toe that was treated with Keflex 500mg four times daily from 07/18/22-07/28/22.
-The wound/nail bed was dry with slight redness and the feet were cool to touch bilaterally with pitting edema (swelling).
-There was an order to cleanse the right great toe with wound cleanser normal saline, pat dry with gauze, and paint with betadine on Mondays and Thursdays leaving open to air.
-There was an order to notify the hospice agency of any change or concerns and the hospice nurse would provide wound care and assess the resident weekly.

Review of Resident #3's PCP visit note dated 08/16/22 revealed:
-Both of the resident's legs were red, tender, and swollen and cool to touch with pulses in the feet not able to be palpated due to the swelling.
-The resident was unable to move his toes on both feet and there was an ulcer to the left outer calf with eschar notes along the wound bed with a small open area which was very tender to touch.
-The right great toe was missing the toenail with scant drainage.
-The heels had blanchable redness and there was a new ulcer on his right elbow as well.

Review of Resident #3's 06/01/22-06/30/22 electronic medication administration record (eMAR) revealed:
-There was an entry for Xeroform gauze as

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needed (PRN) to the right hand and right every other day until seen by wound care.
-There was no documentation of any Xeroform gauze wound care provided to the resident.
-There was no entry or documentation for wound cleanser or betadine on Mondays and Thursdays.

Review of Resident #3's 07/01/22-07/31/22 eMAR revealed:
-There was an entry for Xeroform gauze PRN to the right hand and right every other day until seen by wound care.
-There was no documentation of any Xeroform gauze wound care provided to the resident.
-There was no entry or documentation for wound cleanser or betadine on Mondays and Thursdays.

Review of Resident #3's 08/01/22-08/18/22 2022 eMAR revealed:
-There was an entry for Xeroform gauze PRN to the right hand and right every other day until seen by wound care.
-There was no documentation of any Xeroform gauze wound care provided to the resident.
-There was no entry or documentation for wound cleanser or betadine on Mondays and Thursdays.

Observation of Resident #3's medications on hand on 08/18/22 at 4:40pm revealed there was not any Xeroform gauze or betadine available for use on the resident's wounds.

Review of Resident #3's resident record include eMARs, progress notes, and skin assessment sheets revealed:
-There was no documentation of any wound care to Resident #3's right hand or right toe until home health/hospice wound care was initiated on 08/08/22.
-There were 20 out of 20 opportunities that

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wound care was not provided as ordered every other day to the resident's right hand and foot as ordered on 06/29/22.
-There were 5 out of 5 opportunities that wound care was not provided as ordered using betadine on Mondays and Thursdays as ordered on 08/01/22.

Interview with a medication aide (MA)/personal care aide (PCA) on 08/19/22 at 9:58am revealed:
-She did not realize that there was an active order to perform wound care for Resident #3 every other day or on Mondays and Thursdays.
-She had never performed wound care for Resident #3 and was not sure if anyone else had done so as she had never observed any other staff members performing wound care for Resident #3 either.
-Wound care for Resident #3 should have shown up on the eMAR as a scheduled task and not as a PRN task on the eMAR in order for her to have known she was supposed to carry the task out.
-Resident #3 had wound care supplies in his room, but she was unsure if it was the supplies that were ordered by his PCP and hospice provider.

Interview with a second MA/PCA on 08/19/22 at 1:42pm revealed:
-She did not perform any wound care for Resident #3 when she worked because she did not know there was a task to do so.
-She had never observed any other staff members performing wound care for Resident #3.

Interview with a third MA/PCA on 08/19/22 at 1:54pm revealed:
-He would perform wound care for Resident #3's wounds anytime he provided the resident with a

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bath.
-He would use the supplies that were on hand in the resident's room, but he never recalled using Xeroform or Betadine as ordered, only leaving the wound open to air after cleansing it with wound cleanser.
-Baths were provided to Resident #3 on Tuesdays, Thursdays, and Saturdays.
-He did not provide wound care to Resident #3 if he was not providing the resident with a bath on his scheduled bath days.
-He was not aware that there was a wound care order scheduled every other day and then on Mondays and Thursdays for Resident #3.

Interview with the Operations Manager on 08/19/22 at 10:12am revealed:
-Resident #3's order for wound care was inaccurate on the eMAR as a PRN (as needed) task, instead of a scheduled task every other day and then on Mondays and Thursdays as ordered.
-She had just assumed Operations Manager duties of the facility this week.
-It was the previous Operations Manager's responsibility to ensure that the eMAR was accurate when orders were placed on the eMAR by the pharmacy.
-It was the previous Operation's Manager's responsibility to ensure that the order for Resident #3's wound care had been implemented and carried out as ordered.
-She was not aware that the wound care for Resident #3 was not being carried out as ordered until it had been brought to her attention on the previous day, 08/18/22.

Interview with the Clinical Operations Director on 08/19/22 at 10:42am revealed:
-She has not been aware that Resident #3's wound care had not been implemented as

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ordered or appeared as PRN instead of a scheduled task on the eMAR until being made aware on the previous day, 08/18/22.
-It was the Operation Manager's responsibility to ensure that the wound care order appeared on Resident #3's eMAR accurately as ordered.
-It was the responsibility of the person bathing Resident #3 or the MA to perform wound care, and it was the MA's responsibility to ensure wound care had been performed as ordered and documented on the eMAR accurately each day.
-If she had been aware that Resident #3 was not getting wound care as ordered, she would have provided wound care and notified the resident's PCP for further guidance.

Interview with the Administrator on 08/18/22 at 4:50pm revealed:
-There was no documentation that wound care was performed for Resident #3 because staff did not have the Xeroform gauze dressing or Betadine and would only use a wound cleanser, but could not recall if they used any other kind of dressing.
-She thought the issue in not having Xeroform gauze as ordered was because the pharmacy did not have it in stock.
-She thought staff were performing wound care as ordered but was unable to find any other documentation that the wound care was performed for Resident #3 as ordered.

Interview with the Administrator on 08/19/22 at 11:30am revealed:
-It was the Operations Manager's responsibility to ensure that Resident #3's wound care order appeared accurately on the eMAR.
-It was the Operations Manager's responsibility to ensure that wound care was being performed accurately as ordered.

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C 330	Continued From page 42 -She was not aware that Resident #3 had not been receiving wound care as ordered. Interview with a Pharmacist at the facility's contracted pharmacy provider on 08/19/22 at 3:27pm revealed: -The pharmacy had not received an order for wound cleanser, gauze, and Betadine to be used for wound care on Mondays and Thursdays dated 08/01/22. -The pharmacy received an order for Resident #3 to have wound care every other day with Xeroform gauze dressing to his right hand and right great toe dated 06/29/22 until he was seen by Home Health for wound care. -The order was not written as PRN but was placed on the eMAR as PRN because the pharmacy did not know when Home Health would be initiated. -It was the facility's responsibility to fax all orders for residents to the pharmacy to be entered into the computer and placed on the resident's eMAR. -It was the facility's responsibility to review orders placed on a resident eMAR for accuracy and to obtain clarification or correction of the order prior to approving the order for use. -Resident #3 should have received wound care with Xeroform gauze dressing every other day as ordered until Home Health wound care had been initiated. -There was no shortage of Xeroform gauze, but the supplies were never sent to the facility because they had not been requested by the facility. -It was concerning that Resident #3 did not receive wound care every other day as ordered because it could have resulted in an infection and delayed healing. Interview with Resident #3's Podiatrist on	C 330		

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C 330	Continued From page 43 08/19/22 at 8:51am revealed: -She assessed the resident on 07/05/22. -The resident had an infection of his right foot in the great first toe and the second toe due to his wounds. -She instructed the facility to perform the wound care as ordered and provided an order for antibiotics to treat the infection. Interview with Resident #3's PCP on 08/19/22 at 8:13am revealed: -She last saw the resident on 08/16/22 and the wounds that he was admitted with on 06/29/22 had worsened and he had new wounds present. -She expected the wound care for the resident to be implemented immediately as ordered, was not aware that wound care for the resident had not been implemented or carried out as ordered. -When the wound care for the resident was initially ordered, she spoke with the facility's registered nurse, who assured her that the wound care could be carried out by facility staff as expected. -Not performing wound care for the resident as ordered was concerning because it put the resident at risk of losing the function or the entire extremity in which he had wounds and possibly causing infection, sepsis (severe infection), or death. _____ The facility failed to ensure medications were administered as ordered. Resident #1's Coreg (used to lower blood pressure and treat heart failure) was administered 10 times in a four week period when her diastolic blood pressure (DBP) was low and outside of the ordered parameters to receive the medication placing her at risk for falls, cardiac events, and other adverse health outcomes. Resident #3 failed to receive wound care with Xeroform gauze every other day as	C 330		

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C 330	Continued From page 44 ordered on 06/29/22, and wound care with wound cleanser, Betadine, and gauze as ordered on 08/01/22 on Mondays and Wednesdays, placing him at risk of infection, loss of the extremity, and death. The failure of the facility placed the residents at risk of adverse health outcomes which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 08/19/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 3, 2022.	C 330		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	C 612		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents from COVID-19 related to wearing masks as personal protection equipment (PPE).

The findings are:

Review of the Centers for Disease Control (CDC) guidance for Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 02/01/22 revealed Health Care Personnel (HCP) who are up to date with all recommended COVID-19 vaccine doses should wear source control (A NIOSH-approved N95 or equivalent or higher-level respirator; OR a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated); OR a well-fitting facemask.) when they are in areas of the healthcare facility where they could encounter patients.

Review of the North Carolina Department of Health and Human Services (NC DHHS) for the

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prevention of and spread of COVID-19 in LTC facilities dated 02/10/22 revealed:
-Source control referred to the use of cloth masks, well-fitting facemasks or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing,
talking, sneezing or coughing.
-DHHS continued to recommend facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure per CMS and CDC guidance to include source control.

Review of the facility's Infection Control Policy without a date revealed:
-Strict adherence to the Infection Control Policy was required by staff.
-Staff were educated on appropriate and safe use of personal protective equipment (PPE).
-Staff were required to wear facemasks at all times.

Observation upon entrance to the facility of the Operations Manager who greeted surveyor on 08/18/22 from 8:15am to 9:10am revealed she did not wear a mask as PPE while in the facility or caring for residents.

Observation of a medication aide (MA)/personal care aide (PCA) from 8:15am to 9:10am revealed he did not wear a mask as personal protective equipment (PPE) while in the facility or caring for residents.

Observation of the Clinical Operations Director from 8:50am to 9:10am revealed she did not wear a mask as personal protective equipment (PPE) while in the facility or while interacting with

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C 612	Continued From page 47 residents. Interview with the Operations Manager on 08/18/22 at 9:15am revealed she was not wearing a mask because she did not realize she still needed to as long as she was vaccinated. Interview with the Clinical Operations Director on 08/18/22 at 9:10am revealed: -She and the staff were not wearing masks because the facility thought when the COVID-19 guidance for the public from the CDC relaxed about one month ago they no longer needed to wear them so long as all the staff were vaccinated. -She was not sure why they thought this because she had not seen any guidance to stop wearing masks in LTC facilities, just thought that it applied to them as well. Interview with the Administrator on 08/18/22 at 9:32am revealed: -She thought that when CDC guidance for COVID-19 relaxed approximately one month ago for the public that the staff no longer had to wear masks as long as they were vaccinated. -Some staff were still wearing masks if they wanted to, but the facility was no longer requiring the use of a mask. -She did not realize it was still a requirement for staff to wear a mask as PPE while in the facility and caring for residents even if they were vaccinated. Observation of all staff in the facility on 08/18/22 at 9:10am revealed they applied masks as PPE.	C 612		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights	C 912		

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C 912	Continued From page 48 G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) in which a blood pressure medication was administered outside ordered parameters. Based on observations, interviews, and record reviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Health Care and Medication Administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider was notified of new wounds and a Home Health referral as ordered for 1 of 3 sampled residents (#3) in which the resident was to receive wound care every other day until a home health agency was able to assume wound care duties. [Refer to Tag C246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1, #3) in which a blood pressure medication was administered outside of the ordered parameters and wound care was not provided as ordered (#3). [Refer to Tag C330,	C 912		

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C 912	Continued From page 49 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) in which a blood pressure medication was administered outside ordered parameters. Based on observations, interviews, and record reviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Health Care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure implementation of orders for 2 of 3 sampled residents (#2, #3) for orders in which a resident was to have daily circulation checks performed on an injured extremity (#2) and a resident who was to receive wound care every other day until a home health agency was able to assume wound care duties (#3). [Refer to Tag C249, 10A NCAC 13G .0902(c)(3-4) Health Care (Type A2 Violation)]	C 914		