

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2023
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NAME OF PROVIDER OR SUPPLIER HIGHER STANDARD ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 596 NEAL RD REIDSVILLE, NC 27320
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/28/23.	C 000		
C 255	<p>10A NCAC 13G .0903 (d) Licensed Health Professional Support</p> <p>10A NCAC 13G .0903 Licensed Health Professional Support (d) The facility shall follow-up and implement recommendations made by the licensed health professional including referral to the physician or appropriate health professional when indicated. The facility shall document follow-up on all recommendations made by the licensed health professional.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure follow-up to recommendations made by the Licensed Health Professional Support (LHPS) nurse for 1 f 3 sampled residents (#1) related to a podiatry visit</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 01/27/23 revealed diagnoses included type 2 diabetes mellitus, hypertension, hypolipidemia, and peripheral neuropathy.</p> <p>Review of the report of health services from Resident #1' podiatrist provider revealed: -Resident #1 was seen on 01/12/23. -Resident #1 had 9 toenails trimmed and 1 lesion trimmed. -Resident #1 was to follow up in 3 months. -There were no issues.</p> <p>Review of Resident #1's LHPS evaluation dated</p>	C 255		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 255	<p>Continued From page 1</p> <p>02/17/23 revealed: -Resident #1's toenails needed to be trimmed. -She had thick calluses to the soles of her feet with dry, cracked skin on her heels. -Resident needed a podiatry visit. -All provider documentation needed to be placed in Resident #1's record for review.</p> <p>Review of Resident #1's record revealed there was no documentation Resident #1 had seen a podiatrist since 01/12/23.</p> <p>Observation of Resident #1 on 04/28/23 at 3:49pm revealed: -Resident #1's toenails were extended about one eighth of an inch from the top of her toes. -Resident #1 had cracked skin on the heels of her feet.</p> <p>Interview with the facility's contracted LHPS nurse on 04/28/23 at 3:22pm revealed: -Resident #1 needed to see a podiatrist for foot care. -When she assessed diabetic residents, she always looked to see if the resident had regular dental exams, eye exams, and podiatry care. -Sometimes Resident #1 received care, but she had no way of confirming because the provider notes were not in her record. -Results of not having regular podiatry care could result in skin breakdown, sores, and diabetic ulcers.</p> <p>Interview with Resident #1 on 04/28/23 at 3:50pm revealed: -The podiatrist usually came to the facility to trim her toenails and provide foot care. -She had not seen the podiatrist in a few months. -She could not put her shoes all the way on her shoes felt like it was scraping her foot when she</p>	C 255		

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C 255	<p>Continued From page 2</p> <p>put them on.</p> <p>Telephone interview with Resident #1's Primary Care Provider (PCP) on 04/28/23 at 4:06pm revealed he expected the facility to follow through with the recommendation of the LHPS nurse.</p> <p>Interview with a representative from Resident #1's podiatry provider's office on 04/28/23 at 5:03pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 had her toenails trimmed on 01/12/23. -Resident #1 was scheduled to have podiatry care again on 04/13/23. -She reached to the facility several times leading up to her 04/13/23 and left voice messages, but the facility did not return her call. -The 04/13/23 appointment was cancelled due to the facility not confirming the appointment. -There had not been any additional requests for an appointment for podiatry care. <p>Interview with the supervisor-in-charge (SIC) on 04/28/23 at 5:19pm revealed:</p> <ul style="list-style-type: none"> -Whichever staff was working when the LHPS review was received was responsible for reviewing the LHPS review and following up with any recommendations. -She did not remember seeing the LHPS review dated 02/17/23 and she had not contacted the podiatrist office regarding an appointment for Resident #1. -Usually when a voicemail was left at the facility regarding residents, the Administrator retrieved the message and emailed the transcript of the voicemail to the staff working. -She had not received an email from the Administrator regarding a podiatrist appointment for Resident #1. 	C 255		

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C 255	Continued From page 3 Interview with the Administrator on 04/28/23 at 5:40pm revealed: -SICs were responsible for reviewing LHPS nurse recommendations and for following through with the appointments. -He did not know about the LHPS nurse's recommendation on 02/17/23 for Resident #1 to have podiatry care. -He did not receive a call or voice message from Resident #1's podiatry office. -He thought a former employee may have received the message regarding the podiatry appointment and did not pass the message along to him or other staff.	C 255		
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, record reviews, and interviews, the facility failed to ensure medication was administered as ordered for 1 of 3 sampled residents (#2) related to an insomnia medication. The findings are:	C 330		

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C 330	<p>Continued From page 4</p> <p>Review of Resident #2's current FL2 dated 01/25/23 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease, chronic diastolic congestive heart failure, and acute respiratory failure. -There was an order for temazepam (used to treat insomnia) 22.5mg 1 capsule daily at bedtime.</p> <p>Review of Resident #2's medication administration record (MAR) for February 2023 revealed: -There was an entry for temazepam 22.5 mg 1 capsule daily at bedtime scheduled for administration at 8:00pm. -There was no documentation temazepam was administered for 17 of 28 opportunities between 02/01/23 to 02/28/23. -There was no reason documented as to why temazepam was not administered.</p> <p>Review of Resident #2's MAR for March 2023 revealed: -There was an entry for temazepam 22.5 mg 1 capsule daily at bedtime scheduled for administration at 8:00pm. -There was no documentation temazepam was administered for 6 of 31 opportunities between 03/01/23 and 03/31/23. -There was no reason documented as to why temazepam was not administered.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/28/23 at 11:43am revealed: -Another SIC was working on 02/11/23 when Resident #2's temazepam ran out and she called the pharmacy to see why they would not refill the medication. -She was told Resident #2 needed to be seen by</p>	C 330		

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C 330	<p>Continued From page 5</p> <p>her pain management clinic to get a new refill for temazepam.</p> <p>-She did not know Resident #2 needed to be seen at her pain management clinic prior to getting a prescription refill for temazepam.</p> <p>-She called Resident #2's pain management clinic on 02/11/23 and scheduled her an appointment for 02/21/23, after her medication ran out, but the appointment had to be rescheduled due to not having transportation available.</p> <p>-Staff were to reorder medication from the pharmacy 2 to 3 days prior to running out.</p> <p>-She had not called the pharmacy to request a refill prior to Resident #2 running out of temazepam because she thought other staff had called the pharmacy for the refill.</p> <p>A second interview with the SIC on 04/28/23 at 4:34pm revealed:</p> <p>-Resident #2 had been visiting her pain management clinic once a month prior to running out of temazepam.</p> <p>-She did not know the monthly visits to the pain management clinic were scheduled so Resident #2 could get a refill of her temazepam.</p> <p>-Resident #2 had a scheduled appointment on 02/06/23 with her pain management clinic, which was prior to running out of temazepam.</p> <p>-She did not know about the appointment on 02/06/23 and she thought it was a miscommunication with a former facility staff.</p> <p>-The transportation staff on 02/21/23 was not able to take Resident #2 to her scheduled appointment on 02/21/23.</p> <p>-On 02/21/23, the Administrator rescheduled Resident #2's appointment to 03/06/23.</p> <p>-She did not remember Resident #2 having trouble sleeping when she was out of her temazepam.</p>	C 330		

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C 330	<p>Continued From page 6</p> <p>Interview with a pharmacist from the facility's contracted pharmacy on 04/28/23 at 2:34pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's temazepam was filled by the pharmacy for a 1-month supply with each dispensed date since 09/07/22. -Resident #2 had a current order for temazepam 22.5mg 1 tablet at bedtime. -Temazepam was used to help with sleep. -Temazepam was dispensed to the facility on 01/13/23 and 03/07/23 for a quantity of 30 tablets each time with no refills. -Usually, the facility would let the pharmacy know when they were getting low and the pharmacy reached out to Resident #2's pain management clinic for a new prescription. -The facility called the pharmacy on 02/11/23 for a refill of temazepam and the pharmacy called Resident #2's pain management clinic and was informed they could not provide a refill prescription until Resident #2 was seen by the pain management provider; this information was relayed to the Administrator. <p>Interview with Resident #2 on 04/28/23 at 3:59pm revealed:</p> <ul style="list-style-type: none"> -She was not administered her temazepam for a few weeks a few months ago. -She was told she had to go back to her pain management clinic before she could get a refill of temazepam. -The facility cancelled the first appointment that was scheduled after she ran out of medication, but she did not know why the appointment was cancelled. -It took a while for her to get another appointment. -She did not sleep for about 2 weeks and had increased anxiety when she was not administered 	C 330		

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C 330	<p>Continued From page 7</p> <p>temazepam.</p> <p>Interview with the Administrator on 04/28/23 at 5:40pm revealed:</p> <ul style="list-style-type: none"> -He knew Resident #2 was out of temazepam from 02/12/23 through 03/06/23. -He knew Resident #2 had a scheduled appointment on 02/06/23 to see her pain management provider, but he did not know the appointment was to get a new prescription for temazepam. -Resident #2 did not make it to the appointment on 02/06/23 because a former staff did not communicate the appointment to the former transportation staff. -Resident #2 did not make it to her scheduled appointment with her pain management provider on 02/21/23 because the facility's van broke down in route to pick up Resident #2; he had to reschedule Resident #2's appointment again. -He expected staff to reorder residents' medications 7 days before running out of the medication. -Temazepam was not reordered within 7 days of running out. <p>Telephone interview with a nurse from Resident #2's pain management clinic from a return telephone call on 05/02/23 at 2:19pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was seen in the clinic monthly for pain management and required a monthly appointment to refill her temazepam. -Temazepam was used to treat sleep issues. -Resident #2 or her caretakers were responsible for making the next month's appointment prior to exiting the clinic. -Resident #2 was seen in the pain management clinic on 01/13/23 and on 03/16/23 -There was not an appointment made in February 2023 prior to her running out of the 30-day supply 	C 330		

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C 330	<p>Continued From page 8</p> <p>of temazepam.</p> <p>-The only appointment made in February was scheduled for 02/21/23.</p> <p>-The pain management clinic staff tried to call the facility to schedule for Resident #2 to come in February, but they were unsuccessful with getting anyone to answer the phone.</p> <p>-Resident #2's inability to sleep for 2 weeks and increased anxiety could have been withdrawal symptoms from stopping temazepam without weaning from the medication.</p> <p>_____</p> <p>The facility failed to ensure medications were administered as ordered for a resident (#2) who did not receive a sleep medication for 23 days due to missing a scheduled monthly appointment and a subsequent scheduled appointment required for a refill of the medication, which resulted in the resident not being able to sleep and having increased anxiety for two weeks and placed the resident at risk for withdrawal symptoms. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/28/23 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 12, 2023.</p>	C 330		