Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051073	A. BUILDING: ______ B. WING ______	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT EAGLE POINT	**118 EAGLE POINTE LN CLAYTON, NC 27520**

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 10, 2023 and August 11, 2023.	C 000		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an assessment was completed within 30 days following admission, which included a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status	C 231		

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and physical functioning in activities of daily living for 1 of 3 residents sampled (Resident #3).

The findings are:

Review of Resident #3's current FL-2 dated 04/24/23 revealed:
-Diagnoses included dementia with behavioral disturbance, Alzheimer's disease with behavioral disturbance, adjustment disorder with depressed mood, dysthymia, paroxysmal atrial fibrillation, sleep apnea, and neutropenia.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident required assistance with bathing.
-The resident was incontinent of bowel and bladder.
-The recommended level of care was assisted living.

Review of Resident #3's Resident Register revealed:
-The resident was admitted to the facility on 04/24/23 from home.
-The resident required assistance with dressing, bathing, toileting, nail care, and mouth care.
-The resident register was signed by the responsible party only.
-The resident register was not dated.

Review of Resident #3's record on 08/10/23 revealed:
-There was no care plan available for review.
-There was a printed note on a New Admission Pharmacy Information Sheet for Resident #3 documenting the "resident is only staying with us until 5/24/23".
-There were admission documents initialed and signed by the responsible party dated 04/20/23.

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Interview with the RCC on 08/10/23 at 1:27pm revealed:
-She was responsible for completing care plans.
-She was responsible for completing new admissions.
-Resident #3 was supposed to stay at the facility for 30 days for respite. The responsible party chose for the resident to stay at the facility after 30 days and he became a "full admission" as of 05/24/23.

Review of a care plan for Resident #3 presented by the Co-Owner/Resident Care Coordinator (RCC) on 08/11/23 revealed:
-The care plan assessor certification was dated 03/29/23, a total of 25 days prior to admission.
-There was no physician authorization signature.
-There was no facility name listed on the care plan.
-The resident was assessed to require extensive assistance with bathing, dressing, and grooming, limited assistance with eating, toileting, and ambulation, and supervision with transferring.

Interview with the RCC on 08/11/23 at 10:10am revealed:
-She found the 03/29/23 care plan assessment she completed in the bottom of her work bag on 08/10/23.
-She had not sent the care plan to Resident #3's physician for review and signature.

C 232 | 10A NCAC 13G .0801 (c) Resident Assessment | C 232

10A NCAC 13G .0801Residents Assessment

(c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition

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C 232	Continued From page 3 using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being over a period of time such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	C 232		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to assure an assessment of a resident was completed within 10 days following a significant change in the resident's condition for 1 of 3 residents sampled (Resident #1) who required assistance with activities of daily living including transferring and toileting.

The findings are:

Review of Resident #1's current FL-2 dated 04/11/23 revealed diagnoses included Alzheimer's, hypertension, hypothyroidism, anxiety, gastro-esophageal reflux disease, hyperlipidemia, and bee sting allergy.

Review of Resident #1's care plan dated 05/09/23 revealed:
-The resident was assessed on 04/18/23 to need extensive assistance with activities of daily living including transferring, ambulation, and toileting.
-The resident required the aid of a wheelchair and walker for mobility.
-There were no subsequent care plans for Resident #1 available for review.

Review of Resident #1's licensed health professional support (LHPS) evaluation dated 05/09/23 revealed:
-There was documentation that the resident was "very unsteady on her feet".
-Staff were competency validated for use of a walker and wheelchair.

Review of Resident #1's LHPS evaluation dated 05/30/23 revealed:
-There was documentation that Resident #1's

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cognitive and physical abilities had declined, and the resident could no longer transfer herself.
-Staff were competency validated for use of a Hoyer lift (a medical device used to transfer a person with limited mobility from one location to another) and wheelchair.

Interview with the Medication Aide/Supervisor (MA) on 08/10/23 at 8:13am revealed Resident #1 required the use of a Hoyer lift for transferring.

Observations of Resident #1 on 08/10/23 at 1:47pm revealed the personal care aide (PCA) and MA transferred Resident #1 from wheelchair to bed using a Hoyer lift.

Observations of Resident #1 on 08/11/23 at 8:42am revealed the resident was being transferred from the shower in a Hoyer lift by the PCA and a Facility Manager.

Interview with the facility's Co-Owner/Administrator on 08/11/23 at 1:45pm revealed:
-He did not know why a significant change care plan had not been completed for Resident #1.
-The Co-Owner/Resident Care Coordinator (RCC) was responsible for completing the significant change care plan.
-He would expect a significant change care plan to be completed as soon as a change was noted in a resident status.

Interview with the RCC on 08/11/23 at 3:57pm revealed:
-When she completed a pre-admission assessment on Resident #1 at the resident's home, the resident needed assistance with standing.
-A Hoyer lift was suggested after resident #1 was

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admitted to the facility.
-The Hoyer lift had been in use for Resident #1 about two months.

C 242 — 10A NCAC 13G .0901(a) Personal Care and Supervision — C 242

10A NCAC 13G .0901 Personal Care and Supervision
(a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

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

Based on observations, interviews, and record review, the facility failed to ensure personal care was provided to 1 of 3 residents sampled (Resident #1) who was non-ambulatory and had skin breakdown.

The findings are:

Review of Resident #1's current FL-2 dated 04/11/23 revealed diagnoses included Alzheimer's, hypertension, hypothyroidism, anxiety, gastro-esophageal reflux disease, hyperlipidemia, and bee sting allergy.

Review of the Resident Register for Resident #1 revealed:
-The resident was admitted to the facility on 04/18/23.
-Assistance required for the resident included bathing, dressing, ambulation, getting in/out of bed, toileting, and skin care.

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Review of Resident #1's Care Plan with an assessment date of 04/18/23 revealed:
-Resident #1's skin was normal on 04/18/23.
-The resident was assessed to have occasional incontinence of bowel and bladder.
-The resident was ambulatory with aide of an assistive device.
-There was limited range of motion of the upper extremities.
-The resident required extensive assistance with toileting, ambulation/locomotion, bathing, dressing, persional hygiene, and transferring.

Review of Resident #1's LHPS evaluation dated 05/30/23 revealed:
-There was documentation that Resident #1's cognitive and physical abilities had declined, and the resident could no longer transfer herself.
-Staff were competency validated for use of a Hoyer lift (a medical device used to transfer a person with limited mobility from one location to another) and wheelchair.

Review of Daily Shift Notes documented by a staff dated 07/25/23 revealed:
-On 07/25/23 staff documented there was an open area on Resident #1's buttocks at the top between the cheeks of the residents buttocks and the Resident Care Coordinator (RCC) was notified.
-On 07/31/23 staff documented there was skin breakdown on Resident #1's right buttocks and a skin barrier cream was applied.
-On 08/03/23 staff documented there was skin breakdown on Resident #1's right buttocks.
-On 08/04/23 staff documented no showers were done on 08/04/23 because the staff person worked alone.

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Interview with the PCA on 08/10/23 at 9:45am revealed she was entering Resident #1's room to provide "patient care".

Observations of Resident #1 on 08/10/23 at 8:05am revealed:
-She was lying in bed on her back with her eyes closed.
-The resident did not respond to verbal stimuli.

Interview with the MA on 08/10/23 at 8:13am revealed:
-Resident #1 was non-ambulatory.
-The resident required two staff for assistance personal care.
-A Hoyer lift was used to transfer Resident #1.

Observation of Resident #1 on 08/10/23 at 8:26am revealed:
-The MA entered the resident's room and obtained a blood pressure reading while the resident was in bed.
-The resident remained in bed.

Observation of Resident #1 with the PCA and MA on 08/10/23 at 1:53pm revealed:
-The resident was positioned in bed on her right side.
-The PCA and MA were providing incontinent care to the resident.
-There were three open areas on the left buttocks that were a dark red color. The skin surrounding the areas was white and sloughing.
-There was an open area on the right buttock that was a dark red color. The edges of the skin surrounding the open area was white. There was a reddish discoloration to the lower outer right edge of the open area that measured approximately 2-3 inches.
-There was a circular open reddened area at the

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upper inner aspect of the left buttocks that was approximately the size of a pencil eraser.

Observation of Resident #1 on 08/11/23 at 9:45am revealed the MA and Personal Care Aide (PCA) were transferring the resident from bed to chair using a Hoyer lift.

Interview with the PCA on 08/10/23 at 10:47am revealed:
-There was a reddened area on Resident #1's buttocks.
-The area was not opened.
-The area was healing.
-She was unsure how long the reddened area had been on Resident #1's buttocks.
-She had not been working at the facility for a while and was told on 08/09/23 when she came back to the facility, about the area on resident #1's buttocks by the MA.
-Resident #1 was supposed to have incontinent care provided every two hours.

Observation of Resident #1 on 08/10/23 at 1:07pm revealed the resident was up in a wheelchair seated in the dining room.

Interview with the PCA on 08/10/23 at 1:19pm revealed:
-Resident #1 would receive incontinent care and back to bed after lunch.
-She had not changed Resident #1.

Observations of Resident #1 on 08/10/23 at 1:47pm revealed:
-The resident was transferred from the wheelchair to the bed per Hoyer lift by the PCA and MA.
-There was a total of 3 hours since Resident #1 was changed at 10:47am.

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Interview with the MA on 08/10/23 at 1:47pm revealed:
-The resident has a reddened area on her buttocks that has been there "about a week".
-She reported to the second shift MA about the reddened area on Resident #1's buttocks.
-She told the second shift MA to report the same to the third shift MA.
-She documented in her notes about Resident #1's reddened area on her buttocks.

Interview with a House Manager on 08/10/23 at 1:55pm revealed:
-She had been aware of the open area on Resident #1's buttock for 1-1 ½ weeks.
-It was "maybe last week" when she first saw the area on Resident #1's buttocks.
-The area "was just redness" when she first saw it.
-She implemented every two-hour incontinent checks and incontinent care/change.
-She notified the Resident Care Coordinator (RCC) who was responsible for notifying the Primary Care Provider (PCP).

Interview with the RCC on 08/10/23 at 1:58pm revealed:
-She was first notified of the open area on Resident #1's buttock on 08/02/23 by a House Manager.
-The House Manager had implemented a protocol for changing every two-hours to try to keep the area from getting worse.
-She last saw the area on Resident #1's buttocks on 08/04/23 and it was red with no broken skin areas.

Interview with the RCC on 08/10/23 at 3:48pm revealed:

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-She verbally instructed the House Manager to make sure the MAs and PCAs knew to change Resident #1 every 2 hours.
-She went to the facility on 08/04/23 and told the MA to make sure Resident #1 was changed every 2 hours.
-On 08/09/23, she asked the House Manager if Resident #1 was getting changed every 2 hours and the House Manager told her "she didn't think so".
-On 08/09/23, a sign-in sheet was implemented for staff to initial, date, and time, incontinent care and incontinent brief changes for Resident #1.

Interview with a family member for Resident #1 on 08/10/23 at 4:30pm revealed:
-Resident #1 did not have any skin breakdown when admitted to the facility on 04/18/23
-The facility was getting enough staff to take care of residents.
-The family member found out about the skin break down on Resident #1's buttocks "late last week".
-The facility had implemented a plan to get Resident #1 up every 2 hours.

Observation of Resident #1 on 08/10/23 at 4:30pm revealed the resident was laying in bed on her left side with a positioning cushion to her back.

Interview with a second MA on 08/10/23 at 4:54pm revealed:
-She worked at the facility from 2:00pm - 10:00pm.
-There was a personal care aide (PCA) who worked at the facility from 8:00am - 6:00pm.
-She worked alone at the facility from 6:00pm -10:00pm.
-Resident #1 was put in bed before the staff left at

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6:00pm.
-She first saw an open area on Resident #1's buttocks about 2 weeks ago which was about the size of a pencil eraser.
-She noticed some progression in the skin breakdown on Resident #1's buttock "maybe" one week ago.
-She documented it in a notebook and put zinc ointment on the area when incontinent care was provided.
-She put Resident #1 to bed about one hour ago and the area on the resident's buttocks looked like there was more breakdown.
-She thought the area on the resident's left buttocks was a rash.
-She had not seen the open areas on Resident #1's sacrum before today.
-Resident #1 was changed "every 2 hours or so", and "maybe" less than two hours.
-She knew to change the resident every two hours because that was what was required, and she was told to change the resident every two hours.

Observations of Resident #1 on 08/11/23 at intervals revealed:
-At 8:42am, the resident was being transferred from the shower in the Hoyer lift.
-At 9:50am, the resident was up in the wheelchair seated in the dayroom.
-At 11:05am, the resident continued to be up in the wheelchair seated in the dayroom.
-At 11:45am, the resident was seated in her recliner in her bedroom.
-At 12:50pm, the resident remained in her bedroom in the recliner in an upright seated position.

Interview with the House Manager on 08/11/23 at 12:55pm revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-Resident #1 had not been back to bed.
-There had been a position change from wheelchair to recliner.

Telephone interview with another family member on 08/11/23 at 3:07pm revealed:
-Several weeks ago Resident #1 had a "slight reddened area" but no broken skin on her buttocks.
-Last Friday (08/04/23), she became aware of the skin breakdown on Resident #1's buttocks when another family member saw the breakdown while present when staff were changing the resident.
-She did not know when the skin breakdown occurred.
-The facility kept Resident #1 in her wheelchair from breakfast to lunch, and then to bed after lunch.
-Resident #1 required a lot of help to move/transfer and stand.
-The resident had been non-ambulatory since "shortly after" admission.
-The first couple days after admission, Resident #1 stayed in bed. The facility was being very cautious so the resident would not fall.
-She received an email from the PCP on 07/22/23 that documented Resident #1 had an obvious decline, did not mention any skin breakdown, and would look at palliative services when Resident #1 started to demonstrate breakdown.

Interview with the RCC on 08/11/23 at 3:57pm revealed:
-When she completed a pre-admission assessment on Resident #1 at the resident's home, the resident needed assistance with standing.
-A Hoyer lift was suggested after Resident #1 was admitted to the facility.
-The Hoyer lift had been in use for Resident #1

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	FCL051073	A. BUILDING: ______ B. WING ______	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT EAGLE POINT	**118 EAGLE POINTE LN** **CLAYTON, NC 27520**

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C 242	Continued From page 14	C 242		

about two months.

Telephone interview with the Primary Care Provider (PCP) for Resident #1 on 08/11/23 at 2:07pm revealed:
-She was aware of the skin breakdown on Resident #1's buttock.
-She could not tell when she became aware of the skin breakdown.
-She was at the facility two weeks ago and did not think Resident #1 had any skin breakdown then.

Following record review and observations of Resident #1 on 08/10/23 and 08/11/23, she was determined not to be interviewable.

____

The facility failed to ensure Resident #1, who was non-ambulatory and required extensive assistance for personal care, including incontinent care and repositioning, received personal care, incontinent care, and repositioning resulting in skin breakdown in multiple areas to her buttocks and sacral area. This failure resulted in serious physical harm to the resident and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 08/10/23.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2023.

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C 246	10A NCAC 13G .0902(b) Health Care	C 246		

10A NCAC 13G .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT EAGLE POINT	118 EAGLE POINTE LN CLAYTON, NC 27520

(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 246	Continued From page 15	C 246		

of residents.

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

Based on observations, interviews, and record review, the facility failed to notify the primary care provider (PCP) of a change in condition for 1 of 3 sampled residents (Resident #1) related to skin breakdown.

The findings are:

Review of Resident #1's current FL-2 dated 04/11/23 revealed diagnoses included Alzheimer's, hypertension, hypothyroidism, anxiety, gastro-esophageal reflux disease, hyperlipidemia, and bee sting allergy.

Review of the Resident Register for Resident #1 revealed:
-The resident was admitted to the facility on 04/18/23.
-Assistance required for the resident included bathing, dressing, ambulation, getting in/out of bed, toileting, and skin care.

Review of Resident #1's Care Plan with an assessment date of 04/18/23 revealed:
-Resident #1's skin was normal on 04/18/23.
-The resident was assessed to have occasional incontinence of bowel and bladder.
-The resident was ambulatory with aide of an assistive device.
-There was limited range of motion of the upper extremities.
-The resident required extensive assistance with toileting, ambulation/locomotion, bathing, dressing, persional hygiene, and transferring.

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Review of Resident #1's LHPS evaluation dated 05/30/23 revealed:
-There was documentation that Resident #1's cognitive and physical abilities had declined, and the resident could no longer transfer herself.
-Staff were competency validated for use of a Hoyer lift (a medical device used to transfer a person with limited mobility from one location to another) and wheelchair.

Observations of Resident #1 on 08/10/23 at 8:05am revealed:
-She was lying in bed on her back with her eyes closed.
-The resident did not respond to verbal stimuli.

Review of Daily Shift Notes documented by a staff dated 07/25/23 revealed:
-On 07/25/23 staff documented there was an open area on Resident #1's buttocks at the top between the cheeks of the residents buttocks.
-The Resident Care Coordinator (RCC) was notified.

Interview with the Personal Care Aide (PCA) on 08/10/23 at 10:47am revealed:
-There was a reddened area on Resident #1's buttocks.
-The area was not opened.
-The area was healing.
-She was unsure how long the reddened area had been on Resident #1's buttocks.
-The facility managers should know about Resident #1's skin breakdown.
-She had not told the managers about Resident #1's skin breakdown.
-She had not been working at the facility for a while and was told on 08/09/23, when she came back to the facility, about the area on resident #1's buttocks by the MA.

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C 246	Continued From page 17 Observation of Resident #1's buttocks with the PCA and MA on 08/10/23 at 1:53pm revealed: -There were three open areas on the left buttocks that were a dark red color. The skin surrounding the areas was white and sloughing. -There was an open area on the right buttock that was a dark red color. The edges of the skin surrounding the open area was white. There was a reddish discoloration to the lower outer right edge of the open area that measured approximately 2-3 inches. -There was a circular open reddened area at the upper inner aspect of the left buttocks that was approximately the size of a pencil eraser. Interview with the MA on 08/10/23 at 1:47pm revealed: -There was a reddened area on her buttocks that had been there "about a week". -The resident's family member knew about the skin breakdown. -She reported to the second shift MA about the reddened area on Resident #1's buttocks. -She told the second shift MA to report the same to the third shift MA. -She documented in her notes about Resident #1's reddened area on her buttocks. -There were no residents at the facility who received home health for wound care. Interview with a House Manager on 08/10/23 at 1:55pm revealed: -It was "maybe last week" when she first saw the area on Resident #1's buttocks. -The area "was just redness" when she first saw it. -She had been aware of the open area on Resident #1's buttock for 1-1 ½ weeks. -She implemented every two-hour incontinent	C 246		

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checks and incontinent care/change.
-She notified the Resident Care Coordinator (RCC).
-The RCC was responsible for notifying the PCP.
-She thought the PCP had been notified.

Interview with the RCC on 08/10/23 at 1:58pm revealed:
-She was first notified of the open area on Resident #1's buttock on 08/02/23 by a House Manager.
-The House Manager had implemented a protocol for incontinent care/change every two-hours on 08/09/23, to try to keep the area from getting worse.
-She last saw the area on Resident #1's buttocks on 08/04/23 and it was red with no broken skin areas.
-She emailed the PCP on 08/04/23 to get an order for "zinc".
-She did not know if the PCP had responded.
-The PCP would respond to the RCC.

Interview with the RCC on 08/10/23 at 3:48pm revealed:
-She had not found any documentation indicating she had notified the PCP of Resident #1's skin breakdown.
-She was notified on 08/02/23 that Resident #1 had "redness" on her buttocks.
-She verbally instructed the House Manager to make sure the MAs and PCAs knew to change Resident #1 every 2 hours.
-She went to the facility on 08/04/23 and told the MA to make sure Resident #1 was changed every 2 hours.
-She did not know why the PCP was not contacted on 08/02/23 or 08/04/23.
-She thought the redness on Resident #1's buttock could be anything.

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C 246	Continued From page 19 -She did not return to the facility the next day to check on the resident or look at the resident's skin. -She called the facility to ask how residents were doing but did not ask any specific questions about Resident #1. Interview with a family member for Resident #1 on 08/10/23 at 4:30pm revealed: -Resident #1 did not have any skin breakdown when admitted to the facility. -The family member found out about the skin break down on Resident #1's buttocks "late last week". Interview with a second MA on 08/10/23 at 4:54pm revealed: -She first saw an open area on Resident #1's buttocks about 2 weeks ago which was about the size of a pencil eraser. -She noticed some progression in the skin breakdown on Resident #1's buttock "maybe" one week ago. -She documented it in a notebook and put zinc ointment on the area. -She put Resident #1 to bed about one hour ago and the area on the resident's buttocks looked like there was more breakdown. -She thought the area on the resident's left buttocks was a rash. -She had not seen the open areas on Resident #1's sacrum before today. Interview with the Administrator on 08/11/23 at 1:57pm revealed: -When he saw Resident #1's skin on 08/03/23, the skin was "just pink". -He saw the skin breakdown yesterday (08/10/23). -He assumed when the skin was pink, the PCP	C 246		

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C 246	Continued From page 20 had been notified. -He would expect the PCP to be contacted as soon as needed or when a change is noted, "say within 24 hours". Telephone interview with another family member on 08/11/23 at 3:07pm revealed: -Several weeks ago Resident #1 had a "slight reddened area" but no broken skin on her buttocks. -Last Friday (08/04/23), she became aware of the skin breakdown on Resident #1's buttocks when another family member saw the breakdown while present when staff were changing the resident. -She did not know when the skin breakdown occurred. -The facility kept Resident #1 in her wheelchair from breakfast to lunch, and then to bed after lunch. -Resident #1 required a lot of help to move/transfer and stand. -The resident had been non-ambulatory since "shortly after" admission. -The first couple days after admission, Resident #1 stayed in bed. The facility was being very cautious so the resident would not fall. -She received an email from the PCP on 07/22/23 that documented Resident #1 had an obvious decline, did not mention any skin breakdown, and would look at palliative services when Resident #1 started to demonstrate breakdown. Telephone interview with the Primary Care Provider (PCP) for Resident #1 on 08/11/23 at 2:07pm revealed: -She was aware of the skin breakdown on Resident #1's buttock. -She could not tell when she became aware of the skin breakdown. -She last visited the facility on 08/03/23, looked at	C 246		

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C 246	Continued From page 21 Resident #1's skin, and there was nothing there. -She was at the facility two weeks ago and did not think Resident #1 had any skin breakdown then. -She did not have any real expectations because the facility lets her know what they are doing. -Her first step would be to implement baza cream. -If the skin area got worse, the facility could let her know and she would come by the facility. -If she thought the skin condition was bad enough, she would call in home health/skilled nursing to evaluate. Review of a physician's order dated 08/11/23 revealed the PCP provided an order to start baza cream to buttocks open area four times a day and as needed. ____________________ The facility failed to notify the Primary Care Provider (PCP) for Resident #1 who had a disruption to the skin integrity that presented with redness to the buttocks and progressed to skin breakdown on the left and right buttocks and sacral area before the PCP provided orders for treatment. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 08/10/23. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2023.	C 246		