STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032150	A. BUILDING: _____ B. WING _____	R 05/11/2023

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PLEASANT LIVING FAMILY CARE	5304 YARDLEY TERRACE DURHAM, NC 27707

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{C 000}	Initial Comments The Adult Care Licensure Section conducted a Follow-Up Survey on May 11, 2023.	{C 000}		
{C 022}	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 4 sampled residents who did not respond to the fire drill (#1). The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's documented fire drills revealed: -On 04/07/23, at 10:00am all residents exited.	{C 022}		

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{C 022}	Continued From page 1 -On 04/14/23, at 1:00pm all residents exited. -On 04/21/23, at 2:00pm all residents exited. -On 04/28/23, at 5:00pm all residents exited. -On 05/05/23, at 1:00pm all residents exited. -On 05/11/23, all residents exited (no time was documented). Review of Resident #1's current FL-2 dated 01/23/23 revealed: -Diagnosis included late-onset Alzheimer's dementia without behavioral disturbance. -The resident was ambulatory. -The resident was constantly disoriented. -The resident required assistance with bathing and dressing. -The resident was incontinent of bladder. Review of Resident #1's Resident Register revealed an admission date of 02/01/23. Review of Resident #1's assessment and care plan dated 02/02/23 revealed: -There was no documentation related to Resident #1's orientation or memory. -The resident was dependent on staff for eating and ambulating/transferring. -The resident required limited assistance from staff with bathing and dressing. -The resident required supervision from staff with toileting and grooming/personal hygiene. Observation of the fire drill on 05/11/23 between 8:49am-8:51am revealed: -The fire alarm was sounded by the Administrator. -Resident #1 was seated at the dining room table. -One resident was outside the facility. -Two residents were in their separate bedrooms. -The continuous audible alarm could be heard throughout the facility. -Resident #1 remained seated.	{C 022}		

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{C 022}	Continued From page 2 -The other two residents exited the facility. Observation of Resident #1 on 05/11/23 at 9:00am revealed: -The personal care aide (PCA) talked to Resident #1 about leaving the dining room. -Resident #1 had to be prompted to move toward the edge of the seat and stand up. -The PCA then took both of Resident #1's hands and had the resident walk towards her as she walked backwards through the dining room. Interview with the facility's Owner/Administrator on 05/11/23 at 2:23pm revealed: -They had been doing weekly fire drills. -When she documented all residents exited, it did not include Resident #1. -Resident #1 did not exit the facility without assistance. -One-time Resident #1 was standing up and she told her to go outside, and the resident went outside. -She had been working with Resident #1's family on moving the resident from the facility. -On 03/30/23, she gave a verbal discharge notice to Resident #1's family. -Resident #1's family stated it was not in their budget to hire private duty sitters for Resident #1. -She put 1:1 care (providing support specifically to one individual) in place for Resident #1 while seeking placement for the resident. -She had two personal care aides (PCA) that worked at the facility to assist with Resident #1. -One PCA worked from 8:00am-1:00pm and the other PCA worked from 1:00pm until 7:00pm. -When the PCA left at 7:00pm, all the resident's needs had been met for the day and the Administrator was able to provide 1:1 care for Resident #1. -She stayed in Resident #1's room from "around"	{C 022}		

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{C 022}	Continued From page 3	{C 022}		

10:00pm-4:30am.
-She had a significant other who stayed at the facility and was available if needed.
-She had called multiple facilities to find alternate placement for Resident #1 and the facilities either did not have openings or Resident #1's family stated they were not able to afford the facility.
-After not being able to find a facility, the family told her they would take Resident #1 home and provide care.
-She last talked to Resident #1's family member on 05/08/23, and the family member planned to take Resident #1 home on 05/13/23.

Interviews with the Administrator's significant other on 05/11/23 at 2:47pm and 3:11pm revealed:
-He arrived at the facility every night "about" 7:00pm and left the facility between 7:30am-8:00am.
-He went to sleep between 12:30am-1:00am after he knew everyone was asleep.
-He stayed in the Administrator's private room.
-The Administrator stayed in the private room with him every night.

Interview with a PCA on 05/11/23 at 10:22am revealed:
-She worked at the facility Monday-Friday 8:00am-1:00pm and every other weekend.
-She assisted with anything the residents needed, as well as housekeeping and cooking.

Telephone interview with another PCA on 05/11/23 at 11:42am revealed:
-She worked at the facility on Tuesday-Friday from 1:00pm-6:00pm or 6:30pm; she was always out by 7:00pm.
-The Administrator was the only other staff she saw at the facility when she worked.

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{C 022}	Continued From page 4 -She washed linens, changed the residents beds, and other housekeeping tasks. -She took Resident #1 to the bathroom. Telephone interview with Resident #1's family member on 05/11/23 at 1:43pm and 4:47pm revealed: -The Administrator never asked her to hire private duty sitters for Resident #1. -The Administrator had not talked to her about placement at other facilities. -The Administrator had not given her a discharge notice. -The Administrator called her "about 2-3 weeks ago" and told her she was having repairs done to the facility and asked her to pick Resident #1 up until the repairs were completed. -She was picking Resident #1 up on 05/13/23, and taking the resident to her home. -The plan was for Resident #1 to go to her family member's home and once the repairs at the facility were complete, the resident would return to the facility. -The Administrator did not tell her how long the repairs would take. Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable. _____ The facility failed to ensure a resident (#1), who had a diagnosis of Alzheimer's dementia, was able to evacuate the facility in an emergency without verbal prompting by staff. This failure was detrimental to the health, safety, and welfare of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/23 for	{C 022}		

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{C 022}	Continued From page 5 this violation.	{C 022}		
{C 105}	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 F in the residents' bathroom for 1 of 1 fixture. The findings are: Observation of the resident's bathroom on 05/11/23 at 8:06am revealed: -The hot water temperature at the sink fixture was 124.5 degrees F. -There was visible steam coming from the running hot water. -There was no signage related to the hot water. Interview with the Administrator on 05/11/23 at 8:08am revealed: -She would make a sign for the bathroom to identify the water was hot. -She would call the maintenance provider and ask him to adjust the water heater.	{C 105}		

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{C 105}	Continued From page 6 Second observation of the resident's bathroom on 05/11/23 at 11:37am revealed: -The hot water temperature at the sink fixture was 119.7 degrees F. -There was a sign posted that stated, warning hot water heater is still too high, dated 05/11/23. Interview with the maintenance staff on 05/11/23 at 12:16pm revealed: -He set the water heater's temperature to 115 degrees F today, 05/11/23. -Before today, he had checked the water heater "about one month ago." -The temperature on the water heater was set at 120 degrees F before him lowering it today -He thought the hot water was "pretty safe" between 115 degrees F -120 degrees F. -He did not know the temperature had to be between 100 degrees F and -116 degrees F. Interview with three residents on 05/11/23 between 12:20pm-12:30pm revealed: -One resident stated the water had been "pretty hot", but she thought it was better when she used it before lunch today, 05/11/23. -Another resident stated the water seemed fine when she washed her hands, but she never just turned the hot water on by itself, she turned both the hot and cold water on. -A third resident stated the water had been really hot for a while and she "just added" cold water. Review of the facility's weekly water temperature log revealed there were no temperatures documented. Observation of the calibration of the Administrator and the surveyor's thermometers at 1:28pm on 05/11/23 revealed: -The Administrator's thermometer was calibrated	{C 105}		

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{C 105}	Continued From page 7 at 32.0 degrees F. -The surveyor's thermometer was calibrated at 32.4 degrees F. Observations of the re-check of water temperatures with the Administrator's and surveyor's thermometer on 05/11/23 at 1:31pm revealed: -The hot water temperature taken by the Administrator at the sink was 106 degrees F. -The hot water temperature taken by the surveyor at the sink was 105.3 degrees F. Interview with the Administrator on 05/11/23 at 2:49pm revealed: -She checked the water temperatures once a week. -She did not document the water temperatures. -The water temperature was not too hot the last time she checked the hot water; she did not recall the results of the checked water. -None of the residents took showers or "washed up" without assistance.	{C 105}		
{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: Based on observations, interviews, and record reviews, the facility failed to ensure an appointment was made for 1 of 3 sampled residents (#2) related to a referral for a medical radiology imaging (MRI) for a resident who had a toe injury.	{C 246}		

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{C 246}	Continued From page 8 The findings are: Review of Resident #2's current FL-2 dated 10/18/22 revealed diagnoses included dementia, hypertension, and arteriosclerosis. Review of Resident #2's Primary Care Provider's (PCP) after-visit summary dated 04/20/23 revealed: -At the top of page 1 of the after visit-summary, there was documentation about things we discussed during this visit. -There was documentation to call the telephone number listed, which was highlighted in yellow, to schedule a medical radiology imaging (MRI). The order was placed today, 04/20/23. Telephone interview with a nurse at Resident #2's PCP office on 05/11/23 at 1:05pm revealed: -Resident #2 had an MRI ordered to rule out an infection. -They would have expected someone to call within a couple of days to make an appointment for the MRI. -It was concerning the appointment for the MRI was not made until today, 05/11/23. -The biggest concern was Resident #2 could have an infection and the infection could spread and would be harder to treat. Review of Resident #2's podiatry after-visit summary dated 05/03/23 revealed: -Resident #2 was seen for pain in the left hallux (big toe). -Superficial ulcerations which measured 0.2 centimeters (cm) x 0.2 cm were noted on the distal aspect of the left big toe. -Erythema was noted on the distal aspect of the left big toe with pain on direct palpation. -Treatment for cellulitis with the resident was	{C 246}		

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{C 246}	Continued From page 9	{C 246}		

discussed including a possible need for a culture for targeted antibiotics.
-Treatment options for ulceration were discussed with Resident #2 including the possible complications from improper treatment such as deeper infection, prolonged ulceration, need for intravenous antibiotics, the possibility of hospitalization, and surgical intervention.
-Discussed the need for proper debridement (the medical removal of infected tissue to improve the healing potential of the remaining healthy tissue), antibiotic coverage, and proper offloading of the area.
-Active wound care including debridement was performed on today's exam, 05/02/23.
-Resident #2 was started on Keflex (an antibiotic) 500mg twice a day for 7 days.

Review of Resident #2's discharge instructions from podiatry dated 05/03/23 revealed:
-The resident was to have daily dressing changes with a topical antibiotic and band-aid.
-Take antibiotics as instructed.

Interview with the Administrator on 05/11/23 at 10:56am revealed:
-She had not scheduled Resident #2's MRI.
-She tried to call on Friday, 05/05/23, to schedule the MRI, but no one answered the telephone when she tried.
-She allowed the telephone to ring for "about" 35 minutes.
-She was going to try again today, 05/11/23.

Observation of the Administrator on 05/11/23 at 10:59am revealed:
-She dialed the telephone number provided on Resident #2's after-visit summary.
-At 11:00am, the telephone rang and at 11:01am, the telephone was answered.

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{C 246}	Continued From page 10 -An appointment was made for Resident #1 for 06/08/23 at 1:00pm. Telephone interview with a scheduler at the radiology office on 05/11/23 at 12:57pm revealed: -A referral was received at their office on 04/20/23 for a MRI to rule out infection for Resident #2's left big toe. -She did not see any documentation of incoming calls about the appointment until today 05/11/23 when someone called and scheduled an appointment for 06/08/23. Observation of Resident #2's left great toe on 05/11/23 at 11:40am revealed: -The toe had a band-aid running both vertically and horizontally. -Between the band-aids and below the band-aids, Resident #2's toe was red. Interview with Resident #2 on 05/11/23 at 11:40am revealed: -Her toe was still hurting, but not as bad. -She did not know she was supposed to have an MRI of her toe. -The Administrator had applied a cream to her toe and put on the band-aid; she did not know when, but not today, 5/11/23. Second interview with the Administrator on 05/11/23 at 3:11pm revealed: -She had not scheduled an appointment for Resident #2's MRI because the PCP told her to see the podiatrist and then when she followed up with the PCP, the PCP would decide if Resident #2 still needed an MRI or not. -She thought Resident #2 had a follow-up appointment with the PCP on 05/15/23. Second telephone interview with the nurse at	{C 246}		

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{C 246}	Continued From page 11 Resident #2's PCP office on 05/11/23 at 3:18pm revealed: -There was no documentation the PCP had told Resident #2 the MRI could wait until her next appointment. -Resident #2's discharge instructions, dated 04/20/23, instructed the Administrator to make an appointment for an MRI. -She had talked to the PCP after the telephone call earlier today, 05/11/23, to let the PCP know the appointment was not made until today and the appointment was not until 06/08/23. -The MRI was ordered because originally Resident #2 had been seen in an urgent care clinic and an MRI was ordered but had not been done. -Resident #2 was expected to get the MRI completed and the results would be sent directly to the PCP. Based on record reviews and interviews, Resident #2's MRI was not scheduled for three weeks after the referral was made.	{C 246}		
{C 341}	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	{C 341}		

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{C 341}	Continued From page 12 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed a resident take their medications. The findings are: Observation of the dining room on 05/11/23 from 8:10am-8:19am revealed: -Three residents were sitting at the dining room table eating breakfast. -Two of the residents had a cup of pills sitting at their place setting. -There was a personal care aide (PCA) who was in and out of the dining room. -From 8:15am-8:19am, there was no staff present in the dining room. -At 8:16am, one of the three residents left the room. -At 8:19am, the PCA encouraged one of the two remaining residents to take her medications. -The medications were poured out of the cup onto a napkin where the resident took 1-2 tablets at a time. -The medication aide (MA) was not present in the room when the resident took her medication. -At 8:26am, the PCA assisted the resident away from the table, leaving one resident and her cup of medications sitting on the table with no supervision. -At 8:28am, the Administrator entered the room and removed the remaining cup of medications from the table. Interview with the PCA on 05/11/23 at 10:22am revealed: -When she came into work, the residents were	{C 341}		

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PLEASANT LIVING FAMILY CARE	5304 YARDLEY TERRACE DURHAM, NC 27707

(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 341}	Continued From page 13 usually already at the table. -The Administrator had the medications in the cups at the table when she arrived. -She made sure the residents took their medications, but she did not administer the medications. -She was not in the dining room at all times but she did go in and out to check on the residents. Interview with the Administrator on 05/11/23 at 2:49pm revealed: -She set breakfast up each morning. -She then popped the medications into cups and put the cups at the residents' place setting at the table. -She usually watched the residents take their medications, but she was busy this morning, so the PCA watched. -The PCA watched the residents take their medications, but the PCA did not pop the pills.	{C 341}		