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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on January 4, 2023 to January 6, 2023 with exit conference via telephone on January 6, 2023. The complaint investigation was initiated by the Pasquotank Department of Social Services on November 15, 2022 and November 23, 2022.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult 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 interviews and record reviews, the facility failed to ensure personal care was provided for 2 of 5 sampled residents (#1, #3) including a resident who had a urinary catheter that required daily cleaning and who also needed daily foot care (#3), and for a resident who required repositioning and wound care daily and as needed when home health was not able to attend to the resident (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 11/17/22 revealed:	D 269		

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D 269	Continued From page 1 -Diagnoses included congestive heart failure, bilateral leg weakness, atrial fibrillation, unsteady gait when walking, multiple falls, and decreased activities of daily living (ADLs). -The resident was semi-ambulatory and there was an order for physical therapy 2 times per week. Review of Resident #3's Resident Register dated 11/18/22 revealed: -The was admitted to the facility on 11/22/22. -The resident required assistance with dressing, bathing, nail care, shaving, ambulation, getting in/out of bed, toileting, skin care, and scheduling appointments. -The resident used a walker, wheelchair, and eyeglasses. Review of Resident #3's current care plan dated 01/03/23 revealed: -The resident had a urinary catheter. -The resident required the use of a wheelchair, walker, and physical therapy twice weekly. -The resident had limited range of motion in his left arm -The resident required extensive hands-on assistance with bathing, dressing, ambulation, transferring, toileting, nail care (feet and hands), and mouth care. Review of Resident #3's current Licensed Health Professional Support (LHPS) assessment dated 12/09/22 revealed: -The resident used a wheelchair to ambulate and required extensive assistance with bathing and dressing. -The resident required assistance with transferring, activities of daily living (ADLs), and catheter care.	D 269		

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a. Review of Resident #3's primary care provider (PCP) visit note dated 11/29/22 revealed:
-The resident had a recent hip fracture and crushing of three vertebrae three months prior and bilateral weakness of his legs.
-The resident was easily fatigued, had decreased mobility, painful movement, poor strength, balance, and coordination, and was dependent on a wheelchair.
-The resident was to be provided with supportive care.

Review of Resident #3's emergency department (ED) after visit summary dated 12/13/22 at 5:48am revealed:
-The resident received a diagnosis of problems with a Foley catheter (urinary catheter).
-There was a handwritten note (unknown author) the resident was to see a urology provider due to urinary retention and that a urinary catheter had been replaced with a bigger size; there was blood noted due to the trauma of the removal and reinsertion of the bigger size.

Review of Resident #3's PCP visit note dated 12/13/22 revealed:
-The resident was seen for an acute visit for ED follow-up due to multiple falls and skin tears.
-The resident had a new Foley catheter placed and had large amounts of blood in his urine.
-Home health skilled nursing was pending, and the catheter was to be flushed routinely if hematuria (blood in the urine) was present.

Review of Resident #3's Incident/Accident (I/A) report dated 12/14/22 revealed:
-The resident's catheter was not draining correctly and urine was wetting the resident's bedding and clothing.
-The resident was transported via ambulance to

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D 269	Continued From page 3 the ED. Review of Resident #3's ED after visit summary dated 12/14/22 revealed: -The resident was seen for a diagnosis of Foley catheter in place. -There were discharge instructions for Foley catheter care as follows: -Keep the area clean where the catheter leaves the body using mild soap and warm water on a washcloth. -Clean the area closest to the catheter insertion site using a circular motion around the catheter. -Clean the catheter itself by wiping AWAY from the insertion site for several inches down the tube. -Never wipe upward as this could sweep bacteria up into the urethra (opening of the urinary tract) and cause infection. -Empty the drainage bag when ½ to ¾ full and periodically check the tubing for kinks to make sure there is no pressure on the tubing which could restrict the flow of urine. -Seek medical care if pain develops in the lower back, the catheter becomes clogged and there is no urine drainage, or the urine becomes cloudy, smells bad, or there is blood in it. Review of Resident #3's physician order dated 12/15/22 revealed there was an order to refer the resident to home health. Review of Resident #3's PCP visit note dated 12/20/22 revealed: -The resident was seen due to concerns expressed from the resident, his family, and the facility staff. -He had a slow healing wound to his left forearm and a new stage 2 wound to his right buttocks. -He had retention of urine with hematuria and a	D 269		

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urinary catheter.
-The facility had attempted to contract with home health, but the resident's insurance would not cover the services from the home health company(s) he was referred to.
-There was an order to refer the resident to a skilled nursing facility for wound management, pressure ulcer stage 2 buttocks, and Foley catheter due to the retention of urine with hematuria.

Review of Resident #3's I/A report dated 12/25/22 revealed:
-The resident was disoriented and had blood in his catheter.
-He was sent to the ED via ambulance for further evaluation.

Review of Resident #3's ED after visit summary dated 12/25/22 revealed the resident was seen for a diagnoses of urinary tract infection (UTI) with hematuria (bloody urine).

Review of Resident #3's I/A report dated 01/04/23 revealed:
-It was documented that the hospital stated on 12/13/22 the resident would have blood in his urine due to changing out the catheter and size.
-The resident had been on antibiotics for a UTI since 12/26/22.
-After almost four weeks of having a new catheter and being on antibiotics the urine was still full of blood.
-He was sent to the ED for further evaluation.

Review of Resident #3's ED to Hospital-Admission hospital record dated 01/04/23-01/12/23 revealed:
-The resident was seen in the ED and admitted to the hospital on 01/04/23 where he was treated for

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a UTI and hematuria related to an indwelling urinary catheter, suspected prostatitis (inflammation of the prostate gland possibly associated with infection, injury, or immune system disorders), acute kidney injury possibly secondary to a bacterial infection, asthma, atrial fibrillation, and elevated troponin (a protein not normally found in the blood unless the heart becomes damaged, possibly related to infection, low blood volume, atrial fibrillation, and renal failure).
-There was documentation that the ED provider consulted a urologist at another hospital for guidance of care and possible transfer to treat the resident's antibiotic resistant UTI and acute kidney injury.
-On 01/11/23, the resident was assessed by physical therapy and short-term rehabilitation was recommended.
-On 01/12/23, the resident remained hospitalized.

Review of Resident #3's December 2022 ADL log revealed:
-There was an entry for extensive assistance with bathing; there was to be one staff member to complete the process assisting the resident into and out of the shower, washing, and drying for safety.
-The bathing task was documented as completed once daily from 12/01/22-12/31/22.
-There was an entry for toileting; staff were required to participate in some aspect of being present when the resident was toileting to provide verbal cueing for the process to be completed safely.
-The toileting task was documented as completed three times daily (once per shift) from 12/01/22-12/31/22; there were no refusals documented.
-There was no entry or documentation for the

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resident to receive catheter care from 12/01/22-12/31/22.

Review of the facility's staff communication logs revealed:
-On 12/06/22, Resident #3 slept in his chair most of the day and refused all personal care.
-On 12/14/22, Resident #3 was noted to have a urinary catheter.
-On 12/16/22, Resident #3 refused to shower.
-On 12/28/22, Resident #3 refused to shower.
-On 12/30/22, Resident #3 was noted to be developing a rash around his genital area.

Review of Resident #3's January 2023 ADL log revealed:
-There was an entry for extensive assistance with bathing; there was to be one staff member to complete the process assisting the resident into and out of the shower, washing, and drying for safety.
-The bathing task was documented as completed once daily from 01/01/23-01/04/23.
-There was an entry for toileting; staff were required to participate in some aspect of being present when the resident was toileting to provide verbal cueing for the process to be completed safely.
-The toileting task was documented as completed three times daily (once per shift) from 01/01/23-01/04/23.
-There was no entry or documentation for the resident to receive catheter care from 01/01/23-01/04/23.

Confidential interview with a personal care aide (PCA) on 01/05/23 (time redacted) revealed:
-Resident #3 was oriented and required 2 staff for assistance of activities of daily living (ADLs) which included bathing, changing, toileting,

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showering, and transfers.
-Resident #3 came back from the hospital with a catheter about one month ago - she was unsure why.
-The PCAs were responsible to empty Resident #3's catheter bag and to ensure it was draining properly approximately every hour.
-Resident #3 would complain that it felt like his catheter was uncomfortable, getting pulled, and felt like it was going to come out.
-On or around 12/25/22, Resident #3 had blood in his catheter and had been sent out to the hospital.
-She last saw Resident #3's catheter earlier that week and it looked okay at that time.
-There were no tasks or orders that she was aware of to provide cleaning of the catheter tubing to care for Resident #3's catheter and she was only responsible to empty and clean the opening to the bag.
-She inspected and cleaned the insertion sight of the tube during his showers, but she otherwise did not clean the perineal area and provide catheter care routinely unless it was visibly soiled when she got him up to the bathroom approximately 3-5 times per day because she was not instructed to do so.

Confidential interview with a second PCA on 01/05/23 revealed:
-Resident #3 required help with transfers and toileting.
-The PCAs were responsible to provide Resident #3 with personal care that included bathing/showering, toileting when he rang is bell for assistance (approximately 2-3 times per day), and emptying his catheter bag every 2 hours.
-She emptied his bag every 2 hours and bathed the resident.
-PCAs were not allowed to touch the catheter

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tube or insertion site.
-She thought it was the medication aide's (MA's) responsibility to provide catheter care and clean the site for the resident.

Confidential interview with a MA on 01/05/23 revealed:
-Resident #3 was to receive showers on certain days but sometimes refused them.
-The resident was rarely incontinent and had a urinary catheter so he would only go to the bathroom to have a bowel movement and would ask staff for assistance as needed.
-Home health was responsible to manage and care for Resident #3's catheter but she never saw them at the facility for the resident.
-The MAs and the PCAs were responsible for emptying Resident #3's catheter bag but there were no orders or routine tasks she was aware of to provide catheter care and no one at the facility had been doing so to her knowledge, she did not know why.
-If Resident #3's catheter was observed to be clogged, leaking, have sediment in the bag, or he complained of issues with the catheter, she was responsible to ensure the resident was sent out to the hospital for further evaluation.

Confidential interview with another MA on 01/05/23 revealed:
-Resident #3 used the call bell anytime he requested to be toileted or needed personal care.
-She was not sure how often the PCAs would go into his room to empty his catheter bag.
-Home health was normally responsible to provide catheter care to residents at the facility, but Resident #3's insurance would not cover the service.
-To her knowledge no one at the facility had been providing catheter care and cleaning the area;

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staff were only emptying the bag and ensuring the catheter was draining properly and intact.
-She was not aware of any orders or instructions to care for Resident #3's catheter and thought home health would be responsible to provide those services.
-Resident #3 had been complaining about the catheter burning and he had been on antibiotics for a UTI since the catheter was placed.
-Resident #3 had also been noted to have blood in his urine and was sent back to the ED several times after the catheter was placed where he was diagnosed with a UTI and urinary retention.

Interview with the Resident Care Director (RCD) on 01/04/23 at 4:48pm revealed:
-Resident #3 was not admitted with the catheter but came back with the catheter in place after a visit to the hospital about 2-3 weeks ago.
-She had tried to solicit multiple home health agencies to come care for Resident #3's catheter, but his insurance would not cover home health visits to manage the catheter, so she was working on trying to get him placement in a skilled facility; if that was not successful, his family member was considering removing him from the facility and taking him home.
-The facility staff were expected to be cleaning the tubing, the site, and emptying the bag.
-Resident #3 went to the hospital that morning (01/04/23) for blood in his catheter and the last update from the hospital was that he would either be admitted or transferred to another hospital, but she was not sure why.

Telephone interview with the RCD on 01/06/23 at 9:04am revealed:
-She was responsible for handling resident and family concerns, overseeing care given by facility staff, implementation of orders, processing new

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admissions, ensuring ADLs are completed, care plans, FL-2s, and ensure staff are charting appropriately.
-She performed random chart audits and observed PCAs provide personal care approximately every two days, but she did not document these observations or audits.
-Resident #3 came back from the ED on 12/13/22 with a catheter.
-Resident #3 was supposed to receive daily baths, daily catheter care and draining of the bag as needed, be assisted with toileting, and any other care as he requested.
-She had observed Resident #3 receive personal care and knew that he used his call bell for assistance frequently.
-Staff were expected to provide catheter care and should have known to do so since the resident returned with it from the hospital.
-MAs or the Clinical Director were responsible to process and enter tasks for catheter care into the computer for Resident #3 and she was not aware it had not been done.
-Catheter care should have been done daily when Resident #3 was bathed and sometimes he would refuse to be bathed so she knew it was not done on those days.
-It was important for Resident #3 to receive catheter care to keep it clean and prevent it from becoming infected.

Telephone interview with the Assistant Administrator on 01/06/23 at 9:45am revealed:
-She was responsible when the Administrator was not present to oversee all departments in the facility.
-She checked in daily with direct supervisors to address any issues and to assist as needed.
-PCAs were expected to provide Resident #3 with daily catheter care and draining of the bag, then

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document that care on the ADL log in the computer under toileting.
-The RCD was responsible to implement the task for catheter care under tasks the ADL log; MAs were unable to add orders on the ADL section in the computer.
-The RCD was responsible to review Resident #3's hospital notes for care instructions and enter orders for personal care in the computer.
-She was not aware that Resident #3 did not have a care task for catheter care on his ADL log in the computer.
-If staff were unable to be document catheter care on the ADL log, it should have a been completed and documented on a paper medication administration record (MAR) or communication note.
-She was not aware that Resident #3 was not receiving catheter care and it was important for him to have received it to prevent infection.

Telephone interview with the Administrator on 01/06/23 at 10:10am revealed:
-Resident #3 should have been receiving daily catheter care when he received his showers by PCAs.
-PCAs were expected to provide catheter care using soap and water to wash the perineal area and insertion site/tubing of the catheter as part of the resident's care under ADLs.
-She was not aware that Resident #3 sometimes refused bathing and went without washing.
-It was important for Resident #3 to receive catheter care daily to keep it clean and prevent rash and skin breakdown.
-She did not expect there to be a specific catheter care task on his ADL log in the computer because it was considered to be a part of bathing and PCAs should have been trained to know that.

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D 269	Continued From page 12 Telephone interview with the facility's contracted licensed health professional support (LHPS) nurse on 01/06/23 at 11:00am revealed: -She assessed and signed off on resident and staff LHPS care tasks quarterly. -When she assessed staff competencies, she tried to teach them and demonstrate the tasks on a resident who required the task, but if there was not a resident who needed the task, she would teach and demonstrate the skill as a simulation in a laboratory type setting. -In regard to catheter care, facility staff were trained to provide catheter care every shift (2-3 times per day) to include cleaning around the insertion site, the tubing, and the perineal area while observing the catheter for any issues. -Routine catheter care was important to prevent infection and ensured the catheter was operating properly and remained intact. -Not receiving routine catheter care could contribute to bacterial growth and potential infection. Telephone interview with Resident #3's PCP on 01/05/23 at 3:11pm revealed: -She expected orders and tasks to be implemented within 48 hours of receipt by the facility. -She expected the facility to provide personal care within their policies and procedures. -Resident #3 came back from an ED visit with a catheter due to hematuria. -She expected the facility to provide catheter care and empty the bag within 48 hours. -She was not aware the facility was not providing catheter care to Resident #3's catheter. -It was important to provide catheter care to reduce the risk of infections and for the prevention of UTIs, cellulitis, and systemic infection that could lead to other organ damage.	D 269		

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-She was aware that home health was not covered for the resident which was why she placed an order for him to go to a skilled nursing facility, but the facility was having trouble finding placement and availability for him.

Second telephone interview with Resident #3's PCP on 01/06/23 at 11:10am revealed:
-She expected the facility to provide Resident #3 with catheter care per the LHPS training to reduce his risk of infection.
-She was not aware Resident #3 was not receiving catheter care as instructed by the hospital.
-Resident #3 was diagnosed with a UTI every time he went to the ED after getting his catheter.
-Lack of catheter care could contribute to UTIs and hematuria.

Attempted interview with Resident #3's family member on 01/05/23 at 2:37pm and 01/06/23 at 8:21am were unsuccessful.

b. Review of Resident #3's PCP visit note dated 11/29/22 revealed:
-The resident was seen to establish care and had a recent hip fracture and crushing of three vertebrae three months prior with bilateral weakness of his legs.
-The resident was easily fatigued, had decreased mobility, painful movement, poor strength, balance, and coordination, and was dependent on a wheelchair.
-The resident was to be provided with supportive care.

Review of Resident #3's podiatry visit note dated 12/12/22 revealed:
-The resident was seen for a routine podiatry visit with the severity of his problems gauged as

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chronic and moderate.
-The resident was noted to have fragile skin, limited range of motion, and was dependent on a wheelchair for mobility.
-The resident was diagnosed with peripheral vascular disease, onychomycosis, and nail fungus.
-The following treatments were to be instituted for the general advisement of foot management:
-Check feet daily for fissuring, discolorations, wounds, or lesions.
-Keep feet clean, dry, and moisturized daily; moisturize as needed.
-Apply clean socks daily and maintain adequate footwear.
-There was a printed fax receipt at the top of the document on each page stating the document was faxed to the facility from the provider and received on 12/12/22 at 5:57pm.

Review of Resident #3's December 2022 ADL log revealed:
-There was an entry for extensive assistance with bathing; there was to be one staff member to complete the process assisting the resident into and out of the shower, washing, and drying for safety.
-The bathing task was documented as administered from 12/01/22-12/31/22.
-There was no entry or documentation for the resident to receive specific foot care or skin assessments daily from 12/01/22-12/31/22.

Review of the facility's staff communication logs revealed:
-On 12/06/22, Resident #3 slept in his chair most of the day and refused all personal care.
-On 12/16/22, Resident #3 refused to shower.
-On 12/28/22, Resident #3 refused to shower.

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D 269	Continued From page 15 Review of Resident #3's January 2023 ADL log revealed: -There was an entry for extensive assistance with bathing; there was to be one staff member to complete the process assisting the resident into and out of the shower, washing, and drying for safety. -The bathing task was documented as completed once daily from 01/01/23-01/04/23, no refusals were documented. -There was no entry or documentation for the resident to receive specific foot care or skin assessments daily from 01/01/23-01/04/23. Review of the Administrator's email dated 12/29/22 revealed: -The Administrator sent a request to a staff member at the facility's contracted primary care provider's (PCP's) office to identify the facility's podiatry provider with a request for chart notes on the residents that had been seen. -There was a handwritten note by the Administrator that orders and progress notes were received by the facility the next day, 12/30/22. Review of the Administrator's email dated 01/06/23 revealed: -There was correspondence to the Administrator from the podiatry provider that stated the following: -She included general foot care management in her charting for each patient. -The charting was not necessarily a direct order, but rather guidelines for treatment and overall good foot care. -Please institute the follow treatment for general advisement for foot management: -Check feet daily for fissuring, discolorations, wounds, or lesions.	D 269		

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-Keep feet clean, dry, and moisturized daily; moisturize as needed.
-Apply clean socks daily and maintain adequate footwear.

Confidential interview with a personal care aide (PCA) on 01/05/23 revealed:
-Resident #3 was oriented and required 2 staff for assistance of activities of daily living (ADLs) which included bathing, changing, toileting, showering, and transfers.
-The PCAs were responsible to observe residents' skin for changes or wounds when providing baths and place any observations in the communication log and report them to the mediation aide (MA) on duty.
-There were no specific skin assessment tasks scheduled for any residents outside of bathing that she was aware of.
-Resident #3 was scheduled to receive baths every day but often refused to bathe because he preferred to bathe every other day.
-She would see Resident #3's feet when she bathed him, did not recall any wounds, fissures, or bruising, and would apply clean socks and shoes daily, but there was a period of about 2-3 weeks after admission that he went without socks because he did not have any.
-She was not aware of any specific tasks to look at Resident #3's feet for lesions, wounds, discoloration, or fissures daily.
-She was not aware to ensure Resident #3's feet were cleaned, dried, and moisturized daily.
-She had not been specifically doing those tasks for Resident #3 outside of bathing because she did not know to do so.

Confidential interview with a second PCA on 01/05/23 revealed:
-Resident #3 required help with transfers and

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toileting.
-The PCAs were responsible to provide Resident #3 with personal care that included bathing/showering, toileting when he rang is bell for assistance (approximately 2-3 times per day), and emptying his catheter bag every 2 hours.
-Resident #3 refused daily baths as scheduled and would let staff bathe him every other day, she was not sure why it was documented as having been done daily.
-She would clean Resident #3's feet when she bathed him, but she was not aware of any specific tasks to provide Resident #3 with daily foot care and was unaware of any orders from his podiatrist to do so.
-The Resident Care Director (RCD) was responsible to perform skin assessments on residents upon admission but there were no routine scheduled tasks to perform skin assessments for any residents otherwise that she was aware of.
-The PCAs were responsible to report any observation of skin breakdown they saw during resident care to the MA on duty as needed.
-She was not aware of any tasks to observe Resident #3's feet for regular skin assessments of bruising, fissures, discolorations, or wounds and she had not done so because she did not know to.

Confidential interview with a MA on 01/05/23 revealed:
-Resident #3's skin was fragile and prone to bumps and bruises.
-Resident #3 was to receive showers on certain days but he sometimes refused them.
-The RCD and MAs were responsible to perform skin assessments for residents but she was not aware of a task for Resident #3 to receive daily feet skin assessments for wounds, discolorations,

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lesions, or fissures and that was not being done.
-She saw Resident #3's feet on occasion when providing care to the resident and last saw them the previous week in which she noticed they were in need of care and were dry with flaking skin, but she did not recall any wounds, lesions, or discolorations.
-She was not sure if Resident #3's feet were being cleaned, dried, moisturized, and dressed in clean socks daily by the PCAs, but she always saw the resident with socks and shoes on.
-If skin assessments and care to Resident #3's feet were being done, there would be tasks to document that care on in his ADL log in the computer.
-If there was no foot care documented on the ADL log, she would assume it was not being done.

Confidential interview with another MA on 01/05/23 revealed:
-Resident #3's skin was really thin and he had developed some wounds trying to be independent.
-Resident #3 used the call bell anytime he required to be toileted and needed personal care.
-She was not aware of Resident #3 having any specific tasks or orders to receive care to his feet daily in regard to daily cleaning, drying, and moisturizing or skin assessments and the application of clean socks.
-PCAs were responsible to provide personal care and she did not think anyone at the facility was providing specific foot care to Resident #3 that she was aware of.
-If Resident #3 was receiving specific care for his feet it would have been documented in the computer under a task in his ADL log and she had never observed him receive that care.

Telephone interview with the RCD on 01/06/23 at

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D 269	Continued From page 19 9:04am revealed: -She was responsible for handling resident and family concerns, overseeing care given by facility staff, implementation of orders, processing new admissions, ensuring ADLs are completed, care plans, FL-2s, and ensure staff are charting appropriately. -She performed random chart audits and observed PCAs provide personal care approximately every two days, but she did not document these observations or audits. -Resident #3 was supposed to receive daily baths, daily catheter care and draining of the bag as needed, be assisted with toileting, and any other care as he requested. -She had observed Resident #3 receive personal care and knew that he used his call bell for assistance frequently. -It was the responsibility of the MA or the RCD to have processed and and ensure the orders were implemented. -She was not aware of any specific orders or tasks related to Resident #3's podiatry appointment note regarding daily foot care and skin assessments. -PCAs were responsible to clean residents' feet daily when providing daily baths and therefore Resident #3 should have received personal care to his feet daily when he did not refuse baths. -PCAs were expected to look at resident's skin when they provided baths and report any changes to the MA on duty. Telephone interview with the Assistant Administrator on 01/06/23 at 9:45am revealed: -She was responsible when the Administrator was not present to oversee all departments in the facility. -The podiatry provider came in and saw multiple residents on the same day Resident #3 was seen	D 269		

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and she had been trying to reach out to the provider because no orders were communicated with facility staff prior to the provider leaving.
-The residents' podiatry visit notes were faxed over the to the facility approximately one week after the appointment.
-The RCD was responsible to review the podiatry notes and implement any orders received.
-She did not necessarily expect the tasks communicated on the podiatry note for Resident #3 to be on his ADL tasks because the RCD entered personal care tasks on resident ADL logs based on their level of care at the facility.
-She was not sure if Resident #3 was able to provide the tasks recommended in the podiatry note himself or if he needed assistance with that care.

Telephone interview with the Administrator on 01/06/23 at 10:10am revealed:
-Resident #3's feet should have been cleaned, dried, moisturized and assessed for lesions, wounds, discoloration and fissures daily with his bath as part of his scheduled ADLs by the PCAs.
-There were no specific tasks to do these things for Resident #3 on his ADL log because she did not consider the tasks to be an order from the provider.
-She reached out to a staff member at the podiatry provider on 12/29/22 to figure out who the provider was but had not heard back yet.
-PCAs were trained to clean the feet with every bath and report any skin changes when bathing residents in the communication log that was reviewed daily by the RCD unless there was something that needed immediate attention in which the PCA would report it directly to the MA on duty.
-She was not aware that Resident #3 sometimes refused bathing and went without washing.

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D 269	Continued From page 21 -An official skin assessment was done on each resident upon admission and then monitored as needed by PCAs daily during bathing thereafter. Telephone interview with Resident #3's PCP on 01/05/23 at 3:11pm revealed she expected Resident #3 to receive foot care based on the podiatry providers expectations and documentation. Attempted telephone interview with Resident #3's podiatry provider on 01/05/23 at 4:15pm and on 01/06/23 at 8:15am and 11:05am were unsuccessful. Attempted interview with Resident #3's family member on 01/05/23 at 2:37pm and 01/06/23 at 8:21am were unsuccessful. 2. Review of Resident #1's current FL-2 dated 10/06/22 revealed: -Diagnoses included paraplegia (paralysis of the lower half of the body) and history of skin tears/blisters. -She had an indwelling urinary catheter. -She was incontinent of bowel. Review of Resident #1's September 2022 activities of daily living (ADL) log revealed: -There was an entry for advanced skin care repositioning use pillows and cushions to reposition resident every 2 hours while resident is in bed; pillows and cushions should especially be used under and between bony prominences such as between knees, under heels, under hips, under the lower neck, and under elbows; repositioning should also be done by changing which side resident is lying on or changing whether the resident is lying on their back or side scheduled for 7:00am to 3:00pm, 3:00pm to	D 269		

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11:00pm, and 11:00pm to 7:00am.
-Advanced skin care repositioning was documented every shift on 09/01/22 to 09/30/22.

Review of Resident #1's October 2022 activities of daily living (ADL) log revealed:
-There was an entry for advanced skin care repositioning use pillows and cushions to reposition resident every 2 hours while resident is in bed; pillows and cushions should especially be used under and between bony prominences such as between knees, under heels, under hips, under the lower neck, and under elbows; repositioning should also be done by changing which side resident is lying on or changing whether the resident is lying on their back or side scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am.
-Advanced skin care repositioning was documented every shift on 10/01/22 to 10/31/22.

Review of Resident #1's November 2022 activities of daily living (ADL) log revealed:
-There was an entry for advanced skin care repositioning use pillows and cushions to reposition resident every 2 hours while resident is in bed; pillows and cushions should especially be used under and between bony prominences such as between knees, under heels, under hips, under the lower neck, and under elbows; repositioning should also be done by changing which side resident is lying on or changing whether the resident is lying on their back or side scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am.
-Advanced skin care repositioning was documented every shift on 11/01/22 to 11/10/22 except on 11/08/22 at 7:00am to 3:00pm.

Review of Resident #1's home health skilled

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nursing visit note dated 09/23/22 revealed:
-Resident #1 was admitted to home health services 04/03/21 for suprapubic catheter changes.
-A recertification assessment was performed on Resident #1 on 09/23/22.
-During the recertification assessment Resident #1 was found to have an open wound on her right buttock.
-The wound to Resident #1's right buttock measured 1.9 centimeters (cm) X 0.9 cm X 0.2 cm, the wound bed was red, there was a small amount of drainage, and there was no odor to the wound.

Review of Resident #1's home health skilled nursing visit note dated 09/29/22 revealed the wound to her right buttock measured 1.2 cm X 0.5 cm X 0.1 cm, the wound bed was red, there was a small amount of drainage, and there was no odor to the wound.

Review of Resident #1's home health skilled nursing visit note dated 10/04/22 revealed the wound to her right buttock measured 0.9 cm X 0.9 cm X 0.1 cm, the wound bed was red, there was a scant amount of drainage, and there was no odor to the wound.

Review of Resident #1's home health skilled nursing visit note dated 10/10/22 revealed:
-When home health staff arrived Resident #1's catheter was leaking, and her brief was soiled.
-Home health staff performed wound care and incontinence care for Resident #1.
-Resident #1's right buttock wound had declined with increase measurements, increased drainage, and excoriation (erosion of skin tissue) to surrounding tissue.
-The wound to Resident #1's right buttock

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D 269	Continued From page 24 measured 1.3 cm X 2.0 cm X 0.2 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note dated 10/13/22 revealed: -There was a new wound to Resident #1's right upper buttock. -The wound to her right buttock was a Stage II (Wounds are staged from I to IV. A stage I pressure wound has redness present with no broken skin. A stage II pressure wound is a shallow open ulcer with a pink wound bed. A stage III pressure wound is full thickness tissue loss that exposes fat, but bone, tendon, or muscle are not exposed. A stage IV pressure wound is full thickness tissue loss with exposed bone, tendon, or muscle). -The wound to Resident #1's right buttock measured 1.3 cm X 1.9 cm X 0.2 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to her right upper buttock was a Stage II. -The wound to Resident #1's upper right buttock measured 1.1 cm X 2.1 cm X 0.2 cm, the wound bed was red, there was a scant amount of drainage, and there was not odor to the wound. Review of Resident #1's home health skilled nursing visit note dated 10/18/22 revealed: -The wound to Resident #1's lower right buttock measured 0.3 cm X 0.3 cm X 0.1 cm, the wound bed was pink, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.1 cm X 2.1 cm X 0.2 cm, the wound bed was red, there was a scant amount of drainage, and there was no odor to the wound.	D 269		

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D 269	Continued From page 25 Review of Resident #1's home health skilled nursing visit note dated 10/21/22 revealed: -The wound to Resident #1's lower right buttock measured 0.2 cm X 0.3 cm X 0.1 cm, the wound bed was pink, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.5 cm X 1.6 cm X 0.2 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note date 10/28/22 revealed: -The resident had a bowel movement in her brief which was cleaned up before wound care was performed. -The wound to Resident #1's lower right buttock measured 0.1 cm X 0.2 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.4 cm X 1.5 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note dated 11/01/22 revealed: -The wound to Resident #1's lower right buttock measured 0.1 cm X 0.2 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.4 cm X 1.5 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note dated 11/04/22 revealed: -Resident #1 had a bowel movement in her brief which was cleaned up before wound care was	D 269		

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performed.
-Resident #1's wounds were significantly bigger.
-The wound to Resident #1's lower right buttock measured 3.3 cm X 4.1 cm X 0.3 cm, the wound bed was red, there was a large amount of drainage, and there was no odor to the wound.
-The wound to Resident #1's upper right buttock measured 6.0 cm X 3.5 cm X 0.1 cm, the wound bed was red, there was a large amount of drainage, and there was no odor to the wound.
-Home health informed the facility Administrator to make sure staff was turning and repositioning Resident #1 every 2 hours to keep pressure off her right buttock constantly.

Review of Resident #1's home health skilled nursing visit note dated 11/11/22 revealed:
-The wound to Resident #1's lower right buttock measured 3.3 cm X 4.1 cm X 0.3 cm, the wound bed was black, there was a large amount of drainage, and there was a foul odor to the wound.
-The wound to Resident #1's upper right buttock measured 6.0 cm X 3.5 cm X 0.1 cm, the wound bed was black, there was a large amount of drainage, and there was a foul odor to the wound.
Resident #1's wounds had worsened, and she was sent to the emergency department (ED) for further medical treatment.

Review of Resident #1's ED to hospital admission notes revealed:
-Resident #1 was seen in the ED on 11/11/22 and noted to have a very large sacral wound with a foul odor (The sacrum is the bony prominence at the bottom of the pelvis).
-Resident #1 was admitted to the hospital for intravenous (IV) antibiotics and debridement of the wounds (Debridement is a surgical procedure to remove dead tissue from a wound).
-After Resident #1's wounds were debrided the

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lower right buttock wound measured 9 cm X 6.5 cm X 3.6 cm and the upper right buttock wound measured 8.5 cm X 4.1 cm X 1 .0 cm.
-Resident #1 needed extensive wound care and frequent repositioning.
-Resident #1 was discharged from the hospital and admitted to a skilled nursing facility (SNF) on 11/14/22.
-Resident #1's discharge diagnoses were stage IV sacral pressure ulcer, stage III right ischial (bottom of pelvis) pressure ulcer, and acute sacral osteomyelitis (Osteomyelitis is an infection in the bone).

Telephone interview with Resident #1's family member on 01/05/22 at 4:00pm revealed:
-Resident #2 was not turned and repositioned by facility staff every 2 hours while she was in bed.
-Facility staff got Resident #1 up in her wheelchair around 11:00am every day and would not put her back into bed until around 8:00pm at night.
-Resident #1 often complained to her about having to be up in her wheelchair all day.

Interview with Resident #1 on 01/05/23 at 2:11pm revealed:
-Facility staff were in and out of her room throughout the day but were not turning her every 2 hours while she was in bed.
-She would be repositioned in bed at night before going to sleep but facility staff did not come in during the night to turn or reposition her.
-Sometimes her catheter would leak, and her brief would be wet with urine.
-Since she was paraplegic, she could not feel when her brief was wet or that she had a bowel movement.
-She got up in her wheelchair every day or every other day.
-She would get up in her wheelchair around

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D 269	Continued From page 28 11:30am and would stay in her wheelchair until after dinner when the facility put residents back in bed. -She had a cushion in her wheelchair, but she would sometimes ask facility staff to put a pillow under hips while in the chair to relieve pressure on her bottom. -Facility staff put a pillow under her hips only when asked to do so by her. Interview with a personal care aide (PCA) on 01/04/23 at 4:05pm revealed: -She turned and repositioned Resident #1 every 2 hours while she was in bed. -Resident #1 had a cushion in her wheelchair. -She checked Resident #1 for incontinence every time she turned her in bed. Interview with a second PCA on 01/05/23 at 10:49am revealed: -Sometimes Resident #1's catheter leaked, and her brief would be wet with urine. -Resident #1 was also incontinent of bowel. -Resident #1 was supposed to be turned in bed every 2 hours but sometimes the resident would not let staff turn her and would lie flat on her bottom. -Resident #1 had a cushion in her wheelchair and sometimes staff would put a pillow over the cushion. -Resident #1 was up in her wheelchair for meals only and then was placed back in bed. Interview with a medication aide (MA) on 01/05/23 at 10:35am revealed: -PCAs checked on Resident #1 every 2 hours to turn her and see if her brief needed to be changed. -When she was working with Resident #1, she would go in with the PCAs to check on her.	D 269		

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Telephone interview with a second MA on 01/05/23 at 3:46pm revealed:
-Resident #1 was turned in bed every 2 hours when the resident allowed it.
-Sometimes Resident #1 would not want to be turned.
-Resident #1 got up in her wheelchair for meals but usually did not want the cushion in her wheelchair.

Telephone interview with the Resident Care Coordinator on 01/06/23 at 9:04am revealed:
-Her duties included making sure resident's ADLs such as bathing, turning, and changing were being done.
-She did spot checks to make sure ADLs were being done for residents.
-Spot checks were random and not documented and sometimes included shadowing PCAs.
-She had observed Resident #1's ADLs in the past which included bathing, getting the resident up out of bed, assisting with meals, and turning the resident every 2 hours.
-The resident could also turn herself by using her half bed rails.
-The resident liked to socialize so she would be up in her wheelchair most of the day.

Telephone interview with the Assistant Administrator on 01/06/23 at 9:41am revealed:
-She expected Resident #1 to be repositioned every 2 hours.
-Resident #1 could also help reposition herself using her bedrails.
-Resident #1 was up in her wheelchair a lot because she liked to socialize.

Interview with the Administrator on 01/04/23 at 9:00am revealed:

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D 269	Continued From page 30 -Resident #1 was paralyzed, bed bound, and required wound care by home health and the facility staff in between visits from home health to the resident twice weekly. -Resident #1 could move a little bit on her own in bed using bed rails, could self-propel when up in a wheelchair, and had an air mattress on her bed. Second telephone interview with the Administrator on 01/06/23 at 10:10am revealed: -Resident #1 had a lot of upper body strength and could turn and reposition herself. -Facility staff helped Resident #1 get up out of bed with a hoyer lift and helped reposition Resident #1 every 2 hours. -Resident #1 liked to socialize and liked to be up out of bed. -When Resident #1 was up in her wheelchair staff did not reposition her because she was able to propel herself in the wheelchair. Telephone interview with Resident #1's home health supervisor on 01/04/22 at 3:41pm revealed: -There were some instances when home health staff went to perform wound care on Resident #1, and they had to clean her up before they could change her dressing. -Resident #1 reported to home health staff that she was not being turned by facility staff and home health staff had reeducated facility staff on the importance of turning the resident every 2 hours. Telephone interview with Resident #1's primary care provider (PCP) on 01/05/23 at 3:09pm revealed: -She was not sure if Resident #1 was being turned and repositioned every 2 hours or not. -She would have expected Resident #1 to be	D 269		

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D 269	Continued From page 31 turned and repositioned every 2 hours because she had a pressure wound. -Resident #1 was placed on an alternating pressure mattress sometime in October 2022 that would help relieve pressure on her wounds if she was not being turned. Attempted telephone interview with Resident #1's friend on 01/04/23 at 4:19pm was unsuccessful. Attempted telephone interview with Resident #1's home health nurse on 01/05/23 at 8:45am and 01/06/23 at 8:35am was unsuccessful. _____ The facility failed to ensure personal care for 2 of 5 sampled residents (#1, #3) in which Resident #3 did not receive urinary catheter care per his emergency department (ED) discharge instructions, Licensed Health Professional Support (LHPS) training, and his primary care provider's (PCP's) expectations which contributed to multiple subsequent hospital ED visits on 12/13/22, 12/25/22 and a hospital admission on 01/04/23 resulting in multiple urinary tract infections (UTIs). Resident #1 did not receive wound care and repositioning every two hours as ordered by home health and per her PCP's expectations resulting in a worsening of her wound with a foul odor that resulted in a hospital admission and a subsequent discharge from the hospital to a higher level of care to a skilled nursing facility. The failure of the facility resulted in serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 received on 12/29/22 and amended on 01/05/23. THE CORRECTION DATE FOR THE TYPE A2	D 269		

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D 269	Continued From page 32 VIOLATION SHALL NOT EXCEED February 5, 2023.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION. Based on interviews and record reviews the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1, #3) in which the primary care provider (PCP) was not notified of a resident who had deterioration and worsening of a pressure wound (#1) and for a resident who required a follow-up appointment with a urology specialist and who needed daily urinary catheter care (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 10/06/22 revealed diagnoses included paraplegia (paralysis of the lower half of the body) and history of skin tears/blisters. Review of Resident #1's Resident Register revealed she was admitted to the facility on 11/02/20. Review of Resident #1's admission assessment dated 11/02/20 revealed the resident had no skin breakdown when she was admitted to the facility. Review of the facility's policy for Wound Care (not	D 273		

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dated) included:
-The RCD, SCD/Assistant Administrator, Personal Care Manager (PCM), or assigned MA would make a weekly round with the Home Health nurse (when possible) to visualize and assess the wound.
-If the wound appeared to be worsening, facility staff would document the findings and report them to the PCM, RCD, or SCD/Assistance Administrator.
-The RCD or SCD would notify the resident's PCP, if the resident's PCP was not available, the Administrator would be notified.
-There would be documentation of all phone calls and notifications including date, time of call, and with whom a message was left.
-If a message was not returned within 24-hours, the Administrator would be notified and documentation made.
-Open lines of communication regarding all calls to a resident's PCP would be made to the Home Health agency.
-An RN would document weekly on each resident with wounds and the positive or negative progression, or no changes.
-If the RN was not available, and the PCM had immediate concern, the RCD or SCD/Assistant Administrator would be notified and further action would be determined.

Review of Resident #1's activities of daily living (ADL) log for September 2022 revealed:
-There was an entry for advanced skin care daily skin monitoring examine resident's skin daily during ADLs and immediately report any concerns to a nurse such as changes in skin color, wounds, or rashes; pay close attention to bony prominence's such as the sacrum, lower neck, hips, knees, elbows, and heels scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and

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11:00pm to 7:00am.
-Advanced skin care daily skin monitoring was documented as performed every shift on 09/01/22 to 09/30/22.

Review of Resident #1's activities of daily living (ADL) log for October 2022 revealed:
-There was an entry for advanced skin care daily skin monitoring examine resident's skin daily during ADLs and immediately report any concerns to a nurse such as changes in skin color, wounds, or rashes; pay close attention to bony prominence's such as the sacrum, lower neck, hips, knees, elbows, and heels scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am.
-Advanced skin care daily skin monitoring was documented as performed every shift on 10/01/22 to 10/31/22.

Review of Resident #1's activities of daily living (ADL) log for November 2022 revealed:
-There was an entry for advanced skin care daily skin monitoring examine resident's skin daily during ADLs and immediately report any concerns to a nurse such as changes in skin color, wounds, or rashes; pay close attention to bony prominence's such as the sacrum, lower neck, hips, knees, elbows, and heels scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am.
-Advanced skin care daily skin monitoring was documented as performed every shift on 11/01/22 to 11/10/22 except on 11/08/22 from 7:00am to 3:00pm.

Review of Resident #1's personal care aide (PCA) shift communication logs for September 2022 revealed:
-On 09/05/22 under wounds/rashes/bruising for

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Resident #1 it was documented, "right bottom".
-On 09/06/22 under wounds/rashes/bruising for Resident #1 it was documented, "butt".
-On 09/09/22 under wounds/rashes/bruising for Resident #1 it was documented, "bottom".
-On 09/12/22 under wounds/rashes/bruising for Resident #1 it was documented, "bottom".
-On 09/15/22 under wounds/rashes/bruising for Resident #1 it was documented, "bottom".
-On 09/22/22 under wounds/rashes/bruising for Resident #1 it was documented, "bottom".
-On 09/28/22 under wounds/rashes/bruising for Resident #1 it was documented, "bottom".

Review of Resident #1's record revealed there were no PCA shift communication logs provided by the facility for Resident #1 for October 2022 or November 2022.

Review of Resident #1's September 2022 progress notes revealed:
-On 09/02/22, the resident had a small dime sized bruise like area with skin peeling on the back of her right thigh.
-Resident #1's primary care provider (PCP) had been notified about the area.
-There was no other documentation about Resident #1's skin status.

Review of Resident #1's home health skilled nursing visit note dated 09/23/22 revealed:
-Resident #1 was admitted to home health services 04/03/21 for suprapubic catheter changes.
-A recertification assessment was performed by home health staff on Resident #1 on 09/23/22.
-During the recertification assessment Resident #1 was found to have an open wound on her right buttock.
-Resident #1's PCP was made aware and new

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orders were obtained to treat the wound.
-The wound to her right buttock measured 1.9 centimeters (cm) X 0.9 cm X 0.2 cm.
-The wound bed was pink, there was a small amount of drainage, and there was no odor.
-Resident #1 had a goal that the wound would show signs of healing or close before 11/23/22.

Review of the facility's home health communication log dated 09/23/22 revealed a medication aide (MA) had been made aware by home health staff that Resident #1 had an open wound to her right buttock.

Review of Resident #1's prescription summary dated 09/22/22 revealed there was an order for hydrocolloid dressing "4 X 4" to affected area every other day.

Review of Resident #1's home health skilled nursing visit note dated 09/27/22 revealed:
-Wound care was performed on Resident #1.
-The wound to her right buttock measured 1.2 cm X 0.5 cm X 0.1 cm.
-The wound bed was pink, there was a small amount of drainage, and there was no odor.
-The facility was to perform wound care when home health nurses were not present.

Review of Resident #1's home health skilled nursing visit note dated 09/29/22 revealed the wound to her right buttock measured 1.2 cm X 0.5 cm X 0.1 cm, the wound bed was red, there was a small amount of drainage, and there was no odor to the wound.

Review of Resident #1's home health skilled nursing visit note dated 10/04/22 revealed:
-Resident #1's right buttock wound measured 0.9 cm X 0.9 cm X 0.1 cm.

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-The wound bed was red, there was a scant amount of drainage, and there was no odor.

Review of Resident #1's physician notification sheet for October 2022 revealed:
-On 10/09/22 a MA documented that Resident #1's bandage came off her right thigh and a new dressing had been applied.
-The physician notification from 10/09/22 was signed by Resident #1's PCP.
-There were no other physician notification sheets that addressed Resident #1's buttock wounds.

Review of Resident #1's home health skilled nursing visit note dated 10/10/22 revealed:
-Resident #1's right buttock wound measured 1.3 cm X 2.0 cm X 0.2 cm.
-The wound bed was red, there was a moderate amount of drainage, and there was no odor.
-Resident #1's wound had declined with increase measurements, increased drainage, and excoriation (erosion of skin tissue) to surrounding tissue.
-Home health notified Resident #1's PCP that the wound had worsened and received a new order for wound care to her right buttock to cleanse the wound with normal saline and apply maxsorb silver to the wound bed and cover with a foam dressing (Maxsorb silver is a dressing used to treat moderately to heavily draining wounds).
-The new dressing was to be changed daily and as needed for soiling or accidental removal.
-Facility staff was to change the dressing when home health was not available.

Review of Resident #1's home health skilled nursing visit note dated 10/13/22 revealed:
-Resident #1's right buttock wound measured 1.3 cm X 1.9 cm X 0.2 cm.
-The wound to her right buttock was a Stage II

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D 273	Continued From page 38 (Wounds are staged from I to IV. A stage I pressure wound has redness present with no broken skin. A stage II pressure wound is a shallow open ulcer with a pink wound bed. A stage III pressure wound is full thickness tissue loss that exposes fat, but bone, tendon, or muscle are not exposed. A stage IV pressure wound is full thickness tissue loss with exposed bone, tendon, or muscle). -The wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. -There was a new wound to Resident #1's right upper buttock which measured 1.1 cm X 2.1 cm X 0.2 cm. -The wound bed was red, there was a scant amount of drainage, and there was no odor. -Resident #1's PCP was contacted for wound care orders for her new wound. -The new orders were to cleanse with normal saline, apply maxsorb silver to wound bed, and cover with foam dressing. -The dressing was to be changed daily and as needed for soiling or accidental removal. -Facility staff was to change the dressing when home health was not available. Review of the facility's home health communication log dated 10/13/22 revealed a MA had been made aware of a new wound to Resident #1's right buttock. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for hydrocolloid dressing 4 X 4 apply to bilateral buttocks every three days scheduled for 7:00am to 3:00pm. -Hydrocolloid dressing 4 X 4 every 3 days was documented as performed 10/03/22, 10/06/22, and 10/09/22.	D 273		

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D 273	Continued From page 39 -There was an entry for cleanse with normal saline right buttock, apply maxsorb silver to wound bed, cover with foam dressing, change daily facility to do on days home health cannot. -Maxsorb silver dressing was documented as performed 10/11/22 to 10/31/22. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for cleanse with normal saline right buttock, apply maxsorb silver to wound bed, cover with foam dressing, change daily facility to do on days home health cannot. -Maxsorb silver dressing was documented as performed 11/01/22 to 11/10/22. Review of Resident #1's home health skilled nursing visit note dated 10/18/22 revealed: -The wound to Resident #1's lower right buttock measured 0.3 cm X 0.3 cm X 0.1 cm, the wound bed was pink, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.1 cm X 2.1 cm X 0.2 cm, the wound bed was red, there was a scant amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note dated 10/21/22 revealed: -The wound to Resident #1's lower right buttock measured 0.2 cm X 0.3 cm X 0.1 cm, the wound bed was pink, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.5 cm X 1.6 cm X 0.2 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note date 10/28/22 revealed:	D 273		

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D 273	Continued From page 40 -The wound to Resident #1's lower right buttock measured 0.1 cm X 0.2 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.4 cm X 1.5 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's October 2022 progress notes revealed there was no documentation that home health or Resident #1's PCP had been notified by the facility that her wound had gotten larger, had increased drainage, or that she developed a new wound to her right buttock. Review of Resident #1's home health skilled nursing visit note dated 11/01/22 revealed: -The wound to Resident #1's lower right buttock measured 0.1 cm X 0.2 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. -The wound to Resident #1's upper right buttock measured 1.4 cm X 1.5 cm X 0.1 cm, the wound bed was red, there was a moderate amount of drainage, and there was no odor to the wound. Review of Resident #1's home health skilled nursing visit note dated 11/04/22 revealed: -Resident #1's wounds were significantly bigger than when home health staff last saw the resident. -Resident #1's lower right buttock wound measured 3.3 cm X 4.1 cm X 0.3 cm. -The wound was a stage II. -The wound bed was red, there was a large amount of drainage, and there was no odor. -Resident #1's right upper buttock wound measured 6.0 cm X 3.5 cm X 0.1 cm. -The wound was a stage I.	D 273		

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-The wound bed was red, there was a large amount of drainage, and there was no odor.
-The facility Administrator was made aware of the findings of Resident #1's wounds and was also shown pictures of her wounds.

Interview with the Administrator on 01/04/23 at 9:00am revealed:
-Resident #1 was paralyzed, bed bound, and required wound care by home health and the facility staff in between visits from home health to the resident twice weekly.
-The facility provided wound care to Resident #1 daily when the home health nurse did not come.
-She was never notified that Resident #1's wound changed, worsened, or required a higher level of care by home health or facility staff and did not document this either, therefore Resident #1's primary care provider (PCP) was not notified either.
-Resident #1 could not feel pain due to being paralyzed and never complained of pain associated with the worsening wound.
-Resident #1 was sent to the hospital by the home health nurse from the facility after transport arrangements were made by the facility per the home health nurse's request approximately 2 months ago for further treatment of the worsening wound.
-Home health would document on a progress note at the facility after each visit, but they did not request or review the provider notes from home health until last Tuesday (12/27/22) after a discussion with the home health director.

Review of Resident #1's physician visit noted date 11/08/22 revealed:
-Resident #1 was seen for an acute visit due to two worsening wounds on her right buttock.
-She examined Resident #1's wounds.

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-Resident #1's wounds were unstageable (A wound is unstageable when the depth of the wound is obscured by slough or dead tissue in the wound).
-Resident #1's wounds had increased in size and had necrotic tissue present (Necrotic tissue is death of body tissue due to a lack of blood flow or an infection).
-Resident #1's wounds had a bad odor.
-Resident #1 was given the option of going on hospice because her wounds were significant and could be fatal.
-Resident #1 was given the option of being sent to the emergency department (ED) so the wounds could be evaluated further.
-Resident #1 was given the option of being referred to a wound clinic to evaluate and treat her wounds.
-Resident #1 opted to be referred to a wound clinic.

Review of Resident #1's home health skilled nursing visit note dated 11/11/22 revealed:
-Resident #1's lower right buttock wound measured 3.3 cm X 4.1 cm X 0.3 cm.
-The wound was unstageable.
-The wound bed was black, there was a large amount of drainage, and there was a foul odor.
-Resident #1's upper right buttock wound measured 6.0 cm X 3.5 cm X 0.1 cm.
-The wound was unstageable.
-The wound bed was black, there was a large amount of drainage, and there was a foul odor.
-Due to the condition of Resident #1's wounds she was sent to the ED by home health staff.

Review of Resident #1's November 2022 progress notes revealed there was no documentation that home health or Resident #1's PCP had been notified by the facility that her

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D 273	Continued From page 43 wounds had worsened or had a foul odor. Review of Resident #1's physician notification sheets for November 2022 revealed: -On 11/11/22 a MA documented that Resident #1 was sent to the emergency department (ED) due to home health stating her wound needed further care. -The physician notification from 11/11/22 was signed by Resident #1's PCP. -There were no other physician notification sheets that addressed Resident #1's buttock wounds. Interview with Resident #1 on 01/05/23 at 2:11pm revealed: -Facility staff must not have been doing something right because her sores died and turned black. -Facility staff should have noticed that her wounds were getting worse if they were seeing them every day. -She now resided at a SNF and was told by her PCP that the wounds were better and there had been a big change in her wounds since being admitted to the SNF. Interview with a personal care aide (PCA) on 01/05/23 at 10:49am revealed: -Changes in a resident's skin condition were reported to a MA and documented in a communication log. -PCAs documented in the communication log when they reported something to a MA. -If the MA did not address the problem PCAs would then report to the Resident Care Coordinator (RCC). -The RCC was responsible for doing a skin assessment on residents when they were admitted to the facility. -There were no routine skin assessments	D 273		

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performed on residents after that.
-Sometimes when she was providing care for Resident #1, she could see her wounds because they did not have a dressing on them.
-The wounds on Resident #1's bottom got bad and were draining a lot.
-She reported the change in Resident #1's wounds to a MA.
-She did not know when she reported this change to a MA, but it should be documented in the communication log.

Interview with a MA on 01/05/23 at 10:35am revealed:
-Resident #1 had wounds on her bottom that were being treated by home health.
-MAs performed wound care on Resident #1 on the days home health did not come to the facility.
-If Resident #1's wounds were getting worse she would notify home health staff since they were taking care of her wounds.
-If a PCA reported to her that Resident #1's wounds were worse or had an odor she would report it to facility management, call home health, and document it the resident's progress notes.
-She did not remember it being reported to her that Resident #1's wounds had worsened, and she did not recall them getting worse.

Telephone interview with a second MA on 01/05/23 at 3:46pm revealed:
-Home health was performing Resident #1's dressing changes two times a week.
-MAs performed Resident #1's dressing changes on the days that home health did not come to the facility.
-Resident #1's wound "got bad overnight" and "became wide open".
-She notified home health when Resident #1's wounds started having an odor.

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D 273	Continued From page 45 -She was not sure when that notification was done. -Communication with home health and PCPs should be documented in a resident's progress notes. Telephone interview with the RCC on 01/06/23 at 9:04am revealed: -If a PCA noticed any skin changes or any other changes with a resident they should report it to a MA. -If any skin changes or other changes were reported to a MA or a MA noticed changes themselves those changes should be reported to the RCC and the PCP. -Facility staff or home health staff had not reported any worsening of Resident #1's wounds to her until right before the resident was sent to the ED. -She would expect staff to notify her if Resident #1's wounds had worsened or had an odor. -If she had been made aware of worsening of Resident #1's wounds by facility staff she would have contacted home health or Resident #1's PCP and made them aware. Telephone interview with the Assistant Administrator on 01/06/23 at 9:41am revealed: -She mainly worked on the Special Care Unit (SCU), so she was not involved in Resident #1's day to day care. -She was stopped by a home health nurse sometime in November 2022 and was told that Resident #1's wounds had worsened. -She was not sure the exact day she was told this, but it was 1 to 2 days prior to Resident #1 being sent to the ED. -She asked the home health nurse if they had contacted Resident #1's PCP about her wounds worsening and she thought the home health	D 273		

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nurse said she was unable to reach the PCP.
-She thought the facility sent a message about her worsening wounds to Resident #1's PCP but she was not sure.
-If a PCA noticed any changes in Resident #1's skin condition it should have been reported to a MA and documented in the communication log.
-If changes were reported to a MA or if the MA noticed changes to Resident #1's wounds they should have reported it to the RCC or the PCP.

Second telephone interview with the Administrator on 01/06/23 at 10:10am revealed:
-Full body assessments were performed on residents when they were admitted to the facility.
-Resident's bodies were looked at daily when they were being changed or bathed by PCAs.
-If a PCA saw anything abnormal it should be reported to the RCC and if the RCC was not available it should be reported to a MA.
-If a change in condition was reported a physician notification sheet should be completed and sent to the PCP.
-Resident #1 started with a small rash on her bottom that progressed to a small open area.
-Resident #1 was already receiving home health services for her catheter so home health started seeing her immediately for wound care once the area was identified.
-PCAs did not perform wound care so they may not notice a change in the size of the wounds but if they noticed a foul odor, it should have been documented in the communication log.
-Communication logs were reviewed by the RCC Monday through Friday.
-She had reviewed Resident #1's October 2022 and November 2022 communication logs and there was no documentation of concerns or issues with Resident #1 for those months.
-Home health performed dressing changes on

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Resident #1 and should have reported any worsening of wounds to the PCP.
-MAs changed Resident #1's dressings on the day home health did not come to the facility.
-If a MA noticed any changes to Resident #1's wounds they should have contacted home health to make them aware.

Telephone interview with the home health supervisor on 01/04/23 at 3:41pm revealed:
-Home health was originally seeing Resident #1 because she had a suprapubic catheter that needed to be changed.
-A home health nurse noticed Resident #1's wound on her buttock when she performed a recertification assessment on the resident.
-The facility never reported changes in Resident #1's wounds to home health staff.
-She expected the facility to report any changes to Resident #1's wounds to home health staff.
-If any wound changes were reported to home health staff for Resident #1 home health staff would have come out sooner to see the resident than originally planned.
-If the home health staff came out sooner and there were changes to Resident #1's wounds it would be reported to the PCP, or the resident would be sent to the ED.

Review of a typed statement received on 01/04/23 and signed by Resident #1's PCP revealed she was not notified of Resident #1's worsening wounds until her last visit with her on 11/08/22.

Telephone interview with Resident #1's PCP on 01/05/23 at 3:09pm revealed:
-On 10/11/22, she had noted in her assessment and plan that Resident #1 had a deep tissue injury to her buttocks and that home health was

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already on board with the resident.
-If home health had reported worsening of Resident #1's wounds to the facility she expected the facility to notify her.
-If a PCA or MA noticed a change in Resident #1's wounds she expected them to notify her or home health.
-When she visited Resident #1 on 11/08/22 for a routine visit the facility then made her aware that her wounds had worsened.
-If she had been made aware by the facility that Resident #1's wounds had worsened prior to her visit on 11/08/22 she would have done a virtual visit so she could see the wounds, or she would have had the facility send her a picture of the resident's wounds.
-If the virtual visit or picture showed that Resident #1's wounds had worsened she would have sent the resident to the ED.

Review of Resident #1's ED to hospital admission notes revealed:
-Resident #1 was seen in the ED on 11/11/22 and noted to have a very large sacral wound with a foul odor (The sacrum is the bony prominence at the bottom of the pelvis).
-Resident #1 had large, necrotic wounds over her sacrum and copious foul-smelling pus could be expressed from the wounds.
-One of Resident #1's wounds had a depth that reached to the bone.
-Resident #1 was admitted to the hospital for intravenous (IV) antibiotics and debridement of the wounds (Debridement is a surgical procedure to remove dead tissue from a wound).
-After Resident #1's wounds were debrided the lower right buttock wound measured 9 cm X 6.5 cm X 3.6 cm and the upper right buttock wound measured 8.5 cm X 4.1 cm X 1 .0 cm.
-Resident #1 needed extensive wound care and

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frequent repositioning.
-Resident #1 was discharged and admitted to a skilled nursing facility (SNF) on 11/14/22.
-Resident #1 would receive 6 weeks of IV antibiotic therapy.
-Resident #1's discharge diagnoses were stage IV sacral pressure ulcer, stage III right ischial (bottom of pelvis) pressure ulcer, and acute sacral osteomyelitis (Osteomyelitis is an infection in the bone).

Attempted telephone interview with Resident #1's home health nurse on 01/05/23 at 8:45am and 01/06/23 at 8:35am was unsuccessful.

2. Review of Resident #3's current FL-2 dated 11/17/22 revealed:
-Diagnoses included congestive heart failure, bilateral leg weakness, atrial fibrillation, unsteady gait when walking, multiple falls, and decreased activities of daily living (ADLs).
-The resident was semi-ambulatory and there was an order for physical therapy 2 times per week.

Review of Resident #3's Resident Register dated 11/18/22 revealed:
-The resident was admitted to the facility on 11/22/22.
-The resident required assistance with dressing, bathing, nail care, shaving, ambulation, getting in/out of bed, toileting, skin care, and scheduling appointments.
-The resident used a walker, wheelchair, and eyeglasses.

Review of Resident #3's current care plan dated 01/03/23 revealed:
-The resident had a urinary catheter.
-The resident required the use of a wheelchair,

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walker, and physical therapy twice weekly.
-The resident had limited range of motion in his left arm
-The resident required extensive hands-on assistance with bathing, dressing, ambulation, transferring, toileting, nail care (feet and hands), and mouth care.

Review of Resident #3's ED after visit summary dated 12/13/22 revealed:
-The resident was seen with a diagnosis of problems with a Foley catheter (urinary catheter).
-There was an order for the resident to have an appointment scheduled with a urology provider (genitourinary specialist) in Virginia within 3-days.
-There was a handwritten note (author unknown) the resident was to see a urology provider due to urinary retention and that a urinary catheter had been replaced with a bigger size; there was blood noted due to the trauma of the removal and reinsertion of the bigger size.

Review of Resident #3's Incident/Accident (I/A) report dated 12/14/22 revealed:
-The resident's catheter was not draining correctly and urine was wetting the resident's bedding and clothing.
-The resident was transported via ambulance to the ED.

Review of Resident #3's ED after visit summary dated 12/14/22 revealed the resident was seen with a diagnosis of Foley catheter in place.

Review of Resident #3's facility Appointment/Referral sheet dated 12/14/22 revealed there was documentation that the resident's family member did not want him to see the urology provider in Virginia.

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Review of a telephone physician's order for Resident #3 dated 12/22/22 revealed:
-There was an order to refer the resident to a urologist.
-There was a note that the facility transporter had a copy of the order.

Review of Resident #3's I/A report dated 12/25/22 revealed:
-The resident was disoriented and had blood in his catheter.
-He was sent to the ED via ambulance for further evaluation.

Review of Resident #3's ED after visit summary dated 12/25/22 revealed the resident was seen for a diagnoses of urinary tract infection with hematuria (bloody urine).

Review of Resident #3's ED to Hospital-Admission hospital record dated 01/04/23-01/12/23 revealed:
-The resident was seen in the ED and admitted to the hospital on 01/04/23 where he was treated for a UTI and hematuria related to a indwelling urinary catheter, suspected prostatitis (inflammation of the prostate gland possibly associated with infection, injury, or immune system disorders), acute kidney injury possibly secondary to a bacterial infection, asthma, atrial fibrillation, and elevated troponin (a protein not normally found in the blood unless the heart becomes damaged, possibly related to infection, low blood volume, atrial fibrillation, and renal failure).
-There was documentation that the ED provider consulted a urologist at another hospital for guidance of care and possible transfer to treat an antibiotic resistance UTI and acute kidney injury.
-On 01/11/23, the resident was assessed by

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physical therapy and short-term rehabilitation was recommended.
-On 01/12/23, the resident remained in-patient at the hospital.

Review of Resident #3's facility Appointment/Referral sheet dated 01/03/23 revealed:
-A call was made to a local urology provider, but the appointment would be pushed out six months.
-The resident's family member was notified on 01/05/22.

Confidential interview with a medication aide (MA) on 01/05/23 (time redacted) revealed:
-Resident #3 had been complaining about the catheter burning and he had been on antibiotics for a UTI since the catheter was placed.
-Resident #3 had also been noted to have blood in his urine and was sent back to the ED several times after the catheter was placed where he was diagnosed with a UTI and urinary retention.
-Resident #3 was supposed to follow up with urology but she did not think he had an appointment yet.

Interview with the Resident Care Coordinator (RCC) on 01/04/23 at 4:48pm revealed:
-The transporter was responsible to schedule a follow up appointment for urology for Resident #3.
-She was not sure if he had an appointment yet or if the transporter had called to schedule one.

Interview with the transporter on 01/05/23 at 10:41am revealed:
-She was responsible to make Resident #3's follow-up appointment to the Urology specialist.
-She was on vacation from 12/19/22-12/27/22 and there was no one covering her duties or responsibilities for making follow-up

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appointments for residents when she was out of the office.
-She spoke with Resident #3's family member on 12/28/22 about the referral to the urologist in Virginia, but they said that was too far to pay mileage for transportation and requested an appointment somewhere close to the facility.
-She spoke to Resident #3's family member again on 01/05/23 to notify her that the urologist closer to the facility had an appointment 6 months out in May 2023.

Telephone interview with a receptionist at the urology office in Virginia on 01/05/23 at 2:40pm revealed no one had called to schedule an appointment for Resident #3 and there was no record the resident had even been seen at their office.

Telephone interview with the urology office closer to the facility on 01/05/23 at 2:53pm revealed the resident was not a patient at their practice and he did not have a future appointment scheduled.

Telephone interview with the RCD on 01/06/23 at 9:04am revealed:
-She expected the urology appointment for Resident #3 to have been made by the transporter as soon as possible and was not aware the resident did not have an appointment.
-She was aware the transporter was looking for a urologist closer to the facility.
-It was important for Resident #3 to follow up with urology to find out why he needed the catheter and to see if there was a bigger health issue or concern due to there being blood in his urine.

Telephone interview with the Assistant Administrator on 01/06/23 at 9:45am revealed:
-She was responsible when the Administrator was

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not present to oversee all departments in the facility.
-She checked in daily with direct supervisors to address any issues and to assist as needed and discussed issues every Monday in a group meeting as well.
-When a referral order was received from the hospital or an appointment, it was the MA's responsibility to make a copy of the order and give it to the transporter.
-She expected the transporter to have an appointment made after receiving the order within one business day.
-She was aware that Resident #3's family member desired an appointment closer to the facility but was not aware Resident #3 did not have an appointment to a local urology provider yet as ordered.
-It was sometimes difficult to obtain appointments to specialty providers, but it was important for him to follow up with a urologist because he had come back from the ED with a catheter.

Telephone interview with the Administrator on 01/06/23 at 10:10am revealed:
-She was aware that Resident #3's family member did not want him to go to Virginia for his original urology referral but thought the resident had an appointment scheduled with a local urology provider.
-She was not aware Resident #3 did not have an appointment with a urologist yet.
-She knew appointments at the local urology provider's office were approximately 6 months out and thought Resident #3 had an appointment some time in May 2023 scheduled.
-She expected the transporter to schedule referral appointments within 24-48 hours of receiving the referral order, but no one was expected to make appointments when the

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D 273	Continued From page 55 transporter was out on vacation. -It was important for Resident #3 to have a follow up appointment with a urologist as ordered to ensure he received the care he needed and to see if he needed to keep the catheter. Telephone interview with Resident #3's PCP on 01/05/23 at 3:11pm revealed: -She expected orders to be implemented within 48 hours of receipt by the facility. -She expected the facility to provide care within their policies and procedures. -She expected the facility to have implemented the order for Resident #3 to have an appointment for a urology referral within 5-7 days with the understanding that it could sometimes be hard to get appointments with a specialty provider. -She expected the resident to have an appointment with a urology provider by now knowing it may be a while before the resident could be seen. -She was not aware that the resident did not yet have an appointment scheduled with urology but had made a second referral for an appointment on 12/22/22 after learning the family member wanted him to follow up with a urology provider closer to the facility. -She expected to be notified if the facility was unable to obtain an appointment with a urology provider for Resident #3 in a timely manner. -It was important for Resident #3 to see a urology provider so they could assess his need for maintaining the catheter and to do a void trial to see if he was able to have the catheter discontinued. Attempted interviews with Resident #3's family member on 01/05/23 at 2:37pm and 01/06/23 at 8:21am were unsuccessful	D 273		

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D 273	Continued From page 56 The facility failed to report the deterioration and worsening of pressure wounds for Resident #1 which were deemed by the primary care provider (PCP) to be significant and potentially fatal, in which the resident had to have a surgical procedure to remove dead tissue from the wounds and was diagnosed with an infection in the bone resulting in the resident requiring a higher level of care when discharged from the hospital. The facility also failed to ensure Resident #3 received an appointment to follow-up with a urology specialist after having a urinary catheter placed on 12/13/22 for urinary retention which resulted in subsequent hospital emergency department visits on 12/14/22 and 12/25/22 with diagnosis of urinary tract infections as well as a hospital admission on 01/04/23 in which the resident was diagnosed with hematuria (blood in the urine). The failure of the facility resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/05/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2023.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	D 276		

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D 276	Continued From page 57 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure orders and tasks were implemented for 1 of 5 sampled residents (#1) including a resident who required wound care daily and as needed when home health was not able to attend to the resident (#1). The findings are: Review of Resident #1's current FL-2 dated 10/06/22 revealed diagnoses included paraplegia (paralysis of the lower half of the body) and history of skin tears/blisters. Review of Resident #1's home health skilled nursing visit note dated 09/23/22 revealed: -Resident #1 was admitted to home health services 04/03/21 for suprapubic catheter changes. -A recertification assessment was performed by home health staff on Resident #1 on 09/23/22. -During the recertification assessment Resident #1 was found to have an open wound on her right buttock. -Resident #1's PCP was made aware and new orders were obtained to treat the wound. Review of Resident #1's prescription summary dated 09/22/22 revealed there was an order for hydrocolloid dressing "4 X 4" to affected area every other day. Review of Resident #1's physician order sheet dated 09/27/22 revealed there was an order for apply hydrocolloid dressing to bilateral buttocks every 3 days.	D 276		

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D 276	Continued From page 58 Review of Resident #1's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocolloid dressing 4 X 4 apply to affected area every other day scheduled for 7:00am to 3:00pm. -Hydrocolloid dressing 4 X 4 every other day was documented as performed 09/25/22, 09/27/22, and 09/29/22. -There was an entry for hydrocolloid dressing 4 X 4 apply to bilateral buttocks every three days scheduled for 7:00am to 3:00pm. -Hydrocolloid dressing 4 X 4 every 3 days was not documented as performed. Review of Resident #1's home health skilled nursing visit notes for September 2022 revealed they performed dressing changes on Resident #1 on 09/23/22 and 09/27/22. Review of Resident #1's home health skilled nursing visit note dated 10/04/22 revealed: -Upon start of wound care for Resident #1 the wound did not have a cover over it. -Home health informed the director of the facility that facility staff needed to change the dressing when it became soiled and that she had left extra dressings in the top drawer of Resident #1's nightstand. Review of Resident #1's home health skilled nursing visit note dated 10/10/22 revealed: -Resident #1's wound had declined with increased measurements, increased drainage, and excoriation (erosion of skin tissue) to surrounding tissue. -Home health notified Resident #1's PCP that the wound had worsened and received a new order for wound care to her right buttock to cleanse the	D 276		

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wound with normal saline and apply maxsorb silver to the wound bed and cover with a foam dressing (Maxsorb silver is a dressing used to treat moderately to heavily draining wounds).
-The new dressing was to be changed daily and as needed for soiling or accidental removal.
-Facility staff was to change the dressing when home health was not available.

Review of Resident #1's home health skilled nursing visit note dated 10/13/22 revealed:
-Resident #1 had a new wound to her right upper buttock.
-Resident #1's PCP was contacted for new wound orders.
-Orders for the new wound to Resident #1's right upper buttock where cleanse with normal saline, apply maxsorb silver to wound bed, and cover with foam dressing.
-The dressing was to be changed daily and as needed for soiling or accidental removal.
-Assisted living (AL) staff could change the dressing when home health staff was not available.

Review of Resident #1's home health skilled nursing visit notes for October 2022 revealed home health staff performed Resident #1's dressing changes on 10/04/22, 10/13/22, 10/21/22, and 10/28/22.

Review of Resident #1's October 2022 eMAR revealed:
-There was an entry for hydrocolloid dressing 4 X 4 apply to bilateral buttocks every three days scheduled for 7:00am to 3:00pm.
-Hydrocolloid dressing 4 X 4 every 3 days was documented as performed 10/03/22, 10/06/22, and 10/09/22.
-There was an entry for cleanse with normal

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saline right buttock, apply maxsorb silver to wound bed, cover with foam dressing, change daily facility to do on days home health cannot.
-Maxsorb silver dressing was documented as performed 10/11/22 to 10/31/22.

Review of Resident #1's home health skilled nursing visit note dated 11/04/22 revealed:
-Resident #1's wounds were significantly bigger than when home health staff last saw the resident.
-It was noted during Resident #1's wound care that the resident only had a foam dressing on both right buttock wounds and there was no maxsorb dressings present.
-Home health staff spoke with the facility Administrator and made her aware that Resident #1's dressings were not done correctly.
-Home health staff also made sure that the facility had the correct orders for dressing changes for Resident #1 which they did.
-The Administrator stated she would speak to facility staff and make sure they were following wound care orders as written for Resident #1.

Review of Resident #1's home health skilled nursing visit note dated 11/11/22 revealed:
-Resident #1's wounds had a foul odor and a large amount of drainage.
-Home health staff sent Resident #1 to the emergency department (ED) due to the status of her wounds.

Review of Resident #1's home health skilled nursing visit notes for November 2022 revealed home health performed her wound care on 11/04/22.

Review of Resident #1's November 2022 eMAR revealed:

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-There was an entry for cleanse with normal saline right buttock, apply maxsorb silver to wound bed, cover with foam dressing, change daily facility to do on days home health cannot.
-Maxsorb silver dressing was documented as performed 11/01/22 to 11/10/22.

Interview with Resident #1 on 01/05/23 at 2:11pm revealed she did not know if the facility changed her dressings like they should because she was paralyzed and could not feel what they were doing.

Interview with a PCA on 10/05/23 at 10:49am revealed:
-There were a couple of times when she provided care for Resident #1 that she did not have a dressing on her wounds.
-When she found Resident #1 without a dressing on her wounds she reported it to the MA.

Interview with a MA on 01/05/23 at 10:35am revealed:
-Sometimes the facility would run out of supplies to change Resident #1's dressings.
-When Resident #1 ran out of wound care supplies, she would make home health staff aware when they came out to see the resident.
-Documentation of making home health staff aware should be documented in Resident #1's progress notes.
-When the facility ran out of dressings for Resident #1, she would use house stock dressings to perform wound care on the resident.

Telephone interview with a second MA on 01/05/23 at 3:46am revealed:
-The facility sometimes ran out of dressings to perform Resident #1's dressing changes.
-When the facility was out of Resident #1's

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dressings she would put a regular dressing and tape on the wounds.
-She did not think that Resident #1 ever ran out of the "silver dressing" but sometimes ran out of the foam.
-Home health staff was supposed to bring more wound care supplies for Resident #1 when they visited.
-She would always make sure to ask home health staff for more wound care supplies for Resident #1 when they came to the facility to see the resident.

Review of Resident #1's facility progress notes revealed:
-There was no documentation that Resident #1 had run out of wound care supplies.
-There was no documentation that home health had been contacted to supply more dressings for Resident #1.
-On 11/11/22 Resident #1 was sent to the emergency department (ED) for worsening of her wounds.
-On 11/14/22 Resident #1 was discharged from the facility because she was being admitted to a higher level of care for wound care and intravenous (IV) medications.

Review of Resident #1's home health communication log revealed the Administrator made home health staff aware that Resident #1 needed more supplies when they visited on 11/04/22.

Telephone interview with the Resident Care Coordinator (RCC) on 01/06/22 at 9:04am revealed:
-Home health supplied the facility with the dressings to perform Resident #1's wound care but sometimes they did not leave enough

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dressings.
-When the facility ran out of dressings for Resident #1 they would call home health and make them aware they needed more dressings.
-Home health told the facility they would bring out more dressings for Resident #1 when they came out to see her.
-When the facility ran out of dressings for Resident #1 they would use a dry dressing on the wounds.
-It was reported to Resident #1's primary care provider (PCP) that the facility ran out of dressings for the resident.
-She was not sure if it was documented that this had been reported to the PCP but if it was it would be in Resident #1's progress notes.

Telephone interview with the Assistant Administrator on 01/06/23 at 9:41am revealed:
-She was not aware that Resident #1 ever ran out of dressings until she was pulling notes from the chart for the Department of Social Services.
-She thought the Administrator had made home health aware that Resident #1 ran out of dressings to change her wound.

Interview with the Administrator on 01/04/23 at 9:00am revealed:
-Resident #1 was paralyzed, bed bound, and required wound care by home health and the facility staff in between visits from home health to the resident twice weekly.
-The facility provided wound care to Resident #1 daily when the home health nurse did not come.
-It was the home health nurse's responsibility to supply dressings for Resident #1's wounds.
-Home health did not always leave enough supplies to apply dressings to Resident #1's wounds.
-She reached out to home health to request more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070008	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERBROOKE OF ELIZABETH CITY	143 ROSEDALE DRIVE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 64	D 276		

supplies when the facility ran out and they would bring more dressings on their next scheduled visit.

Second telephone interview with the Administrator on 01/06/23 at 10:10am revealed:
-The facility frequently ran out of dressings for Resident #1.
-When the facility ran out of dressings for Resident #1, they did not leave the old dressing on her wounds but would remove the old dressing, clean the wounds, and apply a sterile non-stick dressing to the wounds.
-The facility would notify home health that they were out of dressings for Resident #1 and home health staff would bring more supplies at their next visit.
-Towards the end of Resident #1 being at the facility she spoke to a home health nurse and made her aware they needed dressings for the resident.
-She and the PCP spoke with the home health supervisor on 11/08/22 and made her aware that the facility was running out of dressings for Resident #1, and she was told home health staff would bring more dressings when they came back out to see the resident.

Telephone interview with the home health supervisor on 01/04/23 at 3:41pm revealed there were times that home health staff went to provide wound care for Resident #1, and she did not have the appropriate dressings in place.

Second telephone interview with the home health supervisor on 01/06/23 at 11:56am revealed:
-She expected the facility to call and make home health staff aware if Resident #1 was running out of wound care supplies.
-If home health staff had been made aware that

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	HAL070008	A. BUILDING: _____ B. WING _____	01/06/2023

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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
D 276	Continued From page 65 Resident #1 was running out of wound care supplies for Resident #1, they were right down the road and would have made a supply drop to the facility. -Home health had never run out of the wound care supplies that were being used for Resident #1's dressing changes so they could always supply more dressings. -She was made aware by the Administrator that Resident #1 was running out of supplies during a conversation right before the resident was sent out to the hospital because her wounds had worsened. Interview with Resident #1's PCP on 01/06/23 at 11:10am revealed: -She was never made aware by the facility that they were running out of supplies to perform Resident #1's wound care. -She expected the facility to perform wound care on Resident #1 as ordered. -If the facility was not able to perform wound care as ordered because they were out of wound care supplies she expected the facility to contact her so she could have given them orders for what to do when they were out of supplies. Attempted telephone interview with Resident #1's home health nurse on 01/05/23 at 8:45am and 01/06/23 at 8:35am was unsuccessful.	D 276		
D9999	Final Observation In accordance with the settlement agreement dated October 23, 2023 tag D269 was decreased from a Type A1 Violation to a Type A2 Violation.	D9999		